11–25–09
Vol. 74 No. 226
Book 1 of 2 Books
Pages 61501–61736

Wednesday
Nov. 25, 2009

Federal Register

The **FEDERAL REGISTER** (ISSN 0097–6326) is published daily, Monday through Friday, except official holidays, by the Office of the Federal Register, National Archives and Records Administration, Washington, DC 20408, under the Federal Register Act (44 U.S.C. Ch. 15) and the regulations of the Administrative Committee of the Federal Register (1 CFR Ch. I). The Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 is the exclusive distributor of the official edition. Periodicals postage is paid at Washington, DC.

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, 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 the issuing agency requests earlier filing. For a list of documents currently on file for public inspection, see *www.federalregister.gov.*

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

The **Federal Register** is published in paper and on 24x microfiche. It is also available online at no charge as one of the databases on GPO Access, a service of the U.S. Government Printing Office.

The online edition of the **Federal Register** *www.gpoaccess.gov/nara,* available through GPO Access, is issued under the authority of the Administrative Committee of the Federal Register as the official legal equivalent of the paper and microfiche editions (44 U.S.C. 4101 and 1 CFR 5.10). It is updated by 6 a.m. each day the **Federal Register** is published and includes both text and graphics from Volume 59, Number 1 (January 2, 1994) forward.

For more information about GPO Access, contact the GPO Access User Support Team, call toll free 1-888-293-6498; DC area 202-512-1530; fax at 202-512-1262; or via e-mail at *gpoaccess@gpo.gov.* The Support Team is available between 7:00 a.m. and 9:00 p.m. Eastern Time, Monday–Friday, except official holidays.

The annual subscription price for the **Federal Register** paper edition is $749 plus postage, or $808, plus postage, 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 $165, plus postage. Six month subscriptions are available for one-half the annual rate. The prevailing postal rates will be applied to orders according to the delivery method requested. The price of a single copy of the daily **Federal Register,** including postage, is based on the number of pages: $11 for an issue containing less than 200 pages; $22 for an issue containing 200 to 400 pages; and $33 for an issue containing more than 400 pages. Single issues of the microfiche edition may be purchased for $3 per copy, including postage. Remit check or money order, made payable to the Superintendent of Documents, or charge to your GPO Deposit Account, VISA, MasterCard, American Express, or Discover. Mail to: U.S. Government Printing Office—New Orders, P.O. Box 979050, St. Louis, MO 63197-9000; or call toll free 1-866-512-1800, DC area 202-512-1800; or go to the U.S. Government Online Bookstore site, see *bookstore.gpo.gov.*

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: 74 FR 12345.

Postmaster: Send address changes to the Superintendent of Documents, Federal Register, U.S. Government Printing Office, Washington, DC 20402, along with the entire mailing label from the last issue received.

SUBSCRIPTIONS AND COPIES

PUBLIC	
Subscriptions:	
Paper or fiche	**202–512–1800**
Assistance with public subscriptions	**202–512–1806**
General online information	**202–512–1530; 1–888–293–6498**
Single copies/back copies:	
Paper or fiche	**202–512–1800**
Assistance with public single copies	**1–866–512–1800 (Toll-Free)**
FEDERAL AGENCIES	
Subscriptions:	
Paper or fiche	**202–741–6005**
Assistance with Federal agency subscriptions	**202–741–6005**

Printed on recycled paper.

Contents

Federal Register

Vol. 74, No. 226

Wednesday, November 25, 2009

Agency for Healthcare Research and Quality
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61690–61692

Agricultural Marketing Service
PROPOSED RULES
Raisins Produced From Grapes Grown in California; Withdrawal, 61585
NOTICES
Results of Soybean Request for Referendum, 61655

Agriculture Department
See Agricultural Marketing Service

Centers for Medicare & Medicaid Services
RULES
Medicare Program:
Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B (for CY 2010), 61738–62188
NOTICES
Medicare Program:
Solicitation of Independent Accrediting Organizations to Participate in the Advanced Diagnostic Imaging Supplier Accreditation Program, 62189–62191

Civil Rights Commission
NOTICES
Meetings; Sunshine Act, 61655–61656

Commerce Department
See Foreign–Trade Zones Board
See Industry and Security Bureau
See International Trade Administration
See National Oceanic and Atmospheric Administration
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61656

Corporation for National and Community Service
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61664

Delaware River Basin Commission
NOTICES
Meeting and Public Hearing, 61664–61666

Education Department
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61666–61668

Energy Department
See Federal Energy Regulatory Commission

Environmental Protection Agency
RULES
Approval and Promulgation of Implementation Plans and Designation of Areas for Air Quality Implementation Plans:
Tennessee; Clean Air Interstate Rule, 61535–61537
Fuel Economy Regulations for Automobiles:
Technical Amendments and Corrections, 61537–61555
PROPOSED RULES
Fuel Economy Regulations for Automobiles:
Technical Amendments and Corrections, 61600–61604
NOTICES
A Framework for Categorizing the Relative Vulnerability of Threatened and Endangered Species to Climate Change, 61671–61673
Access to Confidential Business Information by Computer Sciences Corporation and Its Identified Subcontractors, 61673
Access to Confidential Business Information by Science Applications International Corporation, 61673–61674
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61675–61678
Clean Air Act Operating Permit Program:
Petition for Objection to State Operating Permit for BP Products North America, Inc., Whiting Business Unit, 61678–61679
Emergency Planning and Community Right-to-Know Act:
Contractor Access to Trade Secrets and Address Change for Submitting Trade Secret Claims, 61679
Meetings:
Clean Water Act and Federal Insecticide, Fungicide, and Rodenticide Act Common Effects Aquatic Life Assessment for Pesticides, etc., 61679–61681
Amendment of Class D and E Airspace:
Fort Stewart (Hinesville), GA, 61507
Receipt of Request to Voluntarily Cancel Pesticide Registrations:
Difenzoquat, 61681–61683
Rodenticides; Product Cancellation Order; Correction, 61683–61685
Waivers:
Gwinnett County, Gwinnett County, GA, Department of Water Resources, 61685–61686
Johnston County Department of Public Utilities (the County), North, 61687–61688

Executive Office of the President
See Presidential Documents

Federal Aviation Administration
RULES
Airworthiness Directives:
Bombardier Model DHC–8–102, DHC–8–103, DHC–8–106, et al., Airplanes, 61501–61504
McDonnell Douglas Corporation Model DC 10 10 and DC 10 10F Airplanes, et al., 61504–61506
Amendment of Class D and E Airspace:
Fort Stewart (Hinesville), GA, 61507
IFR Altitudes; Miscellaneous Amendments, 61508–61510
Revocation of Class E Airspace; Hinesville, GA, 61507–61508
NOTICES
Opportunity for Public Comment on Surplus Property Release:
Kinston Regional Jetport, Kinston, NC, 61734
Kinston Regional Jetport, Kinston, North Carolina, 61734–61735

Federal Bureau of Investigation
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61708

Federal Emergency Management Agency
RULES
Changes in Flood Elevation Determinations, 61564–61566
Final Flood Elevation Determinations, 61566–61581
Suspension of Community Eligibility, 61555–61564
PROPOSED RULES
Proposed Flood Elevation Determinations, 61604–61633
NOTICES
Disaster Declarations:
North Dakota, 61696
Puerto Rico, 61696
Meetings:
Federal Radiological Preparedness Coordinating Committee, 61696–61697

Federal Energy Regulatory Commission
RULES
Preventing Undue Discrimination and Preference in Transmission Service, 61511–61512
NOTICES
Combined Notice of Filings, 61668–61671

Federal Maritime Commission
NOTICES
Agreement Filed, 61688
Ocean Transportation Intermediary Licenses Applicants, 61688
Ocean Transportation Intermediary Licenses:
Reissuance, 61689
Revocations, 61688–61689

Federal Railroad Administration
PROPOSED RULES
Railroad Workplace Safety:
Adjacent-Controlled-Track On-Track Safety for Roadway Workers, 61633–61654

Fiscal Service
NOTICES
Rate for use in Federal Debt Collection and Discount and Rebate Evaluation, 61735

Food and Drug Administration
RULES
New Animal Drugs; Change of Sponsor, 61516–61517
Organ-Specific Warnings:
Internal Analgesic, Antipyretic, and Antirheumatic Drug Products for Over-the-Counter Human Use, etc., 61512–61516
NOTICES
Guidance for Industry:
Residual Solvents in Drug Products Marketed in the United States, 61692–61693

Foreign-Trade Zones Board
NOTICES
Application for Expansion:
Foreign-Trade Zone 61 – San Juan, Puerto Rico, 61657–61658

Health and Human Services Department
See Agency for Healthcare Research and Quality
See Centers for Medicare & Medicaid Services
See Food and Drug Administration
See National Institutes of Health
NOTICES
Meetings:
Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, 61689–61690

Homeland Security Department
See Federal Emergency Management Agency
See U.S. Customs and Border Protection

Indian Affairs Bureau
NOTICES
Kalispel Tribe of Indians Tobacco and Liquor Code, 61701–61705

Industry and Security Bureau
NOTICES
Meetings:
Regulations and Procedures Technical Advisory Committee, 61662–61663

Interior Department
See Indian Affairs Bureau
See National Park Service

Internal Revenue Service
RULES
Agreements for Payment of Tax Liabilities in Installments, 61525–61531
Guidance Under Section 2053 Regarding Post-Death Events; Correction, 61524–61525
PROPOSED RULES
Awards of Administrative Costs and Attorneys Fees:
Amendments, 61589–61596

International Trade Administration
NOTICES
Antidumping:
Circular Welded Carbon Steel Pipes and Tubes from Thailand, 61657
Sodium Hexametaphosphate from the People's Republic of China, 61656
Initiation of Antidumping and Countervailing Duty Administrative Reviews, 61658–61662

International Trade Commission
NOTICES
Investigations:
Bulk Welding Wire Containers and Components and Welding Wire, 61706–61707

Justice Department
See Federal Bureau of Investigation
See National Institute of Corrections
NOTICES
Consent Decrees:
United States v. City of Akron, Ohio and State of Ohio, 61707–61708

Labor Department
See Mine Safety and Health Administration
See Occupational Safety and Health Administration
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61708–61709

Legal Services Corporation
NOTICES
Meetings; Sunshine Act, 61711–61712

Maritime Administration
NOTICES
License Applications:
Port Dolphin Energy LLC, Port Dolphin Liquefied Natural Gas Deepwater Port, 61733–61734

Mine Safety and Health Administration
RULES
Refuge Alternatives for Underground Coal Mines, 61531

National Archives and Records Administration
NOTICES
Proposed Records Schedules:
Availability, 61712–61714

National Institute of Corrections
NOTICES
Solicitation for a Cooperative Agreement:
Employment Retention, 61708

National Institutes of Health
NOTICES
Meetings:
Center for Scientific Review, 61693, 61695
National Cancer Institute, 61693
National Institute of Allergy and Infectious Diseases, 61694–61695
National Institute of Arthritis and Musculoskeletal and Skin Diseases, 61694
National Institute of Mental Health, 61694

National Oceanic and Atmospheric Administration
RULES
Fisheries of the Exclusive Economic Zone Off Alaska:
Pacific Cod by Vessels Catching Pacific Cod for Processing by the Inshore Component in the Western Regulatory Area, etc., 61583–61584
Fraser River Sockeye and Pink Salmon Fisheries:
Inseason Orders, 61581–61583
NOTICES
Meetings:
Hydrographic Services Review Panel, 61662
Western Pacific Fishery Management Council, 61663–61664

National Park Service
PROPOSED RULES
Minerals Management, Nonfederal Oil and Gas Development, 61596–61600
NOTICES
Environmental Impact Statements; Availability, etc.:
White-tailed Deer Management Plan, Valley Forge National Historical Park, PA, 61699–61701
National Register of Historic Places:
Notification of Pending Nominations and Related Actions, 61705–61706
Weekly Listing of Historic Properties, 61706

Nuclear Regulatory Commission
NOTICES
Meetings:
ACRS Subcommittee Meeting on Regulatory Policies and Practices, 61714
ACRS Subcommittee on Digital Instrumentation and Control Systems, 61714
ACRS Subcommittee on Radiation Protection and Nuclear Materials, 61715
Proposed Generic Communications:
Inservice Inspection and Testing Requirements of Dynamic Restraints (Snubbers), 61715–61718

Occupational Safety and Health Administration
NOTICES
Meetings:
Advisory Committee on Construction Safety and Health (ACCSH) and ACCSH Work Group, 61709–61711

Postal Regulatory Commission
RULES
New Postal Products, 61531–61535
NOTICES
Post Office Closing, 61718–61719

Presidential Documents
PROCLAMATIONS
Special Observances:
National Child's Day (Proc. 8457), 62197–62198
National Family Week (Proc. 8456), 62193–62196
Thanksgiving Day (Proc. 8458), 62199–62200
EXECUTIVE ORDERS
Government Agencies and Employees:
Improper Payments in Federal Programs; Reducing (EO 13520), 62201–62205

Public Debt Bureau
See Fiscal Service

Securities and Exchange Commission
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61719–61722
Filing of Proposed Amendment to Board Rules Relating to Inspections:
Public Company Accounting Oversight Board, 61722–61726
Self-Regulatory Organizations; Proposed Rule Changes:
Financial Industry Regulatory Authority, Inc., 61727–61729
NYSE Arca, Inc., 61726–61727

State Department
RULES
Visas; Documentation of Immigrants and Nonimmigrants:
Visa Classification Symbols, 61517–61524
PROPOSED RULES
Amendment to the International Arms Traffic in Arms Regulations:
U.S. Government Transfer Programs and Foreign-Owned Military Aircraft and Naval Vessels, 61586–61589
NOTICES
Meetings:
Advisory Committee on International Law, 61729
Defense Trade Advisory Group, 61730
Notifications to the Congress of Proposed Commercial Export Licenses, 61730–61732

Transportation Department
See Federal Aviation Administration
See Federal Railroad Administration
See Maritime Administration
NOTICES
Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits Filed Under Subpart B (Formerly Subpart Q), 61732

Aviation Proceedings; Agreements Filed, 61733

Treasury Department
See Fiscal Service
See Internal Revenue Service
PROPOSED RULES
Drawback Of Internal Revenue Excise Tax, 61585–61586

U.S. Customs and Border Protection
PROPOSED RULES
Drawback Of Internal Revenue Excise Tax, 61585–61586
NOTICES
Agency Information Collection Activities; Proposals, Submissions, and Approvals, 61695–61696
Updated List of Ports-of-Entry Designated for Departure of Nonimmigrant Aliens Subject to Special Registration, 61697–61699

Separate Parts In This Issue

Part II
Health and Human Services Department, Centers for Medicare & Medicaid Services, 61738–62191

Part III
Presidential Documents, 62197–62205

Reader Aids
Consult the Reader Aids section at the end of this page for phone numbers, online resources, finding aids, reminders, and notice of recently enacted public laws.

To subscribe to the Federal Register Table of Contents LISTSERV electronic mailing list, go to http://listserv.access.gpo.gov and select Online mailing list archives, FEDREGTOC-L, Join or leave the list (or change settings); then follow the instructions.

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:
8456.....62195
8457.....62197
8458.....62199

Executive Orders:
13520.....62201

7 CFR

Proposed Rules:
989.....61585

14 CFR
39 (2 documents) 61501, 61504
71 (2 documents) 61507
95.....61508

18 CFR
37.....61511

19 CFR

Proposed Rules:
113.....61585
191.....61585

21 CFR
201.....61512
510.....61516
520.....61516
522.....61516
558.....61516

22 CFR
41.....61517
42.....61517

Proposed Rules:
126.....61586

26 CFR
20.....61524
301.....61525

Proposed Rules:
301.....61589

30 CFR
7.....61531
75.....61531

36 CFR

Proposed Rules:
9.....61576

39 CFR
3020.....61531

40 CFR
52.....61535
86.....61537
97.....61535
600.....61537

Proposed Rules:
86.....61600
600.....61600

42 CFR
410.....61737
411.....61737
414.....61737
415.....61737
485.....61737
498.....61737

44 CFR
64 (2 documents) 61555, 61561
65.....61564
67 (2 documents) 61566, 61572

Proposed Rules:
67 (3 documents) 61604, 61612, 61622

49 CFR

Proposed Rules:
214.....61633

50 CFR
300.....61581
679.....61583

Rules and Regulations

Federal Register
Vol. 74, No. 226
Wednesday, November 25, 2009

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.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2009–1072; Directorate Identifier 2009–NM–169–AD; Amendment 39–16099; AD 2008–09–25 R1]

RIN 2120–AA64

Airworthiness Directives; Bombardier Model DHC–8–102, DHC–8–103, DHC–8–106, DHC–8–201, DHC–8–202, DHC–8–301, DHC–8–311, and DHC–8–315 Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule; request for comments.

SUMMARY: We are adopting a new airworthiness directive (AD) for the products listed above that would revise an existing AD. This AD results from mandatory continuing airworthiness information (MCAI) originated by an aviation authority of another country to identify and correct an unsafe condition on an aviation product. The MCAI describes the unsafe condition as:

Bombardier Aerospace has completed a system safety review of the aircraft fuel system against fuel tank safety standards introduced in Chapter 525 of the Airworthiness Manual through Notice of Proposed Amendment (NPA) 2002–043. The identified non-compliances were then assessed using Transport Canada Policy Letter No. 525–001, to determine if mandatory corrective action is required.

The assessment showed that it is necessary to introduce Critical Design Configuration Control Limitations (CDCCL), in order to preserve critical fuel tank system ignition source prevention features during configuration changes such as modifications and repairs, or during maintenance actions. Failure to preserve critical fuel tank system ignition source prevention features could result in a fuel tank explosion. * * *

This AD requires actions that are intended to address the unsafe condition described in the MCAI.

DATES: This AD becomes effective December 10, 2009.

On June 6, 2008 (73 FR 24157, May 2, 2008), the Director of the Federal Register approved the incorporation by reference of certain publications listed in the AD.

We must receive comments on this AD by January 11, 2010.

ADDRESSES: You may send comments by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* (202) 493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–40, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this AD, contact Bombardier, Inc., 400 Côte-Vertu Road West, Dorval, Québec H4S 1Y9, Canada; telephone 514–855–5000; fax 514–855–7401; e-mail *thd.qseries@aero.bombardier.com;* Internet *http://www.bombardier.com.*

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov*; or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations office (telephone (800) 647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Mazdak Hobbi, Aerospace Engineer, Airframe and Mechanical Systems Branch, ANE–171, FAA, New York Aircraft Certification Office, 1600 Stewart Avenue, Suite 410, Westbury, New York 11590; telephone (516) 228–7330; fax (516) 794–5531.

SUPPLEMENTARY INFORMATION:

Discussion

On April 24, 2008, we issued AD 2008–09–25, Amendment 39–15506 (73 FR 24157, May 2, 2008). That AD applied to all Bombardier Model DHC–8–102, DHC–8–103, DHC–8–106, DHC–8–201, DHC–8–202, DHC–8–301, DHC–8–311, and DHC–8–315 airplanes. That AD required revising the Airworthiness Limitations section (ALS) of the Instructions for Continued Airworthiness to incorporate the critical design configuration control limitations (CDCCL) data specified in the applicable temporary revision (TR) to the applicable maintenance program manual (MPM).

CDCCLs are limitation requirements to preserve a critical ignition source prevention feature of the fuel tank system design that is necessary to prevent the occurrence of an unsafe condition. The purpose of a CDCCL is to provide instruction to retain the critical ignition source prevention feature during configuration change that may be caused by alterations, repairs, or maintenance actions. A CDCCL is not a periodic inspection.

Since we issued that AD, we have determined that it is necessary to clarify the AD's intended effect on spare and on-airplane fuel tank system components, regarding the use of maintenance manuals and instructions for continued airworthiness.

Section 91.403(c) of the Federal Aviation Regulations (14 CFR 91.403(c)) specifies the following:

> No person may operate an aircraft for which a manufacturer's maintenance manual or instructions for continued airworthiness has been issued that contains an airworthiness limitation section unless the mandatory * * * procedures * * * have been complied with.

Some operators have questioned whether existing components affected by the new CDCCLs must be reworked. We did not intend for the AD to retroactively require rework of components that had been maintained using acceptable methods before the effective date of the AD. Owners and operators of the affected airplanes therefore are not required to rework affected components identified as airworthy or installed on the affected airplanes before the required revisions of the ALS. But once the CDCCLs are incorporated into the ALS, future maintenance actions on components

must be done in accordance with those CDCCLs.

FAA's Determination

This product has been approved by the aviation authority of another country, and is approved for operation in the United States. This new AD retains the requirements of the existing AD, and adds a new note to clarify the intended effect of the AD on spare and on-airplane fuel tank system components.

Explanation of Additional Change to AD

AD 2008–09–25 allowed the use of later revisions of the ALS. That provision has been removed from this AD. Allowing the use of ''a later revision'' of specific service documents violates Office of the Federal Register policies for approving materials that are incorporated by reference. Affected operators, however, may request approval to use a later revision of the referenced service documents as an alternative method of compliance, under the provisions of paragraph (g)(1) of this AD.

Differences Between the AD and the MCAI or Service Information

We have reviewed the MCAI and related service information and, in general, agree with their substance. But we might have found it necessary to use different words from those in the MCAI to ensure the AD is clear for U.S. operators and is enforceable. In making these changes, we do not intend to differ substantively from the information provided in the MCAI and related service information.

We might also have required different actions in this AD from those in the MCAI in order to follow FAA policies. Any such differences are highlighted in a Note within the AD.

Costs of Compliance

This revision imposes no additional economic burden. The current costs for this AD are repeated for the convenience of affected operators, as follows:

We estimate that this AD will affect about 118 products of U.S. registry. We also estimate that it will take about 1 work-hour per product to comply with the basic requirements of this AD. The average labor rate is $80 per work-hour. Based on these figures, we estimate the cost of this AD to the U.S. operators to be $9,440, or $80 per product.

FAA's Justification and Determination of the Effective Date

This revision merely clarifies the intended effect on spare and on-airplane fuel tank system components, and makes no substantive change to the AD's requirements. For this reason, it is found that notice and opportunity for prior public comment for this action are unnecessary, and good cause exists for making this amendment effective in less than 30 days.

Comments Invited

This AD is a final rule that involves requirements affecting flight safety, and we did not precede it by notice and opportunity for public comment. We invite you to send any written relevant data, views, or arguments about this AD. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2009–1072; Directorate Identifier 2009–NM–169–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this AD. We will consider all comments received by the closing date and may amend this AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov*, including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this AD.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs,'' describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in ''Subtitle VII, Part A, Subpart III, Section 44701: General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this AD:

1. Is not a ''significant regulatory action'' under Executive Order 12866;

2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing amendment 39–15506 (73 FR 24157, May 2, 2008) and adding the following new AD:

2008–09–25 R1 Bombardier, Inc. (Formerly de Havilland, Inc.): Amendment 39–16099. Docket No. FAA–2009–1072; Directorate Identifier 2009–NM–169–AD.

Effective Date

(a) This airworthiness directive (AD) becomes effective December 10, 2009.

Affected ADs

(b) This AD revises AD 2008–09–25, Amendment 39–15506.

Applicability

(c) This AD applies to all Bombardier Model DHC–8–102, DHC–8–103, DHC–8–106, DHC–8–201, DHC–8–202, DHC–8–301, DHC–8–311, and DHC–8–315 airplanes, certificated in any category, all serial numbers.

Subject

(d) Air Transport Association (ATA) of America Code 28: Fuel.

Reason

(e) The mandatory continuing airworthiness information (MCAI) states:

Bombardier Aerospace has completed a system safety review of the aircraft fuel system against fuel tank safety standards introduced in Chapter 525 of the Airworthiness Manual through Notice of Proposed Amendment (NPA) 2002–043. The identified non-compliances were then assessed using Transport Canada Policy Letter No. 525–001, to determine if mandatory corrective action is required.

The assessment showed that it is necessary to introduce Critical Design Configuration Control Limitations (CDCCL), in order to preserve critical fuel tank system ignition source prevention features during configuration changes such as modifications and repairs, or during maintenance actions. Failure to preserve critical fuel tank system ignition source prevention features could result in a fuel tank explosion. Revisions have been made to Part 2 ''Airworthiness Limitations List'' of the Maintenance Program Manuals of the affected aircraft models to introduce the required CDCCL. The corrective action is revising the Airworthiness Limitations section of the Instructions for Continued Airworthiness to include the CDCCL data.

Restatement of AD 2008–09–25, With Revised Compliance Method

Actions and Compliance

(f) Unless already done, do the following actions.

(1) For all airplanes: Within 60 days after June 6, 2008 (the effective date of AD 2008–09–25), revise the Airworthiness Limitations section of the Instructions for Continued Airworthiness to incorporate the CDCCL data specified in the applicable temporary revision (TR) to the applicable maintenance program manual (MPM). The TRs are listed in Table 1 of this AD.

TABLE 1—TEMPORARY REVISIONS

Model	de Havilland TR	Maintenance program manual
DHC–8–102, DHC–8–103, and DHC–8–106 airplanes.	AWL–98, dated April 12, 2006.	Part 2, ''Airworthiness Limitations List,'' of de Havilland Dash 8 Series 100 MPM, Product Support Manual (PSM) 1–8–7.
DHC–8–201, and DHC–8–202 airplanes	AWL 2–35, dated April 12, 2006.	Part 2, ''Airworthiness Limitations List,'' of de Havilland Dash 8 Series 200 MPM, PSM 1–82–7.
DHC–8–301, DHC–8-311, and DHC–8–315 airplanes.	AWL 3–103, dated April 12, 2006.	Part 2, ''Airworthiness Limitations List,'' of de Havilland Dash 8 Series 300 MPM, PSM 1–83–7.

Note 1: The revisions required by paragraph (f)(1) of this AD may be done by inserting a copy of the applicable TR into the applicable maintenance program manual. When the TR has been included in the general revision of the maintenance program, the general revision may be inserted into the maintenance program manual, provided the relevant information in the general revision is identical to that in the applicable TR, and the temporary revision may be removed.

(2) After accomplishing the actions specified in paragraph (f)(1) of this AD, no alternative CDCCLs may be used unless the CDCCLs are approved as an alternative method of compliance (AMOC) in accordance with the procedures specified in paragraph (g)(1) of this AD.

New Information

Explanation of CDCCL Requirements

Note 2: Notwithstanding any other maintenance or operational requirements, components that have been identified as airworthy or installed on the affected airplanes before the revision of the ALS, as required by paragraph (f)(1) of this AD, do not need to be reworked in accordance with the CDCCLs. However, once the ALS has been revised, future maintenance actions on these components must be done in accordance with the CDCCLs.

FAA AD Differences

Note 3: This AD differs from the MCAI and/or service information as follows: No differences.

Other FAA AD Provisions

(g) The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, New York Aircraft Certification Office, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. Send information to ATTN: Mazdak Hobbi, Aerospace Engineer, Airframe and Mechanical Systems Branch, ANE–171, FAA, New York Aircraft Certification Office, 1600 Stewart Avenue, Suite 410, Westbury, New York 11590; telephone (516) 228–7330; fax (516) 794–5531. Before using any approved AMOC on any airplane to which the AMOC applies, notify your principal maintenance inspector (PMI) or principal avionics inspector (PAI), as appropriate, or lacking a principal inspector, your local Flight Standards District Office. The AMOC approval letter must specifically reference this AD.

(2) *Airworthy Product:* For any requirement in this AD to obtain corrective actions from a manufacturer or other source, use these actions if they are FAA-approved. Corrective actions are considered FAA-approved if they are approved by the State of Design Authority (or their delegated agent). You are required to assure the product is airworthy before it is returned to service.

(3) *Reporting Requirements:* For any reporting requirement in this AD, under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), the Office of Management and Budget (OMB) has approved the information collection requirements and has assigned OMB Control Number 2120–0056.

Related Information

(h) Refer to MCAI Canadian Airworthiness Directive CF–2008–03, dated January 3, 2008, and the TRs specified in Table 1 of this AD, for related information.

Material Incorporated by Reference

(i) You must use the service information contained in Table 2 of this AD to do the actions required by this AD, unless the AD specifies otherwise.

TABLE 2—MATERIAL INCORPORATED BY REFERENCE

de Havilland temporary revision—	Dated—	To—
AWL–98	April 12, 2006	Part 2, ''Airworthiness Limitations List,'' of de Havilland Dash 8 Series 100 Maintenance Program Manual, Product Support Manual 1–8–7.
AWL 2–35	April 12, 2006	Part 2, ''Airworthiness Limitations List,'' of de Havilland Dash 8 Series 200 Maintenance Program Manual, Product Support Manual 1–82–7.
AWL 3–103	April 12, 2006	Part 2, ''Airworthiness Limitations List,'' of de Havilland Dash 8 Series 300 Maintenance Program Manual, Product Support Manual 1–83–7.

(1) The Director of the Federal Register previously approved the incorporation by reference of this service information on June 6, 2008 (73 FR 24157, May 2, 2008).

(2) For service information identified in this AD, contact Bombardier, Inc., 400 Côte-Vertu Road West, Dorval, Québec H4S 1Y9, Canada; telephone 514–855–5000; fax 514–855–7401; e-mail *thd.qseries@aero.bombardier.com*; Internet *http://www.bombardier.com*.

(3) You may review copies of the service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington. For information on the availability of this material at the FAA, call 425–227–1221 or 425–227–1152.

(4) You may also review copies of the service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Issued in Renton, Washington, on November 16, 2009.

Stephen P. Boyd,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E9–28161 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2009–1071; Directorate Identifier 2009–NM–160–AD; Amendment 39–16100; AD 2008–06–21 R1]

RIN 2120–AA64

Airworthiness Directives; McDonnell Douglas Corporation Model DC–10–10 and DC–10–10F Airplanes, Model DC–10–15 Airplanes, Model DC–10–30 and DC–10–30F (KC–10A and KDC–10) Airplanes, Model DC–10–40 and DC–10–40F Airplanes, Model MD–10–10F and MD–10–30F Airplanes, and Model MD–11 and MD–11F Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule; request for comments.

SUMMARY: The FAA is revising an existing airworthiness directive (AD), which applies to all McDonnell Douglas Corporation airplane models identified above. That AD currently requires revising the FAA-approved maintenance program, or the Airworthiness Limitations (AWLs) section of the Instructions for Continued Airworthiness, as applicable, to incorporate new AWLs for fuel tank systems to satisfy Special Federal Aviation Regulation No. 88 requirements. For certain airplanes, this AD also requires the initial accomplishment of a certain repetitive AWL inspection to phase in that inspection, and repair if necessary. This AD clarifies the intended effect of the AD on spare and on-airplane fuel tank system components. This AD results from a design review of the fuel tank system. We are issuing this AD to prevent the potential for ignition sources inside fuel tanks caused by latent failures, alterations, repairs, or maintenance actions, which, in combination with flammable fuel vapors, could result in a fuel tank explosion and consequent loss of the airplane.

DATES: This AD is effective December 10, 2009.

On April 23, 2008 (73 FR 14673, March 19, 2008), the Director of the Federal Register approved the incorporation by reference of a certain publication listed in the AD.

We must receive any comments on this AD by January 25, 2010.

ADDRESSES: You may send comments by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, 3855 Lakewood Boulevard, MC D800 0019, Long Beach, California 90846–0001; telephone 206–544–5000, extension 2; fax 206–766–5683; e-mail *dse.boecom@boeing.com*; Internet *https://www.myboeingfleet.com*.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov*; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Office (telephone 800–647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Philip C. Kush, Aerospace Engineer, Propulsion Branch, ANM–140L, Los Angeles Aircraft Certification Office, FAA, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5263; fax (562) 627–5210.

SUPPLEMENTARY INFORMATION:

Discussion

On March 9, 2008, we issued AD 2008–06–21, Amendment 39–15433 (73 FR 14673, March 19, 2008). That AD applied to all McDonnell Douglas Model DC–10–10 and DC–10–10F airplanes, Model DC–10–15 airplanes, Model DC–10–30 and DC–10–30F (KC–10A and KDC–10) airplanes, Model DC–10–40 and DC–10–40F airplanes, Model MD–10–10F and MD–10–30F airplanes, and Model MD–11 and MD–11F airplanes. That AD required revising the FAA-approved maintenance program, or the Airworthiness Limitations (AWLs) section of the Instructions for Continued Airworthiness, as applicable, to incorporate new AWLs for fuel tank systems to satisfy Special Federal Aviation Regulation No. 88 requirements. For certain airplanes, that AD also required the initial accomplishment of a certain repetitive AWL inspection to phase in that inspection, and repair if necessary. That AD resulted from a design review of the fuel tank systems. The actions specified in that AD are intended to prevent the potential for ignition sources inside fuel tanks caused by latent failures, alterations, repairs, or maintenance actions, which, in combination with flammable fuel vapors, could result in a fuel tank explosion and consequent loss of the airplane.

Critical design configuration control limitations (CDCCLs) are limitation requirements to preserve a critical ignition source prevention feature of the fuel tank system design that is necessary to prevent the occurrence of an unsafe condition. The purpose of a CDCCL is to provide instruction to retain the critical ignition source prevention feature during configuration change that may be caused by alterations, repairs, or maintenance actions. A CDCCL is not a periodic inspection.

Actions Since AD Was Issued

Since we issued that AD, we have determined that it is necessary to clarify the AD's intended effect on spare and

on-airplane fuel tank system components, regarding the use of maintenance manuals and instructions for continued airworthiness.

Section 91.403(c) of the Federal Aviation Regulations (14 CFR 91.403(c)) specifies the following:

> No person may operate an aircraft for which a manufacturer's maintenance manual or instructions for continued airworthiness has been issued that contains an airworthiness limitation section unless the mandatory * * * procedures * * * have been complied with.

Some operators have questioned whether existing components affected by the new CDCCLs must be reworked. We did not intend for the AD to retroactively require rework of components that had been maintained using acceptable methods before the effective date of the AD. Owners and operators of the affected airplanes therefore are not required to rework affected components identified as airworthy or installed on the affected airplanes before the required revisions of the FAA-approved maintenance program, or the AWLs section, as applicable. But once the CDCCLs are incorporated into the FAA-approved maintenance program or the AWLs section, as applicable, future maintenance actions on components must be done in accordance with those CDCCLs.

FAA's Determination and Requirements of This AD

The unsafe condition described previously is likely to exist or develop on other airplanes of the same type design. For this reason, we are issuing this AD to revise AD 2008–06–21. This new AD retains the requirements of the existing AD, and adds a new note to clarify the intended effect of the AD on spare and on-airplane fuel tank system components.

Explanation of Additional Change to AD

AD 2008–06–21 allowed the use of later revisions of Appendixes B, C, and D of Report MDC–02K1003. That provision has been removed from this AD. Allowing the use of ''a later revision'' of specific service documents violates Office of the Federal Register policies for approving materials that are incorporated by reference. Affected operators, however, may request approval to use an alternative CDCCL that is part of a later revision of the referenced service documents as an alternative method of compliance, under the provisions of paragraph (l) of this AD.

Costs of Compliance

This revision imposes no additional economic burden. The current costs for this AD are repeated for the convenience of affected operators, as follows:

There are about 300 airplanes of the affected design in the worldwide fleet. This AD affects about 180 airplanes of U.S. registry. The required actions take about 1 work hour per airplane, at an average labor rate of $80 per work hour. Based on these figures, the estimated cost of the AD for U.S. operators is $14,400, or $80 per airplane.

FAA's Justification and Determination of the Effective Date

This revision merely clarifies the intended effect on spare and on-airplane fuel tank system components, and makes no substantive change to the AD's requirements. For this reason, it is found that notice and opportunity for prior public comment for this action are unnecessary, and good cause exists for making this amendment effective in less than 30 days.

Comments Invited

This AD is a final rule that involves requirements affecting flight safety, and we did not provide you with notice and an opportunity to provide your comments before it becomes effective. However, we invite you to send any written data, views, or arguments about this AD. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2009–1071; Directorate Identifier 2009–NM–160–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this AD. We will consider all comments received by the closing date and may amend this AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov*, including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this AD.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that the regulation:

1. Is not a ''significant regulatory action'' under Executive Order 12866;

2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing Amendment 39–15433 (73 FR 14673, March 19, 2008) and adding the following new AD:

2008–06–21 R1 McDonnell Douglas Corporation: Amendment 39–16100. Docket No. FAA–2009–1071; Directorate Identifier 2009–NM–160–AD.

Effective Date

(a) This airworthiness directive (AD) is effective December 10, 2009.

Affected ADs

(b) This AD revises AD 2008–06–21, Amendment 39–15433.

Applicability

(c) This AD applies to all McDonnell Douglas Corporation Model DC–10–10 and DC–10–10F airplanes, Model DC–10–15 airplanes, Model DC–10–30 and DC–10–30F (KC–10A and KDC–10) airplanes, Model DC–10–40 and DC–10–40F airplanes, Model MD–10–10F and MD–10–30F airplanes, and Model MD–11 and MD–11F airplanes; certificated in any category.

Note 1: This AD requires revisions to certain operator maintenance documents to include new inspections. Compliance with these inspections is required by 14 CFR 91.403(c). For airplanes that have been previously modified, altered, or repaired in the areas addressed by these inspections, the operator may not be able to accomplish the inspections described in the revisions. In this situation, to comply with 14 CFR 91.403(c), the operator must request approval for an alternative method of compliance (AMOC) in accordance with paragraph (l) of this AD. The request should include a description of changes to the required inspections that will ensure the continued operational safety of the airplane.

Unsafe Condition

(d) This AD results from a design review of the fuel tank systems. We are issuing this AD to prevent the potential for ignition sources inside fuel tanks caused by latent failures, alterations, repairs, or maintenance actions, which, in combination with flammable fuel vapors, could result in a fuel tank explosion and consequent loss of the airplane.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Service Information Reference

(f) The term ''Report MDC–02K1003'' as used in this AD, means the Boeing Trijet Special Compliance Item Report, MDC–02K1003, Revision C, dated July 24, 2007.

Restatement of Requirements of AD 2008–06–21, With Changes to Compliance Method

Revise the FAA-Approved Maintenance Program

(g) For Model DC–10–10 and DC–10–10F airplanes, Model DC–10–15 airplanes, Model DC–10–30 and DC–10–30F (KC–10A and KDC–10) airplanes, and Model DC–10–40 and DC–10–40F airplanes: Before December 16, 2008, revise the FAA-approved maintenance program to incorporate the information specified in Appendixes B, C, and D of Report MDC–02K1003.

Revise the Airworthiness Limitations (AWLs) Section

(h) For Model MD–10–10F and MD–10–30F airplanes, and Model MD–11 and MD–11F airplanes: Before December 16, 2008, revise the AWLs section of the Instructions for Continued Airworthiness to incorporate the information specified in Appendixes B, C, and D of Report MDC–02K1003, except that the initial inspection required by paragraph (i) of this AD must be done at the applicable compliance time specified in that paragraph.

Initial Inspection and Repair if Necessary

(i) For Model MD–11 and MD–11F airplanes: Within 60 months after April 23, 2008 (the effective date AD 2008–06–21), do a detailed inspection of the metallic overbraiding and red-wrap tape installed on the tail tank fuel quantity indication system (FQIS) wiring to verify if the metallic overbraiding or red-wrap tape is damaged or shows signs of deterioration, in accordance with ALI 20–2 of Appendix C of Report MDC–02K1003. If any discrepancy is found during the inspection, repair the discrepancy before further flight in accordance with ALI 20–2 of Appendix C of Report MDC–02K1003.

Note 2 : For the purposes of this AD, a detailed inspection is: ''An intensive examination of a specific item, installation, or assembly to detect damage, failure, or irregularity. Available lighting is normally supplemented with a direct source of good lighting at an intensity deemed appropriate. Inspection aids such as mirror, magnifying lenses, etc., may be necessary. Surface cleaning and elaborate procedures may be required.''

No Reporting Requirement

(j) Although Report MDC–02K1003 specifies to submit certain information to the manufacturer, this AD does not require that action.

No Alternative Inspections, Inspection Intervals, or Critical Design Configuration Control Limitations (CDCCLs)

(k) After accomplishing the applicable actions specified in paragraphs (g), (h), and (i) of this AD, no alternative inspections, inspection intervals, or CDCCLs may be used unless the inspections, intervals, or CDCCLs are approved as an AMOC in accordance with the procedures specified in paragraph (l) of this AD.

New Information

Explanation of CDCCL Requirements

Note 3: Notwithstanding any other maintenance or operational requirements, components that have been identified as airworthy or installed on the affected airplanes before the revision of the FAA-approved maintenance program, or the AWLs section, as required by paragraphs (g) and (h) of this AD, do not need to be reworked in accordance with the CDCCLs. However, once the FAA-approved maintenance program, or the AWLs section, as applicable, has been revised, future maintenance actions on these components must be done in accordance with the CDCCLs.

Alternative Methods of Compliance (AMOCs)

(l)(1) The Manager, Los Angeles Aircraft Certification Office (ACO), FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. Send information to ATTN: Philip C. Kush, Aerospace Engineer, Propulsion Branch, ANM–140L, FAA, Los Angeles ACO, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5263; fax (562) 627–5210.

(2) To request a different method of compliance or a different compliance time for this AD, follow the procedures in 14 CFR 39.19. Before using any approved AMOC on any airplane to which the AMOC applies, notify your principal maintenance inspector (PMI) or principal avionics inspector (PAI), as appropriate, or lacking a principal inspector, your local Flight Standards District Office. The AMOC approval letter must specifically reference this AD.

(3) AMOCs approved previously in accordance with AD 2008–06–21, Amendment 39–15433, are approved as AMOCs for the corresponding provisions of this AD.

Material Incorporated by Reference

(m) You must use Boeing Trijet Special Compliance Item Report, MDC–02K1003, Revision C, dated July 24, 2007, to do the actions required by this AD, unless the AD specifies otherwise.

(1) The Director of the Federal Register previously approved the incorporation by reference of Boeing Trijet Special Compliance Item Report, MDC–02K1003, Revision C, dated July 24, 2007, on April 23, 2008 (73 FR 14673, March 19, 2008).

(2) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, 3855 Lakewood Boulevard, MC D800 0019, Long Beach, California 90846–0001; telephone 206–544–5000, extension 2; fax 206–766–5683; e-mail *dse.boecom@boeing.com;* Internet *https://www.myboeingfleet.com.*

(3) You may review copies of the service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington. For information on the availability of this material at the FAA, call 425–227–1221 or 425–227–1152.

(4) You may also review copies of the service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Issued in Renton, Washington, on November 12, 2009.

Stephen P. Boyd,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E9–28163 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2009–0959; Airspace Docket No. 09–ASO–30]

Amendment of Class D and E Airspace; Fort Stewart (Hinesville), GA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends the Class D and E Airspace at Fort Stewart (Hinesville), GA, by changing the airport name from Fort Stewart, Wright AAF, to Wright AAF (Fort Stewart)/Midcoast Regional, Fort Stewart (Hinesville), GA. This is an administrative change and does not affect the boundaries or operating requirements of the airspace.

DATES: Effective 0901 UTC, February 11, 2010. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Melinda Giddens, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–5610.

SUPPLEMENTARY INFORMATION:

History

The Liberty County Airport in Hinesville, GA has closed and the associated Class E5 airspace has been removed. As a result, Wright AAF (Fort Stewart)/MidCoast Regional has become a joint use facility and the name of the airport will be amended to reflect this change. This rule will become effective on the date specified in the **DATES** section. Since this is an administrative change and does not affect the boundaries, altitudes, or operating requirements of the airspace, notice and public comment under 5 U.S.C. 553(b) are unnecessary. Class D and Class E airspace designations are published in paragraphs 5000 and 6005 respectively of FAA Order 7400.9T, dated August 27, 2009, and effective September 15, 2009, which is incorporated by reference in 14 CFR 71.1. The Class D and E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 changes the airport name from Fort Stewart, Wright AAF, to Wright AAF (Fort Stewart)/Midcoast Regional, Fort Stewart, Hinesville, GA.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. 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 26, 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 rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at Wright AAF (Fort Stewart)/Midcoast Regional, Fort Stewart (Hinesville), GA.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

■ In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 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.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9T, Airspace Designations and Reporting Points, signed August 27, 2009, effective September 15, 2009, is amended as follows:

Paragraph 5000 Class D Airspace

* * * * *

ASO GA D Fort Stewart (Hinesville), GA [Amended]

Wright AAF (Fort Stewart)/Midcoast Regional, GA
(Lat. 31°53′21″ N., long. 81°33′44″ W.)

That airspace extending upward from the surface up to and including 2,500 feet MSL within a 4.4-mile radius of Wright AAF (Fort Stewart)/Midcoast Regional. This Class D airspace area is effective during the specific dates and times established in advance by Notice to Airmen. The effective days and times will thereafter be continuously published in the Airport/Facility Directory.

* * * * *

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

ASO GA E5 Fort Stewart (Hinesville), GA [Amended]

Wright AAF (Fort Stewart)/Midcoast Regional, GA
(Lat. 31°53′21″ N., long. 81°33′44″ W.)

That airspace extending upward from 700 feet above the surface within a 6.6-mile radius of Wright AAF (Fort Stewart)/Midcoast Regional.

* * * * *

Issued in College Park, Georgia, on November 9, 2009.

Mark D. Ward,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. E9–28175 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2009–0960; Airspace Docket No. 09–ASO–29]

Revocation of Class E Airspace; Hinesville, GA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action removes the Class E5 Airspace at Liberty County Airport, Hinesville, GA, as the airport has closed, eliminating the need for controlled airspace.

DATES: Effective 0901 UTC, February 22, 2010. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Melinda Giddens, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–5610.

SUPPLEMENTARY INFORMATION:

History

The Liberty County Airport has closed and as a result, the associated Standard Instrument Approach Procedures (SIAPs) were withdrawn and cancelled removing the Class E5 airspace requirement at Liberty County Airport. This rule will become effective on the date specified in the **DATES** section. Since this action eliminates the impact of controlled airspace on users of the National Airspace System in the vicinity of the Liberty County Airport, notice and public procedure under 5 U.S.C. 553(b) are unnecessary. Class E airspace designations for airspace areas extending upward from 700 feet or more above the surface of the earth are published in Paragraph 6005 of FAA Order 7400.9T, signed August 27, 2009, and effective September 15, 2009, which is incorporated by reference in 14 CFR 71.1. The Class E designation listed in this document will be removed from publication subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 removes Class E5 airspace at Liberty County Airport, Hinesville, GA. Controlled airspace is no longer needed as the airport has closed.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. 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 26, 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 rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it removes controlled airspace at Liberty County Airport, Hinesville, GA.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

■ In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 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.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9T, Airspace Designations and Reporting Points, signed August 27, 2009, effective September 15, 2009, is amended as follows:

Paragraph 6005 Class E Airspace Areas Extending Upward From 700 feet or More Above the Surface of the Earth.

* * * * *

ASO GA E5 Hinesville, GA [Removed]

* * * * *

Issued in College Park, Georgia, on November 10, 2009.

Mark D. Ward,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. E9–28199 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 95

[Docket No. 30689; Amdt. No. 483]

IFR Altitudes; Miscellaneous Amendments

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts miscellaneous amendments to the required IFR (instrument flight rules) altitudes and changeover points for certain Federal airways, jet routes, or direct routes for which a minimum or maximum en route authorized IFR altitude is prescribed. This regulatory action is needed because of changes occurring in the National Airspace System. These changes are designed to provide for the safe and efficient use of the navigable airspace under instrument conditions in the affected areas.

DATES: *Effective Date:* 0901 UTC, December 17, 2009.

FOR FURTHER INFORMATION CONTACT: Harry Hodges, Flight Procedure Standards Branch (AMCAFS–420), Flight Technologies and Programs Division, Flight Standards Service, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 South MacArthur Blvd., Oklahoma City, OK 73169 (Mail Address: P.O. Box 25082, Oklahoma City, OK 73125) telephone: (405) 954–4164.

SUPPLEMENTARY INFORMATION: This amendment to part 95 of the Federal Aviation Regulations (14 CFR part 95) amends, suspends, or revokes IFR altitudes governing the operation of all aircraft in flight over a specified route or any portion of that route, as well as the changeover points (COPs) for Federal airways, jet routes, or direct routes as prescribed in part 95.

The Rule

The specified IFR altitudes, when used in conjunction with the prescribed changeover points for those routes, ensure navigation aid coverage that is adequate for safe flight operations and free of frequency interference. The reasons and circumstances that create the need for this amendment involve matters of flight safety and operational efficiency in the National Airspace System, are related to published aeronautical charts that are essential to the user, and provide for the safe and efficient use of the navigable airspace. In addition, those various reasons or

circumstances require making this amendment effective before the next scheduled charting and publication date of the flight information to assure its timely availability to the user. The effective date of this amendment reflects those considerations. In view of the close and immediate relationship between these regulatory changes and safety in air commerce, I find that notice and public procedure before adopting this amendment are impracticable and contrary to the public interest and that good cause exists for making the amendment effective in less than 30 days.

Conclusion

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. 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 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. For the same reason, the FAA certifies that this amendment will 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 95

Airspace, Navigation (air).

Issued in Washington, DC, on November 13, 2009.

John M. Allen,

Director, Flight Standards Service.

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me by the Administrator, part 95 of the Federal Aviation Regulations (14 CFR part 95) is amended as follows, effective at 0901 UTC, December 17, 2009.

PART 95—[Amended]

■ 1. The authority citation for part 95 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40106, 40113, 40114, 40120, 44502, 44514, 44719, 44721.

■ 2. Part 95 is amended to read as follows:

REVISIONS TO IFR ALTITUDES & CHANGEOVER POINTS

[Amendment 484 Effective Date December 17, 2009]

From	To	MEA
§ 95.1001 Direct Routes—U.S. Color Routes **§ 95.10 Amber Federal Airway A1 Is Added To Read**		
ABBOTSFORD, CA NDB #FOR THAT AIRSPACE OVER U.S. TERRITORY.	VICTORIA, CA NDB	#2800
§ 95.6001 Victor Routes—U.S. **§ 95.6017 VOR Federal Airway V17 Is Amended To Read in Part**		
WACO, TX VORTAC *4000—MRA **2500—MOCA	*GAINS, TX FIX	**3000
*GAINS, TX FIX *4000—MRA **5000—MRA	**BRIAN, TX FIX	3000
*BRIAN, TX FIX *5000—MRA	GLEN ROSE, TX VORTAC	3000
§ 95.6018 VOR Federal Airway V18 Is Amended To Read in Part		
LASHE, SC FIX *2200—MOCA	NORMS, SC FIX	*3000
§ 95.6020 VOR Federal Airway V20 Is Amended To Read in Part		
COLUMBUS, GA VORTAC	GRANT, GA FIX	2800
GRANT, GA FIX *2500—MOCA *2500—GNSS MEA	SMARR, GA FIX	*4000
SMARR, GA FIX *2500—MOCA *2500—GNSS MEA	SINCA, GA FIX	*4500
§ 95.6066 VOR Federal Airway V66 Is Amended To Read in Part		
CANER, GA FIX	GRANT, GA FIX	2800
GRANT, GA FIX *2500—MOCA *2500—GNSS MEA	SMARR, GA FIX	*4000
SMARR, GA FIX *2500—MOCA *2500—GNSS MEA	SINCA, GA FIX	*4500
§ 95.6155 VOR Federal Airway V155 Is Amended To Read in Part		
COLUMBUS, GA VORTAC	GRANT, GA FIX	2800

REVISIONS TO IFR ALTITUDES & CHANGEOVER POINTS—Continued

[Amendment 484 Effective Date December 17, 2009]

From	To	MEA
GRANT, GA FIX *2500—MOCA *2500—GNSS MEA	SMARR, GA FIX	*4000
SMARR, GA FIX *2500—MOCA *2500—GNSS MEA	SINCA, GA FIX	*4500
SINCA, GA FIX *3000—MRA **2400—MOCA **2400—GNSS MEA	*BEYLO, GA FIX	**5000
*BEYLO, GA FIX *3000—MRA **2100—MOCA	COLLIERS, SC VORTAC	**3000
§ 95.6166 VOR Federal Airway V166 Is Amended To Read in Part		
BELAY, MD FIX *6000—MRA	*BAINS, MD FIX	2000
§ 95.6288 VOR Federal Airway V288 Is Amended To Read in Part		
*CORIN, UT FIX *13000—MRA *16000—MCA CORIN, UT FIX, E BND **11600—MOCA **12000—GNSS MEA	FORT BRIDGER, WY VOR/DME	**16000
§ 95.6454 VOR Federal Airway V454 Is Amended To Read in Part		
COLUMBUS, GA VORTAC	GRANT, GA FIX	2800
GRANT, GA FIX *2500—MOCA *2500—GNSS MEA	SMARR, GA FIX	*4000
SMARR, GA FIX *2500—MOCA *2500—GNSS MEA	SINCA, GA FIX	*4500
§ 95.6537 VOR Federal Airway V537 Is Amended To Read in Part		
GREENVILLE, FL VORTAC *1600—MOCA *3000—GNSS MEA	MOULTRIE, GA VOR/DME	*5000
§ 95.6626 VOR Federal Airway V626 Is Added To Read		
MYTON, UT VORTAC *12600—MOCA	YMONT, UT FIX	*14000

From	To	MEA	MAA
§ 95.7001 Jet Routes **§ 95.7522 Jet Route J522 Is Amended To Read in Part**			
U.S. CANADIAN BORDER #GNSS REQUIRED ABOVE FL350.	ROCHESTER, NY VOR/DME	18000	35000

[FR Doc. E9–28200 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

18 CFR Part 37

[Docket Nos. RM05–17–005 and RM05–25–005; Order No. 890–D]

Preventing Undue Discrimination and Preference in Transmission Service

November 19, 2009.

AGENCY: Federal Energy Regulatory Commission, Energy.

ACTION: Order on Clarification.

SUMMARY: The Federal Energy Regulatory Commission affirms its basic determinations in Order Nos. 890, 890–A, 890–B, and 890–C, granting clarification regarding certain revisions to its regulations and the *pro forma* open-access transmission tariff, or OATT, adopted in Order Nos. 888 and 889 to ensure that transmission services are provided on a basis that is just, reasonable, and not unduly discriminatory. The Commission grants clarification regarding the requirement to undesignate network resources used to serve off-system sales.

DATES: *Effective Date:* This rule will become effective November 25, 2009.

FOR FURTHER INFORMATION CONTACT: Christina Hayes, Office of the General Counsel—Energy Markets, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. (202) 502–6194.

SUPPLEMENTARY INFORMATION:

Before Commissioners: Jon Wellinghoff, Chairman; Suedeen G. Kelly, Marc Spitzer, and Philip D. Moeller.

Order on Clarification

1. On February 16, 2007, the Commission issued Order No. 890,[1] addressing and remedying opportunities for undue discrimination under the *pro forma* Open Access Transmission Tariff (OATT) adopted in Order No. 888.[2] The *pro forma* OATT was intended to foster greater competition in wholesale power markets by reducing barriers to entry in the provision of transmission service. In the twelve years since Order No. 888, however, flaws in the *pro forma* OATT undermined, in part, its ability to realize the core objective of remedying undue discrimination. The Commission acted in Order No. 890 to correct these flaws by reforming the terms and conditions of the *pro forma* OATT in several critical areas, including the calculation of available transfer capability (ATC), the planning of transmission facilities, and the conditions of services offered by each transmission provider.

2. In Order Nos. 890–A, 890–B, and 890–C, the Commission largely affirmed the reforms adopted in Order No. 890. The Commission concluded that, taken together, these reforms will better enable the *pro forma* OATT to achieve the core objective of remedying undue discrimination in the provision of transmission service. In Order No. 890–C, the Commission granted clarification regarding the degree of consistency required in the calculation of ATC by transmission providers and denied rehearing regarding the requirement to undesignate network resources used to serve off-system sales. Duke Energy Corporation (Duke) has sought clarification of the latter determination.

I. Reforms of the OATT

A. Designation of Network Resources

3. In Order No. 890–C, the Commission affirmed the requirement that network resources used to supply sales of system power off-system must first be undesignated.[3] The Commission explained that transactions in which the buyer and seller are both located on the same transmission system are distinct from transactions involving sales of energy from a network customer to an off-system buyer. In the latter circumstance, the off-system buyer will not be using network service to take delivery from the host transmission provider but, instead, must identify the points of receipt and delivery for the transaction on the host transmission provider's system. The Commission stated that the point-to-point transmission reservation and the corresponding resource-specific undesignation provide the transmission provider with the information it needs regarding the location of particular resources being used by the seller to source the transaction in order to model the effect of the transaction on its transmission system and set aside ATC accordingly.

Request for Clarification

4. Duke argues that the Commission's determination in Order No. 890–C is inconsistent with the *pro forma* OATT and Order No. 888. Duke contends that Order No. 890–C indicates that network customers purchasing system power from an off-system seller cannot take network service from the off-system seller's transmission provider, but instead must procure point-to-point service from the transmission system on which the off-system seller is located. Duke asserts that this is inconsistent with section 31.3 of the *pro forma* OATT, which permits network loads of network customers to not be physically interconnected with the transmission provider from whom they take network service. Duke notes that the Commission has acknowledged in prior cases that, although not generally used for through-and-out service, network service can be used to serve loads on neighboring transmission systems.[4] Duke seeks confirmation that, where an off-system buyer is buying system power from a seller that is a network customer on an adjacent transmission system, the off-system buyer needs transmission service on both the system on which the seller is located and the system on which the buyer is located, but that it remains the choice of the buyer as to whether to procure network or point-to-point service.

5. If the Commission confirms that an off-system buyer is permitted to take network service from both transmission providers, Duke questions whether the seller needs to undesignate specific generating resources or whether it can undesignate a slice of its system. Duke contends that resource-specific undesignations are needed only if the buyer is using point-to-point service on the transmission system on which the seller is located for delivery, not if the off-system buyer takes network service on that system.[5] Duke suggests that, where the buyer is a network customer on both transmission systems, the reason for requiring resource-specific

[1] *Preventing Undue Discrimination and Preference in Transmission Service,* Order No. 890, 72 FR 12266 (March 15, 2007), FERC Stats. & Regs. ¶ 31,241, *order on reh'g,* Order No. 890–A, 73 FR 2984 (January 16, 2008), FERC Stats. & Regs. ¶ 31,261 (2007), *order on reh'g,* Order No. 890–B, 123 FERC ¶ 61,299 (2008), *order on reh'g and clarification,* Order No. 890–C, 126 FERC ¶ 61,228 (2009).

[2] *Promoting Wholesale Competition Through Open Access Non-Discriminatory Transmission Services by Public Utilities; Recovery of Stranded Costs by Public Utilities and Transmitting Utilities,* Order No. 888, 61 FR 21540 (May 10, 1996), FERC Stats. & Regs. ¶ 31,036 (1996), *order on reh'g,* Order No. 888–A, 62 FR 12274 (Mar. 14, 1997), FERC Stats. & Regs. ¶ 31,048 (1997), *order on reh'g,* Order No. 888–B, 81 FERC ¶ 61,248 (1997), *order on reh'g,* Order No. 888–C, 82 FERC ¶ 61,046 (1998), *aff'd in relevant part sub nom. Transmission Access Policy Study Group* v. *FERC,* 225 F.3d 667 (DC Cir. 2000) (*TAPS* v. *FERC*), *aff'd sub nom. New York* v. *FERC,* 535 U.S. 1 (2002).

[3] *See* Order No. 890–C, 126 FERC ¶ 61,228 at P 17 (*citing* Order No. 890–B, 123 FERC ¶ 61,299 at P 206).

[4] Duke Request for Clarification (*citing Midwest Indep. Trans. System Operator, Inc.,* 109 FERC ¶ 61,168, at P 80 (2004)).

[5] Duke Request for Clarification at 4–5 (*citing* Order No. 890–C, 126 FERC ¶ 61,228 at P 18).

undesignation by the seller is eliminated. Duke requests clarification that a slice of system undesignation by the seller would be appropriate in such circumstances.

Commission Determination

6. We confirm that, where an off-system buyer is buying system power from a seller that is a network customer on an adjacent transmission system, the buyer needs transmission service on both the system on which the seller is located and the system on which buyer is located, but that it remains the buyer's choice as to whether to procure network or point-to-point service. The Commission's reference in Order No. 890–C to the use of point-to-point service to take delivery of system power was not intended to restrict the buyer's choice to instead use network service. As Duke notes, there may be a situation in which a buyer and seller of capacity from a network resource both take network service on the same transmission system and the power is delivered under section 31.3 of the *pro forma* OATT to another transmission system on which the buyer's network load is located. In such a situation, both the buyer and seller of power are network customers of the transmission system on which the sale of power takes place. We clarify, to the extent necessary, that the seller in such a situation may support the transaction by undesignating its resources on a system basis.

7. In Order No. 890–C, the Commission noted that the Reliability Standards governing the calculation of ATC were pending Commission review. Concurrent with this order, the Commission in Docket No. RM08–19–000 is directing the North American Electric Reliability Corporation (NERC) to develop modifications to certain of these Reliability Standards to address the modeling of network resources and its impact on the calculation of ATC. To the extent Duke or other parties have concerns regarding the appropriate modeling of network resource designations on the calculation of ATC, the Commission encourages those parties to raise their concerns in NERC's standards development process.

II. Information Collection Statement

8. The Office of Management and Budget (OMB) regulations require that OMB approve certain information collection requirements imposed by an agency.[6] The revisions to the information collection requirements for transmission providers adopted in Order No. 890 were approved under OMB Control Nos. 1902–0233. This order does not substantively alter those requirements. OMB approval of this order is therefore unnecessary. However, the Commission will send a copy of this order to OMB for informational purposes only.

III. Document Availability

9. In addition to publishing the full text of this document in the **Federal Register,** the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the Internet through FERC's Home Page (*http://www.ferc.gov*) and in FERC's Public Reference Room during normal business hours (8:30 a.m. to 5 p.m. Eastern time) at 888 First Street, NE., Room 2A, Washington DC 20426.

10. From FERC's Home Page on the Internet, this information is available on eLibrary. The full text of this document is available on eLibrary in PDF and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number excluding the last three digits of this document in the docket number field.

11. User assistance is available for eLibrary and the FERC's Web site during normal business hours from FERC Online Support at 202–502–6652 (toll free at 1–866–208–3676) or e-mail at *ferconlinesupport@ferc.gov,* or the Public Reference Room at (202) 502–8371, TTY (202) 502–8659. E-mail the Public Reference Room at *public.referenceroom@ferc.gov.*

IV. Effective Date and Congressional Notification

12. This order does not substantively alter the requirements of Order Nos. 890, 890–A, 890–B or 890–C and, therefore, will become effective as of the date of publication in the **Federal Register.**

By the Commission.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–28216 Filed 11–24–09; 8:45 am]

BILLING CODE 6717–01–P

[6] 5 CFR 1320 (2007).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 201

[Docket No. FDA–1977–N–0013] (formerly Docket No. 1977–N–0094L)

RIN 0910–AF36

Organ-Specific Warnings; Internal Analgesic, Antipyretic, and Antirheumatic Drug Products for Over-the-Counter Human Use; Final Monograph; Technical Amendment

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule; technical amendment.

SUMMARY: The Food and Drug Administration (FDA) is amending a final rule that appeared in the **Federal Register** of April 29, 2009 (74 FR 19385) (as amended in the **Federal Register** of June 30, 2009 (74 FR 31177). The final rule requires important new organ-specific warnings and related labeling for over-the-counter (OTC) internal analgesic, antipyretic, and antirheumatic (IAAA) drug products. The new labeling informs consumers about the risk of liver injury when using acetaminophen and the risk of stomach bleeding when using nonsteroidal anti-inflammatory drugs (NSAIDs). This document is intended to clarify some provisions in the final rule which may be unclear. Specifically, this document addresses how blister cards can be labeled to comply with the new required labeling, clarifies the length of time that the ''See new warnings'' flag is required to appear in the labeling, and provides some optional wording to clarify the liver injury warning on OTC acetaminophen products containing multiple active ingredients.

DATES: *Effective Date*: This final rule is effective April 29, 2010.

Compliance Date: The compliance date for all products subject to this final rule, including products with annual sales less than $25,000, is April 29, 2010.

FOR FURTHER INFORMATION CONTACT: Arlene Solbeck, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 22, rm. 5411, Silver Spring, MD 20993–0002, 301–796–2090.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is amending the final rule that was published in the **Federal Register** of

April 29, 2009, (the April 29, 2009, final rule) which requires important new organ-specific warnings and related labeling for OTC IAAA drug products. The new labeling informs consumers about the risk of liver injury when using acetaminophen and the risk of stomach bleeding when using NSAIDs. After the April 29, 2009, final rule was published, we received feedback from manufacturers stating that some of the requirements in the final rule are unclear (Refs. 1 and 2). We are amending the final rule to address these issues raised by the submissions (see section II of this document). One issue involves the liver injury and stomach bleeding warnings that must appear on immediate container labeling. Another issue concerns the posting of a ''See new warnings'' flag on the principal display panel (PDP) of the retail packaging. The third issue concerns the wording of the first bulleted statement in the liver injury warning.

Publication of this document constitutes final action on the change under the Administrative Procedures Act (5 U.S.C. 553). This technical amendment merely clarifies the intent of the final rule with respect to the three minor issues raised in the submissions. FDA therefore, for good cause shown, has determined that notice and public comment are unnecessary under 5 U.S.C. 553(b)(3)(B).

II. April 29, 2009, Final Rule Requirements Being Addressed in This Document

A. Immediate Container Labeling

In the final rule, we require that the new liver injury and stomach bleeding warnings appear on the outer and the immediate container of the retail packaging, where applicable (§ 201.326(a)(1)(iii)(A), (a)(1)(iv)(A)(*1*), (a)(1)(v)(A), (a)(2)(iii)(A), (a)(2)(iv)(A)(*1*), and (a)(2)(v)(A) (21 CFR 201.326(a)(1)(iii)(A), (a)(1)(iv)(A)(*1*), (a)(1)(v)(A), (a)(2)(iii)(A), (a)(2)(iv)(A)(*1*), and (a)(2)(v)(A)). We received feedback from manufacturers seeking clarification of these final rule requirements for blister card packaging (Ref. 1). We did not intend for the final rule to require liver injury or stomach bleeding warnings to appear on each blister unit on a blister card. Rather, we believe it is acceptable that the appropriate warning appear on the blister card in one place, as long as the warning stays intact and readable when drug product is removed from the blister card. Therefore, in this document, we are stating explicitly that the liver injury and stomach bleeding warnings are not required to appear on each blister unit of a blister card, as long as the appropriate warning appears on the blister card and remains intact and readable when drug is removed from the blister card. These modifications appear in § 201.326(a)(1)(iii)(A), (a)(1)(iv)(A)(*1*), (a)(1)(v)(A), (a)(2)(iii)(A), (a)(2)(iv)(A)(*1*), and (a)(2)(v)(A) in the regulatory text of this document.

We also received feedback that certain immediate containers, such as stick packs and sachets, also present space limitations for labeling and that we should not require the liver injury and stomach bleeding warnings to appear on these immediate container packages (Ref 1). We do not agree that these types of immediate containers should be exempt from the requirements in the final rule. Although these packages have limited labeling space, we believe that there is adequate space to accommodate the required warnings on these types of packages. We are also concerned that consumers may routinely remove these packages from the outer carton and, therefore, fail to see the liver injury and stomach bleeding warnings if they are only printed on the carton. For these reasons, we are not exempting these types of immediate containers from the final rule requirements.

B. ''See New Warnings'' Flag

In the April 29, 2009, final rule, we require a ''See new warnings'' flag on the PDP of all OTC drug products containing acetaminophen or NSAIDs to advise consumers of the new required warnings. In the final rule, we state that ''we will require that the 'See New Warnings' flag appear on the PDP for one year after the final rule is published, rather than for the 6 or 9 months suggested by the submission'' (74 FR 19385 at 19388). We explained that ''we continue to believe that educating consumers about the risks associated with OTC IAAA drug products is very important and more likely to be successful if the flag remains on products for 1 year'' (74 FR 19385 at 19388 through 19389). In § 201.326(b) (21 CFR 201.326(b)), the final rule states: ''The labeling of any drug product subject to this section that is initially introduced or initially delivered for introduction into interstate commerce before the effective date and within 12 months after the effective date of the final rule must bear on its PDP, as defined in § 201.60, the statement 'See new warnings information.'''

We intended this provision to require that the ''See new warnings'' statement appear on the PDPs of all OTC drug products containing acetaminophen or NSAIDs that are introduced into interstate commerce by the effective date of the final rule (i.e., by April 29, 2010). We did not intend to require the ''See new warnings'' statement for those products that are introduced into interstate commerce after the final rule effective date. We also intended the provision to require that the statement remain on the label for at least 1 year from the time the product is introduced into interstate commerce. We did not intend to require that the statement remain on the label for any longer than the 1-year period from the time of introduction into interstate commerce. For example, if the ''See new warnings'' flag is included on the PDP of a product introduced into interstate commerce 6 months after publication of the final rule (i.e., October 29, 2009), then the flag must remain on the PDP for a full year (i.e., until October 29, 2010). To make this requirement clear, we are modifying § 201.326(b) in the regulatory text of this document.

C. Liver Injury Warning for OTC Acetaminophen Products Containing Multiple Active Ingredients

In the April 29, 2009, final rule, we require a liver injury warning for all OTC drug products containing acetaminophen. The introductory sentence and first bulleted statement of this warning state: ''This product contains acetaminophen. Severe liver damage may occur if you take [bullet] more than the [insert maximum number of daily dosage units] in 24 hours, which is the maximum daily amount * * *''. Our intention was that the warning would prevent consumers from taking more than 4 grams (g) of an OTC acetaminophen product daily, the proposed maximum safe daily dose for OTC acetaminophen. After the final rule was published, we received feedback from manufacturers of OTC acetaminophen products who were concerned that consumers may be confused about the warning on OTC acetaminophen containing multiple active ingredients (e.g., cold-cold/analgesic combination products) (Refs. 1 and 2). For some combination products, the maximum number of daily dosage units may be limited by an active ingredient other than acetaminophen in the products. In such cases, the maximum number of daily dosage units result in a maximum daily dose of acetaminophen which is significantly below 4 g. To clarify that the maximum number of daily dosage units may not be the maximal daily dose of acetaminophen, we are allowing the optional statement ''for this product'' at the end of the first bulleted statement: ''more than [insert maximum number of daily dosage units] in 24 hours, which

is the maximum daily amount'' [optional: ''for this product'']. We agree with manufacturers that this revision will clarify the warning for OTC acetaminophen products containing multiple active ingredients.

III. Request for Enforcement Discretion

We received feedback requesting that we exercise enforcement discretion for manufacturers of OTC combination acetaminophen products so that they could revise the first bulleted statement of the liver injury warning to clarify that the maximum number of daily dosage units may not be the maximal daily dose of acetaminophen for those products (Ref. 2). As discussed in section II.C of this document, we are allowing the optional statement ''for this product'' at the end of the first bulleted statement: ''more than [insert maximum number of daily dosage units] in 24 hours, which is the maximum daily amount.'' The request asked us to exercise enforcement discretion until we revise this bulleted statement in the final rule. Because we are amending this bulleted statement in this document, the request that we exercise enforcement discretion is no longer applicable.

IV. Analysis of Impacts

We have examined the impacts of this rule under Executive Order 12866 and the Regulatory Flexibility Act (5 U.S.C. 601–612), and the Unfunded Mandates Reform Act of 1995 (Public Law 104–4). 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). We believe that this rule is not a significant regulatory action 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. Our April 29, 2009, final rule requires important new organ-specific warnings (i.e., liver injury and stomach bleeding warnings) and related labeling for OTC drug products containing acetaminophen and NSAIDs to advise consumers of potential risks and when to consult a doctor (74 FR 19385). We are amending the final rule in this document to clarify some of the labeling requirements specified in the final rule. Three amendments are being made. One amendment specifies that manufacturers of OTC acetaminophen and NSAID drug products are not required to put the liver injury or stomach bleeding warning on each blister unit of a blister card as long as the appropriate warning appears on the blister card and remains intact and readable when drug is removed from the blister card (§ 201.326(a)(1)(iii)(A), (a)(1)(iv)(A)(*1*), (a)(1)(v)(A), (a)(2)(iii)(A), (a)(2)(iv)(A)(*1*), and (a)(2)(v)(A)). The second amendment specifies that the ''See new warnings'' flag (§ 201.326(b)) must remain on the label for at least 1 year from the time the manufacturer puts the statement on the PDP. The third amendment clarifies the liver injury warning on OTC acetaminophen products containing multiple active ingredients. We examined the impacts of the amended labeling requirements described in this document when we developed the April 29, 2009, final rule. We determined that the final rule would not have a significant impact on a substantial number of small entities. Because this amendment does not add any new requirements that were not considered in developing the final rule, we do not believe this rule will have a significant economic impact on a substantial number of small entities.

Section 202(a) of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare a written statement, which includes an assessment of anticipated costs and benefits, before proposing ''any rule that includes any Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any one year.'' The current threshold after adjustment for inflation is $133 million, using the most current (2008) Implicit Price Deflator for the Gross Domestic Product. We do not expect the final rule as amended to result in any 1-year expenditure that would meet or exceed this amount.

V. Paperwork Reduction Act of 1995

We conclude that the labeling requirements in this document are not subject to review by the Office of Management and Budget because they do not constitute a ''collection of information'' under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). Rather, the labeling statements are a ''public disclosure of information originally supplied by the Federal government to the recipient for the purpose of disclosure to the public'' (5 CFR 1320.3(c)(2)).

VI. Environmental Impact

We have determined under 21 CFR 25.31(a) 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.

VII. Federalism

FDA has analyzed this final rule in accordance with the principles set forth in Executive Order 13132. Section 4(a) of the Executive order requires agencies to ''construe * * * a Federal statute to preempt State law only where the statute contains an express preemption provision or there is some other clear evidence that the Congress intended preemption of State law, or where the exercise of State authority conflicts with the exercise of Federal authority under the Federal statute.'' The sole statutory provision giving preemptive effect to the final rule is section 751 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379r).

We believe that we have complied with all of the applicable requirements under the Executive order and have determined that the preemptive effects of this rule are consistent with Executive Order 13132.

VIII. References

The following references have been placed on display in the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852 and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday.

1. FDA–1977–N–0013–0039.
2. FDA–1977–N–0013–0040.

List of Subjects in 21 CFR Part 201

Drugs, Labeling, Reporting and recordkeeping requirements.

■ Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, 21 CFR part 201, (as added in the **Federal Registers** of April 29, 2009, and amended June 30, 2009), is amended as follows:

PART 201—LABELING

■ 1. The authority citation for 21 CFR part 201 continues to read as follows:

Authority: 21 U.S.C. 321, 331, 351, 352, 353, 355, 358, 360, 360b, 360gg–360ss, 371, 374, 379e; 42 U.S.C. 216, 241, 262, 264.

■ 2. Section 201.326, (as added at 74 FR 19385, April 29, 2009, and amended at 74 FR 31177, June 30, 2009) is further amended by revising paragraphs (a)(1)(iii)(A), (a)(1)(iv)(A)(*1*), (a)(1)(v)(A), (a)(2)(iii)(A), (a)(2)(iv)(A)(*1*), (a)(2)(v)(A), and (b) to read as follows:

§ 201.326 Over-the-counter drug products containing internal analgesic/antipyretic active ingredients; required warnings and other labeling.

(a) * * *

(1) * * *

(iii) * * *

(A) The liver warning states ''Liver warning [heading in bold type]: This product contains acetaminophen. Severe liver damage may occur if you take [bullet] more than [insert maximum number of daily dosage units] in 24 hours, which is the maximum daily amount [optional: 'for this product'] [bullet] with other drugs containing acetaminophen [bullet] 3 or more alcoholic drinks every day while using this product''. This ''Liver'' warning must be the first warning under the ''Warnings'' heading. For products that contain both acetaminophen and aspirin, this ''Liver'' warning must appear after the ''Reye's syndrome'' and ''Allergy alert'' warnings in § 201.66(c)(5)(ii)(A) and (c)(5)(ii)(B) and before the ''Stomach bleeding'' warning in paragraph (a)(2)(iii)(A) of this section. If there is an outer and immediate container of a retail package, this warning must appear on both the outer and immediate containers. If the immediate container is a blister card, the warning must appear on the blister card and remain intact and readable when drug product is removed from the blister card. The warning does not need to be included on each blister unit.

* * * * *

(iv) * * *

(A) * * *

(*1*) The liver warning states ''Liver warning [heading in bold type]: This product contains acetaminophen. Severe liver damage may occur if your child takes [bullet] more than 5 doses in 24 hours, which is the maximum daily amount [optional: 'for this product'] [bullet] with other drugs containing acetaminophen''. This ''Liver'' warning must be the first warning under the ''Warnings'' heading. If there is an outer and immediate container of a retail package, this warning must appear on both the outer and immediate containers. If the immediate container is a blister card, the warning must appear on the blister card and remain intact and readable when drug product is removed from the blister card. The warning is not required to be included on each blister unit.

* * * * *

(v) * * *

(A) The liver warning states ''Liver warning [heading in bold type]: This product contains acetaminophen. Severe liver damage may occur if [bullet] adult takes more than [insert maximum number of daily dosage units] in 24 hours, which is the maximum daily amount [optional: 'for this product'] [bullet] child takes more than 5 doses in 24 hours [bullet] taken with other drugs containing acetaminophen [bullet] adult has 3 or more alcoholic drinks everyday while using this product.'' If there is an outer and immediate container of a retail package, this warning must appear on both the outer and immediate containers. If the immediate container is a blister card, the warning must appear on the blister card and remain intact and readable when drug product is removed from the blister card. The warning is not required to be included on each blister unit.

* * * * *

(2) * * *

* * * * *

(iii) * * *

(A) The stomach bleeding warning states ''Stomach bleeding warning [heading in bold type]: This product contains an NSAID, which may cause severe stomach bleeding. The chance is higher if you [bullet] are age 60 or older [bullet] have had stomach ulcers or bleeding problems [bullet] take a blood thinning (anticoagulant) or steroid drug [bullet] take other drugs containing prescription or nonprescription NSAIDs (aspirin, ibuprofen, naproxen, or others) [bullet] have 3 or more alcoholic drinks every day while using this product [bullet] take more or for a longer time than directed''. This ''Stomach bleeding'' warning must appear after the ''Reye's syndrome'' and ''Allergy alert'' warnings in § 201.66(c)(5)(ii)(A) and (c)(5)(ii)(B). For products that contain both acetaminophen and aspirin, the acetaminophen ''Liver'' warning in paragraph (a)(1)(iii) of this section must appear before the ''Stomach bleeding'' warning in this paragraph. If there is an outer and immediate container of a retail package, this warning must appear on both the outer and immediate containers. If the immediate container is a blister card, the warning must appear on the blister card and remain intact and readable when drug product is removed from the blister card. The warning is not required to be included on each blister unit.

* * * * *

(iv) * * *

(A) * * *

(*1*) The stomach bleeding warning states ''Stomach bleeding warning [heading in bold type]: This product contains an NSAID, which may cause severe stomach bleeding. The chance is higher if your child [bullet] has had stomach ulcers or bleeding problems [bullet] takes a blood thinning (anticoagulant) or steroid drug [bullet] takes other drugs containing prescription or nonprescription NSAIDs (aspirin, ibuprofen, naproxen, or others) [bullet] takes more or for a longer time than directed''. The ''Stomach bleeding'' warning must appear after the ''Reye's syndrome'' and ''Allergy alert'' warnings in § 201.66(c)(5)(ii)(A) and (c)(5)(ii)(B). If there is an outer and immediate container of a retail package, this warning must appear on both the outer and immediate containers. If the immediate container is a blister card, the warning must appear on the blister card and remain intact and readable when drug product is removed from the blister card. The warning is not required to be included on each blister unit.

* * * * *

(v) * * *

(A) The Stomach bleeding warning states ''Stomach bleeding warning [heading in bold type]: This product contains an NSAID, which may cause severe stomach bleeding. The chance is higher if the user [bullet] has had stomach ulcers or bleeding problems [bullet] takes a blood thinning (anticoagulant) or steroid drug [bullet] takes other drugs containing prescription or nonprescription NSAIDs (aspirin, ibuprofen, naproxen, or others) [bullet] takes more or for a longer time than directed [bullet] is age 60 or older [bullet] has 3 or more alcoholic drinks everyday while using this product''. The ''Stomach bleeding'' warning must appear after the ''Reye's syndrome'' and ''Allergy alert'' warnings in § 201.66(c)(5)(ii)(A) and (c)(5)(ii)(B). If there is an outer and immediate container of a retail package, this warning must appear on both the outer and immediate containers. If the immediate container is a blister card, the warning must appear on the blister card and remain intact and readable when drug product is removed from the blister card. The warning is not required to be included on each blister unit.

* * * * *

(b) *New warnings information statement.* The labeling of any drug product subject to this section that is initially introduced or initially delivered for introduction into interstate commerce before or on April 29, 2010, must bear on its PDP, as defined in § 201.60, the statement ''See new warnings information''. This statement must appear highlighted (e.g., fluorescent or color contrast) or in bold type, be in lines generally parallel to the base on which the package rests as it is designed to be displayed, and be in one

of the following sizes, whichever is greater:

(1) At least one-quarter as large as the size of the most prominent printed matter on the PDP, or

(2) At least as large as the size of the ''Drug Facts'' title, as required in § 201.66(d)(2). The new warnings information statement must remain on the PDP of the drug product for at least 1 year from the date the product is initially introduced into interstate commerce.

* * * * *

Dated: November 17, 2009.

David Horowitz,

Assistant Commissioner for Policy.

[FR Doc. E9–28296 Filed 11–24–09; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 510, 520, 522, and 558

[Docket No. FDA–2009–N–0665]

New Animal Drugs; Change of Sponsor

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the animal drug regulations to reflect a change of sponsor for 29 new animal drug applications (NADAs) and 2 abbreviated new animal drug applications (ANADAs) from Intervet, Inc., to Schering-Plough Animal Health Corp.

DATES: This rule is effective November 25, 2009.

FOR FURTHER INFORMATION CONTACT: David R. Newkirk, Center for Veterinary Medicine (HFV–100), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855, 240–276–8307, e-mail: *david.newkirk@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION: Intervet, Inc., P.O. Box 318, 29160 Intervet Lane, Millsboro, DE 19966, has informed FDA that it has transferred ownership of, and all rights and interest in, the following 29 approved NADAs and 2 approved ANADAs to Schering-Plough Animal Health Corp., 556 Morris Ave., Summit, NJ 07901: NADA 034–478, 034–621, 045–188, 102–380, 104–494, 111–278, 120–648, 121–473, 128–620, 131–310, 131–675, 132–872, 137–600, 138–612, 139–189, 140–856, 140–897, 140–927, 140–954, 140–992, 141–222, 141–236, 141–258, 141–269, 141–276, 141–278, 141–280, 141–282, 141–286; ANADA 200–134 and 200–239. Accordingly, the agency is amending the regulations in 21 CFR parts 520, 522 (21 CFR part 522), and 558 to reflect the transfer of ownership. In addition, § 522.1081 is being revised to reflect a current format.

Following these changes of sponsorship, Intervet, Inc., is no longer the sponsor of an approved application. Accordingly, 21 CFR 510.600(c) is being amended to remove the entries for Intervet, Inc.

This rule does not meet the definition of ''rule'' in 5 U.S.C. 804(3)(A) because it is a rule of ''particular applicability.'' Therefore, it is not subject to the congressional review requirements in 5 U.S.C. 801–808.

List of Subjects

21 CFR Part 510

Administrative practice and procedure, Animal drugs, Labeling, Reporting and recordkeeping requirements.

21 CFR Parts 520 and 522

Animal drugs.

21 CFR Part 558

Animal drugs, Animal feeds.

■ Therefore, under the Federal Food, Drug and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, 21 CFR parts 510, 520, 522, and 558 are amended as follows:

PART 510—NEW ANIMAL DRUGS

■ 1. The authority citation for 21 CFR part 510 continues to read as follows:

Authority: 21 U.S.C. 321, 331, 351, 352, 353, 360b, 371, 379e.

§ 510.600 [Amended]

■ 2. In § 510.600, in the table in paragraph (c)(1), remove the entry for ''Intervet, Inc.''; and in the table in paragraph (c)(2), remove the entry for ''057926''.

PART 520—ORAL DOSAGE FORM NEW ANIMAL DRUGS

■ 3. The authority citation for 21 CFR part 520 continues to read as follows:

Authority: 21 U.S.C. 360b.

§ 520.48 [Amended]

■ 4. In paragraph (b) of § 520.48, remove ''057926'' and in its place add ''000061''.

§ 520.905a [Amended]

■ 5. In paragraph (b) of § 520.905a, remove ''057926'' and in its place add ''000061''.

§ 520.905b [Amended]

■ 6. In paragraph (b) of § 520.905b, remove ''057926'' and in its place add ''000061''.

§ 520.905c [Amended]

■ 7. In paragraph (b) of § 520.905c, remove ''057926'' and in its place add ''000061''.

§ 520.905d [Amended]

■ 8. In paragraph (b)(1) of § 520.905d, remove ''057926'' and in its place add ''000061''.

§ 520.905e [Amended]

■ 9. In paragraph (b) of § 520.905e, remove ''057926'' and in its place add ''No. 000061''.

§ 520.1010 [Amended]

■ 10. In paragraph (b)(2) of § 520.1010, remove ''057926'' and in its place add ''000061''.

§ 520.1200 [Amended]

■ 11. In paragraph (b) of § 520.1200, remove ''057926'' and in its place add ''000061''.

PART 522—IMPLANTATION OR INJECTABLE DOSAGE FORM NEW ANIMAL DRUGS

■ 12. The authority citation for 21 CFR part 522 continues to read as follows:

Authority: 21 U.S.C. 360b.

§ 522.246 [Amended]

■ 13. In paragraph (b)(3) of § 522.246, remove ''057926'' and in its place add ''000061''.

§ 522.1010 [Amended]

■ 14. In paragraph (b)(4) of § 522.1010, remove ''057926'' and in its place add ''000061''.

§ 522.1078 [Amended]

■ 15. In paragraph (b) of § 522.1078, remove ''Nos. 050604, 057926, and 059130'' and in its place add ''Nos. 000061, 050604, and 059130''.

§ 522.1079 [Amended]

■ 16. In paragraph (b) of § 522.1079, remove ''057926'' and in its place add ''000061''.

■ 17. Revise § 522.1081 to read as follows:

§ 522.1081 Chorionic gonadotropin.

(a) *Specifications.* Each vial contains 5,000, 10,000 or 20,000 USP units of lyophilized powder for constitution with accompanying diluent to a 10-milliliter solution.

(b) *Sponsors.* See sponsors in § 510.600(c) of this chapter for use as in paragraph (d) of this section.

(1) Nos. 000402 and 053501 for use as in paragraphs (d)(1)(i)(A), (d)(1)(i)(B) and (d)(1)(i)(C) of this section.

(2) Nos. 058639 and 063323 for use as in paragraphs (d)(1)(i)(A) and (d)(1)(i)(B) of this section.

(3) No. 000061 for use as in paragraphs (d)(1)(i)(A) and (d)(2) of this section.

(c) *Related tolerances.* See § 556.304 of this chapter.

(d) *Conditions of use*—(1) *Cattle*—(i) *Amount.* As a single dose. Dosage may be repeated in 14 days if the animal's behavior or examination of the ovaries *per rectum* indicates retreatment.

(A) 10,000 USP units by intramuscular injection.

(B) 500 to 2,500 USP units by intrafollicular injection.

(C) 2,500 to 5,000 USP units by intravenous injection.

(ii) *Indications for use.* For parenteral use in cows for treatment of nymphomania (frequent or constant heat) due to cystic ovaries.

(iii) *Limitations.* Federal law restricts this drug to use by or on the order of a licensed veterinarian.

(2) *Finfish*—(i) *Amount.* 50 to 510 IU per pound of body weight for males, 67 to 1,816 IU per pound of body weight for females, by intramuscular injection. Up to three doses may be administered.

(ii) *Indications for use.* An aid in improving spawning function in male and female brood finfish.

(iii) *Limitations.* In fish intended for human consumption, the total dose administered per fish (all injections combined) should not exceed 25,000 IU chorionic gonadotropin. Federal law restricts this drug to use by or on the order of a licensed veterinarian.

§ 522.1160 [Amended]

■ 18. In paragraph (b) of § 522.1160, remove ''057926'' and in its place add ''000061''.

§ 522.2476 [Amended]

■ 19. In paragraph (a)(2) of § 522.2476, remove ''057926'' and in its place add ''000061''.

§ 522.2477 [Amended]

■ 20. In paragraph (b)(2) of § 522.2477, remove ''057926'' and in its place add ''000061''.

PART 558—NEW ANIMAL DRUGS FOR USE IN ANIMAL FEEDS

■ 21. The authority citation for 21 CFR part 558 continues to read as follows:

Authority: 21 U.S.C. 360b, 371.

§ 558.258 [Amended]

■ 22. In paragraph (b) of § 558.258, remove ''057926'' and in its place add ''000061''; and in the tables in paragraphs (e)(1) through (e)(5), in the ''Sponsor'' column, remove ''057926'' where it occurs and in its place add ''000061''.

§ 558.665 [Amended]

■ 23. In paragraph (b) of § 558.665, remove ''057926'' and in its place add ''000061''; and in the table in paragraph (e), in the ''Sponsor'' column, remove ''057926'' where it occurs and in its place add ''000061''.

Dated: November 19, 2009.

Steven D. Vaughn,

Director, Office of New Animal Drug Evaluation, Center for Veterinary Medicine.

[FR Doc. E9–28217 Filed 11–24–09; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF STATE

22 CFR Parts 41 and 42

[Public Notice 6798]

Visas: Documentation of Immigrants and Nonimmigrants—Visa Classification Symbols

AGENCY: State Department.

ACTION: Final rule.

SUMMARY: The Department is amending its regulations to add new classification symbols to the immigrant and nonimmigrant classification tables. This amendment is necessary to implement legislation that created additional immigrant and nonimmigrant classifications as described herein. Additionally, the Department is amending or removing existing classifications that have changed as a result of new legislation or the expiration of legislative provisions that had temporarily authorized them.

DATES: This rule is effective November 25, 2009.

FOR FURTHER INFORMATION CONTACT: Emily C. Cooperman, Legislation and Regulations Division, Visa Services, U.S. Department of State, Washington, DC 20520–0106, phone (202) 663–1203.

SUPPLEMENTARY INFORMATION:

Which new immigrant classification symbol is being added?

A new immigrant classification for qualifying family members of U1 Nonimmigrant Victim of Criminal Activity, adjustment of status cases for: Spouse, SU2; Child, SU3; and Parent, SU5.

What is the background for the new immigrant classifications (SU2, SU3, SU5) for qualifying family members of U1 Nonimmigrants?

Under INA 245(m)(3), upon approval of adjustment of the status of a U1 principal alien, the Secretary of Homeland Security may approve a petition for an immigrant visa for a spouse (SU2), a child (SU3), or in the case of an alien child, a parent (SU5) who did not receive a nonimmigrant visa under section 101(a)(15)(U)(ii) if the Secretary of Homeland Security considers such approval necessary to avoid extreme hardship. To request approval of immigrant visa status for such a relative, the principal alien must file with U.S. Citizenship and Immigration Services (USCIS) a Form I–929, Petition for Qualifying Family Member of a U1 Nonimmigrant. Upon approval of the petition, beneficiaries may apply for an immigrant visa at a visa processing post overseas.

Which immigrant classification is being amended due to new legislation?

Certain Iraqis (and Afghanis) employed by or on behalf of the United States Government in Iraq (and Afghanistan), SQ1; Spouse SQ2 and Child SQ3.

What is the background for the amended immigrant visa classifications SQ1, SQ2, SQ3?

In addition to Iraqis employed by or on behalf of the United States Government in Iraq, section 1244 of Public Law 110–181, section 602(b) of Division F, Title IV, of the Omnibus Appropriations Act, 2009, Public Law 111–8, authorizes SQ1 status for an Afghan national who has been employed by or on behalf of the United States Government in Afghanistan on or after October 7, 2001, for a period of not less than one year; has provided faithful and valuable service to the United States Government, which is documented in a positive recommendation or evaluation from the alien's senior supervisor; has been determined by the Chief of Mission (COM) or the COM's designee to have experienced, or be experiencing an ongoing serious threat as a consequence of the employment by or on behalf of the U.S. Government. Further, the alien must clear a background check and appropriate screening as determined by the Department of Homeland Security, be otherwise eligible to receive an immigrant visa, and be otherwise admissible to the United States for permanent residence, except that, in the determination of such admissibility, the

grounds for inadmissibility specified in INA 212(a)(4) (8 U.S.C. 1182(a)(4)) relating to ''public charge'' shall not apply.

Which nonimmigrant classification symbols are being added?

The new nonimmigrant classification symbols are for: Temporary Commonwealth of the Northern Mariana Islands (CNMI)-only transitional workers (CW1, CW2); and Long-Term Investors in the Commonwealth of the Northern Mariana Islands (E2C).

What is the background for the new nonimmigrant classification (CW1 & CW2) for a CNMI transitional worker?

The Department of Homeland Security (DHS) created a new, temporary, CNMI-only transitional worker classification (CW) in accordance with title VII of the Consolidated Natural Resources Act of 2008 (CNRA), Public Law 110–229, that will be implemented beginning November 28, 2009. The transitional worker program is intended to provide for an orderly transition from the CNMI permit system to the U.S. federal immigration system under the INA. A CW transitional worker is an alien worker who is ineligible for another classification under the INA and who performs services or labor for an employer in the CNMI. The CNRA imposes a five-year transition period before the INA requirements become fully applicable in the CNMI. The new CW classification (CW1 for principal transitional workers and CW2 for dependents) will be in effect for the duration of the transition period, unless extended by the Secretary of Labor.

What is the background for the new nonimmigrant classification (E2C CNMI) for a nonimmigrant investor?

The Department of Homeland Security is amending its regulations governing E2 nonimmigrant treaty investors to establish procedures for classifying long-term investors in the CNMI as E2C nonimmigrants. The DHS rule implements the CNMI nonimmigrant investor visa provisions of the CNRA extending the immigration laws of the United States to the CNMI. Among the CNMI-specific provisions applicable during the five-year transition period is a provision authorizing the Secretary of Homeland Security to classify an alien foreign investor in the CNMI as a CNMI-only E2C nonimmigrant investor under section 101(a)(15)(E)(ii) of the INA. This status is provided upon application of the alien and notwithstanding the treaty requirements otherwise applicable. Eligible investors are those who: were admitted to the CNMI in long-term investor status under CNMI immigration law before the transition program effective date; have continuously maintained residence in the CNMI under long-term investor status; are otherwise admissible to the United States under the INA; and maintain the investment(s) that formed the basis for the CNMI long-term investor status.

Why is the Department amending and removing the age restrictions for the T4 & T5 Nonimmigrant visa classes?

Section 201 of the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008, Public Law 110–457, amended section 101(a)(15)(T)(ii) of the INA to provide for T4 and T5 derivative status for any accompanying or following to join parent or unmarried sibling under the age of 18 of an alien who has been accorded T1 status as a victim of trafficking if the Secretary of Homeland Security determines that the parent or sibling faces a present danger of retaliation as a result of the victim's escape from the severe form of trafficking or cooperation with law enforcement. This provision applies without regard to the age of the T1 principal, and is in addition to existing authority in INA 101(a)(15)(T)(ii)(I) for T4 and T5 status for accompanying or following to join parents and unmarried siblings under age 18 of a principal alien who was under the age of 21 as of the date of the principal's application for T1 status. If the principal alien was under the age of 21 at the time of his or her application for T1 status, the parents and any unmarried sibling under 18 who are accompanying or following to join the principal would be entitled to T4 and T5 classification without a DHS determination that they face a present danger of retaliation.

What Classifications are being removed?

The Nonimmigrant Visa class ''Irish Peace Process Program Participant;'' Q2, and the Spouse or Child of the Q2, Q3.

Why are the Q2 and Q3 Classifications being removed?

Section 1(d) of Public Law 108–449 repealed the ''Irish Peace Process Cultural and Training Program Act of 1998, Public Law 105–319, effective October 1, 2008.

Regulatory Findings

Administrative Procedure Act

This regulation involves a foreign affairs function of the United States and, therefore, in accordance with 5 U.S.C. 553(a)(1), is not subject to the rule making procedures set forth at 5 U.S.C. 553.

Regulatory Flexibility Act/Executive Order 13273: Small Business

Because this final rule is exempt from notice and comment rulemaking under 5 U.S.C. 553, it is exempt from the regulatory flexibility analysis requirements set forth at sections 603 and 604 of the Regulatory Flexibility Act (5 U.S.C. 603 and 604). Nonetheless, consistent with section 605(b) of the Regulatory Flexibility Act (5 U.S.C. 605(b)), the Department certifies that this rule will not have a significant economic impact on a substantial number of small entities. This regulates individual aliens who seek consideration for immigrant and nonimmigrant visas and does not affect any small entities, as defined in 5 U.S.C. 601(6).

The Unfunded Mandates Reform Act of 1995

Section 202 of the Unfunded Mandates Reform Act of 1995, Public Law 104–4, 109 Stat. 48, 2 U.S.C. 1532, generally requires agencies to prepare a statement before proposing any rule that may result in an annual expenditure of $100 million or more by State, local, or tribal governments, or by the private sector. This rule will not result in any such expenditure, nor will it significantly or uniquely affect small governments.

The Small Business Regulatory Enforcement Fairness Act of 1996

This rule is not a major rule as defined by 5 U.S.C. 804, for purposes of congressional review of agency rulemaking under the Small Business Regulatory Enforcement Fairness Act of 1996, Public Law 104–121. This rule will not result in an annual effect on the economy of $100 million or more; a major increase in costs or prices; or adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based companies to compete with foreign-based companies in domestic and import markets.

Executive Order 12866

The Department of State has reviewed this rule to ensure its consistency with the regulatory philosophy and principles set forth in Executive Order 12866 and has determined that the benefits of the regulation justify its costs. The Department does not consider the rule to be an economically significant action within the scope of section 3(f)(1) of the Executive Order

since it is not likely to have an annual effect on the economy of $100 million or more or to adversely affect in a material way the economy, a sector of the economy, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities.

Executive Orders 12372 and 13132: Federalism

This regulation will not have substantial direct effects on the States, on the relationship between the national government and the States, or the distribution of power and responsibilities among the various levels of government. Nor will the rule have federalism implications warranting the application of Executive Orders No. 12372 and No. 13132.

Executive Order 12988: Civil Justice Reform

The Department has reviewed the regulations in light of sections 3(a) and 3(b)(2) of Executive Order No. 12988 to eliminate ambiguity, minimize litigation, establish clear legal standards, and reduce burden.

Paperwork Reduction Act

This rule does not impose information collection requirements under the provisions of the Paperwork Reduction Act, 44 U.S.C. Chapter 35.

List of Subjects

22 CFR Part 41

Aliens, Foreign Officials, Immigration, Nonimmigrants, Passports and Visas.

22 CFR Part 42

Immigration, Passports, Visas.

■ For the reasons stated in the preamble, the Department of State amends 22 CFR Parts 41 and 42 as follows:

PART 41—[AMENDED]

■ 1. The authority citation for Part 41 continues to read as follows:

Authority: 8 U.S.C. 1104; Pub. L. 105–277, 112 Stat. 2681–795 through 2681–801.

■ 2. Revise § 41.12 to read as follows:

§ 41.12 Classification symbols.

A visa issued to a nonimmigrant alien within one of the classes described in this section shall bear an appropriate visa symbol to show the classification of the alien. The symbol shall be inserted in the space provided on the visa. The following visa symbols shall be used:

NONIMMIGRANTS

Symbol	Class	Section of law
A1	Ambassador, Public Minister, Career Diplomat or Consular Officer, or Immediate Family.	101(a)(15)(A)(i).
A2	Other Foreign Government Official or Employee, or Immediate Family	101(a)(15)(A)(ii).
A3	Attendant, Servant, or Personal Employee of A1 or A2, or Immediate Family	101(a)(15)(A)(iii).
B1	Temporary Visitor for Business	101(a)(15)(B).
B2	Temporary Visitor for Pleasure	101(a)(15)(B).
B1/B2	Temporary Visitor for Business & Pleasure	101(a)(15)(B).
C1	Alien in Transit	101(a)(15)(C).
C1/D	Combined Transit and Crewmember Visa	101(a)(15)(C) and (D).
C2	Alien in Transit to United Nations Headquarters District Under Sec. 11.(3), (4), or (5) of the Headquarters Agreement.	101(a)(15)(C).
C3	Foreign Government Official, Immediate Family, Attendant, Servant or Personal Employee, in Transit.	212(d)(8).
CW1	Commonwealth of Northern Mariana Islands Transitional Worker	Section 6(d) of Pub. L. 94–241, as added by sec. 702(a) of Pub. L. 110–229.
CW2	Spouse or Child of CW1	Section 6(d) of Pub. L. 94–241, as added by sec. 702(a) of Pub. L. 110–229.
D	Crewmember (Sea or Air)	101(a)(15)(D).
E1	Treaty Trader, Spouse or Child	101(a)(15)(E)(i).
E2	Treaty Investor, Spouse or Child	101(a)(15)(E)(ii).
E2C	Commonwealth of Northern Mariana Islands Investor, Spouse or Child	Section 6(c) of Pub. L. 94–241, as added by sec. 702(a) of Pub. L. 110–229.
E3	Australian Treaty Alien coming to the United States Solely to Perform Services in a Specialty Occupation.	101(a)(15)(E)(iii).
E3D	Spouse or Child of E3	101(a)(15)(E)(iii).
E3R	Returning E3	101(a)(15)(E)(iii).
F1	Student in an academic or language training program	101(a)(15)(F)(i).
F2	Spouse or Child of F1	101(a)(15)(F)(ii).
F3	Canadian or Mexican national commuter student in an academic or language training program.	101(a)(15)(F)(iii).
G1	Principal Resident Representative of Recognized Foreign Government to International Organization, Staff, or Immediate Family.	101(a)(15)(G)(i).
G2	Other Representative of Recognized Foreign Member Government to International Organization, or Immediate Family.	101(a)(15)(G)(ii).
G3	Representative of Nonrecognized or Nonmember Foreign Government to International Organization, or Immediate Family.	101(a)(15)(G)(iii).
G4	International Organization Officer or Employee, or Immediate Family	101(a)(15)(G)(iv).
G5	Attendant, Servant, or Personal Employee of G1 through G4, or Immediate Family.	101(a)(15)(G)(v).
H1B	Alien in a Specialty Occupation (Profession)	101(a)(15)(H)(i)(b).
H1B1	Chilean or Singaporean National to Work in a Specialty Occupation	101(a)(15)(H)(i)(b1).
H1C	Nurse in health professional shortage area	101(a)(15)(H)(i)(c).

NONIMMIGRANTS—Continued

Symbol	Class	Section of law
H2A	Temporary Worker Performing Agricultural Services Unavailable in the United States.	101(a)(15)(H)(ii)(a).
H2B	Temporary Worker Performing Other Services Unavailable in the United States	101(a)(15)(H)(ii)(b).
H3	Trainee	101(a)(15)(H)(iii).
H4	Spouse or Child of Alien Classified H1B/B1/C, H2A/B, or H–3	101(a)(15)(H)(iv).
I	Representative of Foreign Information Media, Spouse and Child	101(a)(15)(I).
J1	Exchange Visitor	101(a)(15)(J).
J2	Spouse or Child of J1	101(a)(15)(J).
K1	Fiance(e) of United States Citizen	101(a)(15)(K)(i).
K2	Child of Fiance(e) of U.S. Citizen	101(a)(15)(K)(iii).
K3	Spouse of U.S. citizen awaiting availability of immigrant visa	101(a)(15)(K)(ii).
K4	Child of K3	101(a)(15)(K)(iii).
L1	Intracompany Transferee (Executive, Managerial, and Specialized Knowledge Personnel Continuing Employment with International Firm or Corporation).	101(a)(15)(L).
L2	Spouse or Child of Intracompany Transferee	101(a)(15)(L).
M1	Vocational Student or Other Nonacademic Student	101(a)(15)(M)(i).
M2	Spouse or Child of M1	101(a)(15)(M)(ii).
M3	Canadian or Mexican national commuter student (Vocational student or other nonacademic student).	101(a)(15)(M)(iii).
N8	Parent of an Alien Classified SK3 or SN3	101(a)(15)(N)(i).
N9	Child of N8 or of SK1, SK2, SK4, SN1, SN2 or SN4	101(a)(15)(N)(ii).
NATO 1	Principal Permanent Representative of Member State to NATO (including any of its Subsidiary Bodies) Resident in the U.S. and Resident Members of Official Staff; Secretary General, Assistant Secretaries General, and Executive Secretary of NATO; Other Permanent NATO Officials of Similar Rank, or Immediate Family.	Art. 12, 5 UST 1094; Art. 20, 5 UST 1098.
NATO 2	Other Representative of member state to NATO (including any of its Subsidiary Bodies) including Representatives, Advisers, and Technical Experts of Delegations, or Immediate Family; Dependents of Member of a Force Entering in Accordance with the Provisions of the NATO Status-of-Forces Agreement or in Accordance with the provisions of the ''Protocol on the Status of International Military Headquarters''; Members of Such a Force if Issued Visas.	Art. 13, 5 UST 1094; Art. 1, 4 UST 1794; Art. 3, 4 UST 1796.
NATO 3	Official Clerical Staff Accompanying Representative of Member State to NATO (including any of its Subsidiary Bodies), or Immediate Family.	Art. 14, 5 UST 1096.
NATO 4	Official of NATO (Other Than Those Classifiable as NATO1), or Immediate Family.	Art. 18, 5 UST 1098.
NATO 5	Experts, Other Than NATO Officials Classifiable Under NATO4, Employed in Missions on Behalf of NATO, and their Dependents.	Art. 21, 5 UST 1100.
NATO 6	Member of a Civilian Component Accompanying a Force Entering in Accordance with the Provisions of the NATO Status-of-Forces Agreement; Member of a Civilian Component Attached to or Employed by an Allied Headquarters Under the ''Protocol on the Status of International Military Headquarters'' Set Up Pursuant to the North Atlantic Treaty; and their Dependents.	Art. 1, 4 UST 1794; Art. 3, 5 UST 877.
NATO 7	Attendant, Servant, or Personal Employee of NATO1, NATO2, NATO 3, NATO4, NATO5, and NATO6 Classes, or Immediate Family.	Arts. 12–20, 5 UST 1094–1098.
O1	Alien with Extraordinary Ability in Sciences, Arts, Education, Business or Athletics	101(a)(15)(O)(i).
O2	Alien Accompanying and Assisting in the Artistic or Athletic Performance by O1	101(a)(15)(O)(ii).
O3	Spouse or Child of O1 or O2	101(a)(15)(O)(iii).
P1	Internationally Recognized Athlete or Member of Internationally Recognized Entertainment Group.	101(a)(15)(P)(i).
P2	Artist or Entertainer in a Reciprocal Exchange Program	101(a)(15)(P)(ii).
P3	Artist or Entertainer in a Culturally Unique Program	101(a)(15)(P)(iii).
P4	Spouse or Child of P1, P2, or P3	101(a)(15)(P)(iv).
Q1	Participant in an International Cultural Exchange Program	101(a)(15)(Q)(i).
R1	Alien in a Religious Occupation	101(a)(15)(R).
R2	Spouse or Child of R1	101(a)(15)(R).
S5	Certain Aliens Supplying Critical Information Relating to a Criminal Organization or Enterprise.	101(a)(15)(S)(i).
S6	Certain Aliens Supplying Critical Information Relating to Terrorism	101(a)(15)(S)(ii).
S7	Qualified Family Member of S5 or S6	101(a)(15)(S).
T1	Victim of a severe form of trafficking in persons	101(a)(15)(T)(i).
T2	Spouse of T1	101(a)(15)(T)(ii).
T3	Child of T1	101(a)(15)(T)(ii).
T4	Parent of T1	101(a)(15)(T)(ii).
T5	Unmarried Sibling under age 18 of T1	101(a)(15)(T)(ii) as amended by sec. 201(a) of Pub. L. 110–457.
TN	NAFTA Professional	214(e)(2).
TD	Spouse or Child of NAFTA Professional	214(e)(2).
U1	Victim of criminal activity	101(a)(15)(U)(i).
U2	Spouse of U1	101(a)(15)(U)(ii).
U3	Child of U1	101(a)(15)(U)(ii).
U4	Parent of U1 under 21 years of age	101(a)(15)(U)(ii).

NONIMMIGRANTS—Continued

Symbol	Class	Section of law
U5	Unmarried Sibling under age 18 of U1 under 21 years of age	101(a)(15)(U)(ii).
V1	Spouse of a Lawful Permanent Resident Alien Awaiting Availability of Immigrant Visa.	101(a)(15)(V)(i) or 101(a)(15)(V)(ii).
V2	Child of a Lawful Permanent Resident Alien Awaiting Availability of Immigrant Visa.	101(a)(15)(V)(i) or 101(a)(15)(V)(ii).
V3	Child of a V1 or V2	203(d) & 101(a)(15)(V)(i) or 101(a)(15)(V)(ii).

PART 42—[AMENDED]

■ 3. The authority citation for Part 42 continues to read as follows:

Authority: 8 U.S.C. 1104; Pub. L. 107–56, sec. 421.

■ 4. Revise § 42.11 to read as follows:

§ 42.11 Classification symbols.

A visa issued to an immigrant alien within one of the classes described below shall bear an appropriate visa symbol to show the classification of the alien.

IMMIGRANTS

Symbol	Class	Section of law
	Immediate Relatives	
IR1	Spouse of U.S. Citizen	201(b).
IR2	Child of U.S. Citizen	201(b).
IR3	Orphan Adopted Abroad by U.S. Citizen	201(b) & 101(b)(1)(F).
IH3	Child from Hague Convention Country Adopted Abroad by U.S. Citizen	201(b) & 101(b)(1)(G).
IR4	Orphan to be Adopted in U.S. by U.S. Citizen	201(b) & 101(b)(1)(F).
IH4	Child from Hague Convention Country to be Adopted in U.S. by U.S. Citizen	201(b) & 101(b)(1)(G).
IR5	Parent of U.S. Citizen at Least 21 Years of Age	201(b).
CR1	Spouse of U.S. Citizen (Conditional Status)	201(b) & 216.
CR2	Child of U.S. Citizen (Conditional Status)	201(b) & 216.
IW1	Certain Spouses of Deceased U.S. Citizens	201(b).
IW2	Child of IW1	201(b).
IB1	Self-petition Spouse of U.S. Citizen	204(a)(1)(A)(iii).
IB2	Self-petition child of U.S. Citizen	204(a)(1)(A)(iv).
IB3	Child of IB1	204(a)(1)(A)(iii).
VI5	Parent of U.S. Citizen Who Acquired Permanent Resident Status Under the Virgin Islands Nonimmigrant Alien Adjustment Act.	201(b) & sec. 2 of the Virgin Islands Nonimmigrant Alien Adjustment Act, (Pub. L. 97–271).
	Vietnam Amerasian Immigrants	
AM1	Vietnam Amerasian Principal	584(b)(1)(A) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Pub. L. 100–102) as amended.
AM2	Spouse or Child of AM1	584(b)(1)(A) and 584(b)(1)(B) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–102) as amended.
AM3	Natural Mother of AM1 (and Spouse or Child of Such Mother) or Person Who has Acted in Effect as the Mother, Father, or Next-of-Kin of AM1 (and Spouse or Child of Such Person).	584(b)(1)(A) and 584(b)(1)(C) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–102) as amended.
	Special Immigrants	
SB1	Returning Resident	101(a)(27)(A).
SC1	Person Who Lost U.S. Citizenship by Marriage	101(a)(27)(B) & 324(a).
SC2	Person Who Lost U.S. Citizenship by Serving in Foreign Armed Forces	101(a)(27)(B) & 327.
SI1	Certain Aliens Employed by the U.S. Government in Iraq or Afghanistan as Translators or Interpreters.	Section 1059 of Pub. L. 109–163 as amended by Pub. L. 110–36.
SI2	Spouse of SI1	Section 1059 of Pub. L. 109–163 as amended by Pub. L. 110–36.
SI3	Child of SI1	Section 1059 of Pub. L. 109–163 as amended by Pub. L. 110–36.
SM1	Alien Recruited Outside the United States Who Has Served or is Enlisted to Serve in the U.S. Armed Forces for 12 Years.	101(a)(27)(K).

IMMIGRANTS—Continued

Symbol	Class	Section of law
SM2	Spouse of SM1	101(a)(27)(K).
SM3	Child of SM1	101(a)(27)(K).
SQ1	Certain Iraqis or Afghans Employed by or on Behalf of the U.S. Government	Section 602(b), Division F, Title VI, Omnibus Appropriations Act of 2009, Pub. L. 111–8 and Section 1244 of Pub. L. 110–181.
SQ2	Spouse of SQ1	Section 602(b), Division F, Title VI, Omnibus Appropriations Act of 2009, Pub. L. 111–8 and Section 1244 of Pub. L. 110–181.
SQ3	Child of SQ1	Section 602(b), Division F, Title VI, Omnibus Appropriations Act of 2009, Pub. L. 111–8 and Section 1244 of Pub. L. 110–181.
SU2	Spouse of U1	INA 245(m)(3) & INA 101(a)(15)(U)(ii).
SU3	Child of U1	INA 245(m)(3) & INA 101(a)(15)(U)(ii).
SU5	Parent of U1	INA 245(m)(3) & INA 101(a)(15)(U)(ii).
	Family-Sponsored Preferences	
	Family 1st Preference	
F11	Unmarried Son or Daughter of U.S. Citizen	203(a)(1).
F12	Child of F11	203(d) & 203(a)(1).
B11	Self-petition Unmarried Son or Daughter of U.S. Citizen	204(a)(1)(A)(iv) & 203(a)(1).
B12	Child of B11	203(d), 204(a)(1)(A)(iv) & 203(a)(1).
	Family 2nd Preference (Subject to Country Limitations)	
F21	Spouse of Lawful Permanent Resident	203(a)(2)(A).
F22	Child of Lawful Permanent Resident	203(a)(2)(A).
F23	Child of F21 or F22	203(d) & 203(a)(2)(A).
F24	Unmarried Son or Daughter of Lawful Permanent Resident	203(a)(2)(B).
F25	Child of F24	203(d) & 203(a)(2)(B).
C21	Spouse of Lawful Permanent Resident (Conditional)	203(a)(2)(A) & 216.
C22	Child of Alien Resident (Conditional)	203(a)(2)(A) & 216.
C23	Child of C21 or C22 (Conditional)	203(d) & 203(a)(2)(A) & 216.
C24	Unmarried Son or Daughter of Lawful Permanent Resident (Conditional)	203(a)(2)(B) & 216.
C25	Child of F24 (Conditional)	203(d) & 203(a)(2)(B) & 216.
B21	Self-petition Spouse of Lawful Permanent Resident	204(a)(1)(B)(ii).
B22	Self-petition Child of Lawful Permanent Resident	204(a)(1)(B)(iii).
B23	Child of B21 or B22	203(d) & 204(a)(1)(B)(ii).
B24	Self-petition Unmarried Son or Daughter of Lawful Permanent Resident	204(a)(1)(B)(iii).
B25	Child of B24	203(d) & 204(a)(1)(B)(iii).
	Family 2nd Preference (Exempt from Country Limitations)	
FX1	Spouse of Lawful Permanent Resident	202(a)(4)(A) & 203(a)(2)(A).
FX2	Child of Lawful Permanent Resident	202(a)(4)(A) & 203(a)(2)(A).
FX3	Child of FX1 or FX2	202(a)(4)(A) & 203(a)(2)(A) & 203(d).
CX1	Spouse of Lawful Permanent Resident (Conditional)	202(a)(4)(A) & 203(a)(2)(A) & 216.
CX2	Child of Lawful Permanent Resident (Conditional)	202(a)(4)(A) & 203(a)(2)(A) & 216.
CX3	Child of CX1 or CX2 (Conditional)	202(a)(4)(A) & 203(a)(2)(A) & 203(d) & 216.
BX1	Self-petition Spouse of Lawful Permanent Resident	204(a)(1)(B)(ii).
BX2	Self-petition Child of Lawful Permanent Resident	204(a)(1)(B)(iii).
BX3	Child of BX1 or BX2	204(a)(1)(B)(ii) & 203(d).
	Family 3rd Preference	
F31	Married Son or Daughter of U.S. Citizen	203(a)(3).
F32	Spouse of F31	203(d) & 203(a)(3).
F33	Child of F31	203(d) & 203(a)(3).
C31	Married Son or Daughter of U.S. Citizen (Conditional)	203(a)(3) & 216.
C32	Spouse of C31 (Conditional)	203(d) & 203(a)(3) & 216.
C33	Child of C31 (Conditional)	203(d) & 203(a)(3) & 216.
B31	Self-petition Married Son or Daughter of U.S. Citizen	204(a)(1)(A)(iv) & 203(a)(3).
B32	Spouse of B31	203(d), 204(a)(1)(A)(iv) & 203(a)(3).
B33	Child of B31	203(d), 204(a)(1)(A)(iv) & 203(a)(3).
	Family 4th Preference	
F41	Brother or Sister of U.S. Citizen at Least 21 Years of Age	203(a)(4).

IMMIGRANTS—Continued

Symbol	Class	Section of law
F42	Spouse of F41	203(d) & 203(a)(4).
F43	Child of F41	203(d) & 203(a)(4).
	Employment-Based Preferences **Employment 1st Preference (Priority Workers)**	
E11	Alien with Extraordinary Ability	203(b)(1)(A).
E12	Outstanding Professor or Researcher	203(b)(1)(B).
E13	Multinational Executive or Manager	203(b)(1)(C).
E14	Spouse of E11, E12, or E13	203(d) & 203(b)(1)(A) & 203(b)(1)(B) & 203(b)(1)(C).
E15	Child of E11, E12, or E13	203(d) & 203(b)(1)(A) & 203(b)(1)(B) & 203(b)(1)(C).
	Employment 2nd Preference (Professionals Holding Advanced Degrees or Persons of Exceptional Ability)	
E21	Professional Holding Advanced Degree or Alien of Exceptional Ability	203(b)(2).
E22	Spouse of E21	203(d) & 203(b)(2).
E23	Child of E21	203(d) & 203(b)(2).
	Employment 3rd Preference (Skilled Workers, Professionals, and Other Workers)	
E31	Skilled Worker	203(b)(3)(A)(i).
E32	Professional Holding Baccalaureate Degree	203(b)(3)(A)(ii).
E34	Spouse of E31 or E32	203(d) & 203(b)(3)(A)(i) & 203(b)(3)(A)(ii).
E35	Child of E31 or E32	203(d) & 203(b)(3)(A)(i) & 203(b)(3)(A)(ii).
EW3	Other Worker (Subgroup Numerical Limit)	203(b)(3)(A)(iii).
EW4	Spouse of EW3	203(d) & 203(b)(3)(A)(iii).
EW5	Child of EW3	203(d) & 203(b)(3)(A)(iii).
	Employment 4th Preference (Certain Special Immigrants)	
BC1	Broadcaster in the U.S. employed by the International Broadcasting Bureau of the Broadcasting Board of Governors or a grantee of such organization.	101(a)(27)(M) & 203(b)(4).
BC2	Accompanying spouse of BC1	101(a)(27)(M) & 203(b)(4).
BC3	Accompanying child of BC1	101(a)(27)(M) & 203(b)(4).
SD1	Minister of Religion	101(a)(27)(C)(ii)(I) & 203(b)(4).
SD2	Spouse of SD1	101(a)(27)(C)(ii)(I) & 203(b)(4).
SD3	Child of SD1	101(a)(27)(C)(ii)(I) & 203(b)(4).
SE1	Certain Employees or Former Employees of the U.S. Government Abroad	101(a)(27)(D) & 203(b)(4).
SE2	Spouse of SE1	101(a)(27)(D) & 203(b)(4).
SE3	Child of SE1	101(a)(27)(D) & 203(b)(4).
SF1	Certain Former Employees of the Panama Canal Company or Canal Zone Government.	101(a)(27)(E) & 203 (b)(4).
SF2	Spouse or Child of SF1	101(a)(27)(E) & 203 (b)(4).
SG1	Certain Former Employees of the U.S. Government in the Panama Canal Zone	101(a)(27)(F) & 203 (b)(4).
SG2	Spouse or Child of SG1	101(a)(27)(F) & 203 (b)(4).
SH1	Certain Former Employees of the Panama Canal Company or Canal Zone Government on April 1, 1979.	101(a)(27)(G) & 203 (b)(4).
SH2	Spouse or Child of SH1	101(a)(27)(G) & 203(b)(4).
SJ1	Certain Foreign Medical Graduates (Adjustments Only)	101(a)(27)(H).
SJ2	Accompanying Spouse or Child of SJ1	101(a)(27)(H) & 203(b)(4).
SK1	Certain Retired International Organization employees	101(a)(27)(I)(iii) & 203(b)(4).
SK2	Spouse of SK1	101(a)(27)(I)(iv) & 203(b)(4).
SK3	Certain Unmarried Sons or Daughters of an International Organization Employee	101(a)(27)(I)(i) & 203(b)(4).
SK4	Certain Surviving Spouses of a deceased International Organization Employee	101(a)(27)(I)(ii) & 203(b)(4).
SL1	Juvenile Court Dependent (Adjustment Only)	101(a)(27)(J) & 203(b)(4).
SN1	Certain retired NATO6 civilians	101(a)(27)(L) & 203(b)(4).
SN2	Spouse of SN1	101(a)(27)(L) & 203(b)(4).
SN3	Certain unmarried sons or daughters of NATO6 civilian employees	101(a)(27)(L) & 203(b)(4).
SN4	Certain surviving spouses of deceased NATO6 civilian employees	101(a)(27)(L) & 203(b)(4).
SP	Alien Beneficiary of a petition or labor certification application filed prior to September 11, 2001, if the petition or application was rendered void due to a terrorist act of September 11, 2001. Spouse, child of such alien, or the grandparent of a child orphaned by a terrorist act of September 11, 2001.	Section 421 of Public Law 107–56.
SR1	Certain Religious Workers	101(a)(27)(C)(ii)(II) & (III) as amended, & 203(b)(4).
SR2	Spouse of SR1	101(a)(27)(C)(ii)(II) & (III) as amended, & 203(b)(4).
SR3	Child of SR1	101(a)(27)(C)(ii)(II) & (III) as amended, & 203(b)(4).

IMMIGRANTS—Continued

Symbol	Class	Section of law
	Employment 5th Preference (Employment Creation Conditional Status)	
C51	Employment Creation OUTSIDE Targeted Areas	203(b)(5)(A).
C52	Spouse of C51	203(d) & 203(b)(5)(A).
C53	Child of C51	203(d) & 203(b)(5)(A).
T51	Employment Creation IN Targeted Rural/High Unemployment Area	203(b)(5)(B).
T52	Spouse of T51	203(d) & 203 (b)(5)(B).
T53	Child of T51	203(d) & 203(b)(5)(B).
R51	Investor Pilot Program, Not in Targeted Area	203(b)(5) & Sec. 610 of the Departments of Commerce, Justice, and State, the Judiciary and Related Agencies Appropriations Act, 1993 (Pub. L. 102–395), as amended.
R52	Spouse of R51	203(d) & 203(b)(5) & Sec. 610 of the Departments of Commerce, Justice, and State, the Judiciary and Related Agencies Appropriations Act, 1993 (Pub. L. 102–395), as amended.
R53	Child of R51	203(d) & 203(b)(5) & Sec. 610 of the Departments of Commerce, Justice, and State, the Judiciary and Related Agencies Appropriations Act, 1993 (Pub. L. 102–395), as amended.
I51	Investor Pilot Program, in Targeted Area	203(b)(5) & Sec. 610 of the Departments of Commerce, Justice, and State, the Judiciary and Related Agencies Appropriations Act, 1993 (Pub. L. 102–395), as amended.
I52	Spouse of I51	203(d) & 203(b)(5) & Sec. 610 of the Departments of Commerce, Justice, and State, the Judiciary and Related Agencies Appropriations Act, 1993 (Pub. L. 102–395), as amended.
I53	Child of I51	203(d) & 203(b)(5) & Sec. 610 of the Departments of Commerce, Justice, and State, the Judiciary and Related Agencies Appropriations Act, 1993 (Pub. L. 102–395), as amended.
	Other Numerically Limited Categories Diversity Immigrants	
DV1	Diversity Immigrant	203(c).
DV2	Spouse of DV1	203(d) & 203(c).
DV3	Child of DV1	203(d) & 203(c).

November 16, 2009.

Michael D. Kirby,

Acting Assistant Secretary for Consular Affairs, Department of State.

[FR Doc. E9–28277 Filed 11–24–09; 8:45 am]

BILLING CODE 4710–06–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 20

[TD 9468]

RIN 1545–BC56

Guidance Under Section 2053 Regarding Post-Death Events; Correction

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Correcting amendment.

SUMMARY: This document contains corrections to final regulations (TD 9468) that were published in the **Federal Register** on Tuesday, October 20, 2009 (74 FR 53652) providing guidance relating to the amount deductible from a decedent's gross estate for claims against the estate under section 2053(a)(3) of the Internal Revenue Code.

DATES: This correction is effective on November 25, 2009 and is applicable in taxable years ending on or after October 20, 2009.

FOR FURTHER INFORMATION CONTACT: Karlene M. Lesho, (202) 622–3090 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The final regulations that are the subject of this document are under sections 2051 and 2053 of the Internal Revenue Code.

Need for Correction

As published, the final regulations (TD 9468) contain errors that may prove to be misleading and are in need of clarification.

List of Subjects in 26 CFR Part 20

Estate taxes, Reporting and recordkeeping requirements.

Correction of Publication

■ Accordingly, 26 CFR part 20 is corrected by making the following correcting amendments:

PART 20—ESTATE TAX; ESTATES OF DECENDENTS DYING AFTER AUGUST 16, 1954

■ **Paragraph 1.** The authority citation for part 20 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par. 2.** Section 20.2053–1 is amended by revising the third sentence of paragraph (d)(7) *Example 3* to read as follows:

§ 20.2053–1 Deduction for expenses, indebtedness, and taxes; in general.

* * * * *

(d) * * *

(7) * * *

Example 3. * * * Instead, pursuant to the protective claim for refund filed by E, the marital deduction will be reduced by the claim once a final judgment is entered in the case. * * *

* * * * *

■ **Par. 3.** Section 20.2053–4 is amended by revising the last sentence of paragraph (d)(3) to read as follows.

§ 20.2053–4 Deduction for claims against the estate.

* * * * *

(d) * * *

(3) * * * See further § 20.2053–1(d)(3).

* * * * *

LaNita VanDyke,

Chief, Publications and Regulations Branch, Legal Processing Division, Associate Chief Counsel (Procedure and Administration)

[FR Doc. E9–28332 Filed 11–24–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 301

[TD 9473]

RIN 1545–AU97

Agreements for Payment of Tax Liabilities in Installments

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations relating to the payment of tax liabilities in installments. The regulations reflect changes to the law made by the Taxpayer Bill of Rights II, the Internal Revenue Service Restructuring and Reform Act of 1998, and the American Jobs Creation Act of 2004. The regulations will affect taxpayers submitting installment agreements to the IRS.

DATES: *Effective Date:* These regulations are effective on November 25, 2009.

Applicability Date: For the date of applicability, *see* § 301.6159(k).

FOR FURTHER INFORMATION CONTACT: Walter Ryan, (202) 622–3620 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains amendments to the Procedure and Administration Regulations (26 CFR part 301) under section 6159 of the Internal Revenue Code (Code). Section 6159 allows the IRS to enter into agreements for the payment of any unpaid tax in installments. Taxpayers may request administrative review of IRS decisions to terminate installment agreements pursuant to section 6159(e), added to the Code by section 202 of the Taxpayer Bill of Rights II, Public Law 104–168 (110 Stat. 1452, 1457 (1996)). Taxpayers may appeal rejections of proposed installment agreements under section 7122(e), added to the Code by section 3462 of Internal Revenue Service Restructuring and Reform Act of 1998 (RRA 98), Public Law 105–206 (112 Stat. 685, 764 (1998)). Section 6159(c), added to the Code by section 3467 of RRA 1998, requires the IRS to accept a proposed installment agreement for income taxes under certain circumstances. Section 3506 of RRA 1998 requires the IRS to send each taxpayer with an installment agreement an annual statement showing the balance due at the beginning of the year, the payments made during the year, and the remaining balance due at the end of the year.

Section 843 of the American Jobs Creation Act of 2004 (AJCA), Public Law 108–357 (118 Stat. 1418, 1600 (2004)), amended section 6159(a) to allow the IRS to enter into installment agreements that provide for partial (as well as full) payment of a tax liability, but excludes partial payment installment agreements from the scope of installment agreements that must be accepted by the IRS. Section 843 of the AJCA also added new section 6159(d), requiring the IRS to review partial payment installment agreements every two years. The primary purpose of the review is to determine whether the financial condition of the taxpayer has significantly changed so as to warrant an increase in the value of the payments being made. *See* H. Rep. No. 108–755, 108th Cong., 2d Sess., 2005 U.S.C.C.A.N. 1341 (October 7, 2004).

On March 5, 2007, a notice of proposed rulemaking (REG–100841–97; 72 FR 9712) was published in the **Federal Register**. The proposed regulations reflected the changes made to section 6159 by the Taxpayer Bill of Rights II, the RRA 98, and the AJCA. The proposed regulations reflected current IRS administrative practice. The IRS received one set of written comments with numerous recommendations. No public hearing was requested or held. After consideration of the comments, the proposed regulations are adopted as revised by this Treasury decision.

Summary of Comments and Explanation of Revisions

The final regulations adopt certain recommendations contained in the comments by clarifying two provisions of the proposed regulations. As explained in this preamble, § 301.6159–1(e)(3) was amended to clarify that the taxpayer may submit a request to modify or terminate the installment agreement. Section 301.6159–1(e)(3) further clarifies that such a request will not suspend the statute of limitations on collection and the taxpayer must comply with the existing installment agreement while the request is being considered. As also explained in this preamble, § 301.6159–1(e)(1)(i) clarifies that the IRS may terminate an installment agreement if the taxpayer provides materially incomplete or inaccurate information in response to an IRS request for a financial update.

The following is a section-by-section analysis of the comments.

Section 301.6159–1(b): Procedures for Submission and Consideration of Proposed Installment Agreements

Section 301.6159–1(b) of the proposed regulations provided that an installment agreement request must be submitted according to procedures prescribed by the IRS. It did not require the IRS to accept or reject the request within a specific time frame. The commenter proposed to limit the IRS's time to consider an installment agreement to 90 days; if the IRS fails to act in that time, the agreement would be granted automatically. The commenter reasoned that the limited time frame would benefit the IRS because more installments agreements would be automatically allowed, thereby increasing revenues, and would benefit the taxpayer by allowing payments to begin quickly and efficiently. The recommendation was not adopted for two reasons. First, the IRS already grants installment agreements quickly and automatically in the vast majority of

cases. If the taxpayer owes less than $25,000 and offers to pay the liabilities in full within 5 years, the agreement can be granted automatically under the IRS's ''streamlined'' installment agreement procedures. *See* Internal Revenue Manual 5.14.5.2 at *http://www.irs.gov/irm/part5/irm_05-014-005.html.* The IRS granted over 2.62 million installment agreements in fiscal year 2008, of which over 2.51 million were granted through the IRS's streamlined procedures. In cases that do not meet the streamlined criteria, the IRS has determined that a more detailed review of the taxpayer's financial situation is warranted. Second, the IRS generally responds to non-streamlined installment agreement requests in a timely manner. During the filing season, however, inventory fluctuations may cause delays. The automatic allowance of installment agreements in such cases would not be appropriate.

Proposed § 301.6159–1(b)(2) provided that an installment agreement request becomes pending when it is accepted for processing. The commenter recommended that the IRS send an automatically-generated response acknowledging the date of acceptance for processing to the taxpayer and the taxpayer's representative. This recommendation was not adopted. The vast majority of installment agreements are streamlined agreements, which the IRS accepts very quickly. The IRS will, however, consider adopting an administrative procedure for the minority of cases where it anticipates a time lag between acceptance for processing and the acceptance or rejection of the installment agreement.

Proposed § 301.6159–1(b)(2) also provided that if an installment agreement request does not contain sufficient information to permit the IRS to evaluate whether the request should be accepted, the IRS will request the needed information. The commenter recommended that all requests for additional information should be reasonably necessary. The proposed regulations already address this recommendation by directing that requests be for ''needed'' information.

Proposed § 301.6159–1(b)(3) allowed a taxpayer to submit a good faith revision of a rejected installment agreement request within 30 days of rejection. The commenter recommended that the time for taxpayers to submit a good faith revision should be extended to 60 days because taxpayers often have difficulty obtaining the necessary documents within 30 days. This recommendation was not adopted. The recommendation would apply to a small number of installment agreement requests that are not accepted under the IRS's streamlined procedures. In these cases, the IRS requests the information necessary for a financial analysis before rejecting the installment agreement request. *See* Internal Revenue Manual 5.15.1.6 at *http://www.irs.gov/irm/part5/irm_05-015-001.html.* Allowing 60 days following the rejection would encourage untimely responses and delay case resolution.

Section 301.6159–1(c): Acceptance, Form, and Terms of Installment Agreements

Section 301.6159–1(c)(1) of the proposed regulations provided that an installment agreement request has not been accepted until the IRS notifies the taxpayer or the taxpayer's representative of the acceptance. Section 6159(a) requires that an installment agreement be in writing, and proposed § 301.6159–1(c)(2) provided that the writing may take the form of a document signed by the taxpayer and the IRS or the written confirmation of an agreement entered into by the taxpayer and the IRS that is mailed or personally delivered to the taxpayer. The commenter recommended that the IRS's notification of the acceptance or rejection of a proposed installment agreement also be directed to the taxpayer's representative and include the terms of the agreement and payment submission information. These recommendations were not adopted in the regulations because they are more appropriately addressed in the IRS's procedures. The IRS currently does, however, provide written notification to the taxpayer and the taxpayer's representative of the acceptance or rejection of an installment agreement and the suggested information.

The commenter was concerned that the IRS intended to change its streamlined procedures and recommended that the procedures be retained. The commenter was also concerned that proposed § 301.6159–1(c)(3)(iii)(A) may represent a departure from the IRS's current policy that limits the acceptance of extensions of the collection statute of limitations in connection with installment agreements to the narrow subset of partial payment installment agreements in which the liability will not be paid in full under the agreement before the collection statute expires. As stated in the preamble to the notice of proposed rulemaking, the regulations were intended to reflect existing practices. The regulations will have no effect on the IRS's streamlined procedures or its policy with regard to waivers of the collection statute.

The commenter stated that the proposed regulations did not explain the inclusion of § 301.6159–1(c)(3)(ii), which provided that an installment agreement may, by its terms, end upon the expiration of the period of limitations on collection, or at some prior date. As explained in the preamble to the proposed regulations, this provision clarifies that the IRS may enter into partial payment installment agreements that end upon the running of the collection statute, or that end prior to that time so that the IRS may collect the balance of the tax liability against any property belonging to the taxpayer before the collection period expires. The IRS does not currently enter into partial payment installment agreements that expire before the end of the collection statute and has no plans to do so routinely in the future.

Proposed § 301.6159–1(c)(3)(v) provided that while an installment agreement is in effect, the IRS may request a financial condition update from the taxpayer at any time. The commenter recommended that the IRS be permitted to request only one financial condition update per year. This recommendation was not adopted. The IRS very rarely requests updates more than once a year. In certain rare circumstances, more frequent updates may be appropriate, such as when the IRS has reason to believe that the taxpayer's financial condition has improved.

Section 301.6159–1(d): Rejection of a Proposed Installment Agreement

Section 301.6159–1(d)(2) of the proposed regulations provided that the IRS may not notify a taxpayer or the taxpayer's representative of the rejection of an installment agreement until an independent review of proposed rejection is completed. The commenter was concerned that the proposed regulations did not provide any guidance as to how the independent administrative review will be assured. The commenter recommended that the review be undertaken by an IRS office located in a different territory. The recommendation was not adopted. Managers in the IRS offices in San Jose, California, and Jacksonville, Florida, supervise employees throughout the United States who review rejected installment agreements. An independent review is assured by assigning these cases to an employee who has no prior involvement in the case and who reports to a supervisor in either of these two offices.

The commenter recommended that the determination that the taxpayer did not submit a good faith revision be

subject to independent administrative review. This recommendation was not adopted because it would delay case resolution and would, in effect, treat requests that were not made in good faith as valid requests. The commenter also recommended that the rejection of revisions that were made in good faith receive independent review. The proposed regulation already provided for this review. Proposed § 301.6159–1(b) stated that if the IRS determines that the taxpayer made a good faith revision within 30 days of the rejection, the provisions of § 301.6159–1 apply to the revised proposal.

Proposed § 301.6159–1(d)(3) provided that a taxpayer may appeal the rejection of an installment agreement request within 30 days of the rejection. The commenter recommended that the 30-day period be tolled while a revised proposal of a rejected request is being evaluated so that the taxpayer would not have to file an appeal while the revision is under consideration. This recommendation was not adopted. The IRS's procedures are designed to allow a quick resolution of the taxpayer's request; tolling the appeal period would add an unneeded layer of complexity to the process and delay case resolution. The commenter also recommended that the IRS provide more definitive guidance as to what qualifies as a good faith revision. This recommendation was not adopted because this guidance is more appropriately left to the IRS procedures.

Section 301.6159–1(e): Modification or Termination of Installment Agreements by the Internal Revenue Service

Proposed § 301.6159–1(e)(2)(i) provided that the IRS may modify or terminate an installment agreement if the IRS determines that the financial condition of the taxpayer has significantly changed. Proposed § 301.6159–1(c)(3)(vi) provided that the IRS and the taxpayer may agree to modify or terminate an installment agreement or may agree to a new installment agreement that supersedes the existing agreement. The commenter recommended that the regulations explicitly allow taxpayers to request a modification or termination of an existing installment agreement, as was stated in existing § 301.6159–1(c)(3). This clarification was adopted in § 301.6159–1(e)(3).

The commenter recommended that the regulations require the taxpayer to comply with the terms of an installment agreement while a request for modification is being considered and that a proposed modification will not result in a suspension of the statute of limitations on collection. These clarifications were also adopted in § 301.6159–1(e)(3).

The commenter recommended that a taxpayer's request to modify an existing installment agreement should be exempt from user fees under regulations §§ 300.1 and 300.2. This recommendation was not adopted because user fees are outside the scope of this regulation project.

Proposed § 301.6159–1(e)(2)(ii)(C) provided that the IRS may modify or terminate an installment agreement if the taxpayer fails to provide a financial condition update requested by the IRS. The commenter recommended that the regulations provide explicitly whether the IRS may terminate an installment agreement if the taxpayer provided materially inaccurate or incomplete information. This recommendation was adopted. Section 301.6159–1(e)(1)(i) was revised to clarify that the IRS may terminate an installment agreement if the taxpayer provided materially inaccurate or incomplete information in connection with a requested financial update.

Proposed § 301.6159–1(e)(3) provided that the IRS will generally notify the taxpayer in writing at least 30 days prior to terminating an installment agreement and describe the reason for the termination, after which the taxpayer may provide information showing that the IRS's reason is incorrect. Proposed § 301.6159–1(e)(4) provided for the administrative appeal of the modification or termination of an installment agreement to the Office of Appeals if the request is properly made within 30 days after the termination or modification is to take effect. The commenter recommended that the regulations clarify that an appeal should be made to the Office of Appeals within 30 days after the modification or termination will take effect, regardless of whether the taxpayer submits additional information under § 301.6159–1(e)(3), has filled out Form 9423, ''Collection Appeal Request,'' or has requested a meeting with a Collection Manager. This recommendation was not adopted in the regulations because it is more appropriately addressed in IRS forms and procedures.

Proposed § 301.6159–1(e)(4) provided, in part, that the taxpayer may administratively appeal the modification or termination of an installment agreement to the Office of Appeals. The commenter recommended that the taxpayer be allowed to appeal the IRS's determination not to modify an installment agreement. This recommendation was not adopted. The IRS routinely grants taxpayer modification requests that result in agreements within the streamlined criteria. *See* Internal Revenue Manual 5.19.1.5.4.24 at *http://www.irs.gov/irm/part5/irm_05-019-001.html.* Taxpayers do not have a statutory right to appeal rejected modification requests, and the IRS has not determined there is a need for additional administrative review of the denial of a modification request.

Section 301.6159–1(f): Effect of Installment Agreement or Pending Installment Agreement on Collection Activity

Section 301.6159–1(f)(1) of the proposed regulations stated that the IRS may not levy during the time an installment agreement is pending. Proposed § 301.6159–1(f)(2) stated that levy is not prohibited if an installment agreement request was made solely to delay collection. The commenter recommended that the solely to delay collection standard in the proposed regulations be replaced with language that references the ''frivolous submission'' standard in section 6702(b) of the Code. This recommendation was not adopted. Under existing IRS procedures, an installment agreement is returned as made solely to delay collection when there is no economic reality to the request, the request fails to address changes previously requested by the IRS in response to a prior request, the request ignores direction provided by revenue officers, the request is made by a taxpayer that has defaulted prior installment agreements, or the request is made at a time that causes it to be classified as a request made to delay enforcement action. *See* Internal Revenue Manual 5.14.3.2 at *http://www.irs.gov/irm/part5/irm_05-014-003.html.* Section 6702(b) imposes a $5,000 penalty for installment agreement requests that reflect a desire to delay or impede the administration of the Federal tax laws, and the IRS has not yet developed procedures defining the kinds of installment agreements that constitute frivolous submissions. The standard in section 6702(b) therefore may not be an appropriate standard for identifying those installment agreements that fail to qualify for the prohibition against levy.

In the alternative, the commenter recommended that the regulations state that a taxpayer may appeal the IRS's levy action when the IRS determines that an installment agreement request was made solely to delay collection, and that damages may be appropriate under section 7433 of the Code. These recommendations were not adopted. Taxpayers' rights to appeal proposed

levies and seek damages are provided for in the regulations under sections 6330 and 7433 of the Code, respectively.

Section 301.6159–1(g): Suspension of the Statute of Limitations on Collection

Section 301.6159–1(g) of the proposed regulations provided that the statute of limitations on collection under section 6502 of the Code is suspended for the period that a proposed installment agreement is pending, plus 30 days following a rejection, and during any appeal. The commenter recommended that the regulations clearly define when an installment agreement is pending. This recommendation is already addressed by proposed § 301.6159–1(b)(2), which provides a detailed explanation of when an installment agreement is pending.

Section 301.6159–1(h): Annual Statement

Section 301.6159–1(h) of the proposed regulations requires the IRS to provide taxpayers with an annual statement setting forth the balance owed at the beginning of the year, the payments made during the year, and the remaining balance at the end of the year. The commenter recommends that the annual statement be as clear as possible and that the IRS provide the taxpayer with a single annual statement describing all tax liabilities covered by the agreement. Currently, the IRS sends an annual statement for each separate liability covered by an installment agreement. No change was made to the final regulations because this recommendation is more appropriately addressed when the IRS updates the forms used for the annual statements.

Section 301.6159–1(i): Biennial Review of Partial Payment Installment Agreements

Section 301.6159–1(i) of the proposed regulations required the IRS to perform a review of the taxpayer's financial condition at least once every two years in cases of partial payment installment agreements. The proposed regulations also stated that the purpose of the review was to determine whether an increase in payments is warranted. The commenter recommended that § 301.6159–1(i) be rephrased to provide that the biennial review of a taxpayer's financial condition may result in a decrease, as well as an increase, in the amount of payments being made. This recommendation was not adopted. While taxpayers may request a decrease in the amount of payments due under an installment agreement, the IRS does not have the information to unilaterally make that determination. The automatic biennial review done by the IRS does not, in every case, result in a request for updated financial information. As explained above, taxpayers may request that their payments be lowered if their financial condition has worsened.

Section 301.6159–1(k): Effective/Applicability Date

Section 301.6159–1(k) of the proposed regulations provided that the effective date of the final regulations would be the date the final regulations are published in the **Federal Register**. The commenter was concerned about how previously proposed or accepted installment agreements will be affected by the regulations and recommended that the effective date of paragraphs (b), (c), and (d) apply prospectively. This recommendation was not adopted. As explained earlier and in the preamble to the proposed regulations, the regulations substantially reflect existing practices. The regulations will therefore have no effect on previously proposed or accepted installment agreements.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, the proposed regulations preceding these regulations were submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these regulations is Walter Ryan, Office of Associate Chief Counsel (Procedure and Administration).

List of Subjects in 26 CFR Part 301

Employment taxes, Estate taxes, Excise taxes, Gift taxes, Income taxes, Penalties, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

■ Accordingly, 26 CFR part 301 is amended as follows:

PART 301—PROCEDURE AND ADMINISTRATION

■ **Paragraph 1.** The authority citation for part 301 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par. 2.** Section 301.6159–0 is added to read as follows:

§ 301.6159–0 Table of contents.

This section lists the major captions that appear in the regulations under § 301.6159–1.

§ 301.6159–1 Agreements for the payment of tax liabilities in installments.

(a) Authority.
(b) Procedures for submission and consideration of proposed installment agreements.
(c) Acceptance, form, and terms of installment agreements.
(d) Rejection of a proposed installment agreement.
(e) Modification or termination of installment agreements by the Internal Revenue Service.
(f) Effect of installment agreement or pending installment agreement on collection activity.
(g) Suspension of the statute of limitations on collection.
(h) Annual statement.
(i) Biennial review of partial payment installment agreements.
(j) Cross reference.
(k) Effective/applicability date.

■ **Par. 3.** Section 301.6159–1 is revised to read as follows:

§ 301.6159–1 Agreements for payment of tax liabilities in installments.

(a) *Authority.* The Commissioner may enter into a written agreement with a taxpayer that allows the taxpayer to make scheduled periodic payments of any tax liability if the Commissioner determines that such agreement will facilitate full or partial collection of the tax liability.

(b) *Procedures for submission and consideration of proposed installment agreements*—(1) *In general.* A proposed installment agreement must be submitted according to the procedures, and in the form and manner, prescribed by the Commissioner.

(2) *When a proposed installment agreement becomes pending.* A proposed installment agreement becomes pending when it is accepted for processing. The Internal Revenue Service (IRS) may not accept a proposed installment agreement for processing following reference of a case involving the liability that is the subject of the proposed installment agreement to the Department of Justice for prosecution or

defense. The proposed installment agreement remains pending until the IRS accepts the proposal, the IRS notifies the taxpayer that the proposal has been rejected, or the proposal is withdrawn by the taxpayer. If a proposed installment agreement that has been accepted for processing does not contain sufficient information to permit the IRS to evaluate whether the proposal should be accepted, the IRS will request the taxpayer to provide the needed additional information. If the taxpayer does not submit the additional information that the IRS has requested within a reasonable time period after such a request, the IRS may reject the proposed installment agreement.

(3) *Revised proposals of installment agreements submitted following rejection.* If, following the rejection of a proposed installment agreement, the IRS determines that the taxpayer made a good faith revision of the proposal and submitted the revision within 30 days of the date of rejection, the provisions of this section shall apply to that revised proposal. If, however, the IRS determines that a revision was not made in good faith, the provisions of this section do not apply to the revision and the appeal period in paragraph (d)(3) of this section continues to run from the date of the original rejection.

(c) *Acceptance, form, and terms of installment agreements*—(1) *Acceptance of an installment agreement*—(i) *In general.* A proposed installment agreement has not been accepted until the IRS notifies the taxpayer or the taxpayer's representative of the acceptance. Except as provided in paragraph (c)(1)(iii) of this section, the Commissioner has the discretion to accept or reject any proposed installment agreement.

(ii) *Acceptance does not reduce liabilities.* The acceptance of an installment agreement by the IRS does not reduce the amount of taxes, interest, or penalties owed. (However, penalties may continue to accrue at a reduced rate pursuant to section 6651(h).)

(iii) *Guaranteed installment agreements.* In the case of a liability of an individual for income tax, the Commissioner shall accept a proposed installment agreement if, as of the date the individual proposes the installment agreement—

(A) The aggregate amount of the liability (not including interest, penalties, additions to tax, and additional amounts) does not exceed $10,000;

(B) The taxpayer (and, if the liability relates to a joint return, the taxpayer's spouse) has not, during any of the preceding five taxable years—

(*1*) Failed to file any income tax return;

(*2*) Failed to pay any required income tax; or

(*3*) Entered into an installment agreement for the payment of any income tax;

(C) The Commissioner determines that the taxpayer is financially unable to pay the liability in full when due (and the taxpayer submits any information the Commissioner requires to make that determination);

(D) The installment agreement requires full payment of the liability within three years; and

(E) The taxpayer agrees to comply with the provisions of the Internal Revenue Code for the period the agreement is in effect.

(2) *Form of installment agreements.* An installment agreement must be in writing. A written installment agreement may take the form of a document signed by the taxpayer and the Commissioner or a written confirmation of an agreement entered into by the taxpayer and the Commissioner that is mailed or personally delivered to the taxpayer.

(3) *Terms of installment agreements.* (i) Except as otherwise provided in this section, an installment agreement is effective from the date the IRS notifies the taxpayer or the taxpayer's representative of its acceptance until the date the agreement ends by its terms or until it is superseded by a new installment agreement.

(ii) By its terms, an installment agreement may end upon the expiration of the period of limitations on collection in section 6502 and § 301.6502–1, or at some prior date.

(iii) As a condition to entering into an installment agreement with a taxpayer, the Commissioner may require that—

(A) The taxpayer agree to a reasonable extension of the period of limitations on collection; and

(B) The agreement contain terms that protect the interests of the Government.

(iv) Except as otherwise provided in an installment agreement, all payments made under the installment agreement will be applied in the best interests of the Government.

(v) While an installment agreement is in effect, the Commissioner may request, and the taxpayer must provide, a financial condition update at any time.

(vi) At any time after entering into an installment agreement, the Commissioner and the taxpayer may agree to modify or terminate an installment agreement or may agree to a new installment agreement that supersedes the existing agreement.

(d) *Rejection of a proposed installment agreement*—(1) *When a proposed installment agreement becomes rejected.* A proposed installment agreement has not been rejected until the IRS notifies the taxpayer or the taxpayer's representative of the rejection, the reason(s) for rejection, and the right to an appeal.

(2) *Independent administrative review.* The IRS may not notify a taxpayer or taxpayer's representative of the rejection of an installment agreement until an independent administrative review of the proposed rejection is completed.

(3) *Appeal of rejection of a proposed installment agreement.* The taxpayer may administratively appeal a rejection of a proposed installment agreement to the IRS Office of Appeals (Appeals) if, within the 30-day period commencing the day after the taxpayer is notified of the rejection, the taxpayer requests an appeal in the manner provided by the Commissioner.

(e) *Modification or termination of installment agreements by the Internal Revenue Service*—(1) *Inadequate information or jeopardy.* The Commissioner may terminate an installment agreement if the Commissioner determines that—

(i) Information which was provided to the IRS by the taxpayer or the taxpayer's representative in connection with either the granting of the installment agreement or a request for a financial update was inaccurate or incomplete in any material respect; or

(ii) Collection of any liability to which the installment agreement applies is in jeopardy.

(2) *Change in financial condition, failure to timely pay an installment or another Federal tax liability, or failure to provide requested financial information.* The Commissioner may modify or terminate an installment agreement if—

(i) The Commissioner determines that the financial condition of a taxpayer that is party to the agreement has significantly changed; or

(ii) A taxpayer that is party to the installment agreement fails to—

(A) Timely pay an installment in accordance with the terms of the installment agreement;

(B) Pay any other Federal tax liability when the liability becomes due; or

(C) Provide a financial condition update requested by the Commissioner.

(3) *Request by taxpayer.* Upon request by a taxpayer that is a party to the installment agreement, the Commissioner may terminate or modify the terms of an installment agreement if the Commissioner determines that the

financial condition of the taxpayer has significantly changed. The taxpayer's request will not suspend the statute of limitations under section 6502 for collection of any liability. While the Commissioner is considering the request, the taxpayer shall comply with the terms of the existing installment agreement.

(4) *Notice.* Unless the Commissioner determines that collection of the tax is in jeopardy, the Commissioner will notify the taxpayer in writing at least 30 days prior to modifying or terminating an installment agreement pursuant to paragraph (e)(1) or (2) of this section. The notice provided pursuant to this section must briefly describe the reason for the intended modification or termination. Upon receiving notice, the taxpayer may provide information showing that the reason for the proposed modification or termination is incorrect.

(5) *Appeal of modification or termination of an installment agreement.* The taxpayer may administratively appeal the modification or termination of an installment agreement to Appeals if, following issuance of the notice required by paragraph (e)(4) of this section and prior to the expiration of the 30-day period commencing the day after the modification or termination is to take effect, the taxpayer requests an appeal in the manner provided by the Commissioner.

(f) *Effect of installment agreement or pending installment agreement on collection activity*—(1) *In general.* No levy may be made to collect a tax liability that is the subject of an installment agreement during the period that a proposed installment agreement is pending with the IRS, for 30 days immediately following the rejection of a proposed installment agreement, during the period that an installment agreement is in effect, and for 30 days immediately following the termination of an installment agreement. If, prior to the expiration of the 30-day period following the rejection or termination of an installment agreement, the taxpayer appeals the rejection or termination decision, no levy may be made while the rejection or termination is being considered by Appeals. This section will not prohibit levy to collect the liability of any person other than the person or persons named in the installment agreement.

(2) *Exceptions.* Paragraph (f)(1) of this section shall not prohibit levy if the taxpayer files a written notice with the IRS that waives the restriction on levy imposed by this section, the IRS determines that the proposed installment agreement was submitted solely to delay collection, or the IRS determines that collection of the tax to which the installment agreement or proposed installment agreement relates is in jeopardy.

(3) *Other actions by the IRS while levy is prohibited*—(i) *In general.* The IRS may take actions other than levy to protect the interests of the Government with regard to the liability identified in an installment agreement or proposed installment agreement. Those actions include, for example—

(A) Crediting an overpayment against the liability pursuant to section 6402;

(B) Filing or refiling notices of Federal tax lien; and

(C) Taking action to collect from any person who is not named in the installment agreement or proposed installment agreement but who is liable for the tax to which the installment agreement relates.

(ii) *Proceedings in court.* Except as otherwise provided in this paragraph (f)(3)(ii), the IRS will not refer a case to the Department of Justice for the commencement of a proceeding in court, against a person named in an installment agreement or proposed installment agreement, if levy to collect the liability is prohibited by paragraph (f)(1) of this section. Without regard to whether a person is named in an installment agreement or proposed installment agreement, however, the IRS may authorize the Department of Justice to file a counterclaim or third-party complaint in a refund action or to join that person in any other proceeding in which liability for the tax that is the subject of the installment agreement or proposed installment agreement may be established or disputed, including a suit against the United States under 28 U.S.C. 2410. In addition, the United States may file a claim in any bankruptcy proceeding or insolvency action brought by or against such person. If a person named in an installment agreement is joined in a proceeding, the United States obtains a judgment against that person, and the case is referred back to the IRS for collection, collection will continue to occur pursuant to the terms of the installment agreement. Notwithstanding the installment agreement, any claim or suit permitted will be for the full amount of the liabilities owed.

(g) *Suspension of the statute of limitations on collection.* The statute of limitations under section 6502 for collection of any liability shall be suspended during the period that a proposed installment agreement relating to that liability is pending with the IRS, for 30 days immediately following the rejection of a proposed installment agreement, and for 30 days immediately following the termination of an installment agreement. If, within the 30 days following the rejection or termination of an installment agreement, the taxpayer files an appeal with Appeals, the statute of limitations for collection shall be suspended while the rejection or termination is being considered by Appeals. The statute of limitations for collection shall continue to run if an exception under paragraph (f)(2) of this section applies and levy is not prohibited with respect to the taxpayer.

(h) *Annual statement.* The Commissioner shall provide each taxpayer who is party to an installment agreement under this section with an annual statement setting forth the initial balance owed at the beginning of the year, the payments made during the year, and the remaining balance as of the end of the year.

(i) *Biennial review of partial payment installment agreements.* The Commissioner shall perform a review of the taxpayer's financial condition in the case of a partial payment installment agreement at least once every two years. The purpose of this review is to determine whether the taxpayer's financial condition has significantly changed so as to warrant an increase in the value of the payments being made or termination of the agreement.

(j) *Cross reference.* Pursuant to section 6601(b)(1), the last day prescribed for payment is determined without regard to any installment agreement, including for purposes of computing penalties and interest provided by the Internal Revenue Code. For special rules regarding the computation of the failure to pay penalty while certain installment agreements are in effect, *see* section 6651(h) and § 301.6651–1(a)(4).

(k) *Effective/applicability date.* This section is applicable on November 25, 2009.

■ **Par. 4.** Section 301.6331–4, paragraph (d) is revised and paragraph (e) is added to read as follows:

§ 301.6331–4 Restrictions on levy while installment agreements are pending or in effect.

* * * * *

(d) *Cross-reference.* For provisions relating to the making of levies while an installment agreement is pending or in effect, *see* § 301.6159–1.

(e) *Effective/applicability date.* Paragraphs (a), (b), and (c) are applicable beginning December 18, 2002. Paragraph (d) is applicable beginning November 25, 2009.

Approved: November 11, 2009.

Steven T. Miller,

Deputy Commissioner of Services and Enforcement.

Approved: November 11, 2009.

Michael F. Mundaca,

Acting Assistant Secretary of the Treasury (Tax Policy).

[FR Doc. E9–28330 Filed 11–24–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF LABOR

Mine Safety and Health Administration

30 CFR Parts 7 and 75

RIN 1219–AB58

Refuge Alternatives for Underground Coal Mines

AGENCY: Mine Safety and Health Administration (MSHA), Labor.

ACTION: Final rule; correction.

SUMMARY: This rule informs the mining community that MSHA rescinds the Agency's intent stated in the preamble to the final rule on Refuge Alternatives for Underground Coal Mines, concerning preemption of private tort litigation with respect to the Agency's approval of specifications for a refuge alternative.

DATES: *Effective Date:* November 25, 2009.

FOR FURTHER INFORMATION CONTACT: Patricia W. Silvey, Director, Office of Standards, Regulations, and Variances, MSHA, 1100 Wilson Boulevard, Room 2350, Arlington, Virginia 22209–3939. Ms. Silvey can be reached at 202–693–9440 (voice), 202–693–9441 (facsimile), or *silvey.patricia@dol.gov* (Internet e-mail).

SUPPLEMENTARY INFORMATION: On December 31, 2008, MSHA published a final rule on Refuge Alternatives for Underground Coal Mines. (73 FR 80656). The preamble includes a discussion on preemption, and states that ''it is MSHA's intent that its approval of specifications for a refuge alternative preempts private tort litigation questioning the propriety of those specifications.'' (73 FR 80658).

On May 20, 2009, the President issued a Memorandum for the Heads of Executive Departments and Agencies on Preemption. The purpose of the Memorandum is to state the general policy of the Administration that preemption of State law by executive departments and agencies should be undertaken only with full consideration of the legitimate prerogatives of the States and with a sufficient legal basis for preemption. The Memorandum directs executive departments and agencies to ''review regulations issued within the past 10 years that contain statements in regulatory preambles or codified provisions intended by the department or agency to preempt State law, in order to decide whether such statements or provisions are justified under applicable legal principles governing preemption.'' In addition, the memorandum states that ''where the head of a department or agency determines that a regulatory statement of preemption or codified regulatory provision cannot be so justified, the head of that department or agency should initiate appropriate action, which may include amendment of the relevant regulation.''

Section 506(b) of the Federal Mine Safety and Health Act of 1977 (Mine Act), concerning ''Effect on State Laws,'' specifically addresses preemption of state law as follows:

> The provisions of any State law or regulation in effect upon the operative date of this Act, or which may become effective thereafter, which provide for more stringent health and safety standards applicable to coal or other mines than do the provisions of this Act or any order issued or any mandatory health or safety standard shall not thereby be construed or held to be in conflict with this Act. 30 U.S.C. 955.

In addition, the House Report to the Mine Act, states that ''Federal law would supersede any State law in conflict with it,'' but that ''State laws providing more stringent standards than exist under the Federal law, however, would not be held in conflict with the [Mine] act.'' H. Rep. No. 95–312, 95th Cong., 1st Sess., at 55 (1977).

In accordance with the Presidential Memorandum on Preemption, MSHA has reviewed the Agency's standards and regulations issued within the past 10 years. MSHA's review found that a statement in the preamble to the Refuge Alternatives final rule is the only rule issued in the past 10 years to contain a preemption statement.

MSHA has determined that the Mine Act does not show any basis, or Congressional intent, for inferring any attempt to preempt state tort law regarding MSHA's approval specifications for refuge alternatives. As stated earlier, the Mine Act provides, for example, that State laws or regulations that provide more stringent requirements than those imposed under the Mine Act, are not construed or held to be in conflict with the Mine Act. MSHA's determination to rescind the preemption statement in the preamble to the Refuge Alternatives rule is consistent with the intent of the Mine Act and is consistent with the Presidential Memorandum. The preemption statement in the preamble was, at best, interpretive guidance purporting to interpret statutory language in the Mine Act, which was included in the preamble of the final rule without seeking prior public comment. It did not create any new law or substantive rule, but simply stated what the agency thought the statute meant. Further, this interpretation was published only recently, making it unlikely that any member of MSHA's regulated community has relied to their detriment on the interpretation. Under these circumstances, notice and comment also are not required in withdrawing this interpretation. *See Warshauer* v. *Solis,* 577 F.3d 1330 (11th Cir. 2009); *MetWest, Inc.* v. *Sec'y of Labor,* 560 F.3d 506, 509–511 (DC Cir. 2009).

Accordingly, MSHA rescinds the last paragraph of the section-by-section discussion of ''Section 7.501 Purpose and Scope,'' starting on line 51 of the center column and ending on line 24 of the third column, 73 FR 80658, for the reason that this statement is not justified under the Mine Act principles governing preemption, and there was no intent by Congress, under the Mine Act, to supersede state action in this regard.

Dated: November 19, 2009.

Joseph A. Main,

Assistant Secretary for Mine Safety and Health.

[FR Doc. E9–28214 Filed 11–24–09; 8:45 am]

BILLING CODE 4510–43–P

POSTAL REGULATORY COMMISSION

39 CFR Part 3020

[Docket Nos. MC2010–2 and CP2010–2; Order No. 324]

New Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Final rule.

SUMMARY: The Commission is adding the Priority Mail Contract 20 to the Competitive Product List. This action is consistent with changes in a recent law governing postal operations. Republication of the lists of market dominant and competitive products is also consistent with new requirements in the law.

DATES: Effective November 25, 2009 and is applicable beginning October 28, 2009.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel,

202–789–6820 or *stephen.sharfman@prc.gov.*

SUPPLEMENTARY INFORMATION: *Regulatory History,* 74 FR 54598 (October 22, 2009).

I. Introduction
II. Background
III. Comments
IV. Commission Analysis
V. Ordering Paragraphs

I. Introduction

The Postal Service seeks to add a new product identified as Priority Mail Contract 20 to the Competitive Product List. For the reasons discussed below, the Commission approves the Request.

II. Background

On October 14, 2009, the Postal Service filed a formal request pursuant to 39 U.S.C. 3642 and 39 CFR 3020.30 *et seq.* to add Priority Mail Contract 20 to the Competitive Product List.[1] The Postal Service asserts that the Priority Mail Contract 20 product is a competitive product ''not of general applicability'' within the meaning of 39 U.S.C. 3632(b)(3). This Request has been assigned Docket No. MC2010–2.

The Postal Service contemporaneously filed a contract related to the proposed new product pursuant to 39 U.S.C. 3632(b)(3) and 39 CFR 3015.5. The contract has been assigned Docket No. CP2010–2.

In support of its Request, the Postal Service filed the following materials: (1) A redacted version of the Governors' Decision, originally filed in Docket No. MC2009–25, authorizing the Priority Mail Contract Group; [2] (2) a redacted version of the contract; [3] (3) a requested change in the Mail Classification Schedule product list; [4] (4) a Statement of Supporting Justification as required by 39 CFR 3020.32; [5] (5) a certification of compliance with 39 U.S.C. 3633(a); [6] and (6) an application for non-public treatment of the materials filed under seal.[7] The redacted version of the contract provides that the contract is terminable on 30 days' notice by either party, but could continue for 3 years from the effective date subject to annual price adjustments. Request, Attachment B.

In the Statement of Supporting Justification, Mary Prince Anderson, Acting Manager, Sales and Communications, Expedited Shipping, asserts that the service to be provided under the contract will cover its attributable costs, make a positive contribution to coverage of institutional costs, and will increase contribution toward the requisite 5.5 percent of the Postal Service's total institutional costs. Request, Attachment D, at 1. W. Ashley Lyons, Manager, Regulatory Reporting and Cost Analysis, Finance Department, certifies that the contract complies with 39 U.S.C. 3633(a). *Id.,* Attachment E.

The Postal Service filed much of the supporting materials, including the supporting data and the unredacted contract, under seal. The Postal Service maintains that the contract and related financial information, including the customer's name and the accompanying analyses that provide prices, certain terms and conditions, and financial projections, should remain confidential. *Id.,* Attachment F, at 2–3.[8]

In Order No. 315, the Commission gave notice of the two dockets, appointed a public representative, and provided the public with an opportunity to comment.[9]

III. Comments

Comments were filed by the Public Representative.[10] No comments were submitted by other interested parties. The Public Representative states that the Postal Service's filing meets the pertinent provisions of title 39 and the relevant Commission rules. *Id.* at 1, 3. He further states that the agreement employs pricing terms favorable to the customer, the Postal Service, and thereby, the public. *Id.* at 3–4. The Public Representative also believes that the Postal Service has provided appropriate justification for maintaining confidentiality in this case. *Id.* at 3.

IV. Commission Analysis

The Commission has reviewed the Request, the contract, the financial analysis provided under seal that accompanies it, and the comments filed by the Public Representative.

Statutory requirements. The Commission's statutory responsibilities in this instance entail assigning Priority Mail Contract 20 to either the Market Dominant Product List or to the Competitive Product List. 39 U.S.C. 3642. As part of this responsibility, the Commission also reviews the proposal for compliance with the Postal Accountability and Enhancement Act (PAEA) requirements. This includes, for proposed competitive products, a review of the provisions applicable to rates for competitive products. 39 U.S.C. 3633.

Product list assignment. In determining whether to assign Priority Mail Contract 20 as a product to the Market Dominant Product List or the Competitive Product List, the Commission must consider whether

> the Postal Service exercises sufficient market power that it can effectively set the price of such product substantially above costs, raise prices significantly, decrease quality, or decrease output, without risk of losing a significant level of business to other firms offering similar products.

39 U.S.C. 3642(b)(1). If so, the product will be categorized as market dominant. The competitive category of products consists of all other products.

The Commission is further required to consider the availability and nature of enterprises in the private sector engaged in the delivery of the product, the views of those who use the product, and the likely impact on small business concerns. 39 U.S.C. 3642(b)(3).

The Postal Service asserts that its bargaining position is constrained by the existence of other shippers who can provide similar services, thus precluding it from taking unilateral action to increase prices without the risk of losing volume to private companies. Request, Attachment D, para. (d). The Postal Service also contends that it may not decrease quality or output without risking the loss of business to competitors that offer similar expedited delivery services. *Id.* It further states that the contract partner supports the addition of the contract to the Competitive Product List to effectuate the negotiated contractual terms. *Id.,* para. (g). Finally, the Postal Service states that the market for expedited delivery services is highly competitive and requires a substantial infrastructure to support a national network. It indicates that large carriers serve this market. Accordingly, the Postal Service states that it is unaware of any small business concerns that could offer comparable service for this customer. *Id.,* para. (h).

[1] Request of the United States Postal Service to Add Priority Mail Contract 20 to Competitive Product List and Notice of Filing (Under Seal) of Contract and Supporting Data, October 14, 2009 (Request).

[2] Attachment A to the Request, reflecting Governors' Decision No. 09–6, April 27, 2009.

[3] Attachment B to the Request.

[4] Attachment C to the Request.

[5] Attachment D to the Request.

[6] Attachment E to the Request.

[7] Attachment F to the Request.

[8] In its application for non-public treatment, the Postal Service requests an indefinite extension of non-public treatment of customer-identifying information. *Id.* at 7. For the reasons discussed in PRC Order No. 323, that request is denied. *See* Docket No. MC2010–1 and CP2010–1, Order Concerning Priority Mail Contract 19 Negotiated Service Agreement, October 26, 2009.

[9] PRC Order No. 315, Notice and Order Concerning Priority Mail Contract 20 Negotiated Service Agreement, October 16, 2009 (Order No. 315).

[10] Public Representative Comments in Response to United States Postal Service Request to Add Priority Mail Contract 20 Negotiated Service Agreement to the Competitive Products List, October 26, 2009 (Public Representative Comments).

No commenter opposes the proposed classification of Priority Mail Contract 20 as competitive. Having considered the statutory requirements and the support offered by the Postal Service, the Commission finds that Priority Mail Contract 20 is appropriately classified as a competitive product and should be added to the Competitive Product List.

Cost considerations. The Postal Service presents a financial analysis showing that Priority Mail Contract 20 results in cost savings while ensuring that the contract covers its attributable costs, does not result in subsidization of competitive products by market dominant products, and increases contribution from competitive products.

Based on the data submitted, the Commission finds that Priority Mail Contract 20 should cover its attributable costs (39 U.S.C. 3633(a)(2)), should not lead to the subsidization of competitive products by market dominant products (39 U.S.C. 3633(a)(1)), and should have a positive effect on competitive products' contribution to institutional costs (39 U.S.C. 3633(a)(3)). Thus, an initial review of proposed Priority Mail Contract 20 indicates that it comports with the provisions applicable to rates for competitive products.

Other considerations. The Postal Service shall notify the Commission if termination occurs prior to the scheduled termination date. Following the scheduled termination date of the agreement, the Commission will remove the product from the Competitive Product List.

In conclusion, the Commission approves Priority Mail Contract 20 as a new product. The revision to the Competitive Product List is shown below the signature of this order and is effective upon issuance of this order.

V. Ordering Paragraphs

It is ordered:

1. Priority Mail Contract 20 (MC2010–2 and CP2010–2) is added to the Competitive Product List as a new product under Negotiated Service Agreements, Domestic.

2. The Postal Service shall notify the Commission if termination occurs prior to the scheduled termination date.

3. The Secretary shall arrange for the publication of this order in the **Federal Register.**

List of Subjects in 39 CFR Part 3020

Administrative practice and procedure; Postal Service.

By the Commission.

Judith M. Grady,

Acting Secretary.

■ For the reasons discussed in the preamble, the Postal Regulatory Commission amends chapter III of title 39 of the Code of Federal Regulations as follows:

PART 3020—PRODUCT LISTS

■ 1. The authority citation for part 3020 continues to read as follows:

Authority: 39 U.S.C. 503; 3622; 3631; 3642; 3682.

■ 2. Revise Appendix A to Subpart A of Part 3020—Mail Classification Schedule to read as follows:

Appendix A to Subpart A of Part 3020—Mail Classification Schedule

Part A—Market Dominant Products

1000 Market Dominant Product List

First-Class Mail
- Single-Piece Letters/Postcards
- Bulk Letters/Postcards
- Flats
- Parcels
- Outbound Single-Piece First-Class Mail International
- Inbound Single-Piece First-Class Mail International

Standard Mail (Regular and Nonprofit)
- High Density and Saturation Letters
- High Density and Saturation Flats/Parcels
- Carrier Route
- Letters
- Flats
- Not Flat-Machinables (NFMs)/Parcels

Periodicals
- Within County Periodicals
- Outside County Periodicals

Package Services
- Single-Piece Parcel Post
- Inbound Surface Parcel Post (at UPU rates)
- Bound Printed Matter Flats
- Bound Printed Matter Parcels
- Media Mail/Library Mail

Special Services
- Ancillary Services
- International Ancillary Services
- Address List Services
- Caller Service
- Change-of-Address Credit Card Authentication
- Confirm
- International Reply Coupon Service
- International Business Reply Mail Service
- Money Orders
- Post Office Box Service

Negotiated Service Agreements
- HSBC North America Holdings Inc. Negotiated Service Agreement
- Bookspan Negotiated Service Agreement
- Bank of America corporation Negotiated Service Agreement
- The Bradford Group Negotiated Service Agreement
- Inbound International
- Canada Post—United States Postal Service Contractual Bilateral Agreement for Inbound Market Dominant Services

Market Dominant Product Descriptions

First-Class Mail

[Reserved for Class Description]
- Single-Piece Letters/Postcards
- [Reserved for Product Description]
- Bulk Letters/Postcards
- [Reserved for Product Description]
- Flats
- [Reserved for Product Description]
- Parcels
- [Reserved for Product Description]
- Outbound Single-Piece First-Class Mail International
- [Reserved for Product Description]
- Inbound Single-Piece First-Class Mail International
- [Reserved for Product Description]

Standard Mail (Regular and Nonprofit)

[Reserved for Class Description]
- High Density and Saturation Letters
- [Reserved for Product Description]
- High Density and Saturation Flats/Parcels
- [Reserved for Product Description]
- Carrier Route
- [Reserved for Product Description]
- Letters
- [Reserved for Product Description]
- Flats
- [Reserved for Product Description]
- Not Flat-Machinables (NFMs)/Parcels
- [Reserved for Product Description]

Periodicals

[Reserved for Class Description]
- Within County Periodicals
- [Reserved for Product Description]
- Outside County Periodicals
- [Reserved for Product Description]

Package Services

[Reserved for Class Description]
- Single-Piece Parcel Post
- [Reserved for Product Description]
- Inbound Surface Parcel Post (at UPU rates)
- [Reserved for Product Description]
- Bound Printed Matter Flats
- [Reserved for Product Description]
- Bound Printed Matter Parcels
- [Reserved for Product Description]
- Media Mail/Library Mail
- [Reserved for Product Description]

Special Services

[Reserved for Class Description]
- Ancillary Services
- [Reserved for Product Description]
- Address Correction Service
- [Reserved for Product Description]
- Applications and Mailing Permits
- [Reserved for Product Description]
- Business Reply Mail
- [Reserved for Product Description]
- Bulk Parcel Return Service
- [Reserved for Product Description]
- Certified Mail
- [Reserved for Product Description]
- Certificate of Mailing
- [Reserved for Product Description]
- Collect on Delivery
- [Reserved for Product Description]
- Delivery Confirmation
- [Reserved for Product Description]
- Insurance
- [Reserved for Product Description]
- Merchandise Return Service
- [Reserved for Product Description]
- Parcel Airlift (PAL)
- [Reserved for Product Description]
- Registered Mail
- [Reserved for Product Description]
- Return Receipt
- [Reserved for Product Description]
- Return Receipt for Merchandise
- [Reserved for Product Description]
- Restricted Delivery

- [Reserved for Product Description]
- Shipper-Paid Forwarding
- [Reserved for Product Description]
- Signature Confirmation
- [Reserved for Product Description]
- Special Handling
- [Reserved for Product Description]
- Stamped Envelopes
- [Reserved for Product Description]
- Stamped Cards
- [Reserved for Product Description]
- Premium Stamped Stationery
- [Reserved for Product Description]
- Premium Stamped Cards
- [Reserved for Product Description]
- International Ancillary Services
- [Reserved for Product Description]
- International Certificate of Mailing
- [Reserved for Product Description]
- International Registered Mail
- [Reserved for Product Description]
- International Return Receipt
- [Reserved for Product Description]
- International Restricted Delivery
- [Reserved for Product Description]
- Address List Services
- [Reserved for Product Description]
- Caller Service
- [Reserved for Product Description]
- Change-of-Address Credit Card Authentication
- [Reserved for Product Description]
- Confirm
- [Reserved for Product Description]
- International Reply Coupon Service
- [Reserved for Product Description]
- International Business Reply Mail Service
- [Reserved for Product Description]
- Money Orders
- [Reserved for Product Description]
- Post Office Box Service
- [Reserved for Product Description]

Negotiated Service Agreements

[Reserved for Class Description]

- HSBC North America Holdings Inc. Negotiated Service Agreement
- [Reserved for Product Description]
- Bookspan Negotiated Service Agreement
- [Reserved for Product Description]
- Bank of America Corporation Negotiated Service Agreement
- The Bradford Group Negotiated Service Agreement

Part B—Competitive Products

2000 Competitive Product List

Express Mail

- Express Mail
- Outbound International Expedited Services
- Inbound International Expedited Services
- Inbound International Expedited Services 1 (CP2008–7)
- Inbound International Expedited Services 2 (MC2009–10 and CP2009–12)

Priority Mail

- Priority Mail
- Outbound Priority Mail International
- Inbound Air Parcel Post
- Royal Mail Group Inbound Air Parcel Post Agreement

Parcel Select

Parcel Return Service

International

- International Priority Airlift (IPA)
- International Surface Airlift (ISAL)
- International Direct Sacks—M-Bags
- Global Customized Shipping Services
- Inbound Surface Parcel Post (at non-UPU rates)
- Canada Post—United States Postal service Contractual Bilateral Agreement for Inbound Competitive Services (MC2009–8 and CP2009–9)
- International Money Transfer Service
- International Ancillary Services

Special Services

- Premium Forwarding Service

Negotiated Service Agreements

- Domestic
- Express Mail Contract 1 (MC2008–5)
- Express Mail Contract 2 (MC2009–3 and CP2009–4)
- Express Mail Contract 3 (MC2009–15 and CP2009–21)
- Express Mail Contract 4 (MC2009–34 and CP2009–45)
- Express Mail & Priority Mail Contract 1 (MC2009–6 and CP2009–7)
- Express Mail & Priority Mail Contract 2 (MC2009–12 and CP2009–14)
- Express Mail & Priority Mail Contract 3 (MC2009–13 and CP2009–17)
- Express Mail & Priority Mail Contract 4 (MC2009–17 and CP2009–24)
- Express Mail & Priority Mail Contract 5 (MC2009–18 and CP2009–25)
- Express Mail & Priority Mail Contract 6 (MC2009–31 and CP2009–42)
- Express Mail & Priority Mail Contract 7 (MC2009–32 and CP2009–43)
- Express Mail & Priority Mail Contract 8 (MC2009–33 and CP2009–44)
- Parcel Select & Parcel Return Service Contract 1 (MC2009–11 and CP2009–13)
- Parcel Select & Parcel Return Service Contract 2 (MC2009–40 and CP2009–61)
- Parcel Return Service Contract 1 (MC2009–1 and CP2009–2)
- Priority Mail Contract 1 (MC2008–8 and CP2008–26)
- Priority Mail Contract 2 (MC2009–2 and CP2009–3)
- Priority Mail Contract 3 (MC2009–4 and CP2009–5)
- Priority Mail Contract 4 (MC2009–5 and CP2009–6)
- Priority Mail Contract 5 (MC2009–21 and CP2009–26)
- Priority Mail Contract 6 (MC2009–25 and CP2009–30)
- Priority Mail Contract 7 (MC2009–25 and CP2009–31)
- Priority Mail Contract 8 (MC2009–25 and CP2009–32)
- Priority Mail Contract 9 (MC2009–25 and CP2009–33)
- Priority Mail Contract 10 (MC2009–25 and CP2009–34)
- Priority Mail Contract 11 (MC2009–27 and CP2009–37)
- Priority Mail Contract 12 (MC2009–28 and CP2009–38)
- Priority Mail Contract 13 (MC2009–29 and CP2009–39)
- Priority Mail Contract 14 (MC2009–30 and CP2009–40)
- Priority Mail Contract 15 (MC2009–35 and CP2009–54)
- Priority Mail Contract 16 (MC2009–36 and CP2009–55)
- Priority Mail Contract 17 (MC2009–37 and CP2009–56)
- Priority Mail Contract 18 (MC2009–42 and CP2009–63)
- Priority Mail Contract 19 (MC2010–1 and CP2010–1)
- Priority Mail Contract 20 (MC2010–2 and CP2010–2)
- Outbound International
- Direct Entry Parcels Contracts
- Direct Entry Parcels 1 (MC2009–26 and CP2009–36)
- Global Direct Contracts (MC2009–9, CP2009–10, and CP2009–11)
- Global Expedited Package Services (GEPS) Contracts
- GEPS 1 (CP2008–5, CP2008–11, CP2008–12, and CP2008–13, CP2008–18, CP2008–19, CP2008–20, CP2008–21, CP2008–22, CP2008–23, and CP2008–24)
- Global Expedited Package Services 2 (CP2009–50)
- Global Plus Contracts
- Global Plus 1 (CP2008–8, CP2008–46 and CP2009–47)
- Global Plus 2 (MC2008–7, CP2008–48 and CP2008–49)
- Inbound International
- Inbound Direct Entry Contracts with Foreign Postal Administrations
- Inbound Direct Entry Contracts with Foreign Postal Administrations (MC2008–6, CP2008–14 and MC2008–15)
- Inbound Direct Entry Contracts with Foreign Postal Administrations 1 (MC2008–6 and CP2009–62)
- International Business Reply Service Competitive Contract 1 (MC2009–14 and CP2009–20)

Competitive Product Descriptions

- Express Mail [Reserved for Group Description]
- Express Mail [Reserved for Product Description]
- Outbound International Expedited Services [Reserved for Product Description]
- Inbound International Expedited Services [Reserved for Product Description]
- Priority [Reserved for Product Description]
- Priority Mail [Reserved for Product Description]
- Outbound Priority Mail International [Reserved for Product Description]
- Inbound Air Parcel Post [Reserved for Product Description]
- Parcel Select [Reserved for Group Description]
- Parcel Return Service [Reserved for Group Description]
- International [Reserved for Group Description]
- International Priority Airlift (IPA) [Reserved for Product Description]
- International Surface Airlift (ISAL) [Reserved for Product Description]
- International Direct Sacks—M-Bags [Reserved for Product Description]
- Global Customized Shipping Services [Reserved for Product Description]
- International Money Transfer Service [Reserved for Product Description]
- Inbound Surface Parcel Post (at non-UPU rates) [Reserved for Product Description]
- International Ancillary Services [Reserved for Product Description]
- International Certificate of Mailing [Reserved for Product Description]

International Registered Mail [Reserved for Product Description]
International Return Receipt [Reserved for Product Description]
International Restricted Delivery [Reserved for Product Description]
International Insurance [Reserved for Product Description]
Negotiated Service Agreements [Reserved for Group Description]
Domestic [Reserved for Product Description]
Outbound International [Reserved for Group Description]

Part C—Glossary of Terms and Conditions [Reserved]

Part D—Country Price Lists for International Mail [Reserved]

[FR Doc. E9–28205 Filed 11–24–09; 8:45 am]
BILLING CODE 7710–FW–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 52 and 97

[EPA–R04–OAR–2009–0765; FRL–8984–6]

Approval and Promulgation of Implementation Plans and Designation of Areas for Air Quality Implementation Plans; Tennessee; Clean Air Interstate Rule

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is taking final action to approve revisions to the Tennessee State Implementation Plan (SIP) submitted by the State of Tennessee through the Tennessee Department of Environment and Conservation (TDEC) on July 13, 2009. This revision incorporates provisions related to the implementation of EPA's Clean Air Interstate Rule (CAIR), promulgated on May 12, 2005, subsequently revised on April 28, 2006, and December 13, 2006, and the CAIR Federal Implementation Plan (FIP) concerning sulfur dioxides (SO_2), nitrogen oxides (NO_X) annual, and NO_X ozone season emissions for the State of Tennessee, promulgated on April 28, 2006, and subsequently revised December 13, 2006.

DATES: *Effective Date:* This final rule is effective November 25, 2009.

ADDRESSES: EPA has established a docket for this action under Docket Identification No. EPA–R04–OAR–2009–0765. All documents in the docket are listed on the *http://www.regulations.gov* Web site. Although listed in the index, some information is not publicly available, *i.e.,* Confidential Business Information or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *http://www.regulations.gov* or in hard copy at the Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. EPA requests that if at all possible, you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 to 4:30, excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Twunjala Bradley, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, Region 4, U.S. Environmental Protection Agency, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. Ms. Bradley can be reached by telephone at (404) 562–9352 and by electronic mail at *bradley.twunjala@epa.gov.*

SUPPLEMENTARY INFORMATION:

Table of Contents

I. EPA's Action
II. Background
III. Final Action
IV. Effective Date
V. Statutory and Executive Order Reviews

I. EPA's Action

EPA is taking final action to approve a revision to Tennessee's SIP, submitted by Tennessee on July 13, 2009, as clarified herein, that is modifying the application of certain provisions of the CAIR FIP concerning NO_X ozone season emissions. (As discussed in the notice of proposed rulemaking for this submission, this less comprehensive CAIR SIP is termed an abbreviated SIP.) Tennessee is subject to the CAIR FIPs that implement the CAIR requirements by requiring certain energy generating units (EGUs) to participate in the EPA administered CAIR cap-and-trade programs addressing SO_2, NO_X annual, and NO_X ozone season emissions. This SIP revision provides a methodology for allocating NO_X allowances for the NO_X ozone season trading program for NO_X SIP Call trading sources that are not EGUs as defined by CAIR, but are subject to the CAIR NO_X ozone season trading program. The CAIR FIPs provide that this methodology will be used to allocate NO_X Ozone Season allowances to sources in Tennessee. Consistent with the flexibility provided in the FIPs, these provisions will also be used to replace or supplement, as appropriate, the corresponding provisions in the CAIR FIP for Tennessee. EPA is also approving technical corrections to the CAIR NO_X Ozone Season Trading Program opt-in provisions, as noted in the August 20, 2007, approval. Since EPA will no longer administer the NO_X Budget Trading Program, Tennessee has chosen to terminate its Budget Trading program rules (TAPCR Rule 1200–03–27–.06). EPA is, therefore, approving provisions which terminate the State's NO_X Budget Trading Program because those requirements are now addressed by the CAIR NO_X Ozone Season FIP, as modified by the State's abbreviated SIP. Finally, EPA is not making any changes to the CAIR FIP, but is amending the appropriate appendices to note EPA's approval of Tennessee's SIP revision.

II. Background

On February 11, 2009, Tennessee adopted a revision to its CAIR NO_X Ozone Season Trading Program, and on July 13, 2009, submitted a request to EPA for approval of these revisions into the SIP. That request was revised on September 21, 2009, and supplemented by a letter to EPA dated September 24, 2009, clarifying portions of the submittal.

The CAIR FIPs established budgets for Tennessee as 50,973 (2009–2014) and 42,478 (2015–thereafter) tons for NO_X annual emissions, 22,842 (2009–2014) and 19,035 (2015-thereafter) tons for NO_X ozone season emissions and 137,216 (2010–2014) and 96,051 (2015-thereafter) tons for SO_2 emissions. In Tennessee's SIP revision, submitted on July 13, 2009, Tennessee has chosen to include all NO_X SIP Call trading sources that are not EGUs under CAIR in the CAIR NO_X ozone season trading program. As a result of this SIP revision, the CAIR NO_X ozone season budget will be increased annually by 5,666 tons to account for such NO_X SIP Call trading sources. The total Tennessee CAIR NO_X ozone season budgets are therefore, 28,508 (2009–2014) and 24,701 (2015-thereafter) tons. EPA is approving Tennessee State trading budgets under TAPCR 1200–3–27–.11(2)(c).

EPA published a notice of proposed rulemaking to approve Tennessee's revisions to the CAIR SIP on October 14, 2009, (74 FR 52717). EPA did not receive any comments during the public comment period for the proposed rulemaking.

EPA notes that, in *North Carolina* v. *EPA,* 531 F.3d 836 (DC Cir. Jul.11, 2008) at 916–21, the Court determined, among other things, that the state SO_2 and NO_X

budget established in CAIR were arbitrary and capricious[1]. However, the action approved today is consistent with the Court's decision to leave CAIR in place to ''temporarily preserve the environmental values covered by CAIR'' pending EPA's development and promulgation of a replacement rule that remedies CAIR's flaws. *North Carolina* v. *EPA,* 550 F.3d at 1178. Pursuant to the Court's ruling, EPA is developing a new rule that will undergo notice and comment which will result in a final replacement rule for CAIR. In the meantime, EPA is implementing CAIR by approving SIP revisions that are consistent with CAIR (such as the provisions setting state SO_2 and NO_X budgets for the CAIR trading programs) in order to ''temporarily preserve'' the environmental benefits achievable under the CAIR trading programs.

III. Final Action

EPA is taking final action to approve Tennessee's SIP revision that includes an abbreviated CAIR SIP submitted on July 13, 2009, as clarified herein. Tennessee is covered by the CAIR FIPs which require participation in the EPA administered CAIR FIP cap and trade programs for SO_2, NO_X annual, and NO_X ozone season emissions. Under this SIP revision and consistent with the flexibility given to the States in the FIPs, EPA is approving Tennessee's CAIR NO_X ozone season provisions expanding the current applicability provisions in the CAIR NO_X ozone season trading program to include units that are not otherwise subject to the trading program but are subject to Tennessee's NO_X Budget Trading Program; revisions to the allocation methodology provisions (interpreted as discussed above) in the CAIR NO_X ozone season trading program to cover these units; and corrections to the CAIR NO_X ozone season trading program opt-in provisions (as discussed above).

As provided for in the CAIR FIP, the provisions in the abbreviated SIP revision will replace or supplement the corresponding provisions of the CAIR FIPs in Tennessee. The abbreviated SIP revision meets the applicable requirements in 40 CFR 51.123(ee), with regard to NO_X ozone season emissions. EPA is not making any changes to the CAIR FIP, but is amending the appropriate appendices to note EPA's approval of Tennessee's SIP revision.

This action also approves the termination of the State's NO_X Budget Trading Program as discussed in Section 1.

IV. What Is the Effective Date

An expedited effective date for this action is authorized under both 5 U.S.C. 553(d)(1), which provides that rule actions may become effective less than 30 days after publication if the rule ''grants or recognizes an exemption or relieves a restriction'' and section 5 U.S.C. 553(d)(3), which allows an effective date less than 30 days after publication ''as otherwise provided by the agency for good cause found and published with the rule.'' EPA finds that there is good cause for this approval to become effective upon publication.

CAIR SIP approvals relieve States and CAIR sources within States from being subject to provisions in the CAIR FIPs that otherwise would apply to them, allowing States to implement CAIR based on their SIP-approved State rule. The relief from these obligations is sufficient reason to allow an expedited effective date of the rule under 5 U.S.C. 553(d)(1). In addition, Tennessee's relief from these obligations provides good cause to make this rule effective immediately upon publication, pursuant to 5 U.S.C. 553(d)(3). The purpose of the 30-day waiting period prescribed in 5 U.S.C. 553(d) is to give affected parties a reasonable time to adjust their behavior and prepare before the final rule takes effect. Where, as here, the final rule relieves obligations rather than imposes obligations, affected parties, such as the State of Tennessee and CAIR sources within the State, do not need time to adjust and prepare before the rule takes effect.

V. Statutory and Executive Order Reviews

Under the Clean Air Act (CAA), the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve State choices, provided that they meet the criteria of the CAA. Accordingly, this action merely approves State law as meeting Federal requirements and does not impose additional requirements beyond those imposed by State law. For that reason, this action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 1312 (64 FR 43255, August 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because applications of those requirements would be inconsistent with the CAA; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have Tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the State, and EPA notes that it will not impose substantial direct costs on Tribal governments or preempt Tribal law.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

[1] The Court also determined that the CAIR trading programs were unlawful (*id.* at 906–8) and that the treatment of title IV allowances in CAIR was unlawful (*id.* at 921–23). For the same reasons that EPA is approving the provisions of Tennessee's SIP revision that use the SO_2 and NO_X budgets set in CAIR, EPA is also approving, as discussed below, Tennessee's SIP revision to the extent the SIP revision adopts the CAIR trading programs, including the provisions addressing applicability, allowance allocations, and use of title IV allowances.

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 25, 2010. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (*See* section 307(b)(2) of the CAA.)

List of Subjects

40 CFR Part 52

Environmental protection, Air pollution control, Electric utilities, Intergovernmental relations, Incorporation by reference, Carbon monoxide, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur dioxide.

40 CFR Part 97

Environmental protection, Air pollution control, Electric utilities, Intergovernmental relations, Incorporation by reference, Nitrogen oxides, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur dioxide.

Dated: November 16, 2009.

J. Scott Gordon,

Acting Regional Administrator, Region 4.

■ 40 CFR parts 52 and 97 are amended as follows:

PART 52—[AMENDED]

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

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

Subpart RR—Tennessee

■ 2. In § 52.2220(c), Table 1 is amended under Chapter 1200–3–27, by revising the entry ''Section 1200–3–27.11'' to read as follows:

§ 52.2220 Identification of plan.

* * * * *

(c) * * *

TABLE 1—EPA-APPROVED TENNESSEE REGULATIONS

State citation	Title/subject	State effective date	EPA approval date	Explanation
* *	* *	*	*	*
Chapter 1200–3–27 Nitrogen Oxides				
* *	* *	*	*	*
Section 1200–3–27.11	CAIR NO_X Ozone Season Trading Program	10/4/09	11/25/09 [Insert citation of publication].	
* *	* *	*	*	*

* * * * *

PART 97—[AMENDED]

■ 3. The authority citation for part 97 continues to read as follows:

Authority: 42 U.S.C. 7401, 7403, 7410, 7426, 7601, and 7651, *et seq.*

■ 4. Appendix A to Subpart AAAA is amended by adding the entry ''Tennessee'' in alphabetical order to read as follows:

Appendix A to Subpart AAAA of Part 97—States With Approved State Implementation Plan Revisions Concerning Applicability

* * * * *

Tennessee

[FR Doc. E9–28148 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 86 and 600

[EPA–HQ–OAR–2005–0169; FRL–8982–1]

RIN 2060–A036

Fuel Economy Regulations for Automobiles: Technical Amendments and Corrections

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: EPA is taking direct final action amending and correcting portions of the Environmental Protection Agency's existing fuel economy and emission regulations. This action makes some minor corrections and amendments to EPA's December 27th 2006 final rule for fuel economy labeling requirements for cars and light trucks, including a slight revision to the minivan definition. This action also makes changes to EPA regulations to administer the Department of Transportation's (DOT's) 2008–2011 model year passenger automobile and light truck corporate average fuel economy (CAFE) standards. Changes include adding reporting requirements for manufacturers to report to EPA their applicable reformed CAFE fuel economy standards (also called ''required fuel economy levels'') and reporting the basis for determining such ''required fuel economy levels.''

This direct final rule also adds provisions to clarify that special test procedures, calculation methods and label formats may be used for advanced technology vehicles for fuel economy labeling and CAFE purposes. Advanced technology vehicles include, but are not limited to electric vehicles, fuel cell vehicles, plug-in hybrid vehicles and vehicles equipped with hydrogen-fueled internal combustion engines. In addition, today's action makes some minor changes to clarify the meaning of, and correct errata in EPA regulations. The above amendments and corrections will allow for the more effective administration of existing regulations.

DATES: This rule is effective on January 25, 2010 without further notice, unless EPA receives adverse comment by December 28, 2009. If EPA receives

adverse comment, we will publish a timely withdrawal in the **Federal Register** informing the public that the rule will not take effect. The incorporation by reference of certain publications listed in this rule is approved by the Director of the Federal Register as of January 25, 2010.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–OAR–2005–0169, by one of the following methods:

- *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.
- *Fax:* (202) 566–1741.
- *Mail:* Environmental Protection Agency, EPA Docket Center (EPA/DC), Air and Radiation Docket, Mail Code 6102T, 1200 Pennsylvania Avenue, NW., Washington, DC 20460, Attention Docket ID No. EPA–HQ–OAR–2005–0169. In addition, please mail a copy of your comments on the information collection provisions to the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attn: Desk Officer for EPA, 725 17th St., NW., Washington, DC 20503.''
- *Hand Delivery:* Docket Center, (EPA/DC) EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC., Attention Docket ID No. OAR–2005–0169. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–HQ–OAR–2005–0169. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.* For additional instructions on submitting comments, go to Section VII of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the EPA Docket Center, EPA/DC, EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC. This Docket Facility is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The EPA Docket Center telephone number is (202) 566–1742. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744.

FOR FURTHER INFORMATION CONTACT: Christine Mikolajczyk, Environmental Protection Agency, Office of Transportation and Air Quality, Compliance and Innovative Strategies Division, 2000 Traverwood Drive, Ann Arbor, MI 48105, telephone number: (734) 214–4403; fax number: (734) 214–4503; e-mail address: *mikolajczyk.christine@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Why Is EPA Using a Direct Final Rule?

EPA is publishing this rule without a prior proposed rule because we view this as a non-controversial action and anticipate no adverse comment. However, in the ''Proposed Rules'' section of today's **Federal Register**, we are publishing a separate document that will serve as the proposed rule to amend EPA's fuel economy regulations if adverse comments are received on this direct final rule. We will not institute a second comment period on this action. Any parties interested in commenting must do so at this time. For further information about commenting on this rule, *see* the **ADDRESSES** section of this document.

If EPA receives adverse comment on a distinct provision of this rulemaking, we will publish a timely withdrawal in the **Federal Register** indicating which provisions we are withdrawing. The provisions that are not withdrawn will become effective on the date set out above, notwithstanding adverse comment on any other provision.

II. Does This Action Apply to Me?

This action applies to manufacturers of new passenger cars and light trucks, including medium-duty passenger vehicles.[1] Regulated categories and entities include:

Category	NAICS Codes[a]	Examples of potentially regulated entities
Industry	336111, 336112	Motor vehicle manufacturers.
Industry	811112, 811198, 541514.	Commercial Importers of Vehicles and Vehicle Components.

[a] North American Industry Classification System (NAICS).

[1] ''Passenger car,'' ''light truck,'' and ''medium-duty passenger vehicle'' are defined in 40 CFR 600.002–08. Generally, the term ''light truck'' means a pick-up truck, sport-utility vehicle, or minivan of up to 8,500 lbs gross vehicle weight rating, and ''medium-duty passenger vehicle'' means a sport-utility vehicle or passenger van from 8,500 to 10,000 lbs gross vehicle weight rating. Medium-duty passenger vehicles do not include pick-up trucks.

This list is not intended to be exhaustive, but rather provides a guide regarding entities likely to be regulated by this action. To determine whether particular activities may be regulated by this action, you should carefully examine the regulations. You may direct questions regarding the applicability of this action to the person listed in **FOR FURTHER INFORMATION CONTACT**.

III. What Amendments Are Being Made in This Action?

Today's direct final rule makes minor, non-controversial changes to EPA's fuel economy and emission regulations. Three separate actions have precipitated most of these changes. First, on December 27, 2006 (71 FR 77872), EPA finalized regulations specifying new methods to determine the fuel economy label estimates posted on the window stickers of new cars and trucks. Second, on April 6, 2006 (71 FR 17566), the Department of Transportation's National Highway Traffic Safety Administration (NHTSA), finalized new average fuel economy (CAFE) standards for 2008–2011 trucks. Third, on March 30, 2009 (74 FR 14196), NHTSA revised CAFE requirements for 2011 trucks and finalized new average fuel economy (CAFE) standards for 2011 passenger automobiles. The EPA regulations being amended for these three actions are contained in 40 CFR Parts 86 and 600.

Today's direct final rule clarifies that special test procedures, calculation methods and label formats may be used for fuel economy labels and CAFE calculations of advanced technology vehicles. Advanced technology vehicles include, but are not limited to electric vehicles, fuel cell vehicles, plug-in hybrid vehicles and vehicles equipped with hydrogen-fueled internal combustion engines. This rule also includes technical amendments to the fuel economy label regulations, including changes to the minivan definition, van definition, interior volume measurements of passenger vehicles, and special purpose class of vehicles. Today's action also corrects some typographical errors and makes other minor modifications to ensure accurate interpretation of the regulations. The changes to the EPA CAFE regulations are being made to conform to the NHTSA regulations, and include adding new reporting provisions that will enable EPA to provide NHTSA with the data it needs to determine compliance with the 2008–2011 CAFE standards for passenger automobiles and light trucks.

In addition, two changes are being made to align the EPA CAFE regulations with a 2007 Energy Independence and Security Act (EISA) amendment extending the alternative fuel vehicle CAFE credits to 2019, and to align the EPA CAFE regulations with a previous NHTSA rulemaking which eliminated the requirement to report separate CAFE values for domestic and imported trucks.

A. Fuel Economy Labeling and CAFE Changes for Advanced Technology Vehicles

According to 49 U.S.C. 32908, fuel economy labels are required for cars, light-duty trucks and other vehicles that meet the definition of automobile. For example, the provisions of 49 U.S.C. 32908 (b) read in part:

> ''(b) Labeling Requirements and Contents.—(1) Under regulations of the Administrator of the Environmental Protection Agency, a manufacturer of automobiles shall attach a label to a prominent place on each automobile manufactured in a model year. The dealer shall maintain the label on the automobile. The label shall contain the following information: * * *''

On December 27, 2006, EPA finalized a new fuel economy labeling rule.[2] Under this rulemaking, EPA regulations state that labeling requirements under Subpart D are applicable to 2008 and later model year cars and light-duty trucks and 2011 and later model year medium duty passenger vehicles (MDPVs).[3] Prior to the 2008 model year, labeling requirements in Subpart D were applicable to gasoline-fueled, diesel-fueled, alcohol-fueled, natural gas fueled, alcohol dual fuel and natural gas dual fuel light-duty vehicles.

Under the regulations in 40 CFR Part 600, advanced technology vehicles are required to meet the labeling requirements for conventional vehicles. Advanced technology vehicles include battery electric vehicles, fuel cell vehicles, plug-in hybrid electric vehicles and vehicles equipped with hydrogen internal combustion engines. While the labeling regulations as written apply the same requirements and options to advanced technology vehicles as are applied to conventional technology vehicles, this was an inadvertent error. EPA adopted the labeling regulations based on it's evaluation of what would be appropriate for conventional technology vehicles, and did not evaluate what changes might or might not be appropriate for advanced technology vehicles. EPA did not intend that these types of vehicles would be required to meet all of the requirements for conventional vehicles. For example, the specific labeling requirements of this subpart were not intended to apply to plug-in hybrids. In EPA's Response to Comments-Fuel Economy Labeling of Motor Vehicles, pages 53–54, EPA states:

> ''Bluewater Network commented that they believe plug-in hybrids will be commercially available in the future and EPA should consider how this emerging technology should be addressed with respect to fuel economy labeling and testing.''
>
> EPA's response:
>
> ''Commercial hybrids available today ultimately obtain all propulsion energy from liquid fuel stored in the fuel tank, while a plug-in hybrid uses a combination of liquid fuel and supplemental energy from the electric grid stored in the battery (*i.e.,* overnight charge). Properly accounting for this supplemental electric energy is the central issue in assessing the performance of plug-in hybrids. Therefore, plug-in hybrids will require a more comprehensive assessment in order to determine the proper test procedures for fuel economy and emissions. Since plug-in hybrid technology is rapidly advancing, we will work with key stakeholders in the next few years to assess the appropriateness of the 5-cycle methodology in capturing the fuel economy impact of the plug-in technology. We agree strongly with those commenters urging against technology-specific adjustment factors. We are especially concerned that such an approach would create an uneven playing field across vehicles. We are aware that technologies are rapidly developing, and we intend to ensure, as part of our ongoing evaluation of the fuel economy test methods, that new and developing technologies are represented appropriately.'' (Complete document available at *http://www.epa.gov/fueleconomy/regulations.htm*)

In this context, EPA is revising several regulatory provisions in 40 CFR Part 600 related to fuel economy testing, labeling and CAFE, to make appropriate modifications for use with advanced technology vehicles. EPA reviewed the various applicable regulations to determine where appropriate modifications were needed to address advanced technology vehicles. In large part this called for changes to regulations that address test procedures for test vehicles and calculation procedures to determine fuel economy for the test vehicle, as well as regulations that address what fuel economy value and other information the label is to include. The Agency's detailed analysis of the need for regulation changes to 40 CFR Part 600 regulations is outlined below.

---

[2] Fuel Economy Labeling of Motor Vehicles: Revisions To Improve Calculation of Fuel Economy Estimates; Final Rule; 71 FR 77872, December 27, 2006.

[3] *See* 40 CFR 600.301–08(a). Note that the term ''automobile'' contained in 40 CFR 600.301–08(a) is defined in 40 CFR 600.002–08 as follows: ''*Automobile* has the meaning given by the Department of Transportation at 49 CFR 523.3.''

1. Part 600 Subpart A

Subpart A contains general applicability, definitions, abbreviations, recordkeeping requirements, data and information requirements for fuel economy vehicles, vehicle acceptability requirements, review of fuel economy data, minimum data requirements and other largely administrative requirements. EPA's review of the requirements contained in this subpart indicated that regulation changes are not needed to this Subpart for purposes of advanced technology vehicles.

2. Part 600 Subpart B

Subpart B contains general applicability, definitions, abbreviations, recordkeeping requirements, equipment requirements, fuel specifications, analytical gas requirements, EPA driving cycles, equipment calibration, test procedures, exhaust sample analysis and fuel economy calculation requirements. EPA's review of the requirements contained in this subpart indicated that regulation changes are needed to 40 CFR 600.111–08 of Subpart B regarding fuel economy test procedures used for advanced technology vehicles. EPA reviewed 40 CFR 600.111–08, which provides that manufacturers shall use the emissions test procedures from 40 CFR Part 86 for conducting FTP, HFET, the US06, SC03 and Cold temperature FTP tests for fuel economy. Part 86 allows for the use of special test procedures for emissions testing under 40 CFR 86.1840 when the Administrator determines that a vehicle in Part 86 ''is not susceptible to satisfactory testing by the procedures set forth in this part.'' A similar provision is not explicitly included in Subpart B for fuel economy testing, nor is 40 CFR 86.1840 referred to as an option. Therefore, under this rulemaking, EPA is modifying 40 CFR 600.111–08 to allow special test procedures for advanced technology vehicles not susceptible to satisfactory testing or testing results under the current test provisions. This can be allowed upon written application by the manufacturer and approval by the Administrator, or at the Administrator's own initiative.

For example, the test procedures used for battery electric vehicles for the FTP (city), highway, US06, SC03, and cold temperature FTP tests contain many differences from those test procedures used for conventional vehicles outlined in 40 CFR 600.111–08. To illustrate this point, consider the FTP (city) test. While electric vehicles are driven over the same preconditioning cycle and test cycle as conventional vehicles, electric vehicles are not refueled (their battery is recharged) and electric vehicles are not required to undergo evaporative canister preconditioning prior to the test (they have no canisters). The test procedure for electric vehicles consists of operating the vehicle over many successive FTP (city) cycles until the battery becomes depleted to the point where the vehicle can no longer follow the driving cycle. The test procedure for conventional vehicles outlined in 40 CFR 600.111–08 consists of operating the vehicle over one FTP (city) cycle. While the test procedures for battery electric and conventional vehicles are similar in general (and comparable to 1975 test procedures), the detailed step-by-step test procedures have many differences due to the inherent differences in the vehicles.

Similarly for plug-in hybrid electric vehicles, EPA did not intend that plug-in hybrid electric vehicles would be required to meet all the specific fuel economy requirements contained in 40 CFR 600.111–08 for conventional vehicles. EPA is currently working on guidance for test procedures and fuel economy labeling requirements for plug-in hybrids. Plug-in hybrid vehicles typically have two operating modes: (1) Operation after the battery has been fully charged (called charge depleting mode) and (2) operation after the battery has been discharged and the vehicle is operating similar to conventional hybrid vehicles (called charge sustaining mode). The Agency anticipates that the fuel economy test procedures for plug-in hybrids will be similar to those for battery electric vehicles during the charge depleting mode and similar to conventional vehicles during the charge sustaining mode. While the test procedures for plug-in hybrid electric vehicles and conventional vehicles are expected to be similar in general (and comparable to 1975 test procedures), the detailed step-by-step test procedures for plug-in hybrid vehicles are expected to contain many differences from the step-by-step requirements described in 40 CFR 600.111–08 due to the inherent differences in the vehicles.

The data derived from Part 86 emissions tests and Part 600 fuel economy tests (using test procedures outlined in Part 600 Subpart B) are used to calculate the fuel economy values for each vehicle model. The methods to calculate the test vehicle's fuel economy for the specific test are provided in 40 CFR 600.113–08. For example, this section specifies how to calculate the fuel economy for the test vehicle for FTP, HFET, US06, SC03 and cold temperature FTP tests. These calculation procedures are specified for vehicles fueled with gasoline, diesel, alcohol-based or natural gas fuel. There are specific calculations for automobiles fueled with natural gas, methanol-fueled automobiles and automobiles designed to operate on mixtures of gasoline and methanol.[4] Fuel economy for vehicles operated on other fuels not listed above may use calculations with advance approval from the Administrator.[5]

Currently, tests of conventional hybrids use the calculation methodology for the gasoline, diesel, or other fuel that they use, as EPA considers that the electric energy used by the hybrid originates in the combustion of the gasoline, diesel, or other fuel. Advanced technology vehicles however may need different calculation procedures. For example, plug-in hybrids may not be treated the same as conventional hybrids, as the plug-in hybrid operates in part on fuel such as gasoline and diesel, and in part on electric power that originates from the electricity grid and not from the combustion of the gasoline or diesel fuel. In that case, EPA would use the current provision at 40 CFR 600.113–08(l) to approve appropriate calculation procedures for use with plug-in hybrids. This same provision could be used for other advanced technology vehicles as well. Electric vehicles could also be covered by this provision, at least for purposes of calculating fuel economy of the test vehicle for later use in labeling. For purposes of CAFE, fuel economy calculation procedures are provided by the Department of Energy to determine the electric vehicles urban and highway fuel economy value.[6] Based on the discretion already provided in 40 CFR 600.113–08(l), EPA does not believe that further modification is needed to this provision for purposes of calculating fuel economy for advanced technology test vehicles.

The use of special test procedures and appropriate fuel economy calculation methods for that test procedure, when determining the fuel economy of an advanced technology test vehicle, will affect both the fuel economy labeling and CAFE programs, as the fuel economy values from the test vehicles over the relevant test procedures are then used in both programs, under other provisions in Part 600.

Once EPA or the manufacturer tests the vehicle, using appropriate test procedures, and calculates the fuel economy for the test vehicle over the tests, then 40 CFR 600.114–08 specifies how to calculate the 5-cycle city and highway fuel economy values for that

[4] *See* 40 CFR 600.113–08 paragraphs (j) and (k).

[5] *See* 40 CFR 600.113–08 paragraph (l).

[6] *See* 10 CFR 474.3 and 49 U.S.C. 32904(a)(2).

test vehicle for purposes of labeling under Subpart D, including specific calculations for hybrid vehicles. 40 CFR 115–08 establishes criteria for determining the fuel economy label calculation method for 2011 and later model year vehicles, mpg-based or 5-cycle, for test groups. Assuming appropriate test and calculation procedures have been used under 40 CFR 600.113–08 and 600.114–08, then no changes are needed to these provisions for advanced technology vehicles.

3. Part 600 Subpart C

Subpart C contains general applicability, definitions, abbreviations, recordkeeping requirements, calculation of FTP-based and HFET-based fuel economy values, calculation of vehicle-specific 5-cycle based fuel economy values, calculation of fuel economy values for labeling requirements. EPA's review of the requirements contained in this subpart indicated that regulation changes are needed to 40 CFR 600.210–08 of Subpart C for purposes of determining the fuel economy label values for advanced technology vehicles.

Fuel economy values for vehicle configurations are calculated under the provisions of 40 CFR 600.206–08, for FTP-based and HFET-based fuel economy, and under 40 CFR 600.207–08, for vehicle-specific 5-cycle based fuel economy values for vehicle configurations. Fuel economy calculations to determine highway and city fuel economy for a model type are provided under 40 CFR 600.208–08, FTP-based and HFET-based fuel economy values for a model type, and section 40 CFR 600.209–08, vehicle-specific 5-cycle fuel economy values for a model type. These provisions apply to all 2008 and later model year light-duty automobiles.[7] No revisions are needed to these provisions for advanced technology vehicles, as these provisions do not specify whether and how to use these values, but only how to calculate them.

Section 600.210–08, however, specifies that manufacturers are to use either the 5 cycle value determined under 40 CFR 600.209–08, or the mpg derived value determined under 40 CFR 600.210–08, for fuel economy labeling for models. EPA is revising this section for advanced technology vehicles, so that the Administrator may prescribe an alternative method for determining the city and highway fuel economy values for general and specific labels for advanced technology vehicles. As discussed above, the 5-cycle and mpg-derived options were developed based on what was considered appropriate for conventional technology vehicles, and this will allow the Administrator to make changes, where appropriate, for use with advanced technology vehicles.

4. Part 600 Subpart D

Subpart D contains general applicability, definitions, abbreviations, recordkeeping requirements, fuel economy label format, labeling of high altitude vehicles, range of fuel economy for comparable automobiles, label reporting and recordkeeping, timetable for data submittal, updating label values, classes of comparable automobiles and multistage manufacturer requirements. EPA's review of the requirements contained in this subpart indicated that regulation changes are needed to 40 CFR 600.307–08 of Subpart D for fuel economy label format requirements for advanced technology vehicles.

Subpart D specifies the fuel economy value and other information to include on the label and the format of the label. The fuel economy values are those determined pursuant to Subpart C. As stated earlier, Subpart D includes advanced technology vehicles in its requirements. The format requirements of 40 CFR 600.307–08 may not be appropriate for some advanced technology vehicles. EPA is revising 40 CFR 600.307–08 so that alternative label formats may be approved for advanced technology vehicles.

5. Part 600 Subpart E

Subpart E contains general applicability, definitions, abbreviations, dealer requirements and requirements to display booklets (Fuel Economy Guides) by dealers. EPA's review of the requirements contained in this subpart indicated that regulation changes are not needed to this Subpart for advanced technology vehicles.

6. Part 600 Subpart F

Subpart F contains general applicability, definitions, abbreviations, recordkeeping requirements, running change data requirements, voluntary submission of additional data, calculation of average fuel economy (CAFE), determination of domestic production, model year report and gas guzzler tax requirements. EPA's review of the requirements contained in this subpart indicated that regulation changes are needed to 40 CFR 600.501–08 of this Subpart to clarify that this section is applicable to advanced technology vehicles.

Subpart F, Procedures for Determining Manufacturer's Average Fuel Economy, is currently applicable to gasoline-fueled, diesel-fueled, alcohol-fueled, natural gas-fueled, alcohol dual fuel and natural gas dual fuel automobiles. Manufacturers that produce only electric vehicles and electric vehicles produced by small volume manufacturers are exempt from the requirements of this subpart, but may optionally comply with the requirements of this Subpart. In today's action, EPA is revising 40 CFR 600.501–93 so that advanced technology vehicles are included in Subpart F.

Section 600.510–08 describes the requirements for calculating manufacturer's corporate average fuel economy (commonly called CAFE). Results of calculations from 40 CFR 600.208–08 and 40 CFR 600.206–08 are used to determine CAFE using test procedures outlined in Subpart B. Since EPA is modifying Subpart B (40 CFR 600.111–08) to allow special test procedures for advanced technology vehicles, further modifications to Subpart F for advanced technology vehicles are not necessary.

As discussed above, EPA's authority to approve special test procedures will be used, for example, to approve test procedure modifications used for testing battery electric vehicles, fuel cell vehicles, plug-in hybrid vehicles and hydrogen-fueled vehicles equipped with internal combustion engines. As in 1998 to 2003 model years, when battery electric vehicles were included in manufacturer's CAFE calculations, the Agency will take steps to assure that the test procedures for advanced technology vehicles will be comparable to 1975 test procedures. While the Agency believes additional CAFE adjustments will not be necessary, EPA will follow the procedures specified in 40 CFR 600.510–08(f) if any additional average fuel economy adjustments is appropriate for purposes of CAFE calculation based on a special test procedure change.

B. Fuel Economy Labeling

1. Minivan Definition

On December 27, 2006 (71 FR 77872) EPA finalized the following definition for ''minivan'', which was previously not defined as a separate comparable class, for the purpose of labeling:

''Minivan means a light truck which is designed primarily to carry no more than eight passengers having an integral enclosure fully enclosing the driver, passenger, and load-carrying compartments, with a total interior volume at or below 180 cubic feet, and rear seats readily removed or folded to floor level to facilitate cargo carrying. A

[7] *See* 40 CFR 600.201.

minivan typically includes one or more sliding doors and a rear liftgate.'' [40 CFR 600.002–08.]

The interior volume specification of no more than 180 cubic feet was included as a way to distinguish minvans from full-sized vans. However, after the labeling rule was finalized, we were informed by some manufacturers that their 2008 model year minivans exceeded the 180 cubic feet interior volume limit, and thus would not be considered a minivan for purposes of showing comparison fuel economy on the label. Our intention in creating the minivan class was to provide consumers with better comparison information, based on actual classes of vehicles that they may be shopping for. It was not our intention to exclude vehicles that have for years been marketed and advertised as ''minivans.'' Therefore, we are making two modifications to our regulations that will allow these vehicles to be considered as ''minivans'' for the purpose of presenting comparable fuel economy information on the label.

First, we are eliminating the total interior volume specification from the definition of ''minivan'' and updating the definition slightly to help avoid confusion with EPA's definition of full-sized vans. Absent the interior volume specification, the updated definition should be sufficient to distinguish the minivan class from full-size passenger and cargo vans, SUVs and other similar truck classes, in most cases. Second, in cases where the distinction between the different truck classes may be less clear, we are adding a provision to the truck classification regulations that parallels an existing provision for car classification which allows EPA to reclassify light trucks into a more appropriate classification, as appropriate. This added flexibility will allow EPA to better accommodate today's rapidly changing vehicle designs, not only for minivans, but for other designs that are gaining in popularity, such as the so-called ''crossover'' vehicles, which share attributes of minivans, SUVs and even station wagons.

2. Van Definition

The current EPA ''Van'' definition has been used for fuel economy labeling purposes since before 1980, as follows:

''*Van* means any light truck having an integral enclosure fully enclosing the driver compartment and load-carrying device, and having no body sections protruding more than 30 inches ahead of the leading edge of the windshield.'' [40 CFR 600.002–08.]

This definition was appropriate for vans which were marketed in the late 1970s and 1980s. However, over the past 20 years, the body styles of full sized vans have evolved to shapes with longer nose sections, where the nose of the van extends forward more than 30 inches from the leading edge of the windshield. This direct final rule makes a minor change in the ''Van'' definition to make it compatible with today's vehicles. The new definition will include vehicles that are considered to be full-sized vans, but have body sections which protrude more than 30 inches forward of the leading edge of the windshield.

3. Interior Volume Measurements

We did not propose any changes to the existing EPA regulations for determining the interior volumes of vehicles. The interior volume measurements have been used to determine the various passenger car classes since the early 1980's. We received no comments about the interior volume measurement methods during the new fuel economy label rulemaking. However, after the rule became final, some manufacturers pointed out that the basis for the measurements, an SAE procedure J1100, dated 1975, was outdated, and that the newly revised SAE J1100 contained updated dimension codes which are referenced in our regulations. Rather than incorporating by reference the new version of the SAE procedure, we have simply updated some of the calculation procedures to be consistent with the new SAE methods, thus maintaining alignment with standard industry practices. In particular, the cargo volume index for station wagons is now calculated based on the average width of the cargo area (calculated by averaging the width at shoulder height and the width at the wheel wells), whereas it used to be based simply on the shoulder width measurement.

4. Special Purpose Vehicle Class of Comparable Vehicles

We are also revising the regulations for the ''special purpose vehicle'' class of comparable vehicles to clarify that EPA has the discretion to classify advanced technology vehicles in separate comparable classes. For example, the Administrator may determine that advanced technology vehicles (such as battery electric vehicles, fuel cell vehicles, plug-in hybrid electric vehicles and vehicles equipped with hydrogen internal combustion engines) or other types of vehicles are best classified as a type of ''special purpose vehicle,'' separate from other classes of vehicles. EPA will work with manufacturers in determining the need for separate classes. EPA used a similar approach from the 1999 to 2007 model year to classify minivans and SUVs listed in the Fuel Economy Guide, however the label (window sticker) for these ''special purpose vehicles'' included both minivans and SUVs until the regulations were revised for 2008 model year vehicles. Today's action provides EPA with the additional flexibility to determine appropriate names for such classes of vehicles, different from the name ''special purpose vehicle.''

The provisions of 49 U.S.C. 32908(b) require fuel economy labels to contain ''the range of fuel economy of comparable automobiles of all manufacturers.'' Based on this authority, EPA regulations have traditionally required fuel economy labels to contain the highest and lowest fuel economy values for all vehicles in each comparable class. Separate city and highway ranges were required prior to model year 2008. Beginning with 2008 model year, fuel economy labels are required to contain the highest and lowest combined (city/highway) fuel economy values for all vehicles within each comparable class of vehicles. Vehicle classes currently include two seaters, minicompact cars, subcompact cars, compact cars, midsize cars, large cars, small station wagons, midsize station wagons, large station wagons, small pickup trucks, standard pickup trucks, vans, minivans, sport utility vehicles (SUVs) and a ''catch-all'' class of ''special purpose vehicles.''

EPA is concerned that advanced technology vehicles (which are beginning to be introduced into commerce is relative small numbers) [8] may have fuel economy values which are an order of magnitude greater than conventional vehicles. Classifying these vehicles in the same comparable class of vehicles as conventional gasoline-fueled vehicles will tend to undermine the usefulness of providing the range of the highest and lowest mpg values within each vehicle class. For example, comparing mid-sized gasoline vehicles (mid-sized 2009 vehicles ranged from 11 to 46 combined city/highway mpg) to a mid-sized electric vehicle which gets 100 miles per gallon-equivalent makes all gasoline vehicles in the class appear to have very poor fuel economy. Furthermore, since the new technology vehicles may be available in such small

[8] Some fuel cell vehicles are being sold or leased in very small volumes, *e.g.* 10 vehicles or less annually. Initially, electric vehicles, hydrogen-fueled vehicles and some plug-in hybrid vehicles are also expected to be sold or leased in limited numbers, perhaps 2–10 models per year with sales of less than 500 per model.

numbers initially (and for other reasons) manufacturers have commented that the new technology vehicles should not be compared to conventional vehicles.

In summary, today's action will provide EPA with the regulatory discretion to classify these advanced technology vehicles appropriately. For example, it may be appropriate to establish classes for electric-powered cars and electric-powered trucks. Again, we should emphasize that EPA will work with the affected manufacturers when determining the need for separate classes.

5. Other Certification and Fuel Economy Labeling Changes

Today's action also includes the following minor changes and corrections:

40 CFR Cite	Change	Reason for change
§ 86.132–00(n)	Clarify the preconditioning cycle used for EPA US06 tests.	To make EPA preconditioning consistent with Industry practice.
§ 86.135–90(c); § 86.159–08(b)(9); § 86.230–90(e)(3); § 600.111–08(a)(9(ii).	Revise extra cooling provisions to clarify that variable speed fan(s) may be used and/or the hood closed if approved in advance by the Administrator.	To provide flexibility in extra cooling provisions. EPA experienced several test vehicle problems in 2008 due to inherent undercooling of fixed speed fans.
§ 86.164–08 (c)(1)(i)(D)(2) and (c)(2)(i)(C)(2)	Clarify US06 ''highway'' portion is 0–130 seconds * * * instead of 1–130 seconds. Clarify that the sampling system should be turned off 5 seconds after the engine stops running (*e.g.* 602 or 603 seconds) instead of 596 seconds.	Corrects errors to ensure consistent test procedures and measurement methods.
§ 86.210–08(a)	The reference that reads ''86.109–4'' should read ''86.109–94''.	Corrects a typographical error.
§ 600.002–08	Revised definition of ''Fuel.''	Add hydrogen and LPG (propane) to the fuel definition.
§ 600.002–08	Revised definition of ''Fuel Economy'' for electric vehicles.	To be consistent with current EPA policy and ensure accurate interpretation of the regulations.
§ 600.008–08(b)(3)(i)	Correcting a regulatory reference. ''The manufacturer may * * * accept lower * * * fuel economy results for use in Subpart C or F * * *'' is changed to read: ''The manufacturer may * * * accept lower * * * fuel economy results for use in Subpart D or F * * *''.	Corrects an error.
§ 600.107–08(c)	Add test fuel requirements for fuels not specifically covered in § 86.113, *e.g.* ethanol, hydrogen, LPG (propane).	To ensure accurate interpretation of the regulations.
§ 600.111–08 Introductory paragraph	Clarify that the applicable test procedures for fuel economy data vehicles are in accordance with Part 86 test procedures, including the provisions of 86.1840 Special Test Procedures and other Part 86 subsections.	To ensure accurate interpretation of the regulations.
§ 600.113–08(h)(1)	Correct error by removing a meaningless term, (''x C'' term) from the mpg equation.	Corrects a typographical error.
§ 600.113–08(k)	In the definition for D_{NG} that follows the formula for mpg, the ''3'' in the term ''ft3'' should be superscripted, *i.e.,* ''ft^3''.	Corrects a typographical error.
§ 600.114–08(b)(2)(ii)(A)	Revise a term in the equation for StartFC from 0.0055155 to 0.005515.	Corrects a typographical error.
§ 600.114–08(c)(1)(i)(B)	Revise a term in the equation for Running FC from Bag 3_{20} 3 FE to Bag 3_{20} FE.	Corrects a typographical error.
§ 600.115–08 Introductory paragraph	Add text that clarifies that alternative fuel vehicles and MDPVs may continue to base FE Label values on mpg-based derived 5-cycle calculations in 2011 and later model year.	Requirements were outlined in preamble to the Final Rule at 71 FR 77897–98 and 71 FR 77907, Dec 27, 2006, but were not clarified in regulatory text.
§ 600.115–08(a)(1)(i)	Add ''(c)'' so the paragraph will read ''is determined according to the provisions of § 600.114–08(a) or (c) * * * '' Paragraph (c) is used to calculate HEV 5-cycle FE values.	To ensure accurate interpretation of the regulations.
§ 600.115–08(a)(1)(ii)	Replace ''(a)(i)'' with ''(a)(1)(i)'' in the sentence ''Using the same FTP data as used in paragraph (a)(i) * * *''.	Corrects a typographical error.
§ 600.210–08 (a)	Clarify that dedicated alternative fueled vehicles and dual fueled vehicles when operating on alternative fuel may use the derived 5-cycle method of determining FE labels. Allow alternative label methods in paragraph (e) of this section''.	To ensure accurate interpretation of the regulations.

40 CFR Cite	Change	Reason for change
§ 600.210–08 (a)(2)(i) and (a)(2)(ii)	Clarify rounding. Clarify that MT FTP FE and MT HFET FE should be rounded to 4 decimal places.	§ 600.210–08(a)(2)(i) and (ii) specify rounding ''to the nearest tenth;'' however referenced paragraph 600.208–08(b)(3) already rounds model type city & highway values to 4 decimal places. Change is needed for regulatory consistency.
§ 600.210–08 (a)(2)(i)	Insert a space in ''MTFTP'' to make it ''MT FTP.'' Correct reference from ''600.208–08(a)'' to ''600.208–08(b)''.	Corrects typographical errors.
§ 600.210–08 (a)(3)(i)	Correct a regulatory reference. Correct reference from ''paragraph (a)(1) or (b)(2)'' to ''paragraph (a)(1) or (a)(2)''.	Corrects a typographical error.
§ 600.315–08(b)(1)	In 600.315–08, paragraph (b)(1), delete the ''A'' in the word ''Atwo'', to read ''two seater'' not ''Atwo seater''.	Corrects a typographical error.

C. CAFE Amendments

1. New 2008–2011 Passenger Automobile and Truck CAFE Requirements

In April, 2006, the National Highway Traffic Safety Administration (NHTSA) promulgated final rules which established CAFE standards for 2008–2011 trucks.[9] In these rules, NHTSA included two sets of standards, the first called ''Unreformed,'' applicable for 2008 through 2010 model year trucks, and the second called ''Reformed,'' optional for 2008 through 2010 model year and required beginning with 2011 model year trucks. Then in March 2009, NHTSA promulgated a final rule which revised the 2011 truck ''reformed'' CAFE requirements and established new ''reformed'' CAFE standards for 2011 model year passenger automobiles.[10] NHTSA's 2008–2011 CAFE requirements include two requirements which are not covered by EPA's current regulations.

First, NHTSA is for the first time requiring trucks known as ''medium duty passenger vehicles'' (MDPVs) to be including in the manufacturers' fleet CAFE. NHTSA adopted the same criteria to define MDPVs as contained in EPA's Tier 2 emission regulations.[11] NHTSA regulations define MDPVs as follows:

''*Medium duty passenger vehicle* means a vehicle which would satisfy the criteria in Sec.523.5 (relating to light trucks) but for its gross vehicle weight rating or its curb weight, which is rated at more than 8,500 lbs GVWR or has a vehicle curb weight of more than 6,000 pounds or has a basic vehicle frontal area in excess of 45 square feet, and which is designed primarily to transport passengers, but does not include a vehicle that:

(1) Is an ''incomplete truck'' as defined in this subpart; or

(2) Has a seating capacity of more than 12 persons; or

(3) Is designed for more than 9 persons in seating rearward of the

driver's seat; or

(4) Is equipped with an open cargo area (for example, a pick-up truck box or bed) of 72.0 inches in interior length or more. A covered box not readily accessible from the passenger compartment will be considered an open cargo area for purposes of this definition.'' [49 CFR 523.2]

In EPA's recent fuel economy labeling rule, we also adopted this same definition and added labeling requirements for new MDPVs beginning in 2011, at the same time as the new ''reformed'' CAFE requirements take effect. However, we made no changes to our CAFE regulations at that time, saying that we would instead do so via today's separate regulatory action. We finalized the NHTSA definition of MDPV's in our regulations at 40 CFR 600.002–08 in the 2006 fuel economy labeling rule.[12] NHTSA requires MDPVs to be included in CAFE starting in 2011, but in order to correctly implement NHTSA's new requirements we must make minor revisions to EPA regulations to enable MDPVs to be included in the CAFE calculations for 2011 and later.

The second change needed to EPA CAFE regulations is to add manufacturer reporting requirements to the CAFE ''model year report'' submitted to EPA every year.[13] Today's action will require the model year report to contain the applicable CAFE fuel economy standard (also called ''required fuel economy level'') and the basis for determining that required fuel economy level. According to NHTSA requirements, the ''required fuel economy level'' for each manufacturer is based on the ''footprint'' of the vehicles which are introduced into commerce by that manufacturer. Thus, today's action adds NHTSA's footprint definition, and footprint reporting requirements, including the features used to determine footprint, such as wheelbase, front track width, and rear track width.

2. Technical Amendments to Conform to the Energy Independence and Security Act of 2007

The Energy Independence and Security Act of 2007 extended the provision allowing CAFE incentives for alternate fuel vehicles to 2019, codified at 42 U.S.C. 32905. In today's direct final rule, we have amended our fuel economy regulations to be consistent with the Energy Independence and Security Act of 2007.[14] The Energy Independence and Security Act of 2007 provides that the maximum increase in average fuel economy for a manufacturer attributable to dual fueled ethanol and duel-fueled natural gas vehicles is as follows:

(1) 1.2 miles a gallon for each of model years 1993 through 2014;

(2) 1.0 miles per gallon for model year 2015;

(3) 0.8 miles per gallon for model year 2016;

(4) 0.6 miles per gallon for model year 2017;

(5) 0.4 miles per gallon for model year 2018;

(6) 0.2 miles per gallon for model year 2019; and

(7) 0 miles per gallon for model years after 2019.

In addition, the Energy Independence and Security Act of 2007 modified 49 U.S.C. 32906(b), removing the ''offsets'' to the maximum increase in average fuel economy in the event that NHTSA were to reduce the CAFE standard for passenger automobiles below 27.5 mpg.

[9] Ref. 71 FR 17566, April 6, 2006 and 71 FR 19449, April 14, 2006.

[10] Ref. 74 FR 14196, March 30, 2009.

[11] *See* 65 FR 6698, February 10, 2000.

[12] *See* 71 FR 77872, December 27, 2006.

[13] *See* 40 CFR 600.512–01.

[14] Public Law 110–140, December 19, 2007.

3. Harmonization With NHTSA Rule Combining Domestic and Foreign Trucks Into a Single CAFE Averaging Set

On April 4, 1994, NHTSA finalized regulations combining all domestic and imported trucks into a single truck class for CAFE purposes beginning with the 1996 model year.[15] Previously, NHTSA's regulations required the calculation and reporting of separate domestic and imported truck CAFE values and EPA's CAFE regulations likewise included separate calculations. However, EPA regulations were not modified at the time that NHTSA changed its regulations.[16] Thus, in today's action, we are removing the requirements for manufacturers to report separate import and domestic information and data for trucks. For consistency, today's action references NHTSA regulations for passenger car and light truck categories (although no change was needed to the domestic and import passenger car categories at this time).

4. Other CAFE Changes

Today's action also includes the following minor changes and corrections:

40 CFR Cite	Change	Reason for change
§ 600.002–08	Revise light truck definition	Clarify that MDPVs are included beginning in 2011.
§ 600.010–08(d)	Revised CAFE minimum test requirements	Clarify that city & highway tests are required for 2011 and later MDPVs.
§ 600.501–93	Revise Subpart F applicability	Consistency with DOT; clarify that MDPVs are included in 2011 and later CAFEs.
§ 600.510–08(e)	In section 600.510–08, paragraph (e), in the expression for ''IW'', an extraneous letter ''x'' that appears to the left of a multiplication sign should be deleted.	To ensure accurate interpretation of the regulations.
§ 600.511–80(a)	Added ''Except with advance approval of the Administrator,''.	To allow exceptions per 49 U.S.C. 32904(b)(5); and 49 CFR 526.3.
§ 600.511–80(b)(5)	Revise reference to U.S. Code per NHTSA request	Correct errata due to a revision in U.S. Code.

D. Miscellaneous Regulatory Corrections and Changes

This Direct Final Rule includes a technical amendment to the Durability regulations applicable to Light-Duty Vehicles, Light-Duty Trucks and complete Heavy-Duty Vehicles. Specifically, the equation used to calculate the equivalency factors under the Durability Program was incorrect in the final rulemaking despite the fact that the notice of proposed rulemaking (NPRM) had the correct equation format. The equivalency factors are used to equate aging on the manufacturer's durability cycles to aging on the EPA standard cycles if a manufacturer uses their own proprietary aging cycle as allowed under the Durability regulations. Therefore, this action revises the Durability Program regulatory language using the correct equivalency factor equation format stated in the NPRM. The correction essentially involves reversing the numerator and denominator of the equivalency factor definition as stated at 40 CFR 86.1823–08(e)(1)(iii)(B)(1), such that the equivalency factor is stated correctly as follows: ''The equivalency factor is the ratio described by dividing the aging time on the alternative cycle by the aging time on the SRC.''

Today's action also includes a minor revision to the preconditioning cycle used by EPA for the US06 test. Previously, the provisions of 40 CFR 86.132–00(n) require EPA to use a UDDS preconditioning cycle if the soak period since the last exhaust test is greater than two hours. Manufacturers may use a UDDS, a 505, 866, highway, US06 or an SC03 preconditioning cycle (if the soak period since the last exhaust test is greater than two hours) and it is common industry practice to use the US06 cycle. Today's action revises the provisions of 40 CFR 86.132–00(n) so that EPA preconditioning for the US06 is consistent with manufacturers. We believe that this revision will reduce EPA burden (because a UDDS cycle takes approximately 23 minutes to run while a US06 cycle takes 10 minutes to run).

IV. Statutory and Executive Order Reviews

A. Executive Order 12866: Regulatory Planning and Review

Under Executive Order (EO) 12866 (58 FR 51735, October 4, 1993), this action is a ''significant regulatory action'' because it has the potential to raise novel legal or policy issues. Accordingly, EPA submitted this action to the Office of Management and Budget (OMB) for review under EO 12866 and any changes made in response to OMB recommendations have been documented in the docket for this action.

B. Paperwork Reduction Act

This action does not impose any substantive new information collection burden under the provisions of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.* for the changes to the minivan definition, the requirements to include medium-duty passenger vehicles (MDPVs) in CAFE calculations, the additional CAFE footprint reporting requirements, or any other certification, fuel economy labeling and CAFE changes contained in this direct final rule. Burden is defined at 5 CFR 1320.3(b). Note that the data submittal requirements to include MDPVs in 2011 and later CAFE data and to report footprint information for reformed CAFE have already been established by NHTSA in its final rules for new passenger automobile and truck CAFE standards,[17] and the accompanying NHTSA ICR (OMB 2127–00019).

The revision to the minivan definition in today's action has a de minimis impact; however, if anything, the revision is expected to reduce manufacturers' information collection burden. For example, manufacturers were previously required to calculate and report to EPA the total interior volume of each style of minivan and full-sized van to determine whether the van was at or below 180 cubic feet in interior volume. Today's action eliminates the 180 cubic feet interior volume specification from the minivan definition, thus slightly reducing manufacturers reporting and recordkeeping burden.

Regarding the MDPV requirements for 2011 and later CAFEs, the following

[15] *See* 59 FR 16312, April 4, 1994.

[16] Regardless of the fact that EPA regulations have not been in alignment with NHTSA's, we have been providing NHTSA with the correct combined import/domestic truck CAFE calculations since that time.

[17] *See* 49 CFR 537.7(c)(4), as amended by 71 FR 17678, April 6, 2006 and 74 FR 14196, March 30, 2009.

statement was made in EPA's Information Collection Request (ICR) for the 2008 Fuel Economy Labeling rule:

''Also beginning with model year 2011, medium-duty passenger vehicles (MDPVs) will be included in the labeling program. MDPVs essentially include SUVs and passenger vans that are between 8,500 and 10,000 lbs. ''GVWR'' (gross vehicle weight ratings). This change is congruent with the National Highway Traffic Safety Administration's (NHTSA's) expansion of the Corporate Average Fuel Economy (CAFE) program to include MDPVs beginning the same model year (71 FR 17565; April 6, 2006). Because more vehicle testing is required under CAFE than under labeling, the impacts of increased testing for MDPVs will be in the ICR for the rule to implement EPA's role in the CAFE program, which will be finalized in a separate action, in time for model year 2011, *or in the appropriate fuel economy program information collection renewal.''*[18] (Emphasis added.)

Thus, in the 2008 FE Label rulemaking EPA indicated we would either include the MDPV information collection requirements in an ICR for today's rulemaking or include it in the EPA's emission and fuel economy ICR renewal request to OMB (which occurs every three years). EPA elected the latter approach, and has included the additional MDPV testing, reporting and recordkeeping burden for fuel economy labeling and CAFE purposes in ICR 0783.54 (OMB 2060–0320), the renewal of the Motor Vehicle Emissions and Fuel Economy Compliance ICR which was submitted to OMB for review on October 23, 2008. Since EPA MDPV ICR requirements have been previously submitted to OMB and because they were also included in NHTSA's ICR (OMB 2127–00019), they are not included in today's action.

Regarding footprint information, the reporting requirements for footprint information and related data were not specifically addressed in the ICR for EPA's Fuel Economy Labeling Rule (ICR 0783.51, OMB 2060–0104) because any change in burden was considered to be negligible and within the margin of error for the information technology estimate in that ICR; and because the information collection burden was partially included in the NHTSA ICR (OMB 2127–00019). The information collection burden for footprint information is currently included in EPA's ICR 0783.54 (OMB 2060–0320), the renewal of the Motor Vehicle Emissions and Fuel Economy Compliance ICR, which was submitted to OMB for review on October 23, 2008.

Additionally, the footprint information reported to EPA for final CAFE reports (wheelbase, track width and sales information) is essentially the same information which will have been previously reported to NHTSA when manufacturers submitted their preliminary CAFE (PCAFE) and mid-model year CAFE reports to NHTSA. Reporting footprint information to EPA with final sales data is expected to be a minimal burden because manufacturers will have already established company business practices to track footprint and sales information for NHTSA and because manufacturers have been reporting CAFE final sales information to EPA since 1978.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) generally requires an agency to prepare a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements under the Administrative Procedure Act or any other statute unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small organizations, and small governmental jurisdictions.

For purposes of assessing the impacts of this direct final rule on small entities, a small entity is defined as: (1) A small business as defined by the Small Business Administration (SBA) regulations at 13 CFR 121.201; (2) a small governmental jurisdiction that is a government of a city, county, town, school district or special district with a population of less than 50,000; and (3) a small organization that is any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.

After considering the economic impacts of this final rule on small entities, I certify that this action will not have a significant economic impact on a substantial number of small entities. Based on Small Business Administration size standards, small businesses in the automobile manufacturing industry are defined as those having less than 1000 employees per firm. Additionally, they are identified using the North America Industrial Classification System (NAICS) by NAICS code 336111. Out of a total of approximately 80 automotive manufacturers subject to this direct final rule, EPA estimates that approximately 10 of these could be classified as small entities based on SBA size standards. No new burden for fuel economy labeling is being imposed by this direct final rule. The new reporting requirement for the reform CAFE footprint data has already been established by NHTSA in its final rule for new truck CAFE standards,[19] and thus this direct final rule imposes no additional burden.

D. Unfunded Mandates Reform Act

This rule does not contain a Federal mandate that may result in expenditures of $100 million or more for State, local, and Tribal governments, in the aggregate, or the private sector in any one year. This action simply makes minor amendments, clarifications, and corrections that will allow for the more effective administration of existing regulations. Thus, this rule is not subject to the requirements of sections 202 or 205 of the Unfunded Mandates Reform Act. This rule is also not subject to the requirements of section 203 of the Unfunded Mandates Reform Act because it contains no regulatory requirements that might significantly or uniquely affect small governments. This action imposes no enforceable duty on any State, local or Tribal governments.

E. Executive Order 13132: Federalism

Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999), requires EPA to develop an accountable process to ensure ''meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications.'' ''Policies that have federalism implications'' is defined in the Executive Order to include regulations that have ''substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.''

This direct final rule does not have federalism implications. It will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132. Thus, Executive Order 13132 does not apply to this rule.

F. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This action does not have Tribal implications, as specified in Executive Order 13175 (65 FR 67249, November 9, 2000). The impacts of this direct final rule are limited to the regulated entities: the automotive manufacturing industry. Thus, Executive Order 13175 does not apply to this action.

[18] *See* 71 FR 77872, December 27, 2006.

[19] *See* 49 CFR 537.7(c)(4), as amended by 71 FR 17678, Apr. 6, 2006.

G. Executive Order 13045 ''Protection of Children From Environmental Health Risks and Safety Risks''

Executive Order 13045: ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997) applies to any rule that: (1) Is determined to be ''economically significant'' as defined under Executive Order 12866, and (2) concerns an environmental health or safety risk that EPA has reason to believe may have a disproportionate effect on children. If the regulatory action meets both criteria, the Agency must evaluate the environmental health or safety effects of the planned rule on children, and explain why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the Agency.

EPA interprets EO 13045 (62 FR 19885, April 23, 1997) as applying only to those regulatory actions that concern health or safety risks, such that the analysis required under section 5–501 of the EO has the potential to influence the regulation. This action is not subject to EO 13045 because it does not establish an environmental standard intended to mitigate health or safety risks.

H. Executive Order 13211 (Energy Effects)

This rule is not a ''significant energy action'' as defined in Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001) because it is not likely to have a significant adverse effect on the supply, distribution, or use of energy. Further, we have concluded that this rule is not likely to have any adverse energy effects.

I. National Technology Transfer Advancement Act

Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (''NTTAA''), Public Law 104–113, 12(d) (15 U.S.C. 272 note) directs EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (*e.g.,* materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

This action does not involved technical standards. Therefore, EPA did not consider the use of any voluntary consensus standards.

J. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

Executive Order (EO) 12898 (59 FR 7629, Feb. 16, 1994) establishes Federal executive policy on environmental justice. Its main provision directs Federal agencies, to the greatest extent practicable and permitted by law, to make environmental justice part of their mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of their programs, policies, and activities on minority populations and low-income populations in the United States.

EPA has determined that this direct final rule will not have disproportionately high and adverse human health or environmental effects on minority or low-income populations because it does not affect the level of protection provided to human health or the environment. This action simply makes minor amendments, clarifications, and corrections that will allow for the more effective administration of existing regulations without impacting the current fuel economy and emission control measures.

K. Congressional Review Act

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A Major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2). This rule will be effective January 25, 2010.

L. Statutory Provisions and Legal Authority

Statutory authority for the fuel economy labeling program and for corporate average fuel economy can be found at 42 U.S.C. 7401–7671q, 49 U.S.C. 32901–32919, and Public Law 109–58. Statutory authority for vehicle emission control program is found in the Clean Air Act, as amended, 42 U.S.C. 7401 *et seq.,* in particular sections 202 and 206 of the Act, 42 U.S.C. 7521 and 7525.

List of Subjects

40 CFR Part 86

Administrative practice and procedure, Confidential business information, Incorporation by reference, Labeling, Motor vehicle pollution, Reporting and recordkeeping requirements.

40 CFR Part 600

Administrative practice and procedure, Electric power, Fuel economy, Incorporation by reference, Labeling, Reporting and recordkeeping requirements.

Dated: November 9, 2009.

Lisa P. Jackson,

Administrator.

■ For the reasons set forth in the preamble, parts 86 and 600 of title 40, chapter I of the Code of Federal Regulations, are amended as follows:

PART 86—CONTROL OF EMISSIONS FROM NEW AND IN-USE HIGHWAY VEHICLES AND ENGINES

■ 1. The authority citation for part 86 continues to read as follows:

Authority: 42 U.S.C. 7401–7671q.

Subpart B—[Amended]

■ 2. Amend § 86.132–00 by revising paragraph (n)(1)(i) and removing and reserving paragraph (n)(1)(ii) to read as follows:

§ 86.132–00 Vehicle preconditioning.

* * * * *

(n) * * *

(1) * * *

(i) Preconditioning may consist of a 505, 866, highway, US06 or SC03 test cycles.

(ii) [Reserved]

* * * * *

■ 3. Amend § 86.135–90 by revising paragraph (b) to read as follows:

§ 86.135–90 Dynamometer procedure.

* * * * *

(b) During dynamometer operation, a fixed speed cooling fan shall be positioned so as to direct cooling air to the vehicle in an appropriate manner with the engine compartment cover open. In the case of vehicles with front engine compartments, the fan shall be squarely positioned within 12 inches (30.5 centimeters) of the vehicle. In the case of vehicles with rear engine compartments (or if special designs

make the above impractical), the cooling fan shall be placed in a position to provide sufficient air to maintain vehicle cooling. The fan capacity shall normally not exceed 5300 cfm (2.50 m3/sec). If however, the manufacturer can show that during field operation the vehicle receives additional cooling, and that such additional cooling is needed to provide a representative test, the fan capacity may be increased, additional fans used, variable speed fan(s) may be used, and/or the engine compartment cover may be closed if approved in advance by the Administrator. For example, the hood may be closed to provide adequate air flow to an intercooler through a factory installed hood scoop. Additionally, the Administrator may conduct certification, fuel economy and in-use testing using the additional cooling set-up approved for a specific vehicle.

* * * * *

■ 4. Amend § 86.159–08 by revising paragraph (b)(9) to read as follows:

§ 86.159–08 Exhaust emission test procedures for US06 emissions.

* * * * *

(b) * * *

(9) During dynamometer operation, a fixed speed cooling fan with a maximum discharge velocity of 15,000 cfm will be positioned so as to direct cooling air to the vehicle in an appropriate manner with the engine compartment cover open. In the case of vehicles with front engine compartments, the fan shall be positioned within 24 inches (61 centimeters) of the vehicle. In the case of vehicles with rear engine compartments (or if special designs make the above impractical), the cooling fan(s) shall be placed in a position to provide sufficient air to maintain vehicle cooling. The Administrator may approve modified cooling configurations, additional cooling, variable speed fan(s), and/or a closed engine compartment cover if necessary to satisfactorily perform the test. In approving requests for additional or modified cooling, the Administrator will consider such items as actual road cooling data and whether such additional cooling is needed to provide a representative test. For example, the hood may be closed to provide adequate air flow to an intercooler through a factory installed hood scoop. Additionally, the Administrator may conduct certification, fuel economy and in-use testing using the additional cooling set-up approved for a specific vehicle.

* * * * *

■ 5. Amend § 86.164–08 by revising paragraphs (c)(1)(i)(D)(*2*) and (c)(2)(i)(C)(*2*) to read as follows:

§ 86.164–08 Supplemental Federal Test Procedure calculations.

* * * * *

(c) * * *

(1) * * *

(i) * * *

(D) * * *

(*2*) In the case of a 2-phase US06 test run according to the provisions of § 86.159–08(f)(2) and part 600 of this chapter:

YUS06 = Calculated mass emissions per mile, using the summed mass emissions of the ''US06 City'' phase and the ''US06 Highway'' phase, based on the measured driving distance of the US06 test schedule. The ''US06 City'' phase shall be sampled during seconds 0–130 and from 495 seconds until five seconds after the engine stops running (*e.g.* 602 or 603 seconds) of the US06 driving schedule. The ''US06 Highway'' phase shall be sampled during seconds 130–495 of the US06 driving schedule),

* * * * *

(2) * * *

(i) * * *

(C) * * *

(*2*) In the case of a 2-phase US06 test run according to the provisions of § 86.159–08(f)(2) and part 600 of this chapter:

YUS06 = Calculated mass emissions per mile, using the summed mass emissions of the ''US06 City'' phase and the ''US06 Highway'' phase, based on the measured driving distance of the US06 test schedule. The ''US06 City'' phase shall be sampled during seconds 0–130 and from 495 seconds until five seconds after the engine stops running (*e.g.* 602 or 603 seconds) of the US06 driving schedule. The ''US06 Highway'' phase shall be sampled during seconds 130–495 of the US06 driving schedule),

* * * * *

■ 6. Section 86.210–08 is amended by revising paragraph (a) introductory text to read as follows:

§ 86.210–08 Exhaust gas sampling system; Diesel-cycle vehicles not requiring particulate emissions measurements.

(a) *General applicability.* The exhaust gas sampling system requirements of § 86.109–94 (which apply to Otto-cycle vehicles), also apply to diesel vehicles that are not required to undergo particulate measurement as allowed under § 600.111–08(e) of this chapter, except that heated flame ionization detector (HFID), probe, sample lines and filters are required as described as follows:

* * * * *

■ 7. Section 86.230–11 is amended by revising paragraph (e)(3) to read as follows:

§ 86.230–11 Test sequence: general requirements.

* * * * *

(e) * * *

(3) The manufacturer may use, for certification and fuel economy testing, alternative engine compartment cooling fans or systems, including those which provide a variable air flow, if the manufacturer has determined that comparable results are obtained. Manufacturers may perform the test with the engine compartment closed, *e.g.* to provide adequate air flow to air flow to an intercooler through a factory installed hood scoop, if needed to provide a representative test. Additionally, the Administrator may conduct certification, fuel economy and in-use testing using the additional cooling set-up approved for a specific vehicle.

* * * * *

■ 8. Section 86.230–94 is amended by revising paragraph (e)(3) to read as follows:

§ 86.230–94 Test sequence: general requirements.

* * * * *

(e) * * *

(3) The manufacturer may use, for certification and fuel economy testing, alternative engine compartment cooling fans or systems, including those which provide a variable air flow, if the manufacturer has determined that comparable results are obtained. For 2009 and later model year vehicles, manufacturers may perform the test with the engine compartment closed, *e.g.* to provide adequate air flow to air flow to an intercooler through a factory installed hood scoop, if needed to provide a representative test. For 2009 and later model year vehicles, the Administrator may conduct certification, fuel economy and in-use testing using the additional cooling set-up approved for a specific vehicle.

* * * * *

■ 9. Section 86.1823–08 is amended by revising paragraph (e)(1)(iii)(B)(*1*) to read as follows:

§ 86.1823–08 Durability demonstration procedures for exhaust emissions.

* * * * *

(e) * * *

(1) * * *

(iii) * * *

(B) * * *

(*1*) The equivalency factor may be determined by an evaluation of the SRC and the customized/alternative cycle

using catalyst time-at-temperature data from both cycles with the BAT equation to calculate the required bench aging time of each cycle. Once the bench aging time is calculated for each cycle, the equivalency factor is the ratio described by dividing the bench aging time on the customized/alternative cycle by the bench aging time on the SRC.

* * * * *

PART 600—FUEL ECONOMY OF VEHICLES

■ 10. The authority citation for part 600 continues to read as follows:

Authority: 49 U.S.C. 32901–23919q, Public Law 109–58.

Subpart A—[Amended]

■ 11. Section 600.002–08 is amended as follows:

■ a. In the definition of ''Fuel,'' paragraph (4) is amended by removing the period and adding in its place ''; or''.

■ b. By adding paragraphs (5) and (6) to the definition of ''Fuel.''

■ c. By revising paragraph (2) of the definition of ''Fuel economy.''

■ d. By revising the definition of ''Light truck.''

■ e. By revising the definition of ''Minivan.''

■ f. By revising the definition of ''Van.''

§ 600.002–08 Definitions.

* * * * *

Fuel means:

* * * * *

(5) Liquid Petroleum Gas (LPG), commonly referred to as ''propane,'' for LPG-powered automobiles; or

(6) Hydrogen for hydrogen fuel cell automobiles and for automobiles equipped with hydrogen internal combustion engines.

Fuel economy means:

* * * * *

(2) For the purpose of calculating average fuel economy pursuant to the provisions of Part 600, Subpart F, fuel economy for electrically powered automobiles means the equivalent petroleum-based fuel economy as determined by the Secretary of Energy in accordance with the provisions of 10 CFR 474.

* * * * *

Light truck means an automobile that is not a passenger automobile, as defined by the Secretary of Transportation at 49 CFR 523.5. This term is interchangeable with ''non-passenger automobile.'' The term the ''light truck'' includes medium-duty passenger vehicles which are manufactured during 2011 and later model years.

* * * * *

Minivan means a light truck which is designed primarily to carry no more than eight passengers, having an integral enclosure fully enclosing the driver, passenger, and load-carrying compartments, and rear seats readily removed, folded, stowed, or pivoted to facilitate cargo carrying. A minivan typically includes one or more sliding doors and a rear liftgate. Minivans typically have less total interior volume or overall height than full sized vans and are commonly advertised and marketed as ''minivans.''

* * * * *

Van means any light truck having an integral enclosure fully enclosing the driver compartment and load carrying compartment. The distance from the leading edge of the windshield to the foremost body section of vans is typically shorter than that of pickup trucks and SUVs.

* * * * *

■ 12. Section 600.010–08 is amended by revising paragraph (d) to read as follows:

§ 600.010–08 Vehicle test requirements and minimum data requirements.

* * * * *

(d) Minimum data requirements for the manufacturer's average fuel economy. For the purpose of calculating the manufacturer's average fuel economy under § 600.510, the manufacturer shall submit FTP (city) and HFET (highway) test data representing at least 90 percent of the manufacturer's actual model year production, by configuration, for each category identified for calculation under § 600.510–08(a).

■ 13. Section 600.011–93 is amended by revising paragraph (a) and by adding paragraph (b)(3) to read as follows:

§ 600.011–93 Reference materials.

(a) *Incorporation by reference.* The documents in paragraph (b) of this section have been incorporated by reference. The incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be inspected at the U.S. Environmental Protection Agency, Office of Air and Radiation, 1200 Pennsylvania Ave., NW., Washington, DC 20460, phone (202) 272–0167, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

(b) * * *

(3) *SAE Material.* The following table sets forth material from the Society of Automotive Engineers that has been incorporated by reference. The first column lists the number and name of the material. The second column lists the section(s) of this part, other than § 600.011–93, in which the matter is referenced. The second column is presented for information only and may not be all inclusive. Copies of these materials may be obtained from Society of Automotive Engineers World Headquarters, 400 Commonwealth Dr., Warrendale, PA 15096–0001, phone (877) 606–7323 (U.S. and Canada) or (724) 776–4970 (outside the U.S. and Canada), or at *http://www.sae.org.*

Document No. and name	40 CFR part 600 reference
Motor Vehicle Dimensions—Recommended Practice SAE 1100a (Report of Human Factors Engineering Committee, Society of Automotive Engineers, approved September 1973 as revised September 1975).	600.315–08; 600.315–82.

Subpart B—[Amended]

■ 14. Section 600.107–08 is amended by adding paragraph (c) to read as follows:

§ 600.107–08 Fuel Specifications.

* * * * *

(c) Test fuels which do not have fuel specifications provided in the provisions of § 86.113 of this chapter may be used if approved in advance by the Administrator.

■ 15. Section 600.111–08 is amended as follows:

■ a. By adding introductory text to this § 600.111–08.

■ b. By revising paragraph (b)(9)(ii).

■ c. By adding paragraph (f).

§ 600.111–08 Test Procedures.

This section provides test procedures for the FTP, highway, US06, SC03, and the cold temperature FTP tests. Testing shall be performed according to test procedures and other requirements contained in Part 86 and Part 600 of this

chapter, including the provisions of Part 86, Subparts B, C, and S.

* * * * *

(b) * * *

(9) * * *

(ii) Open the vehicle engine compartment cover and position the cooling fan(s) required. Manufacturers may request the use of additional cooling fans or variable speed fan(s) for additional engine compartment or under-vehicle cooling and for controlling high tire or brake temperatures during dynamometer operation. With prior EPA approval, manufacturers may perform the test with the engine compartment closed, *e.g.* to provide adequate air flow to an intercooler (through a factory installed hood scoop). Additionally, the Administrator may conduct fuel economy testing using the additional cooling set-up approved for a specific vehicle.

* * * * *

(f) *Special Test Procedures.* The Administrator may prescribe test procedures, other than those set forth in this Subpart B, for any vehicle which is not susceptible to satisfactory testing and/or testing results by the procedures set forth in this part. For example, special test procedures may be used for advanced technology vehicles, including, but not limited to battery electric vehicles, fuel cell vehicles, plug-in hybrid electric vehicles and vehicles equipped with hydrogen internal combustion engines. Additionally, the Administrator may conduct fuel economy testing using the special test procedures approved for a specific vehicle.

■ 16. Section 600.113–08 is amended by revising paragraphs (h)(1) and (k) to read as follows:

§ 600.113–08 Fuel Economy Calculations for FTP, HFET, US06, and cold temperature FTP tests.

* * * * *

(h)(1) For gasoline-fueled automobiles tested on test fuel specified in § 86.113–04(a), the fuel economy in miles per gallon is to be calculated using the following equation:

$$mpg = (5174 \times 10^4 \times CWF \times SG)/[((CWF \times HC) + (0.429 \times CO) + (0.273 \times CO_2)) \times ((0.6 \times SG \times NHV) + 5471)]$$

Where:

HC = Grams/mile HC as obtained in paragraph (g) of this section.

CO = Grams/mile CO as obtained in paragraph (g) of this section.

CO_2 = Grams/mile CO_2 as obtained in paragraph (g) of this section.

CWF = Carbon weight fraction of test fuel as obtained in paragraph (g) of this section.

NHV = Net heating value by mass of test fuel as obtained in paragraph (g) of this section.

SG = Specific gravity of test fuel as obtained in paragraph (g) of this section.

* * * * *

(k) For automobiles fueled with natural gas, the fuel economy in miles per gallon of natural gas is to be calculated using the following equation:

$$mpg_e = \frac{CWF_{HC/NG} \times D_{NG} \times 121.5}{(0.749 \times CH_4) + CWF_{NMHC} + (0.429 \times CO) + (0.273 \times (CO_2 - CO_{2NG}))}$$

Where:

mpg_e = miles per equivalent gallon of natural gas.

$CWF_{HC/NG}$ = carbon weight fraction based on the hydrocarbon constituents in the natural gas fuel as obtained in paragraph (g) of this section.

D_{NG} = density of the natural gas fuel [grams/ft³ at 68 °F (20 °C) and 760 mm Hg (101.3 kPa)] pressure as obtained in paragraph (g) of this section.

CH_4, NMHC, CO, and CO_2 = weighted mass exhaust emissions [grams/mile] for methane, non-methane HC, carbon monoxide, and carbon dioxide as calculated in § 600.113.

CWF_{NMHC} = carbon weight fraction of the non-methane HC constituents in the fuel as determined from the speciated fuel composition per paragraph (f)(3) of this section.

CO_{2NG} = grams of carbon dioxide in the natural gas fuel consumed per mile of travel.

$$CO_{2NG} = FC_{NG} \times D_{NG} \times WF_{CO2}$$

Where:

$$FC_{NG} = \frac{(0.749 \times CH_4) + (CWF_{NMHC} \times NMHC) + (0.429 \times CO) + (0.273 \times CO_2)}{CWF_{NG} \times D_{NG}}$$

= cubic feet of natural gas fuel consumed per mile.

CWF_{NG} = the carbon weight fraction of the natural gas fuel as calculated in paragraph (f) of this section.

WF_{CO2} = weight fraction carbon dioxide of the natural gas fuel calculated using the mole fractions and molecular weights of the natural gas fuel constituents per ASTM D 1945–91 ''Standard Test Method for Analysis of Natural Gas by Gas Chromatography'' (incorporated by reference at § 600.011–93).

* * * * *

■ 17. Section 600.114–08 is amended by revising paragraphs (b)(2)(ii)(A) and (c)(1)(i)(B) to read as follows:

§ 600.114–08 Vehicle-specific 5-cycle fuel economy calculations.

(b) * * *

(2) * * *

(ii) * * *

$$\text{(A) } StartFC = 0.33 \times \frac{(0.005515 + 1.13637 \times StartFuel_{75})}{60.0}$$

Where:

$$StartFuel_{75} = 3.6 \times \left(\frac{1}{Bag\ 1\ FE_{75}} - \frac{1}{Bag\ 3\ FE_{75}} \right)$$

Where:

Bag y FE_{75} = the fuel economy in miles per gallon of fuel during the specified bag of the FTP test conducted at an ambient temperature of 75 °F.

* * * * *

(c) * * *

(1) * * *

(i) * * *

$$\text{(B) Running FC (gallons per mile)} = 0.82 \times \left[\frac{0.48}{Bag\ 4_{75}\ FE} + \frac{0.41}{Bag\ 3_{75}\ FE} + \frac{0.11}{US06\ City\ FE} \right]$$

$$+ 0.18 \times \left[\frac{0.5}{Bag\ 2_{20}\ FE} + \frac{0.5}{Bag\ 3_{20}\ FE} \right] + 0.133 \times 1.083 \times \left[\frac{1}{SC03\ FE} - \left(\frac{0.61}{Bag\ 3_{75}\ FE} + \frac{0.39}{Bag\ 4_{75}\ FE} \right) \right]$$

Where:

$Bag Y_X$ FE = the fuel economy in miles per gallon of fuel during the specified bag Y of the FTP test conducted at an ambient temperature X of 75 °F or 20 °F.

US06 City FE = fuel economy in miles per gallon over the city portion of the US06 test.

SC03 FE = fuel economy in miles per gallon over the SC03 test.

* * * * *

■ 18. Section 600.115–08 is amended as follows:

■ a. By revising the introductory text.

■ b. By revising paragraph (a)(1)(i).

■ c. By revising paragraph (a)(1)(ii).

§ 600.115–08 Criteria for determining the fuel economy label calculation method for 2011 and later model year vehicles.

This section provides the criteria to determine if the derived 5-cycle method for determining fuel economy label values, as specified in § 600.210–08 (a)(2) or (b)(2), as applicable, may be used to determine label values for 2011 and later model year vehicles. Separate criteria apply to city and highway fuel economy for each test group. The provisions of this section are optional. If this option is not chosen, or if the criteria provided in this section are not met, fuel economy label values for 2011 and later model year vehicles must be determined according to the vehicle-specific 5-cycle method specified in § 600.210–08(a)(1) or (b)(1), as applicable. However, dedicated alternative-fuel vehicles, dual fuel vehicles when operating on alternative fuel, and MDPVs may use the derived 5-cycle method for determining fuel economy labels for 2011 and later model years whether or not the criteria provided in this section are met.

(a) * * *

(1) * * *

(i) The vehicle-specific 5-cycle city fuel economy from the official FTP, HFET, US06, SC03 and Cold FTP tests for the test group is determined according to the provisions of § 600.114–08(a) or (c) and rounded to the nearest one tenth of a mile per gallon.

(ii) Using the same FTP data as used in paragraph (a)(1)(i) of this section, the corresponding derived 5-cycle city fuel economy is calculated according to the following equation:

$$\text{Derived 5-cycle city fuel economy} = \frac{1}{\left(\{City\ Intercept\} + \frac{\{City\ Slope\}}{FTP\ FE} \right)}$$

Where:

City Intercept = Intercept determined by the Administrator. *See* § 600.210–08(a)(2)(iii).

City Slope = Slope determined by the Administrator. *See* § 600.210–08(a)(2)(iii).

FTP FE = the FTP-based city fuel economy from the official test used for certification compliance, determined under § 600.113–08(a), rounded to the nearest tenth.

* * * * *

■ 19. Section 600.210–08 is amended as follows:

■ a. By revising paragraph (a) introductory text.

■ b. By revising paragraphs (a)(2)(i) and (a)(2)(ii).

■ c. By revising paragraph (a)(3)(i).

■ d. By adding paragraph (e).

§ 600.210–08 Calculation of fuel economy values for labeling.

(a) *General Labels.* Except as permitted in paragraph (e) of this section, fuel economy for general labels can be determined by two methods. The first is based on vehicle-specific model-type 5-cycle data as determined in § 600.209–08(b). This method is optional beginning in the 2008 model year for all vehicles, including medium-duty passenger vehicles, and required beginning in the 2011 model year (except for dedicated alternative-fuel vehicles, dual fuel vehicles when operating on alternative fuel, and medium duty passenger vehicles) unless otherwise indicated according to the provisions in § 600.115–08. The second method is the derived 5-cycle method, and is based on fuel economy that is derived from vehicle-specific 5-cycle model type data as determined in paragraph (a)(2) of this section. This method is required for 2008 through 2010 model years (except for medium-duty passenger vehicles, in which case it is optional), and is permitted beginning in 2011 model year under the provisions of § 600.115–08. If the manufacturer determines that the resulting label values from either of these methods are not representative of the fuel economy for that model type, they may voluntarily lower these values. All 2011 and later model year medium-

duty passenger vehicles, dedicated alternative-fueled vehicles, and dual fuel vehicles when operating on alternative fuel must be labeled for fuel economy, using the derived 5-cycle method or, at the manufacturer's option, the vehicle-specific 5-cycle method. Fuel economy label values for dual fuel vehicles operating on alcohol-based or natural gas fuel are calculated separately.

* * * * *

(2) * * *

(i) For each model type, determine the derived five-cycle city fuel economy using the following equation and coefficients determined by the Administrator:

$$\text{Derived 5-cycle City Fuel Economy} = \frac{1}{\left(\{\text{City Intercept}\} + \frac{\{\text{City Slope}\}}{\text{MT FTP FE}}\right)}$$

Where:

City Intercept = Intercept determined by the Administrator based on historic vehicle-specific 5-cycle city fuel economy data.

City Slope = Slope determined by the Administrator based on historic vehicle-specific 5-cycle city fuel economy data.

MT FTP FE = the model type FTP-based city fuel economy determined under § 600.208–08(b), rounded to the nearest 0.0001 mpg.

(ii) For each model type, determine the derived five-cycle highway fuel economy using the equation below and coefficients determined by the Administrator:

$$\text{Derived 5-cycle Highway Fuel Economy} = \frac{1}{\left(\{\text{Highway Intercept}\} + \frac{\{\text{Highway Slope}\}}{\text{MT HFET FE}}\right)}$$

Where:

Highway Intercept = Intercept determined by the Administrator based on historic vehicle-specific 5-cycle highway fuel economy data.

Highway Slope = Slope determined by the Administrator based on historic vehicle-specific 5-cycle highway fuel economy data.

MT HFET FE = the model type highway fuel economy determined under § 600.208–08(b), rounded to the nearest 0.0001 mpg.

* * * * *

(3) * * *

(i) City and Highway label values for dual fuel alcohol-based and natural gas vehicles when using the alternate fuel are separately determined by the following calculation:

$$\textit{Derived } FE_{alt} = FE_{alt} \times \frac{5cycle_{gas}}{FE_{gas}}$$

Where:

FE_{alt} = The unrounded FTP-based model-type city or HFET-based model-type highway fuel economy from the alternate fuel, as determined in § 600.208(b)(5)(ii).

5-cycle FE_{gas} = The unrounded vehicle-specific or derived 5-cycle model-type city or highway fuel economy, as determined in paragraph (a)(1) or (a)(2) of this section.

FE_{gas} = The unrounded FTP-based city or HFET-based model type highway fuel economy from gasoline (or diesel), as determined in § 600.208(b)(5)(i).

The result, rounded to the nearest whole number, is the alternate fuel label value for dual fuel vehicles.

* * * * *

(e) *Fuel economy values and other information for advanced technology vehicles.* (1) The Administrator may prescribe an alternative method of determining the city and highway model type fuel economy values for general, unique or specific fuel economy labels other than those set forth in this Subpart C for advanced technology vehicles including, but not limited to battery electric vehicles, fuel cell vehicles, plug-in hybrid electric vehicles and vehicles equipped with hydrogen internal combustion engines.

(2) For advanced technology vehicles, the Administrator may prescribe special methods for calculating and/or determining information other than fuel economy that is required to be displayed on fuel economy labels as specified in section 600.307–08(k) of this part. For example, the Administrator may prescribe methods to determine the city and highway electrical energy consumption values and the all electric driving range for battery electric vehicles and plug-in hybrid electric vehicles.

Subpart D—[Amended]

■ 20. Section 600.307–08 is amended by adding new paragraph (k) to read as follows:

§ 600.307–08 Fuel economy label format requirements.

* * * * *

(k) *Special label format requirements.* The Administrator may prescribe special label format and information requirements for vehicles which are not specifically described in this section and for which sample labels are not provided in Appendix IV of this Part 600. These types of vehicles may include, but are not limited to battery electric vehicles, fuel cell vehicles, plug-in hybrid electric vehicles and vehicles equipped with hydrogen internal combustion engines. The format and information requirements for the labels of such vehicles will be designed to provide simple, easy to understand, fuel economy values in accordance with the way the fuel is expected to be dispensed, sold or marketed in the field to the ultimate consumer. The Administrator may prescribe special label format and information requirements for other information required to be displayed on fuel economy labels pursuant to 49 U.S.C. 32908(b)(1)(F). For example, the Administrator may prescribe special label format and information requirements to display the city and highway electrical energy consumption values and the all electric driving range for battery electric vehicles and plug-in hybrid electric vehicles.

■ 21. Section 600.315–08 is amended as follows:

■ a. By revising paragraph (a)(2) introductory text.
■ b. By revising paragraph (a)(3)(i).
■ c. By revising paragraphs (b)(1), (b)(2), (b)(3).
■ d. By revising paragraph (c) introductory text and paragraph (c)(1).
■ e. By revising paragraph (e) introductory text.
■ f. By revising paragraph (e)(2)(ii).
■ g. By revising paragraph (g)(1) introductory text and paragraph (g)(1)(i).
■ h. By revising paragraph (g)(2) introductory text and paragraph (g)(2)(iii).
■ i. By revising paragraph (h)(2) introductory text, (h)(3), and (h)(4)(ii).

§ 600.315–08 Classes of comparable automobiles.

(a) * * *

(2) The Administrator will classify light trucks (nonpassenger automobiles) into the following classes: Small pickup trucks, standard pickup trucks, vans, minivans, and SUVs. Pickup trucks will be separated by car line on the basis of gross vehicle weight rating (GVWR). For pickup truck car lines with more than one GVWR, the GVWR of the pickup truck car line is the arithmetic average of all distinct GVWRs less than or equal to 8,500 pounds available for that car line. The Administrator may determine that specific light trucks should be most appropriately placed in a different class or in the special purpose vehicle class as provided in paragraph (a)(3)(i) and (a)(3)(ii) of this section, based on the features and characteristics of the specific vehicle, consumer information provided by the manufacturer, and other information available to consumers.

* * * * *

(3)(i) *Special purpose vehicles.* All automobiles with GVWR less than or equal to 8,500 pounds and all medium-duty passenger vehicles which possess special features and which the Administrator determines are more appropriately classified separately from typical automobiles or which do not meet the requirements of paragraphs (a)(1) and (2) of this section will be classified as special purpose vehicles. For example, the Administrator may determine that advanced technology vehicles (such as battery electric vehicles, fuel cell vehicles, plug-in hybrid electric vehicles and vehicles equipped with hydrogen internal combustion engines) should be appropriately classified as a type of ''special purpose vehicle.'' The Administrator may determine appropriate names for such types of special purpose vehicles, different from the name ''special purpose vehicle.''

* * * * *

(b) *Interior volume index—passenger automobiles.* (1) The interior volume index shall be calculated for each car line which is not a ''two seater'' car line, in cubic feet rounded to the nearest 0.1 cubic foot. For car lines with more than one body style, the interior volume index for the car line is the arithmetic average of the interior volume indexes of each body style in the car line.

(2) For all body styles except station wagons and hatchbacks with more than one seat (*e.g.,* with a second or third seat) equipped with seatbelts as required by DOT safety regulations, interior volume index is the sum, rounded to the nearest 0.1 cubic feet, of the front seat volume, the rear seat volume(s), if applicable, and the luggage capacity.

(3) For all station wagons and hatchbacks with more than one seat (*e.g.,* with a second or third seat) equipped with seatbelts as required by DOT safety regulations, interior volume index is the sum, rounded to the nearest 0.1 cubic feet, of the front seat volume, the rear seat volume, and the cargo volume index.

(c) All interior and cargo dimensions are measured in inches to the nearest 0.1 inch. All dimensions and volumes shall be determined from the base vehicles of each body style in each car line, and do not include optional equipment. The dimensions H61, W3, W5, L34, H63, W4, W6, L51, H201, L205, L210, L211, H198, W201, and volume V1 are to be determined in accordance with the procedures outlined in Motor Vehicle Dimensions SAE J1100a (Report of Human Factors Engineering Committee, Society of Automotive Engineers, approved September 1973 and last revised September 1975), as incorporated by reference as specified in § 600.011–93, except as noted herein:

(1) *SAE J1100a(2.3)*—Cargo dimensions. All dimensions are measured with the front seat positioned the same as for the interior dimensions and the second seat, for the station wagons and hatchbacks, in the upright position. All head restraints shall be in the stowed position and considered part of the seat.

* * * * *

(e) The rear seat volume is calculated in cubic feet, for vehicles with a rear seat equipped with rear seat belts (as required by DOT), by dividing 1,728 into the product of three terms listed below and rounding the quotient to the nearest 0.001 cubic feet:

* * * * *

(2) * * *

(ii) W4—Shoulder room-second, if hip room is not more than 5 inches less than shoulder room. (In inches, W4 is obtained according to paragraph (c) of this section), and

* * * * *

(g) * * *

(1) For station wagons the cargo volume index V10 is calculated, in cubic feet, by dividing 1,728 into the product of three terms and rounding the quotient to the nearest 0.001 cubic feet:

(i) Average cargo width, which is the arithmetic average of:

(A) W4—Shoulder room-second (in inches obtained according to paragraph (c) of this section); and

(B) W201—Cargo width-wheelhouse (in inches obtained according to paragraph (c) of this section).

* * * * *

(2) For hatchbacks, the cargo volume index V11 is calculated, in cubic feet, by dividing 1,728 into the product of three terms and rounding the quotient to the nearest 0.001 cubic foot:

* * * * *

(iii) H198—Second seatback to load floor height. (In inches obtained according to paragraph (c) of this section.)

(h) * * *

(2) For all passenger automobiles except station wagons and hatchbacks with more than one seat (*e.g.,* with a second or third seat) equipped with seat belts as required by DOT safety regulations:

* * * * *

(3) For station wagons with more than one seat (*e.g.,* with a second or third seat) equipped with seat belts as required by DOT safety regulations:

(i) The dimensions H201, L205, and W201 determined in accordance with paragraph (c) of this section, and

(ii) The cargo volume index V10 determined in accordance with paragraph (g)(1) of this section.

(4) * * *

(ii) The cargo volume index V11 determined in accordance with paragraph (g)(2) of this section.

* * * * *

Subpart E—[Amended]

■ 22. Section 600.501–93 is amended by revising paragraph (a) to read as follows:

§ 600.501–93 General applicability.

(a) The provisions of this subpart are applicable to 1993 and later model year passenger automobiles and light trucks, and to the manufacturers of passenger automobiles and light trucks as determined by the Secretary of Transportation in 49 CFR 531.3 and 49

CFR 533.3. The provisions of this subpart are applicable to medium-duty passenger vehicles manufactured in 2011 model year and later model years and to the manufacturers of such vehicles.

* * * * *

■ 23. Section 600.502–81 is amended by adding a new paragraph (a)(4) to read as follows:

§ 600.502–81 Definitions.

(a) * * *

(4) *Footprint* means the area between the wheels of an automobile as defined by the Secretary of Transportation at 49 CFR 523.2.

* * * * *

■ 24. Section 600.510–08 is amended as follows:

■ a. By revising paragraph (a)(1).

■ b. By removing and reserving paragraph (a)(2).

■ c. By revising paragraph (a)(3).

■ d. By removing and reserving paragraph (a)(4).

■ e. By revising paragraph (b)(2)(i) introductory text.

■ f. By removing and reserving paragraphs (b)(2)(i)(A) and (b)(2)(i)(B).

■ g. By revising paragraph (b)(3)(i) introductory text.

■ h. By removing and reserving paragraphs (b)(3)(i)(A) and (b)(3)(i)(B).

■ i. By revising paragraph (c)(2)(v) introductory text.

■ j. By revising paragraph (c)(2)(vi) introductory text.

■ k. By revising the equation for IW in paragraph (e).

■ l. By revising paragraph (g)(3).

■ m. By revising paragraph (h) introductory text.

■ n. By removing and reserving paragraph (i).

§ 600.510–08 Calculation of average fuel economy.

(a) * * *

(1) An average fuel economy calculation will be made for the category of passenger automobiles as determined by the Secretary of Transportation. For example, categories may include, but are not limited to domestically manufactured and/or non-domestically manufactured passenger automobiles as determined by the Secretary of Transportation.

(2) [Reserved]

(3) An average fuel economy calculation will be made for the category of trucks as determined by the Secretary of Transportation. For example, categories may include, but are not limited to domestically manufactured trucks, non-domestically manufactured trucks, light-duty trucks, medium-duty passenger vehicles, and/or heavy-duty trucks as determined by the Secretary of Transportation.

(4) [Reserved]

(b) * * *

(2) * * *

(i) Separate fuel economy values will be calculated for model types and base levels associated with car lines for each category of passenger automobiles and trucks as determined by the Secretary of Transportation pursuant to paragraphs (a)(1) and (a)(3) of this section.

(A) [Reserved]

(B) [Reserved]

* * * * *

(3) * * *

(i) Separate fuel economy values will be calculated for vehicle configurations associated with car lines for each category of passenger automobiles and trucks as determined by the Secretary of Transportation pursuant to paragraphs (a)(1) and (a)(3) of this section.

(A) [Reserved]

(B) [Reserved]

* * * * *

(c) * * *

(2) * * *

(v) For alcohol dual fuel model types, for model years 1993 through 2019, the harmonic average of the following two terms; the result rounded to the nearest 0.1 mpg:

* * * * *

(vi) For natural gas dual fuel model types, for model years 1993 through 2019, the harmonic average of the following two terms; the result rounded to the nearest 0.1 mpg:

* * * * *

(e) * * *

* * * * *

$$IW = (9.2917 \times 10^{-3} \times SF_{3IWC} \times FE_{3IWC}) - (3.5123 \times 10^{-3} \times SF_{4ETW} \times FE_{4IWC}).$$

* * * * *

(g) * * *

(3) Alcohol dual fuel passenger automobiles and natural gas dual fuel passenger automobiles manufactured during model years 1993 through 2019 must meet the minimum driving range requirements established by the Secretary of Transportation (49 CFR part 538) to obtain the CAFE credit determined in paragraphs (c)(2)(v) and (vi) of this section.

(h) For model years 1993 and later, and for each category of automobile identified in paragraph (a) of this section, the maximum increase in average fuel economy determined in paragraph (c) of this section attributable to alcohol dual fuel automobiles and natural gas dual fuel automobiles shall be as follows:

Model year	Maximum Increase (mpg)
1993–2014	1.2
2015	1.0
2016	0.8
2017	0.6
2018	0.4
2019	0.2
2020 and later	0

* * * * *

(i) [Reserved]

■ 25. Section 600.511–80 is amended as follows:

■ a. By revising paragraph (a) introductory text.

■ b. By revising paragraph (b)(5).

■ c. By removing and reserving paragraphs (d) and (e).

§ 600.511–80 Determination of domestic production.

(a) Except with advance approval of the Administrator, an automobile shall be considered domestically produced in any model year if it is included within a domestically produced car line (car line includes station wagons for purposes of this paragraph), unless the assembly of such automobile is completed in Canada or Mexico and such automobile is not imported into the United States prior to the expiration of 30 days following the end of the model year. For purposes of this paragraph a car line will be considered domestically produced if the following ratio is less than 0.25:

* * * * *

(b) * * *

(5) All elections under paragraph (b)(4) of this section shall be made in accordance with the procedures established by the Secretary of Transportation pursuant to 49 U.S.C. 32904(b)(3)(C).

* * * * *

■ 26. Section 600.512–08 is amended by adding new paragraphs (c)(8) and (c)(9) to read as follows:

§ 600.512–08 Model Year Report.

* * * * *

(c) * * *

(8) For 2008–2010 light truck model year reports, the average fuel economy standard or the ''required fuel economy level'' pursuant to 49 CFR Part 533, as applicable. Model year reports for light trucks meeting required fuel economy levels pursuant to 49 CFR 533.5(g) and (h) shall include information in sufficient detail to verify the accuracy of the calculated required fuel economy level. Such information is expected to include but is not limited to, production information for each unique footprint

within each model type contained in the model year report and the formula used to calculate the required fuel economy level. Model year reports for required fuel economy levels shall include a statement that the method of measuring vehicle track width, measuring vehicle wheelbase and calculating vehicle footprint is accurate and complies with applicable Department of Transportation requirements.

(9) For 2011 and later model year reports, the ''required fuel economy level'' pursuant to 49 CFR Parts 531 or 533, as applicable. Model year reports shall include information in sufficient detail to verify the accuracy of the calculated required fuel economy level, including but is not limited to, production information for each unique footprint within each model type contained in the model year report and the formula used to calculate the required fuel economy level. Model year reports shall include a statement that the method of measuring vehicle track width, measuring vehicle wheelbase and calculating vehicle footprint is accurate and complies with applicable Department of Transportation requirements.

[FR Doc. E9–27945 Filed 11–24–09; 8:45 am]
BILLING CODE 6560–50–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 64

[Docket ID FEMA–2008–0020; Internal Agency Docket No. FEMA–8103]

Suspension of Community Eligibility

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: This rule identifies communities, where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP), that are scheduled for suspension on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If the Federal Emergency Management Agency (FEMA) receives documentation that the community has adopted the required floodplain management measures prior to the effective suspension date given in this rule, the suspension will not occur and a notice of this will be provided by publication in the **Federal Register** on a subsequent date.

DATES: *Effective Dates:* The effective date of each community's scheduled suspension is the third date (''Susp.'') listed in the third column of the following tables.

FOR FURTHER INFORMATION CONTACT: If you want to determine whether a particular community was suspended on the suspension date or for further information, contact David Stearrett, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2953.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance which is generally not otherwise available. In return, communities agree to adopt and administer local floodplain management aimed at protecting lives and new construction from future flooding. Section 1315 of the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage as authorized under the NFIP, 42 U.S.C. 4001 *et seq.;* unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed in this document no longer meet that statutory requirement for compliance with program regulations, 44 CFR part 59. Accordingly, the communities will be suspended on the effective date in the third column. As of that date, flood insurance will no longer be available in the community. However, some of these communities may adopt and submit the required documentation of legally enforceable floodplain management measures after this rule is published but prior to the actual suspension date. These communities will not be suspended and will continue their eligibility for the sale of insurance. A notice withdrawing the suspension of the communities will be published in the **Federal Register.**

In addition, FEMA has identified the Special Flood Hazard Areas (SFHAs) in these communities by publishing a Flood Insurance Rate Map (FIRM). The date of the FIRM, if one has been published, is indicated in the fourth column of the table. No direct Federal financial assistance (except assistance pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act not in connection with a flood) may legally be provided for construction or acquisition of buildings in identified SFHAs for communities not participating in the NFIP and identified for more than a year, on FEMA's initial flood insurance map of the community as having flood-prone areas (section 202(a) of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4106(a), as amended). This prohibition against certain types of Federal assistance becomes effective for the communities listed on the date shown in the last column. The Administrator finds that notice and public comment under 5 U.S.C. 553(b) are impracticable and unnecessary because communities listed in this final rule have been adequately notified.

Each community receives 6-month, 90-day, and 30-day notification letters addressed to the Chief Executive Officer stating that the community will be suspended unless the required floodplain management measures are met prior to the effective suspension date. Since these notifications were made, this final rule may take effect within less than 30 days.

National Environmental Policy Act. This rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Considerations. No environmental impact assessment has been prepared.

Regulatory Flexibility Act. The Administrator has determined that this rule is exempt from the requirements of the Regulatory Flexibility Act because the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed no longer comply with the statutory requirements, and after the effective date, flood insurance will no longer be available in the communities unless remedial action takes place.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This rule meets the applicable standards of Executive Order 12988.

Paperwork Reduction Act. This rule does not involve any collection of information for purposes of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*

List of Subjects in 44 CFR Part 64

Flood insurance, Floodplains.

■ Accordingly, 44 CFR part 64 is amended as follows:

PART 64—[AMENDED]

■ 1. The authority citation for part 64 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp.; p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp.; p. 376.

§ 64.6 [Amended]

■ 2. The tables published under the authority of § 64.6 are amended as follows:

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
Region III				
Pennsylvania:				
Aldan, Borough of, Delaware County	420401	August 26, 1974, Emerg; September 17, 1980, Reg; Date of this **Federal Register** publication, Susp.	Nov. 18, 2009 ...	Nov. 25, 2009.
Aston, Township of, Delaware County ..	421602	April 21, 1975, Emerg; July 16, 1981, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Bethel, Township of, Delaware County	421606	May 9, 1978, Emerg; August 10, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Brookhaven, Borough of, Delaware County.	420403	October 22, 1971, Emerg; February 14, 1976, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Chadds Ford, Township of, Delaware County.	420402	February 25, 1972, Emerg; September 5, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Chester, City of, Delaware County	420404	December 10, 1971, Emerg; August 1, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Chester, Township of, Delaware County	420405	December 3, 1971, Emerg; May 15, 1984, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Chester Heights, Borough of, Delaware County.	420406	November 3, 1972, Emerg; January 16, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Clifton Heights, Borough of, Delaware County.	420407	August 18, 1972, Emerg; May 16, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Collingdale, Borough of, Delaware County.	420408	October 13, 1972, Emerg; February 2, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Colwyn, Borough of, Delaware County	420409	September 15, 1972, Emerg; May 2, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Concord, Township of, Delaware County.	420410	February 25, 1972, Emerg; January 5, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Darby, Borough of, Delaware County ...	420411	September 8, 1972, Emerg; July 18, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Darby, Township of, Delaware County	421603	November 8, 1974, Emerg; April 3, 1984, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Eddystone, Borough of, Delaware County.	420413	September 15, 1972, Emerg; February 2, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Edgmont, Township of, Delaware County.	420414	March 31, 1974, Emerg; September 1, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Folcroft, Borough of, Delaware County	420415	February 2, 1973, Emerg; August 1, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Glenolden, Borough of, Delaware County.	420416	June 30, 1972, Emerg; November 18, 1981, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Haverford, Township of, Delaware County.	420417	June 16, 1972, Emerg; July 5, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Lansdowne, Borough of, Delaware County.	420418	June 23, 1975, Emerg; February 3, 1982, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
Lower Chichester, Township of, Delaware County.	421604	October 9, 1974, Emerg; September 22, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Marcus Hook, Borough of, Delaware County.	420419	June 10, 1975, Emerg; September 16, 1981, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Marple, Township of, Delaware County	420420	December 3, 1971, Emerg; September 1, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Media, Borough of, Delaware County ...	420421	May 18, 1976, Emerg; September 28, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Middletown, Township of, Delaware County.	420422	December 1, 1972, Emerg; February 15, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Millbourne, Borough of, Delaware County.	422408	August 7, 1975, Emerg; September 22, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Morton, Borough of, Delaware County ..	420423	June 18, 1974, Emerg; January 16, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Nether Providence, Township of, Delaware County.	420424	November 12, 1971, Emerg; December 1, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Newtown, Township of, Delaware County.	420991	September 15, 1972, Emerg; September 17, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Norwood, Borough of, Delaware County	420425	August 18, 1972, Emerg; May 13, 1982, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Parkside, Borough of, Delaware County	420426	December 10, 1971, Emerg; July 5, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Prospect Park, Borough of, Delaware County.	420427	September 19, 1974, Emerg; March 18, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Radnor, Township of, Delaware County	420428	February 25, 1972, Emerg; August 1, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Ridley, Township of, Delaware County	420429	September 8, 1972, Emerg; January 6, 1983, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Ridley Park, Borough of, Delaware County.	420430	August 29, 1974, Emerg; January 2, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Rose Valley, Borough of, Delaware County.	420431	May 12, 1972, Emerg; February 2, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Rutledge, Borough of, Delaware County	420432	December 4, 1974, Emerg; March 18, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Sharon Hill, Borough of, Delaware County.	420433	July 19, 1974, Emerg; August 15, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Springfield, Township of, Delaware County.	420434	November 26, 1971, Emerg; January 19, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Swarthmore, Borough of, Delaware County.	420435	March 9, 1973, Emerg; May 16, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Thornbury, Township of, Delaware County.	425390	August 6, 1971, Emerg; July 24, 1973, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tinicum, Township of, Delaware County	421605	February 7, 1975, Emerg; May 1, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Trainer, Borough of, Delaware County	420437	December 10, 1971, Emerg; September 30, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
Upland, Borough of, Delaware County	420438	December 3, 1971, Emerg; December 10, 1976, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Upper Chichester, Township of, Delaware County.	420439	December 17, 1971, Emerg; May 16, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Upper Darby, Township of, Delaware County.	420440	December 10, 1971, Emerg; March 1, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Upper Providence, Township of, Delaware County.	420441	December 3, 1971, Emerg; June 15, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Yeadon, Borough of, Delaware County	420442	September 19, 1974, Emerg; November 1, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Region IV				
Alabama:				
Macon County, Unincorporated Areas.	010148	May 29, 1975, Emerg; April 1, 1982, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Notasulga, Town of, Macon County	010149	July 2, 1975, Emerg; November 24, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tuskegee, City of, Macon County	010150	August 8, 1975, Emerg; January 6, 1982, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Mississippi:				
Bolton, Town of, Hinds County	280216	July 30, 1974, Emerg; April 3, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Clinton, City of, Hinds County	280071	January 15, 1974, Emerg; August 17, 1981, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Hinds County, Unincorporated Areas. ...	280070	December 19, 1973, Emerg; July 2, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Jackson, City of, Hinds County	280072	April 19, 1973, Emerg; April 1, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Pearl River Valley Water Supply District, Hinds, Leake, and Madison County.	280338	N/A, Emerg; March 5, 1993, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Raymond, Town of, Hinds County	280320	April 17, 1980, Emerg; August 1, 1986, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Terry, Town of, Hinds County	280073	May 27, 1975, Emerg; April 3, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tennessee:				
Kingston, City of, Roane County	470274	August 18, 1975, Emerg; December 15, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Oak Ridge, City of, Roane County	475441	December 17, 1971, Emerg; October 27, 1972, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Roane County, Unincorporated Areas.	470267	October 21, 1974, Emerg; September 30, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Region V				
Illinois:				
Benton, City of, Franklin County	170237	April 3, 1975, Emerg; December 14, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Christopher, City of, Franklin County	170238	May 15, 1975, Emerg; August 19, 1987, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Freeman Spur, Village of, Franklin County.	170953	July 3, 2003, Emerg; August 4, 2008, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
Valier, Village of, Franklin County	170870	July 22, 1975, Emerg; July 2, 1987, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
West City, Village of, Franklin County ..	170872	September 8, 1975, Emerg; May 25, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
West Frankfort, City of, Franklin County	170239	May 13, 1975, Emerg; May 16, 1983, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Zeigler, City of, Franklin County	170240	January 6, 1983, Emerg; August 5, 1985, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Minnesota:				
Douglas County, Unincorporated Areas.	270623	April 16, 1974, Emerg; September 1, 1988, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Ohio:				
Campbell, City of, Mahoning County	390368	June 17, 1975, Emerg; September 3, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Canfield, City of, Mahoning County	390369	June 25, 1975, Emerg; November 1, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Champaign County, Unincorporated Areas..	390055	May 12, 1976, Emerg; April 3, 1985, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Christiansburg, Village of, Champaign County.	390056	August 9, 1976, Emerg; November 2, 1984, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Columbiana, City of, Columbiana County.	390077	February 26, 1975, Emerg; September 30, 1988, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Craig Beach, Village of, Mahoning County.	390745	April 29, 1976, Emerg; April 17, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Lowellville, Village of, Mahoning County	390620	July 9, 1975, Emerg; September 3, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Mahoning County, Unincorporated Areas.	390367	July 25, 1973, Emerg; February 15, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Mechanicsburg, Village of, Champaign County.	390057	October 2, 1975, Emerg; September 1, 1986, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
North Lewisburg, Village of, Champaign County.	390058	February 24, 1975, Emerg; December 7, 1984, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Poland, Village of, Mahoning County	390370	May 23, 1975, Emerg; July 21, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Sebring, Village of, Mahoning County ...	390371	November 26, 1976, Emerg; August 11, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
St. Paris, Village of, Champaign County	390059	February 24, 1977, Emerg; May 29, 1979, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Struthers, City of, Mahoning County	390372	April 8, 1975, Emerg; November 19, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Urbana, City of, Champaign County	390060	April 21, 1975, Emerg; April 3, 1984, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Youngstown, City of, Mahoning County	390373	April 18, 1973, Emerg; July 18, 1977, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Region VII				
Iowa:				

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
Montour, City of, Tama County	190782	April 25, 2001, Emerg; March 22, 2006, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tama, City of, Tama County	190262	August 11, 1975, Emerg; January 17, 1990, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tama County, Unincorporated Areas.	190908	N/A, Emerg; May 4, 2006, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Kansas:				
Belle Plaine, City of, Sumner County	200466	July 25, 1975, Emerg; July 17, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Bennington, City of, Ottawa County	200467	February 6, 2009, Emerg; August 1, 2009, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Culver, City of, Ottawa County	200257	August 20, 1975, Emerg; January 1, 1987, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Delphos, City of, Ottawa County	200487	August 6, 1975, Emerg; July 1, 1988, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Geuda Springs, City of, Sumner County	200414	July 17, 2002, Emerg; NA Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Mulvane, City of, Sumner County	200326	October 15, 1974, Emerg; September 29, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Sumner County, Unincorporated Areas	200348	September 16, 1975, Emerg; April 16, 1990, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tescott, City of, Ottawa County	200258	April 22, 1975, Emerg; June 1, 1987, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Wellington, City of, Sumner County	200349	June 6, 1974, Emerg; April 16, 1990, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Region VIII				
Utah:				
Grantsville, City of, Tooele County	490141	July 9, 1975, Emerg; July 10, 1985, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Stockton, Town of, Tooele County	490144	March 23, 1976, Emerg; August 5, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tooele, City of, Tooele County	490145	March 10, 1975, Emerg; September 29, 1989, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tooele County, Unincorporated Areas	490140	June 7, 1976, Emerg; November 16, 1990, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Wendover, Town of, Tooele County	490222	July 25, 1975, Emerg; August 19, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Region IX				
Arizona:				
Colorado City, City of, Mohave County	040059	July 1, 1988, Emerg; August 4, 1988, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Fort Mojave Indian Tribe, Mohave County.	040133	N/A, Emerg; March 18, 1996, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Region X				
Idaho:				
Bonner County, Unincorporated Areas	160206	May 14, 1975, Emerg; August 1, 1984, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Clark Fork, City of, Bonner County	160132	June 30, 1976, Emerg; March 15, 1982, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
East Hope, City of, Bonner County	160237	May 15, 1997, Emerg; October 6, 2000, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Priest River, City of, Bonner County	160026	May 16, 1975, Emerg; February 17, 1982, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Sandpoint, City of, Bonner County	160025	March 26, 1975, Emerg; February 17, 1982, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Washington:				
Granger, City of, Yakima County	530219	June 16, 1975, Emerg; December 22, 1980, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Mabton, City of, Yakima County	530221	April 5, 1976, Emerg; September 1, 1981, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Naches, City of, Yakima County	530223	April 29, 1975, Emerg; January 19, 1983, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Selah, City of, Yakima County	530226	July 18, 1974, Emerg; May 3, 1982, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Tieton, City of, Yakima County	530265	November 7, 1979, Emerg; March 18, 1985, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Toppenish, City of, Yakima County	530228	April 4, 1975, Emerg; July 17, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Union Gap, City of, Yakima County	530229	April 30, 1975, Emerg; May 2, 1983, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Wapato, City of, Yakima County	530230	March 7, 1975, Emerg; July 17, 1978, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Yakima, City of, Yakima County	530311	January 20, 1975, Emerg; December 15, 1981, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.
Yakima County, Unincorporated Areas	530217	April 11, 1974, Emerg; June 5, 1985, Reg; Date of this **Federal Register** publication, Susp.	.....do	Do.

*do = Ditto.
Code for reading third column: Emerg.—Emergency; Reg.—Regular; Susp.—Suspension.

Dated: November 5, 2009.

Edward L. Connor,

Acting Assistant Administrator, Mitigation Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–28309 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 64

[Docket ID FEMA–2008–0020; Internal Agency Docket No. FEMA–8105]

Suspension of Community Eligibility

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: This rule identifies communities, where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP), that are scheduled for suspension on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If the Federal Emergency Management Agency (FEMA) receives documentation that the community has adopted the required floodplain management measures prior to the effective suspension date given in this rule, the suspension will not occur and a notice of this will be provided by publication in the **Federal Register** on a subsequent date.

DATES: *Effective Dates:* The effective date of each community's scheduled suspension is the third date (''Susp.'') listed in the third column of the following tables.

FOR FURTHER INFORMATION CONTACT: If you want to determine whether a particular community was suspended on the suspension date or for further information, contact David Stearrett,

Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2953.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance which is generally not otherwise available. In return, communities agree to adopt and administer local floodplain management aimed at protecting lives and new construction from future flooding. Section 1315 of the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage as authorized under the NFIP, 42 U.S.C. 4001 *et seq.;* unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed in this document no longer meet that statutory requirement for compliance with program regulations, 44 CFR part 59. Accordingly, the communities will be suspended on the effective date in the third column. As of that date, flood insurance will no longer be available in the community. However, some of these communities may adopt and submit the required documentation of legally enforceable floodplain management measures after this rule is published but prior to the actual suspension date. These communities will not be suspended and will continue their eligibility for the sale of insurance. A notice withdrawing the suspension of the communities will be published in the **Federal Register.**

In addition, FEMA has identified the Special Flood Hazard Areas (SFHAs) in these communities by publishing a Flood Insurance Rate Map (FIRM). The date of the FIRM, if one has been published, is indicated in the fourth column of the table. No direct Federal financial assistance (except assistance pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act not in connection with a flood) may legally be provided for construction or acquisition of buildings in identified SFHAs for communities not participating in the NFIP and identified for more than a year, on FEMA's initial flood insurance map of the community as having flood-prone areas (section 202(a) of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4106(a), as amended). This prohibition against certain types of Federal assistance becomes effective for the communities listed on the date shown in the last column. The Administrator finds that notice and public comment under 5 U.S.C. 553(b) are impracticable and unnecessary because communities listed in this final rule have been adequately notified.

Each community receives 6-month, 90-day, and 30-day notification letters addressed to the Chief Executive Officer stating that the community will be suspended unless the required floodplain management measures are met prior to the effective suspension date. Since these notifications were made, this final rule may take effect within less than 30 days.

National Environmental Policy Act. This rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Considerations. No environmental impact assessment has been prepared.

Regulatory Flexibility Act. The Administrator has determined that this rule is exempt from the requirements of the Regulatory Flexibility Act because the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed no longer comply with the statutory requirements, and after the effective date, flood insurance will no longer be available in the communities unless remedial action takes place.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This rule meets the applicable standards of Executive Order 12988.

Paperwork Reduction Act. This rule does not involve any collection of information for purposes of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*

List of Subjects in 44 CFR Part 64

Flood insurance, Floodplains.

■ Accordingly, 44 CFR part 64 is amended as follows:

PART 64—[AMENDED]

■ 1. The authority citation for part 64 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp.; p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp.; p. 376.

§ 64.6 [Amended]

■ 2. The tables published under the authority of § 64.6 are amended as follows:

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
Region IV				
North Carolina:				
Blowing Rock, Town of, Watauga County.	370252	July 8, 1975, Emerg; June 1, 1978, Reg; December 3, 2009, Susp.	Dec. 3, 2009	Dec. 3, 2009.
Boone, Town of, Watauga County	370253	August 22, 1974, Emerg; September 28, 1979, Reg; December 3, 2009, Susp.	.....do	Do.
Region V				
Illinois:				
Brookport, City of, Massac County	170468	May 23, 1997, Emerg; N/A, Reg; December 3, 2009, Susp.	.....do	Do.
Massac County, Unincorporated Areas	170467	July 25, 1975, Emerg; July 5, 1983, Reg; December 3, 2009, Susp.	.....do	Do.
Michigan:				
Almena, Township of, Van Buren County.	260528	May 11, 1976, Emerg; February 11, 1983, Reg; December 3, 2009, Susp.	.....do	Do.

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
Arlington, Township of, Van Buren County.	260705	June 2, 1977, Emerg; July 18, 1985, Reg; December 3, 2009, Susp.	.....do	Do.
Bangor, City of, Van Buren County	260529	October 27, 1976, Emerg; May 4, 1989, Reg; December 3, 2009, Susp.	.....do	Do.
Covert, Township of, Van Buren County	260259	April 12, 1974, Emerg; April 3, 1978, Reg; December 3, 2009, Susp.	.....do	Do.
Geneva, Township of, Van Buren County.	261142	January 15, 2009, Emerg; N/A, Reg; December 3, 2009, Susp.	.....do	Do.
Paw Paw, Village of, Van Buren County	260598	April 21, 1977, Emerg; January 5, 1979, Reg; December 3, 2009, Susp.	.....do	Do.
South Haven, City of, Van Buren County.	260211	May 16, 1974, Emerg; March 4, 1980, Reg; December 3, 2009, Susp.	.....do	Do.
South Haven, Township of, Van Buren County.	260212	April 22, 1975, Emerg; May 15, 1980, Reg; December 3, 2009, Susp.	.....do	Do.
Waverly, Township of, Van Buren County.	260678	August 29, 1994, Emerg; N/A, Reg; December 3, 2009, Susp.	.....do	Do.
Wisconsin: Barron, City of, Barron County.	550010	July 24, 1975, Emerg; September 29, 1989, Reg; December 3, 2009, Susp.	.....do	Do.
Chetek, City of, Barron County	550012	November 8, 1974, Emerg; June 3, 1986, Reg; December 3, 2009, Susp.	.....do	Do.
Prairie Farm, Village of, Barron County	550015	July 25, 1975, Emerg; May 15, 1986, Reg; December 3, 2009, Susp.	.....do	Do.
Rice Lake, City of, Barron County	550016	July 10, 1975, Emerg; April 1, 1982, Reg; December 3, 2009, Susp.	.....do	Do.
Region VI				
Louisiana:				
Bogalusa, City of, Washington County	220232	April 11, 1977, Emerg; May 4, 1988, Reg; December 3, 2009, Susp.	.....do	Do.
Washington Parish, Unincorporated Areas.	220230	September 23, 1977, Emerg; May 4, 1988, Reg; December 3, 2009, Susp.	.....do	Do.
Oklahoma:				
Cherokee County, Unincorporated Areas.	400488	January 9, 1987, Emerg; March 18, 1991, Reg; December 3, 2009, Susp.	.....do	Do.
Fort Gibson, Town of, Cherokee County	400123	July 8, 1977, Emerg; July 16, 1980, Reg; December 3, 2009, Susp.	.....do	Do.
Tahlequah, City of, Cherokee County ...	400037	May 13, 1975, Emerg; November 1, 1979, Reg; December 3, 2009, Susp.	.....do	Do.
Region IX				
California:				
Brea, City of, Orange County	060214	August 28, 1974, Emerg; December 2, 1980, Reg; December 3, 2009, Susp.	.....do	Do.
Cypress, City of, Orange County	060217	February 26, 1975, Emerg; February 12, 1979, Reg; December 3, 2009, Susp.	.....do	Do.
Fullerton, City of, Orange County	060219	October 1, 1971, Emerg; July 5, 1977, Reg; December 3, 2009, Susp.	.....do	Do.
Huntington Beach, City of, Orange County.	065034	April 16, 1971, Emerg; February 16, 1983, Reg; December 3, 2009, Susp.	.....do	Do.
Laguna Hills, City of, Orange County ...	060760	N/A, Emerg; October 31, 1997, Reg; December 3, 2009, Susp.	.....do	Do.
Newport Beach, City of, Orange County	060227	May 12, 1972, Emerg; September 1, 1978, Reg; December 3, 2009, Susp.	.....do	Do.
Orange County, Unincorporated Areas	060212	April 30, 1971, Emerg; September 14, 1979, Reg; December 3, 2009, Susp.	.....do	Do.
Stanton, City of, Orange County	060234	October 15, 1974, Emerg; March 16, 1979, Reg; December 3, 2009, Susp.	.....do	Do.
Region X				
Oregon:				
Cave Junction, City of, Josephine County.	410107	May 13, 1975, Emerg; June 10, 1980, Reg; December 3, 2009, Susp.	.....do	Do.
Grants Pass, City of, Josephine County	410108	April 24, 1974, Emerg; April 15, 1981, Reg; December 3, 2009, Susp.	.....do	Do.
Josephine County, Unincorporated Areas.	415590	December 31, 1970, Emerg; June 1, 1982, Reg; December 3, 2009, Susp.	.....do	Do.

*do = Ditto.
Code for reading third column: Emerg.—Emergency; Reg.—Regular; Susp.—Suspension.

Dated: November 17, 2009.

Deborah S. Ingram,

Acting Deputy Assistant Administrator for Mitigation, Mitigation Directorate.

[FR Doc. E9–28318 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 65

[Docket ID FEMA–2008–0020]

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: Modified Base (1% annual-chance) Flood Elevations (BFEs) are finalized for the communities listed below. These modified BFEs will be used to calculate flood insurance premium rates for new buildings and their contents.

DATES: The effective dates for these modified BFEs are indicated on the following table and revise the Flood Insurance Rate Maps (FIRMs) in effect for the listed communities prior to this date.

ADDRESSES: The modified BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations listed below for the modified BFEs for each community listed. These modified BFEs have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Assistant Administrator for Mitigation has resolved any appeals resulting from this notification.

The modified BFEs are not listed for each community in this notice. However, this final rule includes the address of the Chief Executive Officer of the community where the modified BFEs determinations are available for inspection.

The modified BFEs are made pursuant to section 206 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.,* and with 44 CFR part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The modified BFEs are the basis for the floodplain management measures that the community is required to either adopt or to show evidence of being already in effect in order to qualify or to remain qualified for participation in the National Flood Insurance Program (NFIP).

These modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities.

These modified BFEs are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings. The changes in BFEs are in accordance with 44 CFR 65.4.

National Environmental Policy Act. This final rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This final rule involves no policies that have federalism implications under Executive Order 13132, Federalism.

Executive Order 12988, Civil Justice Reform. This final rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 65 is amended to read as follows:

PART 65—[AMENDED]

■ 1. The authority citation for part 65 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 65.4 [Amended]

■ 2. The tables published under the authority of § 65.4 are amended as follows:

State and county	Location and case No.	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Alabama: St. Clair (FEMA Docket No: B–1036).	Town of Moody (08–04–4404P).	January 9, 2009; January 16, 2009; *The Birmingham News.*	The Honorable Joe Lee, Mayor, Town of Moody, 670 Park Avenue, Moody, AL 35004.	May 18, 2009	010187
Arizona:					
Maricopa (FEMA Docket No: B–1039).	Unincorporated areas of Maricopa County (09–09–0381P).	January 8, 2009; January 15, 2009; *Arizona Business Gazette.*	The Honorable Andrew W. Kunasek, Chairman, Maricopa County Board of Supervisors, 301 West Jefferson Street, 10th Floor, Phoenix, AZ 85003.	May 15, 2009	040037
Maricopa (FEMA Docket No: B–1046).	City of Peoria (08–09–1474P).	January 22, 2009; January 29, 2009; *Arizona Business Gazette.*	The Honorable Bob Barrett, Mayor, City of Peoria, City of Peoria Municipal Complex, 8401 West Monroe Street, Peoria, AZ 85345.	January 12, 2009	040050
Maricopa (FEMA Docket No: B–1039).	City of Tolleson (09–09–0381P).	January 8, 2009; January 15, 2009; *Arizona Business Gazette.*	The Honorable Charles P. Hayes, Mayor, City of Tolleson, 9555 West Van Buren Street, Tolleson, AZ 85353.	May 15, 2009	040055

State and county	Location and case No.	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Pinal (FEMA Docket No: B–1036).	City of Apache Junction (08–09–1318P).	January 12, 2009; January 19, 2009; *Apache Junction News*.	The Honorable Douglas Coleman, Mayor, City of Apache Junction, 300 East Superstition Boulevard, Apache Junction, AZ 85219.	May 19, 2009	040120
Pinal (FEMA Docket No: B–1044).	City of Casa Grande (08–09–1919P).	February 20, 2009; February 27, 2009; *Casa Grande Dispatch*.	The Honorable Robert M. Jackson, Mayor, City of Casa Grande, 510 East Florence Boulevard, Casa Grande, AZ 85222.	February 10, 2009	040080
California:					
Monterey (FEMA Docket No: B–1036).	City of Salinas (08–09–1361P).	January 12, 2009; January 19, 2009; *The Salinas Californian*.	The Honorable Dennis Donohue, Mayor, City of Salinas, 200 Lincoln Avenue, Salinas, CA 93901.	May 19, 2009	060202
San Diego (FEMA Docket No: B–1039).	City of San Diego (08–09–1767P).	January 23, 2009; January 30, 2009; *San Diego Transcript*.	The Honorable Jerry Sanders, Mayor, City of San Diego, 202 C Street, 11th Floor, San Diego, CA 92101.	June 2, 2009	060295
Colorado:					
Boulder (FEMA Docket No: B–1042).	City of Boulder (08–08–0790P).	February 6, 2009; February 13, 2009; *The Daily Camera*.	The Honorable Shaun McGrath, Mayor, City of Boulder, P.O. Box 791, Boulder, CO 80306.	January 28, 2009	080024
Boulder (FEMA Docket No: B–1042).	Unincorporated areas of Boulder County (08–08–0790P).	February 6, 2009; February 13, 2009; *The Daily Camera*.	The Honorable Ben Pearlman, Chairman, Boulder County Board of Commissioners, P.O. Box 471, Boulder, CO 80306.	January 28, 2009	080023
Jefferson (FEMA Docket No: B–1036).	Unincorporated areas of Jefferson County (08–08–0667P).	January 7, 2009; January 14, 2009; *High Timber Times*.	The Honorable Kathy Hartman, Chairman, Jefferson County Board of Commissioners, 100 Jefferson County Parkway, Golden, CO 80419.	May 14, 2009	080087
Florida:					
Miami-Dade (FEMA Docket No: B–1042).	City of Miami (08–04–6874P).	February 9, 2009; February 16, 2009; *Miami Herald*.	The Honorable Manual A. Diaz, Mayor, City of Miami, 3500 Pan American Drive, Miami, FL 33133.	January 30, 2009	120650
Pinellas (FEMA Docket No: B–1042).	City of Clearwater (08–04–6704P).	February 6, 2009; February 13, 2009; *St. Petersburg Times*.	The Honorable Frank V. Hibbard, Mayor, City of Clearwater, P.O. Box 4748, Clearwater, FL 33758.	January 28, 2009	125096
Georgia:					
Barrow (FEMA Docket No: B–1036).	Unincorporated areas of Barrow County (08–04–5850P).	January 7, 2009; January 14, 2009; *The Barrow County News*.	Mr. Douglas H. Garrison, Chairman, Barrow County Board of Commissioners, 233 East Broad Street, Winder, GA 30680.	May 14, 2009	130497
Gwinnett (FEMA Docket No: B–1044).	Unincorporated areas of Gwinnett County (08–04–6361P).	January 2, 2009; January 9, 2009; *Gwinnett Daily Post*.	The Honorable Charles E. Bannister, Chairman, Gwinnett County Board of Commissioners, 75 Langley Drive, Lawrenceville, GA 30045.	May 11, 2009	130322
Liberty (FEMA Docket No: B–1042).	City of Flemington (08–04–4998P).	January 25, 2009; February 1, 2009; *Coastal Courier*.	The Honorable Sandra S. Martin, Mayor, City of Flemington, P.O. Box 46, Hinesville, GA 31310.	June 2, 2009	130124
Liberty (FEMA Docket No: B–1042).	City of Hinesville (08–04–4998P).	January 25, 2009; February 1, 2009; *Coastal Courier*.	The Honorable James Thomas, Mayor, City of Hinesville, 115 East Martin Luther King Jr. Drive, Hinesville, GA 31313.	June 2, 2009	130125
Walton (FEMA Docket No: B–1052).	Unincorporated areas of Walton County (08–04–1976P).	April 9, 2008; April 16, 2008; *Walton Tribune*.	The Honorable Kevin Little, Chairman, Walton County Board of Commissioners, 1269 Good Hope Road, Monroe, GA 30655.	August 15, 2008	130185
Kansas: Pottawatomie (FEMA Docket No: B–1036).	Unincorporated areas of Pottawatomie County (08–07–1722P).	January 8, 2009; January 15, 2009; *The Wamego Times*.	The Honorable Corwin Seamans, Chairman, Pottawatomie County Commissioners, 207 North 1st Street, Westmoreland, KS 66549.	May 15, 2009	200621
Louisiana: Catahoula (FEMA Docket No: B–1052).	Unincorporated areas of Catahoula Parish (08–06–1686P).	September 10, 2008; September 17, 2008; *Catahoula News Booster*.	The Honorable Jackie Paulk, President, Catahoula Parish, P.O. Box 258, Harrisonburg, LA 71340.	August 27, 2008	220047
Maryland: Allegany (FEMA Docket No: B–1052).	Unincorporated areas of Allegany County (08–03–1580P).	January 9, 2009; January 16, 2009; *Cumberland Times News*.	The Honorable James J. Stakem, President, Allegany County Board of Commissioners, 701 Kelly Road, 4th Floor, Cumberland, MD 21502.	January 30, 2009	240001
Missouri: St. Charles (FEMA Docket No: B–1036).	Unincorporated areas of St. Charles County (09–07–0032P).	January 12, 2009; January 19, 2009; *St. Charles County Business Record*.	The Honorable Steve Ehlmann, County Executive, St. Charles County, Administration Building, 201 North 2nd Street, St. Charles, MO 63301.	May 19, 2009	290315
North Carolina: Edgecombe (FEMA Docket No: B–1044).	Town of Tarboro (08–04–1283P).	February 3, 2009; February 10, 2009; *The Daily Southerner*.	Mr. Samuel W. Noble, Jr., Manager, Town of Tarboro, P.O. Box 220, 500 Main Street, Tarboro, NC 27886.	January 27, 2009	370094
Pennsylvania: Lehigh (FEMA Docket No: B–1042).	Township of Upper Macungie (08–03–1442P).	February 6, 2009; February 13, 2009; *The Morning Call*.	The Honorable Edward Earley, Chairman, Upper Macungie Township, 8330 Schantz Road, Breinigsville, PA 18031.	January 29, 2009	421044

State and county	Location and case No.	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Puerto Rico: Puerto Rico (FEMA Docket No: B–1036).	Commonwealth of Puerto Rico (08–02–1455P).	January 9, 2009; January 16, 2009; *Puerto Rico Daily Sun*.	The Honorable Anibal Acevedo-Vila, Governor, Commonwealth of Puerto Rico, P.O. Box 82, La Fortaleza, San Juan, PR 00901.	May 18, 2009	720000
Rhode Island: Newport (FEMA Docket No: B–1044).	Town of Portsmouth (09–01–0279P).	February 20, 2009; February 27, 2009; *Newport Daily News*.	The Honorable Dennis Canario, President, Portsmouth Town Council, 64 Birchwood Drive, Portsmouth, RI 02871.	February 9, 2009	445405
South Carolina:					
Jasper (FEMA Docket No: B–1048).	Town of Hardeeville (07–04–6247P).	February 4, 2009; February 11, 2009; *Jasper County Sun*.	The Honorable A. Brooks Willis, Mayor, Town of Hardeeville, 205 East Main Street, Hardeeville, SC 29927.	June 11, 2009	450113
Jasper (FEMA Docket No: B–1048).	Unincorporated areas of Jasper County (07–04–6247P).	February 4, 2009; February 11, 2009; *Jasper County Sun*.	The Honorable George Hood, Chairman, Jasper County Council, P.O. Box 1149, Ridgeland, SC 29936.	June 11, 2009	450112
Tennessee:					
Rutherford (FEMA Docket No: B–1036).	City of Murfreesboro (08–04–3762P).	January 11, 2009; January 18, 2009; *The Murfreesboro Post*.	The Honorable Tommy Bragg, Mayor, City of Murfreesboro, 111 West Vine Street, Murfreesboro, TN 37130.	May 18, 2009	470168
Wilson (FEMA Docket No: B–1052).	City of Lebanon (08–04–4560P).	October 15, 2008; October 22, 2008; *The Wilson Post*.	The Honorable Donald W. Fox, Mayor, City of Lebanon, 200 North Castle Heights Avenue, Suite 100, Lebanon, TN 37087.	February 19, 2009	470208
Wilson (FEMA Docket No: B–1052).	City of Mount Juliet (08–04–1366P).	April 11, 2008; April 18, 2008; *The Wilson Post*.	The Honorable Linda C. Elam, Mayor, City of Mount Juliet, 2425 North Mount Juliet Road, Mount Juliet, TN 37122.	April 9, 2008	470290
Wilson (FEMA Docket No: B–1039).	City of Mount Juliet (08–04–4369P).	January 9, 2009; January 16, 2009; *Lebanon Democrat*.	The Honorable Linda C. Elam, Mayor, City of Mount Juliet, P.O. Box 256, Mount Juliet, TN 37121.	May 18, 2009	470290
Texas:					
Bexar (FEMA Docket No: B–1036).	City of San Antonio (08–06–0269P).	January 12, 2009; January 19, 2009; *San Antonio Express News*.	The Honorable Phil Hardberger, Mayor, City of San Antonio, P.O. Box 839966, San Antonio, TX 78283.	May 19, 2009	480045
Collin (FEMA Docket No: B–1052).	City of Wylie (07–06–2304P).	June 18, 2008; June 25, 2008; *Wylie News*.	The Honorable John Mondy, Mayor, City of Wylie, 2000 State Highway 78 North, Wylie, TX 75098.	October 23, 2008	480759
Dallas (FEMA Docket No: B–1036).	City of Garland (08–06–0905P).	January 5, 2009; January 12, 2009; *Dallas Morning News*.	The Honorable Ronald E. Jones, Mayor, City of Garland, P. O. Box 469002, Garland, TX 75046.	May 12, 2009	485471
Dallas (FEMA Docket No: B–1052).	City of Sachse (07–06–2304P).	June 18, 2008; June 25, 2008; *Daily Commercial Recorder*.	The Honorable Mike Felix, Mayor, City of Sachse, 5560 State Highway 78, Sachse, TX 75048.	October 23, 2008	480186
McLennan (FEMA Docket No: B–1036).	Unincorporated areas of McLennan County (09–06–0208P).	January 9, 2009; January 16, 2009; *Waco Tribune-Herald*.	The Honorable Jim Lewis, McLennan County Judge, P.O. Box 1728, Waco, TX 76701.	May 18, 2009	480456
McLennan (FEMA Docket No: B–1036).	City of Waco (09–06–0208P).	January 9, 2009; January 16, 2009; *Waco Tribune-Herald*.	The Honorable Virginia Dupuy, Mayor, City of Waco, P.O. Box 2570, Waco, TX 76702.	May 18, 2009	480461
Tarrant (FEMA Docket No: B–1036).	Unincorporated areas of Tarrant County (08–06–1292P).	January 9, 2009; January 16, 2009; *Commercial Recorder*.	The Honorable B. Glen Whitley, Tarrant County Judge, 100 East Weatherford Street, Fort Worth, TX 76196.	May 18, 2009	480582
Washington: Spokane (FEMA Docket No: B–1044).	Unincorporated areas of Spokane County (08–10–0786P).	February 12, 2009; February 19, 2009; *Spokesman Review*.	The Honorable Todd Mielke, Chairman, Spokane County Board of Commissioners, Spokane County Courthouse, Room 300, 1116 West Broadway Avenue, Spokane, WA 99260.	January 30, 2009	530174

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Deborah S. Ingram,

Acting Deputy Assistant Administrator for Mitigation, Mitigation Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–28316 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2008–0020]

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: Base (1% annual-chance) Flood Elevations (BFEs) and modified BFEs are made final for the communities listed below. The BFEs and modified BFEs are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing BFEs and modified BFEs for each

community. This date may be obtained by contacting the office where the maps are available for inspection as indicated on the table below.

ADDRESSES: The final BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations listed below for the modified BFEs for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Assistant Administrator for Mitigation has resolved any appeals resulting from this notification.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67. FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and FIRM available at the address cited below for each community. The BFEs and modified BFEs are made final in the communities listed below. Elevations at selected locations in each community are shown.

National Environmental Policy Act. This final rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This final rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This final rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 67 is amended as follows:

PART 67—[AMENDED]

■ 1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.11 [Amended]

■ 2. The tables published under the authority of § 67.11 are amended as follows:

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
Garland County, Arkansas, and Incorporated Areas Docket No.: FEMA–B–1021			
Molly Creek	Weston Road	+409	City of Hot Springs.
	Approximately 450 feet upstream of Albert Pike Road/US 270.	+544	
Molly Creek Tributary 1	Stover Road (Formerly Marie St.)	+484	City of Hot Springs.
	Molly Springs Road	+506	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

City of Hot Springs
Maps are available for inspection at the Garland County Library, 1427 Malvern Avenue, Hot Springs, AR 71901.

Ventura County, California, and Incorporated Areas Docket Nos.: FEMA–D–7642 and FEMA–B–1024			
Arroyo Santa Rosa	At the confluence with Conejo Creek	+233	Unincorporated Areas of Ventura County.
	Approximately 0.6 mile upstream of East Las Posas Road	+378	
Arroyo Santa Rosa Overflow	Between Arroyo Santa Rosa and Arroyo Santa Rosa Tributary at East Las Posas Road.	+2	Unincorporated Areas of Ventura County.
Arroyo Santa Rosa Tributary	At the confluence with Arroyo Santa Rosa	+250	Unincorporated Areas of Ventura County.
	Approximately 400 feet upstream of Santa Rosa Road	+379	
Calleguas Creek/ Arroyo Los Posas/ Arroyo Simi	At the downstream side of State Highway 1	+23	Unincorporated Areas of Ventura County, City of Camarillo, City of Moorpark, City of Simi Valley.
	Approximately 100 feet downstream of U.S. Highway 101	+143	
	Approximately 0.9 mile upstream of Seminary Road	+248	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
	Approximately 0.96 mile upstream of Collins Drive	+619	
Camarillo Hills Drain	Approximately 0.9 mile upstream of the confluence with Revolon Slough.	+62	Unincorporated Areas of Ventura County, City of Camarillo.
	Approximately 190 feet downstream of South Las Posas Road.	+91	
	Approximately 40 feet upstream of West Ventura Boulevard.	+95	
	At Arneill Road	+185	
Conejo Creek	At the confluence with Calleguas Creek	+95	Unincorporated Areas of Ventura County, City of Camarillo, City of Thousand Oaks.
	At confluence of Arroyo Santa Rosa	+233	
Edgemore Drain	At the confluence with Camarillo Hills Drain	+117	City of Camarillo.
	Approximately 520 feet upstream of Getman Street	+153	
Gabbert Canyon Creek	At the confluence with Calleguas Creek	+425	Unincorporated Areas of Ventura County.
	At the confluence of Walnut Canyon Drain	+451	
Lang Creek	Upstream of Hillcrest Drive	+728	City of Thousand Oaks.
	Approximately 520 feet upstream of Combes Avenue	+772	
Mission Drain	At the confluence with Camarillo Hills Drain	+132	City of Camarillo.
	Approximately 430 feet downstream of Mission Drive	+173	
Peach Hill Wash	At the confluence with Arroyo Simi	+426	Unincorporated Areas of Ventura County, City of Moorpark.
	Approximately 1,170 feet upstream of Country Hill Road	+477	
Somis Drain	At the confluence with Calleguas Creek	+168	City of Camarillo.
	At Las Posas Road	+203	
Thousand Oaks North Drain	At the confluence with Arroyo Conejo	+736	City of Thousand Oaks.
	Approximately 800 feet upstream of El Cerrito Drive	+889	
Walnut Canyon Drain	At the confluence with Gabbert Canyon	+451	Unincorporated Areas of Ventura County, City of Moorpark.
	Approximately 2,840 feet upstream of Casey Road	+645	
West Camarillo Hills Tributary	At the confluence with Camarillo Hills Drain	+124	City of Camarillo.
	Approximately 20 feet downstream of Las Posas Road	+155	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

City of Camarillo
Maps are available for inspection at City Hall, 601 Carmen Drive, Camarillo, CA 93010.

City of Moorpark
Maps are available for inspection at the City Hall, 799 Moorpark Avenue, Moorpark, CA 93021.

City of Simi Valley
Maps are available for inspection at the City Hall, 2929 Tapo Canyon Road, Simi Valley, CA 93063.

City of Thousand Oaks
Maps are available for inspection at the Public Works Department, 2100 Thousand Oaks Boulevard, Thousand Oaks, CA 91362.

Unincorporated Areas of Ventura County
Maps are available for inspection at the Ventura County Hall of Administration, 800 South Victoria Avenue, Ventura, CA 93009.

Kankakee County, Illinois, and Incorporated Areas
Docket No.: FEMA–B–1016

South Branch. Rock Creek	Upstream side of South Locust Street	+665	Unincorporated Areas of Kankakee County.
	Approximately 2,600 feet downstream of Sycamore Street	+665	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
ADDRESSES			
Unincorporated Areas of Kankakee County			
Maps are available for inspection at the Kankakee County Administration Building, 189 East Court Street, Kankakee, IL 60901.			
Neosho County, Kansas, and Incorporated Areas Docket No.: FEMA–B–1016			
Little Turkey Creek	Approximately 127 feet downstream of Katy Road	+925	Unincorporated Areas of Neosho County.
	Approximately 675 feet downstream of U.S. Highway 169	+932	
Neosho River	Approximately 1.2 miles downstream of State Highway 39	+917	Unincorporated Areas of Neosho County.
	Approximately 1.13 miles upstream of State Highway 39	+920	
Puckets Run Creek	Approximately 120 feet upstream of East State Street	+896	Unincorporated Areas of Neosho County.
	At East Railroad Street	+897	
	Approximately 75 feet downstream of Atchison, Topeka and Santa Fe Railroad.	+898	
	Approximately 350 feet downstream of Queen Road	+902	
Santa Fe Lake	Approximately 115 feet downstream of West 35 Street	+944	Unincorporated Areas of Neosho County.
	At Atchison, Topeka and Santa Fe Railroad	+945	
Tolen Creek	Approximately 0.32 mile upstream of Pratt Road	+896	Unincorporated Areas of Neosho County.
	Approximately 1.95 miles upstream of Pratt Road	+910	
Tributary to Puckets Run Creek	Intersection of Trib Street and Missouri-Kansas-Texas Railroad.	+895	Unincorporated Areas of Neosho County.
	Intersection of Trib Street and East Street	+899	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES			
Unincorporated Areas of Neosho County			
Maps are available for inspection at 100 South Main Street, Erie, KS 66733.			
Douglas County, Nevada, and Incorporated Areas Docket No.: FEMA–B–7779			
Airport Tributary Wash	Approximately 5,400 feet upstream of Freemont Street	+4958	Unincorporated Areas of Douglas County.
	Approximately 7,445 feet upstream of Freemont Street	+5019	
Airport Wash	Approximately 2,475 feet upstream of East Valley Road	+4902	Unincorporated Areas of Douglas County.
	Approximately 9,175 feet upstream of East Valley Road	+5009	
Bobwhite Wash	Confluence with Juniper Road Wash	+5123	Unincorporated Areas of Douglas County.
	Approximately 1,390 feet upstream of confluence with Juniper Road Wash.	+5135	
Buckbrush Wash	Approximately 645 feet downstream of Fuller Avenue	+4786	Unincorporated Areas of Douglas County.
	Approximately 3,320 feet upstream of Lindsay Lane	+5019	
Buckeye Creek	Approximately 4,933 feet downstream of Orbit Way	+4762	Unincorporated Areas of Douglas County.
	Approximately 7,624 feet upstream of Juniper Road	+5008	
Calle De Asco Wash	Confluence with Calle Hermosa Wash	+5070	Unincorporated Areas of Douglas County.
	Approximately 3,525 feet upstream of confluence with Calle Hermosa Wash.	+5114	
Calle Hermosa Wash	Approximately 469 feet downstream of Ty Lane	+4884	Unincorporated Areas of Douglas County.
	Approximately 1,598 feet upstream of Calle Hermosa Road.	+5122	
Johnson Lane Wash	Approximately 3,555 feet downstream of Squires Street	+4782	Unincorporated Areas of Douglas County.
	Approximately 2,939 feet upstream of Nye Drive	+4991	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
Juniper Road Wash	Approximately 1,935 feet downstream of Coyote Road	+4881	Unincorporated Areas of Douglas County.
	Approximately 3,500 feet upstream of Carlson Drive	+5194	
Sunrise Pass Wash	At MacKay Way	+4907	Unincorporated Areas of Douglas County.
	Approximately 3,310 feet upstream of MacKay Way	+4991	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

Unincorporated Areas of Douglas County

Maps are available for inspection at 1615 8th Street, Minden, NV 89423.

Gloucester County, New Jersey (All Jurisdictions)
Docket No.: FEMA–B–1017

Brunt Mill Branch	At county boundary	+87	Township of Franklin.
	Approximately 1,573 feet upstream of West Boulevard	+93	
Delaware River	At county boundary	+9	Township of Greenwich, Borough of National Park, Borough of Paulsboro, Township of Logan, Township of West Deptford.
	At county boundary	+9	
Little Ease Run	Approximately 546 feet downstream of East Washington Drive.	+103	Borough of Clayton, Borough of Glassboro.
	Approximately 2.1 miles upstream of County Route 610 (Academy Street).	+119	
Mantua Creek	At mouth	+9	Township of Deptford, Borough of Glassboro, Borough of Paulsboro, Borough of Pitman, Borough of Wenonah, Township of East Greenwich, Township of Mantua, Township of Washington, Township of West Deptford.
	Approximately 62 feet upstream of County Route 634 (Fish Pond Road).	+110	
Oldmans Creek Reach 1	At mouth	+9	Township of Logan.
	Approximately 1,034 feet upstream of Interstate 295	+9	
Pargey Creek	At confluence with Repaupo Creek	+9	Township of East Greenwich, Township of Greenwich, Township of Logan, Township of Woolwich.
	At County Route 653 (Swedesboro Avenue)	+9	
Raccoon Creek Reach 1	At mouth	+9	Township of Logan, Borough of Swedesboro, Township of Woolwich.
	Approximately 106 feet upstream of County Route 551 (Kings Highway).	+9	
Raccoon Creek Reach 2	Approximately 3,625 feet downstream of County Route 551 (Tomlin Station Road).	+12	Township of Elk, Borough of Glassboro, Township of Harrison, Township of Woolwich.
	Approximately 2,707 feet upstream of Richwood Road	+110	
Repaupo Creek	At confluence with Delaware River	+9	Township of East Greenwich, Township of Greenwich, Township of Logan.
	Approximately 2,390 feet upstream of State Route 44	+9	
Scotland Run Reach 2	Approximately 420 feet downstream of County Route 610 (Academy Street).	+111	Borough of Clayton, Township of Franklin, Township of Monroe.
	Approximately 5,825 feet upstream of County Route 610 (Academy Street).	+118	
South Branch Raccoon Creek	Confluence with Raccoon Creek Reach 2	+16	Township of Harrison, Township of South Harrison.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
	Approximately 657 feet upstream of County Route 581 (Commissioners Road).	+45	
Still Run #1	At confluence with White Sluice Run	+9	Township of East Greenwich, Township of Greenwich.
	Approximately 0.7 mile upstream of County Route 653 (Swedesboro Avenue).	+9	
Still Run #2	Approximately 1,200 feet upstream of State Highway 55	+107	Township of Elk, Borough of Clayton.
	Approximately 5,313 feet upstream of County Route 608 (Clayton Avenue).	+115	
White Sluice Run	At mouth	+9	Township of Greenwich.
	At confluence with London Branch and Still Run #1	+9	
Woodbury Creek	At mouth	+9	Borough of National Park, City of Woodbury, Township of West Deptford.
	Approximately 7,987 feet upstream of Interstate 295	+9	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

Borough of Clayton
Maps are available for inspection at the Borough Hall, 125 North Delsea Drive, Clayton, NJ 08312.

Borough of Glassboro
Maps are available for inspection at the Borough Hall, 1 South Main Street, Glassboro, NJ 08028.

Borough of National Park
Maps are available for inspection at the Borough Hall, 7 South Grove Avenue, National Park, NJ 08063.

Borough of Paulsboro
Maps are available for inspection at the Paulsboro Municipal Building, 1211 Delaware Street, Paulsboro, NJ 08066.

Borough of Pitman
Maps are available for inspection at the Borough Hall, 110 South Broadway, Pitman, NJ 08071.

Borough of Swedesboro
Maps are available for inspection at the Borough Hall, 1500 Kings Highway, Swedesboro, NJ 08085.

Borough of Wenonah
Maps are available for inspection at the Borough Office, 1 South West Avenue, Wenonah, NJ 08090.

City of Woodbury
Maps are available for inspection at City Hall, 33 Delaware Street, Woodbury, NJ 08096.

Township of Deptford
Maps are available for inspection at the Township Department of Emergency Management, 1011 Cooper Street, Deptford, NJ 08096.

Township of East Greenwich
Maps are available for inspection at the East Greenwich Township Hall/Municipal Building, 159 Democrat Road, Mickleton, NJ 08056.

Township of Elk
Maps are available for inspection at the Elk Township Hall, 667 Whig Lane Road, Monroeville, NJ 08343.

Township of Franklin
Maps are available for inspection at the Franklin Municipal Building, 1571 Delsea Drive, Franklinville, NJ 08322.

Township of Greenwich
Maps are available for inspection at the Greenwich Municipal Building, 420 Washington Street, Gibbstown, NJ 08027.

Township of Harrison
Maps are available for inspection at the Harrison Municipal Building, 114 Bridgeton Pike, Mullica Hill, NJ 08062.

Township of Logan
Maps are available for inspection at the Logan Township Hall, 125 Main Street, Bridgeport, NJ 08302.

Township of Mantua
Maps are available for inspection at the Township Offices, 401 Main Street, Mantua, NJ 08051.

Township of Monroe
Maps are available for inspection at the Monroe Township Hall, 125 Virginia Avenue, Williamstown, NJ 08094.

Township of South Harrison
Maps are available for inspection at the South Harrison Township Hall, 664 Harrisonville Road, Harrisonville, NJ 08039.

Township of Washington
Maps are available for inspection at the Washington Township Municipal Building, 523 Egg Harbor Road, Sewell, NJ 08080.

Township of West Deptford
Maps are available for inspection at the West Deptford Municipal Office, 400 Crown Point Road, West Deptford, NJ 08086.

Township of Woolwich

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
Maps are available for inspection at the Township Hall, 121 Woodstown Road, Woolwich, NJ 08085.			
Waupaca County, Wisconsin, and Incorporated Areas Docket No.: FEMA–B–1021			
Little Wolf River/Big Falls Pond	0.33 mile downstream of bridge at County Highway G	+879	Village of Big Falls, Unincorporated Areas of Waupaca County.
	1.1 miles upstream of bridge at County Highway G	+910	
Waupaca River/Weyauwega Lake.	2.65 miles upstream of confluence with Wolf River	+756	City of Waupaca, City of Weyauwega, Unincorporated Areas of Waupaca County.
	390 feet upstream of bridge at Anderson Road	+893	
Wolf River	Southern Waupaca County boundary	+753	Village of Fremont, Unincorporated Areas of Waupaca County.
	3.58 miles downstream of bridge at County Highway X	+756	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

City of Waupaca
Maps are available for inspection at 111 South Main Street, Waupaca, WI 54981.

City of Weyauwega
Maps are available for inspection at 109 East Main Street, Weyauwega, WI 54983.

Unincorporated Areas of Waupaca County
Maps are available for inspection at 811 Harding Street, Waupaca, WI 54981.

Village of Big Falls
Maps are available for inspection at 220 Main Street, Big Falls, WI 54926.

Village of Fremont
Maps are available for inspection at 317 Wolf River Drive, Fremont, WI 54940.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Deborah S. Ingram,

Acting Deputy Assistant Administrator for Mitigation, Mitigation Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–28310 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2008–0020]

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: Base (1% annual-chance) Flood Elevations (BFEs) and modified BFEs are made final for the communities listed below. The BFEs and modified BFEs are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing BFEs and modified BFEs for each community. This date may be obtained by contacting the office where the maps are available for inspection as indicated on the table below.

ADDRESSES: The final BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations listed below for the modified BFEs for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Assistant Administrator for Mitigation has resolved any appeals resulting from this notification.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67. FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and FIRM available at the address cited below for each community. The BFEs and modified BFEs are made final in the communities listed below. Elevations at

selected locations in each community are shown.

National Environmental Policy Act. This final rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This final rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This final rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 67 is amended as follows:

PART 67—[AMENDED]

■ 1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.11 [Amended]

■ 2. The tables published under the authority of § 67.11 are amended as follows:

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground modified	Communities affected
Merrick County, Nebraska, and Incorporated Areas Docket No.: FEMA–B–1010			
Platte River	Approximately 0.50 mile downstream of Union Pacific Railroad.	+1,685	Unincorporated Areas of Merrick County.
	Approximately 0.68 miles upstream of State Highway 14 ..	+1,711	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

Unincorporated Areas of Merrick County

Maps are available for inspection at 1510 18th Street, Central City, NE 68826.

Thurston County, Nebraska, and Incorporated Areas Docket No.: FEMA–B1012			
Logan Creek	Approximately 2.20 miles downstream of State Highway 94.	+1,318	Unincorporated Areas of Thurston County, Omaha Indian Tribe.
	Approximately 1.65 miles upstream of State Highway 94 ..	+1,332	
Middle Creek	Approximately 0.81 mile downstream of Avenue B	+1,405	Unincorporated Areas of Thurston County, Village of Emerson, Winnebago Indian Tribe.
	Approximately 0.27 mile upstream of County Road 15	+1,425	
Unnamed Tributary to Logan Creek.	Approximately 0.75 mile upstream of State Highway 9	+1,333	Unincorporated Areas of Thurston County, Omaha Indian Tribe.
	Approximately 0.30 mile upstream of State Highway 9	+1,347	
Unnamed Tributary to Middle Creek.	Approximately 530 feet downstream of Lagan Street	+1,419	Village of Emerson, Winnebago Indian Tribe.
	Approximately 750 feet upstream of 1st Street	+1,441	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

Omaha Indian Tribe

Maps are available for inspection at 100 Main Street, Macy, NE 68039.

Unincorporated Areas of Thurston County

Maps are available for inspection at 106 South 5th Street, Pender, NE 68047.

Village of Emerson

Maps are available for inspection at 211 West Front Street, Emerson, NE 68733.

Winnebago Indian Tribe

Maps are available for inspection at 100 Buff Street, Winnebago, NE 68071.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground modified	Communities affected
Buncombe County, North Carolina and Incorporated Areas Docket No.: FEMA–D–7826 and FEMA–B–7795			
Avery Creek	Approximately 0.5 mile upstream of the confluence with the French Broad River.	+2,051	Unincorporated Areas of Buncombe County.
	Approximately 0.5 mile upstream of Misty Valley Parkway	+2,100	
Beaverdam Creek (into French Broad River) Tributary 1.	Approximately 900 feet upstream of Hillcrest Road	+2,107	Unincorporated Areas of Buncombe County, Town of Woodfin.
	Approximately 340 feet upstream of Baird Cove Road (State Road 2088).	+2,348	
Beaverdam Creek (into South Hominy Creek).	At the confluence with South Hominy Creek	+2,107	Unincorporated Areas of Buncombe County.
	Approximately 50 feet downstream of Wise Road (State Road 3467).	+2,270	
Beaverdam Creek (into South Hominy Creek) Tributary.	At the confluence with Beaverdam Creek (into South Hominy Creek).	+2,214	Unincorporated Areas of Buncombe County.
	Approximately 0.6 mile upstream of the confluence with Beaverdam Creek (into South Hominy Creek).	+2,250	
Bee Branch	At the confluence with Willow Creek	+2,281	Unincorporated Areas of Buncombe County.
	Approximately 50 feet upstream of Bee Branch Road	+2,418	
Beetree Creek	At the confluence with Swannanoa River	+2,148	Unincorporated Areas of Buncombe County.
	Approximately 0.9 mile upstream of Bee Tree Road (State Road 2428).	+2,682	
Bent Creek	Approximately 0.4 mile upstream of the confluence with French Broad River.	+2,019	Unincorporated Areas of Buncombe County.
	Approximately 0.6 mile upstream of Blue Ridge Parkway	+2,031	
Bill Moore Creek	Approximately 900 feet upstream of the confluence with Hominy Creek.	+2,069	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 110 feet upstream of Reeves Cove Road (State Road 3439).	+2,160	
Broad River	The Buncombe/Henderson county boundary	+1,719	Unincorporated Areas of Buncombe County.
	Approximately 0.3 mile upstream of NC Highway 9	+2,592	
Brush Creek	At the confluence with Cane Creek	+2,164	Unincorporated Areas of Buncombe County.
	Approximately 220 feet upstream of Dotson Cove Road	+2,511	
Bull Creek	At the confluence with Swannanoa River	+2,109	Unincorporated Areas of Buncombe County.
	Approximately 1,260 feet upstream of the confluence with the Swannanoa River.	+2,109	
Camp Branch	At the confluence with Swannanoa River	+2,315	Town of Black Mountain.
	Approximately 660 feet upstream of Camp Branch Road	+2,526	
Cane Creek	Approximately 0.5 mile upstream of the confluence with the French Broad River.	+2,061	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 1,510 feet upstream of the confluence with Garren Creek.	+2,309	
Cane Creek (into Hominy Creek).	Approximately 0.3 mile upstream of the confluence with Hominy Creek.	+2,009	City of Asheville.
	Approximately 1,490 feet upstream of Sand Hill Road	+2,011	
Curtis Creek	At the confluence with South Hominy Creek	+2,244	Unincorporated Areas of Buncombe County.
	Approximately 20 feet upstream of Curtis Creek Road (State Road 1113).	+2,383	
Dick Branch	At the confluence with Flat Creek (into French Broad River).	+1,940	Unincorporated Areas of Buncombe County.
	Approximately 240 feet upstream of Flat Creek Church Road (State Road 1764).	+1,962	
Dillingham Creek	Just upstream of Dillingham Road (State Road 2173)	+2,273	Unincorporated Areas of Buncombe County.
	Approximately 40 feet upstream of Dillingham Road (State Road 2173).	+2,545	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground modified	Communities affected
Dingle Creek	Approximately 0.2 mile upstream of the confluence with French Broad River.	+2,008	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 1,660 feet upstream of Ballantree Drive	+2,631	
Dix Creek	At the confluence with Newfound Creek	+1,929	Unincorporated Areas of Buncombe County.
	Approximately 900 feet upstream of Old Leicester Highway (State Road 1002).	+2,026	
Eller Cove	At the confluence with Reems Creek	+2,078	Town of Weaverville.
	Approximately 40 feet upstream of Eller Hollow Road (State Road 2104).	+2,172	
Emma Branch	Approximately 300 feet upstream of the confluence with Smith Mill Creek.	+1,977	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 0.7 mile upstream of Eliada Home Road	+2,299	
Emma Branch Tributary 2	At the confluence with Emma Branch	+2,069	City of Asheville.
	Approximately 0.5 mile upstream of Brickyard Road	+2,309	
Flat Creek	At the confluence with Broad River	+1,946	Unincorporated Areas of Buncombe County.
	Approximately 1.1 miles upstream of the confluence with the Broad River.	+2,066	
Flat Creek (into French Broad River).	At NC Highway 251	+1,770	Unincorporated Areas of Buncombe County.
	Approximately 1,870 feet upstream of Chambers Road	+2,205	
Flat Creek (into Swannanoa River).	At the confluence with Swannanoa River	+2,360	Town of Black Mountain, Town of Montreat.
	Just downstream of Kentucky Road	+2,686	
Flat Creek (into Swannanoa River) Tributary 1.	At the confluence with Flat Creek (into Swannanoa River)	+2,379	Town of Black Mountain.
	Approximately 830 feet upstream of NC Highway 9	+2,458	
Fourmile Branch	Approximately 2,000 feet upstream of the confluence with French Broad River.	+2,002	Unincorporated Areas of Buncombe County, City of Asheville, Town of Biltmore Forest.
	Approximately 90 feet downstream of US Highway 25	+2,193	
French Broad River Tributary 149.	At the confluence with French Broad River	+2,046	Unincorporated Areas of Buncombe County.
	Approximately 1,420 feet upstream of River Glen Drive	+2,192	
Gap Creek	At the confluence with Cane Creek	+2,163	Unincorporated Areas of Buncombe County.
	Approximately 210 feet upstream of Windsong Drive	+2,359	
Garren Creek	At the confluence with Cane Creek	+2,294	Unincorporated Areas of Buncombe County.
	Approximately 250 feet upstream of Bleeker Lane	+2,382	
Gashes Creek	At the confluence with Swannanoa River	+2,023	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 1,680 feet upstream of US Highway 74	+2,225	
George Branch	At the confluence with Hominy Creek	+2,178	Unincorporated Areas of Buncombe County.
	Approximately 400 feet upstream of Curtis Farm Road (State Road 1101).	+2,208	
Gill Branch	Approximately 50 feet upstream of the confluence with Reems Creek.	+1,966	Town of Weaverville.
	Approximately 100 feet upstream of Weaver Boulevard (State Road 1725).	+2,111	
Glady Fork	At the confluence with South Hominy Creek	+2,292	Unincorporated Areas of Buncombe County.
	Approximately 1,360 feet upstream of Black Oak Cove Road (State Road 3464).	+2,362	
Gouches Branch	Approximately 1,000 feet upstream of the confluence with Newfound Creek.	+1,977	Unincorporated Areas of Buncombe County.
	Approximately 480 feet upstream of Gouches Branch Road (State Road 1377).	+2,012	
Grassy Branch	At the confluence with Swannanoa River	+2,057	Unincorporated Areas of Buncombe County, City of Asheville.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground modified	Communities affected
	Approximately 0.4 mile upstream of Upper Grassy Branch Road (State Road 2400).	+2,229	
Gregg Branch	Approximately 25 feet upstream of the confluence with Beetree Creek.	+2,243	Unincorporated Areas of Buncombe County.
	Approximately 1,080 feet upstream of Old Bee Tree Road (State Road 2418).	+2,304	
Haw Creek	At the confluence with Swannanoa River	+2,010	City of Asheville.
	Approximately 1,800 feet upstream of the confluence with the Swannanoa River.	+2,013	
Herron Cove Branch	Approximately 50 feet upstream of the confluence with Reems Creek.	+2,032	Town of Weaverville.
	Approximately 230 feet upstream of Fontana Drive	+2,086	
Hogeye Branch	At the confluence with Sandy Mush Creek	+2,184	Unincorporated Areas of Buncombe County.
	Approximately 0.6 mile upstream of Hogeye Road (State Road 1393).	+2,314	
Hominy Creek	Just upstream of Morgan Cove Road (State Road 1141) ..	+2,178	Unincorporated Areas of Buncombe County.
	Approximately 150 feet upstream of the Buncombe/Haywood County boundary.	+2,252	
Hominy Creek Tributary 21	Approximately 100 feet upstream of the confluence with Hominy Creek.	+2,099	Unincorporated Areas of Buncombe County.
	Approximately 1,520 feet upstream of Lindsey Road (State Road 1128).	+2,107	
Hominy Creek Tributary 25	Approximately 75 feet upstream of the confluence with Hominy Creek.	+2,152	Unincorporated Areas of Buncombe County.
	Approximately 780 feet upstream of North Morgan Branch Road (State Road 1140).	+2,191	
Ivy Creek	At the Buncombe/Madison County boundary	+1,908	Unincorporated Areas of Buncombe County.
	Approximately 550 feet upstream of NC Highway 197	+2,111	
Killian Branch	Approximately 250 feet upstream of the confluence with Beaverdam Creek (into French Broad River).	+2,120	City of Asheville.
	Approximately 1.0 mile upstream of Inglewood Road	+2,288	
Lee Creek	Approximately 320 feet upstream of the confluence with French Broad River.	+1,890	Unincorporated Areas of Buncombe County.
	Approximately 0.5 mile upstream of Roberts Road (State Road 1314).	+2,362	
Little Piney Branch	At the confluence with Flat Creek (into Swannanoa River)	+2,558	Town of Montreat.
	Approximately 1,810 feet upstream of Harmony Road Extension.	+3,351	
Long Branch (into Beetree Creek).	At the confluence with Beetree Creek	+2,299	Unincorporated Areas of Buncombe County.
	Approximately 0.5 mile upstream of Long Branch Road (State Road 2429).	+3,083	
Long Branch (into Sandy Mush Creek).	At the confluence with Sandy Mush Creek	+2,397	Unincorporated Areas of Buncombe County.
	Approximately 90 feet upstream of Boyd Cove Road (State Road 1398).	+2,530	
Maney Branch	At the confluence with Reems Creek	+2,395	Unincorporated Areas of Buncombe County.
	Approximately 220 feet upstream of Beech Spring Drive ..	+2,460	
Martin Branch	At the confluence with Turkey Creek	+1,976	Unincorporated Areas of Buncombe County.
	Approximately 1,250 feet upstream of Martin Branch Road (State Road 1610).	+2,018	
Martin Creek	At the confluence with North Fork Ivy Creek	+2,378	Unincorporated Areas of Buncombe County.
	Approximately 1,460 feet upstream of Martins Creek Road (State Road 2027).	+2,506	
McKinnish Branch	At the confluence with Smith Mill Creek	+2,105	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 150 feet upstream of McKinnish Cove Road (State Road 1320).	+2,195	
Moore Creek	Just upstream of Monte Vista Road (State Road 1224)	+2,202	Unincorporated Areas of Buncombe County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground modified	Communities affected
	Approximately 0.5 mile upstream of Holcombe Cove Road (State Road 1236).	+2,380	
Morgan Branch (into Ivy Creek)	At the confluence with Ivy Creek	+2,059	Unincorporated Areas of Buncombe County.
	Approximately 770 feet upstream of Arrowood Road (State Road 2155).	+2,072	
Morgan Branch (into South Hominy Creek).	At the confluence with South Hominy Creek	+2,235	Unincorporated Areas of Buncombe County.
	Approximately 830 feet upstream of Blackfoot Trail	+2,276	
Newfound Creek	Approximately 75 feet upstream of the confluence with French Broad River.	+1,876	Unincorporated Areas of Buncombe County.
	Approximately 90 feet upstream of Newfound Road (State Road 1104).	+2,388	
Newfound Creek Tributary 17	At the confluence with Newfound Creek	+1,955	Unincorporated Areas of Buncombe County.
	Approximately 330 feet upstream of Sunview Drive	+1,958	
Newfound Creek Tributary 26	Approximately 400 feet upstream of the confluence with Newfound Creek.	+2,012	Unincorporated Areas of Buncombe County.
	Approximately 620 feet upstream of Old Newfound Road (State Road 1378).	+2,023	
North Fork Ivy Creek	Approximately 50 feet upstream of the confluence with Dillingham Creek and Ivy Creek.	+2,186	Unincorporated Areas of Buncombe County.
	Approximately 100 feet downstream of Burleson Branch Road (State Road 2079).	+2,533	
North Fork Swannanoa River	At the confluence with Swannanoa River	+2,231	Unincorporated Areas of Buncombe County, Town of Black Mountain.
	Approximately 3.0 miles upstream of North Fork Right Fork Road (State Road 2476).	+2,762	
North Turkey Creek	At the confluence with South Turkey Creek and Turkey Creek.	+2,027	Unincorporated Areas of Buncombe County.
	Approximately 0.7 mile upstream of Bryant Lane	+2,234	
Ox Creek	At the confluence with Reems Creek	+2,182	Unincorporated Areas of Buncombe County.
	Approximately 30 feet upstream of Ox Creek Road (State Road 2109).	+2,420	
Ox Creek Tributary 1	At the confluence with Ox Creek	+2,382	Unincorporated Areas of Buncombe County.
	Approximately 620 feet upstream of the confluence with Ox Creek.	+2,402	
Parker Branch	At the confluence with Newfound Creek	+1,939	Unincorporated Areas of Buncombe County.
	Approximately 1,150 feet upstream of the confluence with Newfound Creek.	+1,944	
Pole Creek	Just upstream of Dogwood Road (State Road 1220)	+2,100	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 270 feet upstream of Milksick Cove Road (State Road 1215).	+2,301	
Potato Branch	At the confluence with South Turkey Creek	+2,318	Unincorporated Areas of Buncombe County.
	Approximately 940 feet upstream of the confluence with South Turkey Creek.	+2,335	
Poverty Branch	At the confluence with North Fork Ivy Creek	+2,210	Unincorporated Areas of Buncombe County.
	Approximately 0.9 mile upstream of the confluence with North Fork Ivy Creek.	+2,293	
Puncheon Branch	At the confluence with Flat Creek (into Swannanoa River)	+2,617	Town of Montreat.
	Approximately 1,350 feet upstream of Oklahoma Road	+3,296	
Ragsdale Creek	Approximately 0.8 mile upstream of Sand Hill Road (State Road 3412).	+2,064	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 40 feet upstream of Willow Pond Lane	+2,397	
Reed Creek	At Murdock Avenue	+2,087	City of Asheville.
	Approximately 360 feet downstream of Grovewood Road	+2,219	
Reed Creek Tributary 2	Approximately 320 feet upstream of the confluence with Reed Creek.	+2,010	City of Asheville.
	Approximately 280 feet upstream of Broadway Street	+2,017	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground modified	Communities affected
Reed Creek Tributary 6	Approximately 225 feet upstream of the confluence with Reed Creek.	+2,088	City of Asheville.
	Approximately 140 feet upstream of Hillside Street	+2,141	
Reems Creek	At NC Highway 251	+1,799	Unincorporated Areas of Buncombe County, Town of Weaverville.
	Approximately 90 feet downstream of Blackberry Inn Road (State Road 2115).	+2,526	
Reeves Creek	At the confluence with Reems Creek	+2,262	Unincorporated Areas of Buncombe County.
	Approximately 0.4 mile upstream of Lula Cove Road	+2,392	
Robinson Creek	At the confluence with Cane Creek	+2,094	Unincorporated Areas of Buncombe County.
	Approximately 170 feet upstream of Concord Road (State Road 3150).	+2,264	
Rock Creek	At the confluence with Broad River	+2,089	Unincorporated Areas of Buncombe County.
	Approximately 1,230 feet upstream of Press Owenby Drive.	+2,582	
Ross Creek	At the confluence with Swannanoa River	+2,004	City of Asheville.
	Approximately 20 feet downstream of Vance Gap Road	+2,347	
Round Hill Branch	Approximately 500 feet upstream of the confluence with Newfound Creek.	+2,046	Unincorporated Areas of Buncombe County.
	Approximately 860 feet upstream of Green Valley Road (State Road 1383).	+2,138	
Sams Branch	At the confluence with South Hominy Creek	+2,375	Unincorporated Areas of Buncombe County.
	Approximately 1,220 feet upstream of Falling Brook Drive	+2,549	
Sandymush Creek	Approximately 400 feet upstream of the confluence with French Broad River.	+1,728	Unincorporated Areas of Buncombe County.
	Approximately 840 feet upstream of Garrett Cove Road (State Road 1392).	+2,635	
Saw Branch	At the confluence with South Hominy Creek	+2,412	Unincorporated Areas of Buncombe County.
	Approximately 1,350 feet upstream of the confluence with South Hominy Creek.	+2,476	
Sluder Branch	At the confluence with Newfound Creek	+1,964	Unincorporated Areas of Buncombe County.
	Approximately 1,580 feet upstream of Branchview Drive	+2,002	
Smith Mill Creek	Approximately 950 feet upstream of the confluence with French Broad River.	+1,977	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 0.4 mile upstream of Johnston School Road (State Road 1319).	+2,201	
South Hominy Creek	Approximately 220 feet upstream of the confluence with Hominy Creek.	+2,102	Unincorporated Areas of Buncombe County.
	Approximately 400 feet upstream of Davis Creek Road (State Road 1103).	+2,560	
South Hominy Creek Tributary 2.	At the confluence with South Hominy Creek	+2,150	Unincorporated Areas of Buncombe County.
	Approximately 40 feet upstream of Bailey Road (State Road 3452).	+2,181	
South Turkey Creek	At the confluence with North Turkey Creek and Turkey Creek.	+2,027	Unincorporated Areas of Buncombe County.
	Approximately 10 feet downstream of South Turkey Creek Road (State Road 1384).	+2,346	
Stanfield Branch	At the confluence with Dick Branch	+1,952	Unincorporated Areas of Buncombe County.
	Approximately 50 feet upstream of the confluence of Stanfield Branch Tributary 2.	+2,083	
Stanfield Branch Tributary 2	At the confluence with Stanfield Branch	+2,081	Unincorporated Areas of Buncombe County.
	Approximately 1,620 feet upstream of the confluence with Stanfield Branch.	+2,127	
Stony Fork	At the confluence with South Hominy Creek	+2,312	Unincorporated Areas of Buncombe County.
	Approximately 50 feet upstream of NC Highway 151	+2,613	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground modified	Communities affected
Sugar Cove	At the confluence with Reems Creek	+2,299	Unincorporated Areas of Buncombe County.
	Approximately 540 feet upstream of Sugar Cove Road (State Road 2114).	+2,435	
Sugar Creek	At the confluence with Sandy Mush Creek	+2,162	Unincorporated Areas of Buncombe County.
	Approximately 140 feet upstream of the confluence of Andys Branch.	+2,247	
Swannanoa River	Approximately 1,000 feet upstream of the confluence with French Broad River.	+1,991	Unincorporated Areas of Buncombe County, City of Asheville, Town of Biltmore Forest, Town of Black Mountain.
	Approximately 1,680 feet upstream of Dunsmore Avenue (State Road 2531).	+2,518	
Swannanoa River Tributary 24	At the confluence with Swannanoa River	+2,182	Unincorporated Areas of Buncombe County.
	Approximately 0.8 mile upstream of Patton Hill Road	+2,403	
Swannanoa River Tributary 26	At the confluence with Swannanoa River	+2,198	Unincorporated Areas of Buncombe County.
	Approximately 110 feet upstream of Druid Hill Road (State Road 2445).	+2,456	
Swannanoa River Tributary 28	At the confluence with Swannanoa River	+2,206	Unincorporated Areas of Buncombe County.
	Approximately 0.8 mile upstream of the confluence of Swannanoa River Tributary of Tributary 28.	+2,447	
Swannanoa River Tributary 33	At the confluence with Swannanoa River	+2,242	Unincorporated Areas of Buncombe County, Town of Black Mountain.
	Approximately 40 feet downstream of Wagon Trail	+2,331	
Swannanoa River Tributary 35	At the confluence with Swannanoa River	+2,365	Town of Black Mountain.
	Approximately 710 feet upstream of Avena Road	+2,432	
Swannanoa River Tributary of Tributary 26.	At the confluence with Swannanoa River Tributary 26	+2,270	Unincorporated Areas of Buncombe County.
	Approximately 110 feet upstream of Druid Hill Road (State Road 2445).	+2,387	
Swannanoa River Tributary of Tributary 28.	At the confluence with Swannanoa River Tributary 28	+2,273	Unincorporated Areas of Buncombe County.
	Approximately 190 feet upstream of Woodland Drive (State Road 2460).	+2,642	
Swannanoa River Tributary of Tributary 33.	At the confluence with Swannanoa River Tributary 33	+2,285	Unincorporated Areas of Buncombe County, Town of Black Mountain.
	Approximately 0.4 mile upstream of the confluence with Swannanoa River Tributary 33.	+2,329	
Sweeten Creek	At the confluence with Swannanoa River	+1,997	City of Asheville.
	Approximately 1,800 feet upstream of US Highway 25	+2,299	
Sweeten Creek Tributary 2	At the confluence with Sweeten Creek	+2,010	City of Asheville.
	Approximately 60 feet upstream of Shady Oak Drive	+2,069	
Sweeten Creek Tributary 3	At the confluence with Sweeten Creek	+2,018	City of Asheville.
	Approximately 1,370 feet upstream of Forest Street	+2,206	
Sweeten Creek Tributary 4	At the confluence with Sweeten Creek	+2,078	Unincorporated Areas of Buncombe County, City of Asheville.
	Approximately 1,150 feet upstream of West Chapel Road	+2,139	
Taylor Creek	The Buncombe/Rutherford county boundary	+2,000	Unincorporated Areas of Buncombe County.
	Approximately 1,000 feet upstream of the Buncombe/Rutherford county boundary.	+2,034	
Tomahawk Branch	At the confluence with Swannanoa River	+2,287	Town of Black Mountain.
	Approximately 490 feet upstream of Hiawassee Avenue (State Road 2495).	+2,383	
Town Branch Creek	At the confluence with Dillingham Creek	+2,436	Unincorporated Areas of Buncombe County.
	Approximately 190 feet upstream of Martin Lane (State Road 2165).	+2,768	
Trantham Creek	At the confluence with Cane Creek	+2,265	Unincorporated Areas of Buncombe County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground modified	Communities affected
	Approximately 960 feet upstream of Ivy Cove Road	+2,391	
Trent Branch	Approximately 300 feet upstream of the confluence with Ragsdale Creek.	+2,024	City of Asheville.
	Approximately 0.5 mile upstream of I–40	+2,064	
Tributary to Camp Branch	At the confluence with Camp Branch	+2,345	Unincorporated Areas of Buncombe County, Town of Black Mountain.
	Approximately 1,060 feet upstream of NC Highway 9	+2,477	
Tributary to Tributary to Camp Branch.	At the confluence with Tributary to Camp Branch	+2,363	Unincorporated Areas of Buncombe County, Town of Black Mountain.
	Approximately 590 feet upstream of Settings Boulevard	+2,517	
Turkey Creek	At the confluence with Sandy Mush Creek	+1,772	Unincorporated Areas of Buncombe County.
	At the confluence with North Turkey Creek and South Turkey Creek.	+2,027	
Warren Creek	At the confluence with South Hominy Creek	+2,304	Unincorporated Areas of Buncombe County.
	Approximately 1,860 feet upstream of the confluence with South Hominy Creek.	+2,336	
Webb Branch	Approximately 900 feet upstream of the confluence with Hominy Creek.	+2,142	Unincorporated Areas of Buncombe County.
	Approximately 0.4 mile upstream of US Highway 25/19	+2,203	
Williams Branch	At the confluence with Dillingham Creek	+2,285	Unincorporated Areas of Buncombe County.
	Approximately 1.3 miles upstream of Williams Branch Road (State Road 2174).	+3,133	
Willow Creek	At the confluence with Sandy Mush Creek	+2,266	Unincorporated Areas of Buncombe County.
	Approximately 80 feet upstream of Willow Cove Road (State Road 1395).	+2,544	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

City of Asheville
Maps are available for inspection at City Hall, 70 Court Plaza, Asheville, NC 28801.

Town of Biltmore Forest
Maps are available for inspection at Biltmore Forest Town Hall, 355 Vanderbilt Road, Biltmore Forest, NC 28803.

Town of Black Mountain
Maps are available for inspection at Black Mountain Town Hall, 102 Montreat Road, Black Mountain, NC 28711.

Town of Montreat
Maps are available for inspection at Montreat Town Hall, 96 Rainbow Terrace, Montreat, NC 28757.

Town of Weaverville
Maps are available for inspection at Weaverville Town Hall, 30 South Main Street, Weaverville, NC 28787.

Town of Woodfin
Maps are available for inspection at Woodfin Town Hall, 90 Elk Mountain Road, Woodfin, NC 28804.

Unincorporated Areas of Buncombe County
Maps are available for inspection at Buncombe County Planning Department, 46 Valley Street, Asheville, NC 28801.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Deborah S. Ingram,

Acting Deputy Assistant Administrator for Mitigation, Mitigation Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–28317 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 300

RIN 0648–XS30

Fraser River Sockeye and Pink Salmon Fisheries; Inseason Orders

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Temporary orders; inseason orders; request for comments.

SUMMARY: NMFS publishes Fraser River salmon inseason orders to regulate salmon fisheries in U.S. waters. The orders were issued by the Fraser River Panel (Panel) of the Pacific Salmon Commission (Commission) and subsequently approved and issued by NMFS during the 2009 salmon fisheries within the U.S. Fraser River Panel Area. These orders established fishing dates, times, and areas for the gear types of U.S. treaty Indian and all citizen fisheries during the period the Panel exercised jurisdiction over these fisheries.

DATES: The effective dates for the inseason orders are set out in this document under the heading Inseason Orders. Comments will be accepted through December 10, 2009.

ADDRESSES: You may submit comments, identified by 0648–XS30 by any one of the following methods:

Electronic Submissions: Submit all electronic public comments via the Federal eRulemaking Portal *http://www.regulations.gov*

Fax: 206–526–6736

Mail: NMFS NWR, 7600 Sand Point Way NE, Seattle, WA 98115.

Instructions: All comments received are a part of the public record and will generally be posted to *http://www.regulations.gov* without change. All Personal Identifying Information (for example, name address, etc.) voluntarily submitted by the commenter may be publicly accessible. Do not submit Confidential Business Information or otherwise sensitive or protected information.

NMFS will accept anonymous comments (enter N/A in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, WordPerfect, or Adobe PDF file formats only.

FOR FURTHER INFORMATION CONTACT: Peggy Busby, by phone at 206–526–4323, *peggy.busby@noaa.gov*

SUPPLEMENTARY INFORMATION: The Treaty between the Government of the United States of America and the Government of Canada concerning Pacific Salmon was signed at Ottawa on January 28, 1985, and subsequently was given effect in the United States by the Pacific Salmon Treaty Act (Act) at 16 U.S.C. 3631–3644.

Under authority of the Act, Federal regulations at 50 CFR part 300, subpart F provide a framework for the implementation of certain regulations of the Commission and inseason orders of the Commission's Fraser River Panel for U.S. sockeye and pink salmon fisheries in the Fraser River Panel Area.

The regulations close the U.S. portion of the Fraser River Panel Area to U.S. sockeye and pink salmon fishing unless opened by Panel orders that are given effect by inseason regulations published by NMFS. During the fishing season, NMFS may issue regulations that establish fishing times and areas consistent with the Commission agreements and inseason orders of the Panel. Such orders must be consistent with domestic legal obligations and are issued by Regional Administrator, Northwest Region, NMFS. Official notification of these inseason actions is provided by two telephone hotline numbers described at 50 CFR 300.97(b)(1) and in 74 FR 20610 (May 5, 2009). The inseason orders are published in the **Federal Register** as soon as practicable after they are issued. Due to the frequency with which inseason orders are issued, publication of individual orders is impractical. Therefore, the 2009 orders are being published in this single document to avoid fragmentation.

Inseason Orders

The following inseason orders were adopted by the Panel and issued for U.S. fisheries by NMFS during the 2009 fishing season. Each of the following inseason actions was effective upon announcement on telephone hotline numbers as specified at 50 CFR 300.97(b)(1)and in 74 FR 20610 (May 5, 2009); those dates and times are listed herein. The times listed are local times, and the areas designated are Puget Sound Management and Catch Reporting Areas as defined in the Washington State Administrative Code at Chapter 220–22.

Order Number 2009–01: Issued 3 p.m., August 25, 2009

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open to drift gillnets from 12 p.m. (noon), Wednesday, August 26, 2009 to 12 p.m. (noon) Saturday, August 29, 2009.

All Citizen Fisheries

Areas 7 and 7A Reef net: Open to pink salmon fishing with non-retention of sockeye salmon 5 a.m. to 9 p.m. on Wednesday, August 26, 2009, 5 a.m. to 9 p.m. on Thursday, August 27, 2009; and 5 a.m. to 9p.m. on Friday, August 28, 2009.

Order Number 2009–02: Issued 1:50 p.m., August 26, 2009

Treaty Indian Fisheries

Areas 6, 7, and 7A: Open to drift gillnets and purse seine from 5 a.m., Friday, August 28, 2009 to 8 a.m., Saturday, August 29, 2009.

All Citizen Fisheries

Area 7 Purse Seine: Open to pink salmon fishing with non-retention of sockeye salmon 5 a.m. to 9 p.m. on Thursday, August 27, 2009.

Area 7 Gillnet: Open to pink salmon fishing with non-retention of sockeye salmon 8 a.m. to 11:59 p.m. (midnight) on Thursday August 27, 2009.

Area 7 Purse Seine Open to pink salmon fishing with non-retention of sockeye salmon 3 p.m. to 9 p.m. on Thursday, August 27, 2009.

Area 7A Gillnet: Open 3 p.m. to 11:59 p.m. (midnight) on Thursday August 27, 2009.

Order Number 2009–03: Issued 12:15 p.m., August 28, 2009

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open to drift gillnets from 12 p.m. (noon), Saturday, August 29, 2009 to 12 p.m. (noon) Wednesday, September 2, 2009.

Areas 6, 7, and 7A: Open to drift gillnets and purse seine from 5 a.m., Sunday, August 30, 2009 to 8 a.m., Monday, August 31, 2009; and from 5 a.m., Tuesday, September 1, 2009 to 8 a.m., Wednesday, September 2, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the Province of British Columbia.

All Citizen Fisheries

Areas 7 and 7A Purse seine: Open to pink salmon fishing with non-retention of sockeye salmon 5 a.m. to 9 p.m., Saturday, August 29, 2009 and Monday, August 31, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Areas 7 and 7A Gillnet: Open to pink salmon fishing with non-retention of sockeye salmon 8 a.m. to 11:59 p.m. (midnight) on Saturday, August 29, 2009 and Monday, August 31, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Areas 7 and 7A Reef net: Open to pink salmon fishing with non-retention of sockeye salmon 5 a.m. to 9 p.m. on Saturday, August 29, 2009; 5 a.m. to 9 p.m. on Sunday, August 30, 2009; 5 a.m. to 9 p.m. on Monday, August 31, 2009; and 5 a.m. to 9 p.m. on Tuesday, September 1, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Order Number 2009–04: Issued 12:30 p.m., September 1, 2009

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open to drift gillnets from 12 p.m. (noon) Wednesday, September 2, 2009 to 12 p.m. (noon) Saturday, September 5, 2009.

Areas 6, 7, and 7A: Open to drift gillnets and purse seines from 8 a.m., Wednesday, September 2, 2009 to 11 a.m., Saturday, September 5, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the Province of British Columbia.

All Citizen Fisheries

Areas 7 and 7A Purse seine: Open to pink salmon fishing with non-retention of sockeye salmon 10 a.m. to 9 p.m. Thursday, September 3, 2009; and 5 a.m. to 9 p.m. Friday, September 4; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Areas 7 and 7A Gillnet: Open to pink salmon fishing with non-retention of sockeye salmon 10 a.m. to 11:59 p.m. (midnight) on Thursday, September 3, 2009; and 8 a.m. to 11:59 p.m. (midnight) on Friday, September 4, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Areas 7 and 7A Reef net: Open for pink salmon fishing with non-retention of sockeye salmon 5 a.m. to 9 p.m. on Wednesday, September 2, 2009; 5 a.m. to 9 p.m. on Thursday, September 3, 2009; and 5 a.m. to 9 p.m. on Friday, September 4, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Order Number 2009–05: Issued 12:05 p.m., September 4, 2009

Treaty Indian Fishery

Areas 48, 5 and 6C: Open to drift gillnets from 12 p.m. (noon) Saturday, September 5, 2009 to 12 p.m. (noon) Wednesday, September 9, 2009.

Areas 6, 7, and 7A: Open to drift gillnets and purse seines from 11 a.m., Saturday, September 5, 2009 to 11 a.m. Wednesday, September 9, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the Province of British Columbia.

All Citizen Fisheries

Areas 7 and 7A Purse seine: Open to pink salmon fishing with non-retention of sockeye salmon 10 a.m. to 9 p.m. Monday, September 7, 2009; and 5 a.m. to 9 p.m. Tuesday, September 8; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Areas 7 and 7A Gillnet: Open to pink salmon fishing with non-retention of sockeye salmon 10 a.m. to 11:59 p.m. (midnight) on Monday, September 7, 2009; and 8 a.m. to 11:59 p.m. (midnight) on Tuesday, September 8, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Areas 7 and 7A Reef net: Open to pink salmon fishing with non-retention of sockeye salmon 5 a.m. to 9 p.m. on Saturday, September 5, 2009; 5 a.m. to 9 p.m. on Sunday, September 6, 2009; 5 a.m. to 9 p.m. on Monday, September 7; and 5 a.m. to 9 p.m. on Tuesday, September 8, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Order Number 2009–06: Issued 2:15 p.m., September 8, 2009

Treaty Indian Fisheries

Areas 4B, 5 and 6C: Open to drift gillnets from 12 p.m. (noon) Wednesday, September 9, 2009 to 12 p.m. (noon) Saturday, September 12, 2009.

Areas 6, 7, and 7A: Open to drift gillnets and purse seines from 11 a.m. Wednesday, September 9, 2009 to 11 a.m. Saturday, September 12, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the Province of British Columbia.

All Citizen Fisheries

Areas 7 and 7A Purse Seine: Open to pink salmon fishing with non-retention of sockeye salmon 10 a.m. to 9 p.m. Thursday, September 10, 2009; and 5 a.m. to 9 p.m. Friday, September 11; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Areas 7 and 7A Gillnet: Open to pink salmon fishing with non-retention of sockeye salmon 10 a.m. to 11:59 p.m. (midnight) on Thursday, September 10, 2009; and 8 a.m. to 11:59 p.m. (midnight) on Friday, September 11, 2009; southerly and easterly of a straight line drawn from the Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Areas 7 and 7A Reef net: Open to pink salmon fishing with non-retention of sockeye salmon 5 a.m. to 9 p.m. on Wednesday, September 9, 2009; 5 a.m. to 9 p.m. on Thursday, September 10, 2009; and 5 a.m. to 9 p.m. on Friday, September 11, 2009; southerly and easterly of a straight line drawn from the

Iwersen Dock on Point Roberts in the State of Washington to the Georgina Point Light at the entrance to Active Pass in the province of British Columbia.

Order Number 2009–07: Issued 1:45 p.m., September 10, 2009

All Citizen Fisheries

Areas 7 and 7A Purse Seine: Will remain closed after 9 p.m. Thursday, September 10, 2009; and will not reopen Friday, September 11, 2009.

Areas 7 and 7A Gillnet: Will remain closed after 11:59 p.m. (midnight) on Thursday, September 10, 2009; and will not reopen on Friday, September 11, 2009.

Areas 7 and 7A Reef net: Will remain closed after 9 p.m. on Thursday, September 10, 2009; and will not reopen Friday, September 11, 2009.

Order Number 2009–08: Issued 11:45 a.m., September 11, 2009

Treaty Indian Fisheries

Areas 4B, 5, and 6C: Open to drift gillnets from 12 p.m. (noon) Saturday, September 12, 2009 to 11:59 p.m. (midnight) on Monday, September 14, 2009.

Areas 6, 7, and 7A: Open to drift gillnets and purse seines from 11 a.m. Saturday, September 12, 2009 to 9 p.m. Monday, September 14, 2009. Iwersen Dock Line restriction is not in effect. Iwerson Dock Line restriction rescinded effective 11:05 a.m. Friday, September 11, 2009.

The Fraser River Panel approved the following relinquishment of regulatory control in U.S. Puget Sound Panel waters:

Area 4B, 5, and 6C: Relinquish regulatory control effective 12:01 a.m., Tuesday, September 15, 2009.

Order Number 2009–09: Issued 1:20 p.m., September 12, 2009

Treaty Indian Fisheries

Areas 6, 7, and 7A: Fishery closed at 9:00 p.m. Sunday, September 13, 2009.

Order Number 2009–10: Issued 12:01 a.m., September 18, 2009

The Fraser River Panel approved the following relinquishment of regulatory control in U.S. Puget Sound Panel waters:

Area 7: Relinquish Regulatory Control effective 12:01 a.m. Friday, September 18, 2009.

Classification

The Assistant Administrator for Fisheries NOAA (AA), finds that good cause exists for the inseason orders to be issued without affording the public prior notice and opportunity for comment under 5 U.S.C. 553(b)(B) as such prior notice and opportunity for comments is impracticable and contrary to the public interest. Prior notice and opportunity for public comment is impracticable because NMFS has insufficient time to allow for prior notice and opportunity for public comment between the time the stock abundance information is available to determine how much fishing can be allowed and the time the fishery must open and close in order to harvest the appropriate amount of fish while they are available.

The AA also finds good cause to waive the 30–day delay in the effective date, required under 5 U.S.C. 553(d)(3), of the inseason orders. A delay in the effective date of the inseason orders would not allow fishers appropriately controlled access to the available fish at that time they are available.

This action is authorized by 50 CFR 300.97, and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 3636(b).

Dated: November 20, 2009.

Emily H. Menashes,

Acting DirectorOffice of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E9–28319 Filed 11–24–09; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 09100091344–9056–02]

RIN 0648–XT10

Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Cod by Vessels Catching Pacific Cod for Processing by the Inshore Component in the Western Regulatory Area of the Gulf of Alaska

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Temporary rule; closure.

SUMMARY: NMFS is prohibiting directed fishing for Pacific cod by vessels catching Pacific cod for processing by the inshore component in the Western Regulatory Area of the Gulf of Alaska (GOA). This action is necessary to prevent exceeding the 2009 total allowable catch (TAC) of Pacific cod apportioned to vessels catching Pacific cod for processing by the inshore component of the Western Regulatory Area of the GOA.

DATES: Effective 1200 hrs, Alaska local time (A.l.t.), November 22, 2009, until 2400 hrs, A.l.t., December 31, 2009.

FOR FURTHER INFORMATION CONTACT: Josh Keaton, 907–586–7228.

SUPPLEMENTARY INFORMATION: NMFS manages the groundfish fishery in the GOA exclusive economic zone according to the Fishery Management Plan for Groundfish of the Gulf of Alaska (FMP) prepared by the North Pacific Fishery Management Council under authority of the Magnuson-Stevens Fishery Conservation and Management Act. Regulations governing fishing by U.S. vessels in accordance with the FMP appear at subpart H of 50 CFR part 600 and 50 CFR part 679.

The 2009 TAC of Pacific cod apportioned to vessels catching Pacific cod for processing by the inshore component of the Western Regulatory Area of the GOA is 14,558 metric tons (mt) as established by the final 2009 and 2010 harvest specifications for groundfish of the GOA (74 FR 7333, February 17, 2009).

In accordance with § 679.20(d)(1)(i), the Regional Administrator has determined that the 2009 TAC of Pacific cod apportioned to vessels catching Pacific cod for processing by the inshore component of the Western Regulatory Area of the GOA will soon be reached. Therefore, the Regional Administrator is establishing a directed fishing allowance of 14,508 mt, and is setting aside the remaining 50 mt as bycatch to support other anticipated groundfish fisheries. In accordance with § 679.20(d)(1)(iii), the Regional Administrator finds that this directed fishing allowance has been reached. Consequently, NMFS is prohibiting directed fishing for Pacific cod by vessels catching Pacific cod for processing by the inshore component in the Western Regulatory Area of the GOA.

After the effective date of this closure the maximum retainable amounts at § 679.20(e) and (f) apply at any time during a trip.

Classification

This action responds to the best available information recently obtained from the fishery. The Assistant Administrator for Fisheries, NOAA (AA), finds good cause to waive the requirement to provide prior notice and opportunity for public comment pursuant to the authority set forth at 5 U.S.C. 553(b)(B) as such requirement is impracticable and contrary to the public interest. This requirement is

impracticable and contrary to the public interest as it would prevent NMFS from responding to the most recent fisheries data in a timely fashion and would delay the closure of Pacific cod apportioned to vessels catching Pacific cod for processing by the inshore component of the Western Regulatory Area of the GOA. NMFS was unable to publish a notice providing time for public comment because the most recent, relevant data only became available as of November 19, 2009.

The AA also finds good cause to waive the 30-day delay in the effective date of this action under 5 U.S.C. 553(d)(3). This finding is based upon the reasons provided above for waiver of prior notice and opportunity for public comment.

This action is required by § 679.20 and is exempt from review under Executive Order 12866.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: November 20, 2009.

Emily H. Menashes,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E9–28295 Filed 11–20–09; 4:15 am]

BILLING CODE 3510–22–S

Proposed Rules

Federal Register
Vol. 74, No. 226
Wednesday, November 25, 2009

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

Agricultural Marketing Service

7 CFR Part 989

[Doc. No. AMS–FV–08–0042; FV08–989–2 PR]

Raisins Produced From Grapes Grown in California; Withdrawal of a Proposed Rule

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Withdrawal of proposed rule.

SUMMARY: This document withdraws a proposed rule published in the **Federal Register** on July 18, 2008, on use of an estimated trade demand figure to compute volume regulation percentages for 2008–09 Natural (sun-dried) Seedless (NS) raisins covered under the Federal marketing order for California raisins (order). The order regulates the handling of raisins produced from grapes grown in California and is administered locally by the Raisin Administrative Committee (Committee). The proposal provided parameters for implementing volume regulation for 2008–09 NS raisins, if supplies were short, for the purpose of maintaining the industry's export markets and stabilizing the domestic market. Since the 2008–09 NS crop was larger than anticipated, this action is no longer warranted. Therefore, the proposed rule is being withdrawn.

DATES: The proposed rule published on July 18, 2008 (73 FR 41302), is withdrawn effective November 25, 2009.

FOR FURTHER INFORMATION CONTACT: Rose M. Aguayo, Marketing Specialist, or Kurt J. Kimmel, Regional Manager, California Marketing Field Office, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA; *Telephone:* (559) 487–5901, *Fax:* (559) 487–5906, or *E-mail: Rose.Aguayo@ams.usda.gov* or *Kurt.Kimmel@ams.usda.gov.*

Small businesses may request information on complying with this regulation by contacting Jay Guerber, Marketing Order Administration Branch, Fruit and Vegetable Programs, AMS, USDA, 1400 Independence Avenue, SW., STOP 0237, Washington, DC 20250–0237; *Telephone:* (202) 720–2491, *Fax:* (202) 720–8938, or *E-mail: Jay.Guerber@usda.gov.*

SUPPLEMENTARY INFORMATION: Marketing Agreement and Order No. 989, both as amended (7 CFR part 989), regulate the handling of raisins produced from grapes grown in California, hereinafter referred to as the ''order.'' The order is effective under the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674), hereinafter referred to as the ''Act.''

This action withdraws a proposed rule published in the **Federal Register** on July 18, 2008 (73 FR 41302), on use of an estimated trade demand figure to compute volume regulation percentages for 2008–09 NS raisins. Specifically, the proposed rule would have provided parameters for implementing volume regulation for 2008–09 crop NS raisins, if supplies were short, for the purpose of maintaining a raisin reserve pool to support a portion of the industry's export markets and help stabilize the domestic market.

Historically, reserve raisins have been used by the Committee to support market development programs that have strengthened export sales and reduced surpluses, thus stabilizing the domestic market. In two previous years when raisin supplies were low, the Committee recommended an alternative method of calculating its volume control percentages, including the use of an estimated trade demand figure, to ensure that a reserve was maintained and the export programs could continue from year to year.

Subsequent to publication of the proposed rule, the Committee determined that the 2008–09 crop was larger than anticipated and that use of the alternative method for calculating volume control percentages would be unnecessary for that crop year. Therefore, the proposed action is no longer warranted.

Accordingly, the proposed rule regarding use of an estimated trade demand figure to compute volume regulation percentages for 2008–09 NS raisins published in the **Federal Register** July 18, 2008 (73 FR 41302), is hereby withdrawn.

List of Subjects in 7 CFR Part 989

Grapes, Marketing agreements, Raisins, Reporting and recordkeeping requirements.

Authority: 7 U.S.C. 601–674.

Dated: November 17, 2009.

Rayne Pegg,

Administrator, Agricultural Marketing Service.

[FR Doc. E9–28149 Filed 11–24–09; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF HOMELAND SECURITY

Bureau of Customs and Border Protection

DEPARTMENT OF THE TREASURY

19 CFR Parts 113 and 191

[USCBP–2009–0021]

RIN 1505–AC18

Drawback of Internal Revenue Excise Tax

AGENCIES: Customs and Border Protection, Department of Homeland Security; Department of the Treasury.

ACTION: Notice of proposed rulemaking; second extension of comment period.

SUMMARY: This document provides a second 30-day extension period for interested parties to submit comments on the proposal to amend title 19 of the Code of Federal Regulations to preclude the filing of substitution drawback claims for internal revenue excise tax paid on imported merchandise in situations where no excise tax was paid upon the substituted merchandise or where the substituted merchandise is the subject of a different claim for refund or drawback of excise tax under any provision of the Internal Revenue Code. The proposed rule was published in the **Federal Register** on October 15, 2009, with comments due on or before November 16, 2009. A related proposed rulemaking prepared by the Alcohol and Tobacco Tax and Trade Bureau (TTB) within the Department of the Treasury was published in the same edition of the **Federal Register**, with comments due on or before December 14, 2009. A subsequent notice extending the time within which the public may submit comments on CBP's proposed

rulemaking to coincide with the December 14, 2009 TTB comment deadline was published in the **Federal Register** (74 FR 57125) on November 4, 2009. In response to a request from the public to provide additional time to prepare comments on the proposed rule, CBP is extending the comment period for an additional 30 days to January 12, 2010.

DATES: Comments on the proposed rule must be received on or before January 12, 2010.

ADDRESSES: You may submit comments, identified by *USCBP docket number,* by *one* of the following methods:

• *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments via docket number USCBP–2009–0021.

• *Mail:* Trade and Commercial Regulations Branch, Regulations and Rulings, Office of International Trade, U.S. Customs and Border Protection, 799 9th Street, NW. (Mint Annex), Washington, DC 20229–1179.

Instructions: All submissions received must include the agency name and USCBP docket number for this proposed rulemaking. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. For detailed instructions on submitting comments and additional information on the rulemaking process, see the ''Public Participation'' heading of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.* Submitted comments may also be inspected during regular business days between the hours of 9 a.m. and 4:30 p.m. at the Trade and Commercial Regulations Branch, Regulations and Rulings, Office of International Trade, U.S. Customs and Border Protection, 799 9th Street, NW., 5th Floor, Washington, DC. Arrangements to inspect submitted comments should be made in advance by calling Joseph Clark at (202) 325–0118.

FOR FURTHER INFORMATION CONTACT: William Rosoff, Entry Process and Duty Refunds, Regulations and Rulings, Office of International Trade, (202) 325–0047.

SUPPLEMENTARY INFORMATION:

Public Participation

Interested persons are invited to participate in this rulemaking by submitting written data, views, or arguments on all aspects of the proposed rule. Customs and Border Protection (CBP) also invites comments that relate to the economic, environmental, or federalism effects that might result from this proposed rule. If appropriate to a specific comment, the commenter should reference the specific portion of the proposed rule, explain the reason for any recommended change, and include data, information, or authority that support such recommended change.

Background

Customs and Border Protection (CBP) published a document in the **Federal Register** (74 FR 52928) on October 15, 2009 proposing to amend title 19 of the Code of Federal Regulations to preclude the filing of substitution drawback claims for internal revenue excise tax paid on imported merchandise in situations where no excise tax was paid upon the substituted merchandise or where the substituted merchandise is the subject of a different claim for refund or drawback of excise tax under any provision of the Internal Revenue Code. The document solicited public comment on the proposed amendments, and requested that submitted comments be received by CBP on or before November 16, 2009.

A related proposed rulemaking prepared by the Alcohol and Tobacco Tax and Trade Bureau (TTB) within the Department of the Treasury was published in the same edition of the **Federal Register** (74 FR 52937, October 15, 2009). Comments on TTB's proposed rule are due on or before December 14, 2009.

A subsequent notice extending the time within which the public may submit comments on CBP's proposed rulemaking to coincide with the December 14, 2009 TTB comment deadline was published in the **Federal Register** (74 FR 57125) on November 4, 2009.

Second Extension of Comment Period

CBP received a written submission from the trade, dated November 2, 2009, requesting that the comment period be extended for an additional 30 days to provide adequate time to prepare comments on the proposed rule. Upon review, a decision has been made to grant the request. Accordingly, the comment period is extended to January 12, 2010 and comments must be received by CBP on or before that date.

Dated: November 20, 2009.

Sandra L. Bell,

Executive Director, Regulations and Rulings, Office of International Trade, U.S. Customs and Border Protection.

Approved: November 20, 2009.

Timothy E. Skud,

Deputy Assistant Secretary of the Treasury.

[FR Doc. E9–28285 Filed 11–24–09; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF STATE

22 CFR Part 126

[Public Notice: 6813]

RIN 1400–AC52

Amendment to the International Arms Traffic in Arms Regulations: U.S. Government Transfer Programs and Foreign-Owned Military Aircraft and Naval Vessels

AGENCY: Department of State.

ACTION: Proposed rule.

SUMMARY: The Department of State is proposing to amend Section 126.6 of the International Traffic in Arms Regulations (ITAR) pertaining to U.S. Government transfer programs and foreign-owned military aircraft and naval vessels. Section 126.6 is being amended to clarify the particular circumstances when a license is not required by the Directorate of Defense Trade Controls.

DATES: The Department of State will accept comments on this proposed rule until January 25, 2010.

ADDRESSES: Interested parties may submit comments within 60 days of the date of the publication by any of the following methods:

• *E-mail: DDTCResponseTeam@state.gov* with an appropriate subject line.

• *Mail:* Department of State, Directorate of Defense Trade Controls, Office of Defense Trade Controls Policy, ATTN: Regulatory Change, 126.6, SA–1, 12th Floor, Washington, DC 20522–0112.

Persons with access to the Internet may also view this notice by going to the U.S. Government regulations.gov Web site at *http://regulations.gov/index.cfm.*

FOR FURTHER INFORMATION CONTACT: Director Charles B. Shotwell, Office of Defense Trade Controls Policy, Department of State, Telephone (202) 663–2792 or Fax (202) 261–8199; E-mail *DDTCResponseTeam@state.gov.* ATTN: Regulatory Change, 126.6.

SUPPLEMENTARY INFORMATION: Section 126.6 of the ITAR specifies when a license from the Directorate of Defense Trade Controls is not required for certain specified U.S. Government transfer programs and exports involving foreign-owned military aircraft and naval vessels. The title of this particular section has been changed from ''Foreign-owned military aircraft and naval vessels, and the Foreign Military Sales program'' to ''U.S. Government transfer programs and foreign-owned military aircraft and naval vessels'' to more accurately describe its coverage. Section 126.6 is being amended to clarify the particular circumstances when a license is not required by the Directorate of Defense Trade Controls. Current regulatory language was implemented when the U.S. Government executed these programs with mostly U.S. Government personnel. Over the years the U.S. Government, especially the Department of Defense, has expanded operations and migrated to utilization of the Defense Transportation System as well as commercial carriers to, in some instances, fully replace government transportation systems and personnel. As a result, U.S. Customs and Border Protection was unclear as to which programs were U.S. Government programs and, therefore, which items were qualified to be exported from the United States without an associated export license. The proposed changes address this issue. Also, the proposed amendment addresses in more detail the export requirements involving the Foreign Military Sales program and extends the exemption to exports pursuant to section 1206 of the National Defense Authorization Act for Fiscal Year 2006, as amended and extended, or section 1206 of the National Defense Authorization Act for Fiscal Year 2008. It further delineates requirements, authorized periods for license exemptions, documentary requirements, and the applicable terms and conditions relating to the U.S. Government's transfer and/or loan of defense articles to foreign governments or international organizations.

Regulatory Analysis and Notices

Administrative Procedure Act and Executive Order 12866

Applicability of 5 U.S.C. 553 and Executive Order 12866 is under discussion with the Office of Management and Budget.

Regulatory Flexibility Act

The applicability of the Regulatory Flexibility Act is contingent on the applicability of 5 U.S.C. 553, which will be determined at a later time.

Unfunded Mandates Act of 1995

This proposed amendment does not involve a mandate that will result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of $100 million or more in any year and it will not significantly or uniquely affect small governments. Therefore, no actions were deemed necessary under the provisions of the Unfunded Mandates Reform Act of 1995.

Small Business Regulatory Enforcement Fairness Act of 1996

This proposed amendment has been found not to be a major rule within the meaning of the Small Business Regulatory Enforcement Fairness Act of 1996.

Executive Orders 12372 and 13132

This proposed amendment will not have substantial effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 13132, it is determined that this amendment does not have sufficient federalism implications to require consultations or warrant the preparation of a federalism summary impact statement. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal programs and activities do not apply to this proposed amendment.

Paperwork Reduction Act

This proposed rule would not impose any new reporting or recordkeeping requirements subject to the Paperwork Reduction Act, 44 U.S.C. Chapter 35.

List of Subjects in 22 CFR Part 126

Arms and munitions, Exports.

Accordingly, for the reasons set forth above, Title 22, Chapter I, Subchapter M, part 126 is proposed to be amended as follows:

PART 126—GENERAL POLICIES AND PROVISIONS

1. The authority citation for part 126 continues to read as follows:

Authority: Secs. 2, 38, 40, 42 and 71, Public Law 90–629, 90 Stat. 744 (22 U.S.C. 2752, 2778, 2780, 2791 and 2797); E.O. 11958, 42 FR 4311; 3 CFR, 1977 Comp., p. 79; 22 U.S.C. 2651a; 22 U.S.C. 287c; E.O. 12918, 59 FR 28205; 3 CFR, 1994 Comp., p. 899; Sec. 1225, Public Law 108–375.

2. Section 126.6 is amended by revising paragraphs (a)(1), (a)(2), (a)(3), (b), (c), and (d) to read as follows:

§ 126.6 U.S. Government transfer programs and foreign-owned military aircraft and naval vessels.

(a) * * *

(1) The defense article to be exported was sold, granted, leased, or loaned by the Department of Defense to the government of a foreign country or to an international organization pursuant to the Arms Export Control Act, as amended, (AECA) or the Foreign Assistance Act of 1961, as amended;

(2) The defense article is exported to representatives of the government of the foreign country or international organization in the United States;

(3) The defense article is to be exported from the United States:

(i) On a military aircraft or naval vessel of the government of the foreign country or international organization. The shippers export declaration (SED) must be entered in the Automated Export System (AES) by such government or international organization prior to export;

(ii) By the Department of Defense via the Department of Defense Transportation System (DTS) in accordance with the vetting procedures and the requirements in DoD 5105.38–M, ''Security Assistance Management Manual'' (SAMM), and DoD Regulations 4500.9E and 4500.9R, ''Defense Transportation Regulations'' (DTR). The SED must be entered in the AES by the cognizant or responsible military service or implementing agency; or

(iii) By a Department of Defense contracted carrier via the DTS in accordance with the vetting procedures and the requirements in DoD 5105.38–M, ''Security Assistance Management Manual'' (SAMM), and DoD Regulations 4500.9E and 4500.9R, ''Defense Transportation Regulations'' (DTR). The SED must be entered in the AES by the cognizant or responsible military service or implementing agency; and

(4) In the event the defense article to be exported is classified, the export is made by a person having the appropriate USG security clearance, in compliance with the Department of Defense National Industrial Security Program Operating Manual (DoD NISPOM), and pursuant to an approved transportation plan.

(b) *Foreign military aircraft and naval vessels.* A license is not required for the entry into and subsequent exit from the United States of military aircraft or naval vessels of any foreign state if no overhaul, repair, or modification of the aircraft or naval vessel is to be

performed. However, Department of State approval for overflight (pursuant to 49 U.S.C. 40103) and naval visits must be obtained from the Department of State, Bureau of Political-Military Affairs, Office of International Security Operations.

(c) *Foreign Military Sales program.* A license from the Directorate of Defense Trade Controls is not required if the defense article or defense service is to be exported to a foreign country or international organization under the Foreign Military Sales (FMS) program of the AECA pursuant to a jointly-signed Letter of Offer and Acceptance (LOA) authorizing such export where such export meets the criteria stated below:

(1) Exports of the defense article or defense service using this exemption may take place only during the period in which the FMS Program LOA and implementing USG FMS contracts and subcontracts are in effect and serve as authorization for the exports hereunder in lieu of a license. The Department of Defense shall ensure that defense articles and defense services exported are limited to those authorized under the valid LOA, maintain the dollar value balance shipped against the LOA, and shall promptly notify U.S. Customs and Border Protection (CBP) of any amendments or modifications to the LOA, including the remaining balance when the LOA is completed, closed, or is no longer valid as an authorization;

(2) The defense article or defense service to be exported is specifically identified in an executed LOA, in furtherance of the FMS program, signed by an authorized representative of the Department of Defense and an authorized representative of the foreign government;

(3) The total value of the defense articles and defense services exported must not exceed that value authorized by the relevant LOA and any relevant contract and subcontract;

(4) The export is not to a country proscribed in § 126.1 of this subchapter;

(5) The U.S. person responsible for the transfer or the Department of Defense (in the case of DTS shipments) maintains records of all exports in accordance with Part 122 of this subchapter;

(6) For exports of defense articles:

(i) The shipment is made by the relevant foreign diplomatic mission of the purchasing country or its authorized freight forwarder, provided that the freight forwarder is so designated in writing by the foreign government to, and is registered with, the Directorate of Defense Trade Controls pursuant to Part 122 of this subchapter;

(ii) Prior to shipment, the Department of Defense shall lodge the LOA, and any amendments or modifications thereto, with the Port Director of U.S. Customs and Border Protection of the primary port;

(iii) The relevant foreign diplomatic mission of the purchasing country, or its authorized freight forwarder, prepares and provides to the Port Director of U.S. Customs and Border Protection a properly executed DSP–94 that has been countersigned by an authorized representative of the Department of Defense verifying that the export is in accordance with the LOA. The exporter must also provide any other documents required by the Port Director of U.S. Customs and Border Protection in carrying out its responsibilities. The AES SED or, if authorized, the outbound manifest must be annotated as follows: ''This shipment is being exported under the authority of Department of State Form DSP–94 pursuant to a current and valid FMS Case [case identification], implemented [implementation date]. 22 CFR 126.6(c) applicable. The U.S. Government point of contact is_____, telephone number _____,''; and

(iv) In the event the defense article to be exported is classified, the export must be made by a person having the appropriate USG security clearance and must be made in compliance with the Department of Defense National Industrial Security Program Operating Manual (DoD NISPOM) and pursuant to an approved transportation plan; and

(7) For exports of defense services:

(i) The U.S. exporter must have entered into a contract with the Department of Defense that:

(A) Specifically defines the scope of the defense service to be exported;

(B) Cites the FMS case identifier;

(C) Identifies the foreign recipients of the defense service;

(D) Identifies any other U.S. or foreign parties that may be involved and their roles/responsibilities to the extent known when the contract is executed; and

(E) Specifies the period during which the defense service may be performed;

(ii) The U.S. person that is a party to a contract with the Department of Defense for the provision of defense services pursuant to an FMS case must maintain a valid registration with the Directorate of Defense Trade Controls for the entire time that the defense service is being provided. In any instance when that U.S. person employs a U.S. subcontractor, that subcontractor may only provide defense services pursuant to this subsection when registered with Directorate of Defense Trade Controls, and when such subcontract meets the requirements of paragraphs (c)(7)(i)(A) thorugh (E) of this section;

(iii) In instances when the defense service involves the transfer of classified technical data, the U.S. person transferring the defense service must have the appropriate USG security clearance and a transportation plan, if appropriate, in compliance with the Department of Defense National Industrial Security Program Operating Manual (DoD NISPOM);

(iv) Where defense articles are exported along with defense services, the exporter must comply with paragraph (c)(6) of this section; and

(v) The U.S. exporter reports its initial export, citing this section of the International Traffic in Arms Regulations. The U.S. exporter must maintain records of the export to include the FMS case identifier, the contract and subcontract number, the foreign country, and the duration of the service being provided. These records must be kept in accordance with § 122.5 of this subchapter.

(d) *Other USG Programs.* A license from the Directorate of Defense Trade Controls is not required if:

(1) Defense articles to be exported were sold, granted, leased or loaned by the Department of Defense to a foreign country or international organization pursuant to section 1206 of the National Defense Authorization Act for Fiscal Year 2006, as amended and extended, or section 1206 of the National Defense Authorization Act for Fiscal Year 2008;

(2) The defense article is to be exported from the United States:

(i) By the Department of Defense via the Department of Defense Transportation System (DTS) in accordance with the vetting procedures and the requirements in DoD 5105.38–M, ''Security Assistance Management Manual'' (SAMM), and DoD Regulations 4500.9E and 4500.9R, ''Defense Transportation Regulations'' (DTR). The SED must be entered in the AES by the cognizant or responsible military service or implementing agency; or

(ii) By a Department of Defense contracted carrier via the DTS in accordance with the vetting procedures and the requirements in DoD 5105.38–M, ''Security Assistance Management Manual'' (SAMM), and DoD Regulations 4500.9E and 4500.9R, ''Defense Transportation Regulations'' (DTR). The SED must be entered in the AES by the cognizant or responsible military service or implementing agency; and

(3) In the event the defense article to be exported is classified, the export is made by a person having the appropriate USG security clearance, in

compliance with the Department of Defense National Industrial Security Program Operating Manual (DoD NISPOM) and pursuant to an approved transportation plan.

Dated: November 3, 2009.

Ellen O. Tauscher,

Under Secretary, Arms Control and International Security, Department of State.

[FR Doc. E9–27685 Filed 11–24–09; 8:45 am]

BILLING CODE 4710–25–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 301

[REG–111833–99]

RIN 1545–AX46

Regulations Under I.R.C. Section 7430 Relating to Awards of Administrative Costs and Attorneys Fees

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking and notice of public hearing.

SUMMARY: This document contains proposed regulations relating to awards of administrative costs and attorneys fees under section 7430 to conform to the amendments made in the Taxpayer Relief Act of 1997 and the IRS Restructuring and Reform Act of 1998. The regulations affect taxpayers seeking attorneys fees and costs. This document also provides notice of a public hearing on these proposed regulations.

DATES: Written or electronic comments must be received by February 8, 2010. Outlines of topics to be discussed at the public hearing scheduled for 10 a.m. on March 10, 2010 must be received by February 10, 2010.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–111833–99), room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–111833–99), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC. Alternatively, taxpayers may submit comments electronically via the Federal eRulemaking Portal at *http://www.regulations.gov* (IRS REG–111833–99). The public hearing will be held in the Internal Revenue Building, Room 2615, 1111 Constitution Avenue, NW., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Concerning the hearing, submission of written comments, and to be placed on the building access list to attend the hearing, contact Regina Johnson, (202) 622–7180; concerning the proposed regulations, contact Ronald J. Goldstein (202) 622–4910 (not toll-free numbers).

Background and Explanation of Provisions

The proposed amendments to the Treasury Regulations incorporate the 1997 and 1998 amendments to section 7430 of the Internal Revenue Code relating to awards of attorneys fees. These amendments were enacted as part of the Taxpayer Relief Act of 1997, Public Law 105–34, 111 Stat. 788, and the IRS Restructuring and Reform Act of 1998, Public Law 105–206, 112 Stat. 685.

The Taxpayer Relief Act of 1997 (TRA) contained several amendments to section 7430 that are addressed in the proposed amendments to the regulations. First, the TRA provided that a taxpayer has ninety days after the date the IRS mails to the taxpayer a final decision determining tax, interest or penalty, to file an application with the IRS to recover administrative costs. Second, a taxpayer has ninety days after the date the IRS mails to the taxpayer, by certified or registered mail, a final adverse decision regarding an award of administrative costs, to file a petition with the Tax Court. Third, the TRA clarified the application of the net worth requirements by providing that individuals filing joint returns should be treated as separate taxpayers for purposes of determining net worth. The TRA added trusts to the list of taxpayers subject to the net worth requirements and also specified the date on which the net worth determination should be made.

The TRA also added section 7436 to the Code, which gives the Tax Court jurisdiction in certain employment tax cases. Under section 7436, if the IRS determines in connection with an audit that (1) one or more individuals performing services for the taxpayer are employees of the taxpayer or (2) the taxpayer is not entitled to relief from employment taxes under section 530 of the Revenue Act of 1978 with respect to the individual(s), and the IRS sends a Notice of Determination of Worker Classification (NDWC) to the taxpayer by certified or registered mail, the taxpayer may petition the Tax Court to determine (1) whether the IRS's determination, as set forth in the NDWC, is correct and (2) the proper amount of employment tax under the determination. Various restrictions on assessment and collection in section 6213 apply to a section 7436 proceeding in the same manner as if the NDWC were a notice of deficiency. Section 7436(d)(2) provides that section 7430 applies to proceedings brought under section 7436.

The proposed amendments reflect the changes outlined in this preamble. Additional clarifying changes address the calculation of net worth. First, the regulation specifies that net worth will be calculated using the fair market value of assets to provide a more accurate assessment of a taxpayer's actual and current net worth as of the administrative proceeding date. Second, the regulation specifies which net worth and size limitations apply when a taxpayer is an owner of an unincorporated business. Third, the regulation has been amended to clarify the net worth requirement in cases involving partnerships subject to the unified audit and litigation procedures of sections 6221 through 6234 of the Code (the TEFRA partnership procedures).

The IRS Restructuring and Reform Act of 1998 (RRA) also contained several amendments affecting section 7430. First, the RRA increased the hourly rate limitation from $110 per hour to $125 per hour. Second, two special factors were added that may be considered to increase an attorney's hourly rate: Difficulty of the issues presented and local availability of tax experts. Third, the RRA added a provision that requires a court to consider whether the IRS has lost cases with substantially similar issues in other circuit courts of appeal in deciding whether the IRS's position was substantially justified. Fourth, the RRA created an exception to the requirement that to recover attorneys fees, the taxpayer must have paid or incurred the fees. The exception provides that if an individual who is authorized to practice before the Tax Court or the IRS is representing the taxpayer on a *pro bono* basis, then the taxpayer may petition for an award of reasonable attorneys fees in excess of the amounts that the taxpayer paid or incurred, as long as the fee award is ultimately paid to the individual or the individual's employer. Fifth, the period for recovery of reasonable administrative costs was extended to include costs incurred after the date on which the first letter of proposed deficiency, commonly known as a 30-day letter, is mailed to the taxpayer. The regulations clarify, however, that a taxpayer may be eligible to recover reasonable administrative costs from the date of the 30-day letter only if at least one issue (other than recovery of

administrative costs) remains in dispute as of the date that the IRS takes a position in the administrative proceeding.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations and, because these regulations do not impose on small entities a collection of information requirement, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Therefore, a Regulatory Flexibility Analysis is not required. Pursuant to section 7805(f) of the Internal Revenue Code, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) or electronic comments that are submitted timely to the IRS. The IRS and Treasury Department specifically request comments on the clarity of the proposed rules and how it may be made easier to understand. All public comments will be made available for public inspection and copying.

A public hearing has been scheduled for 10 a.m. on March 10, 2010 in the Internal Revenue Building, Room 2615, 1111 Constitution Avenue, NW., Washington, DC. Due to building security procedures, visitors must enter at the Constitution Avenue entrance. In addition, all visitors must present photo identification to enter the building. Because of access restrictions, visitors will not be admitted beyond the immediate entrance area more than 30 minutes before the hearing starts. For information about having a visitor's name placed on the building access list to attend the hearing, *see* the **FOR FURTHER INFORMATION CONTACT** caption.

An outline of the topics to be discussed and the time to be devoted to each topic (a signed original and eight (8) copies) must be submitted by any person that wishes to present oral comments at the hearing. Outlines must be received by February 10, 2010.

The rules of 26 CFR 601.601(a)(3) apply to the hearing. A period of 10 minutes will be allotted to each person for making comments.

An agenda showing the scheduling of the speakers will be prepared after the deadline for receiving requests to speak has passed. Copies of the agenda will be available free of charge at the hearing.

Drafting Information

The principal author of these regulations is Ronald J. Goldstein, Office of Associate Chief Counsel (Procedure and Administration).

List of Subjects in 26 CFR Part 301

Employment taxes, Estate taxes, Excise taxes, Gift taxes, Income taxes, Penalties, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 301 is proposed to be amended as follows:

PART 301—PROCEDURE AND ADMINISTRATION

Paragraph 1. The authority citation for part 301 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Section 301.7430–0 is amended by:

1. Adding a new entry for § 301.7430–3(c)(4).
2. Adding new entries for § 301.7430–4(b)(3)(iii)(A) through (F) and (d).
3. Revising the entries for § 301.7430–5.
4. Revising the section heading for § 301.7430–6.
5. Adding new entries for §§ 301.7430–7 and 301.7430–8.

The additions and revisions read as follows:

§ 301.7430–0 Table of contents.

* * * * *

§ 301.7430–3 Administrative proceeding and administrative proceeding date.

* * * * *

(c) * * *

(4) First letter of proposed deficiency that allows the taxpayer an opportunity for administrative review in the Office of Appeals.

* * * * *

§ 301.7430–4 Reasonable administrative costs.

* * * * *

(b) * * *

(3) * * *

(iii) * * *

(A) In general.

(B) Special factor.

(C) Limited availability.

(D) Local availability of tax expertise.

(E) Difficulty of the issues.

(F) Example.

(c) * * *

(d) *Pro bono* services.

(1) In general.

(2) Requirements.

(3) Nominal fee.

(4) Payment when services provided for a nominal fee.

(5) Requirements.

(6) Hourly rate.

(7) Examples.

§ 301.7430–5 Prevailing party.

(a) In general.

(b) Position of the Internal Revenue Service.

(c) Examples.

(d) Substantially justified.

(1) In general.

(2) Position in courts of appeal.

(3) Examples.

(4) Included costs.

(5) Examples.

(6) Exception.

(7) Presumption.

(e) Amount in controversy.

(f) Most significant issue or set of issues presented.

(1) In general.

(2) Example.

(g) Net worth and size limitations.

(1) Individuals.

(2) Estates and trusts.

(3) Others.

(4) Special rule for charitable organizations and certain cooperatives.

(5) Special rule for TEFRA partnerships.

(h) Determination of prevailing party.

(i) Examples.

§ 301.7430–6 Effective/applicability dates.

§ 301.7430–7 Qualified offers.

(a) In general.

(b) Requirements for treatment as a prevailing party based upon having made a qualified offer.

(1) In general.

(2) Liability under the last qualified offer.

(3) Liability pursuant to the judgment.

(c) Qualified offer.

(1) In general.

(2) To the United States.

(3) Specifies the offered amount.

(4) Designated at the time it is made as a qualified offer.

(5) Remains open.

(6) Last qualified offer.

(7) Qualified offer period.

(8) Interest as a contested issue.

(d) [Reserved].

(e) Examples.

(f) Effective date.

§ 301.7430–8 Administrative costs incurred in damage actions for violations of section 362 or 524 of the Bankruptcy Code.

(a) In general.

(b) Prevailing party.
(c) Administrative proceeding.
(d) Costs incurred after filing of bankruptcy petition.
(e) Time for filing claim for administrative costs.
(f) Effective date.

Par. 3. Section 301.7430–1 is amended by:

1. Revising paragraphs (b)(1)(ii)(A), (d)(1)(i), (d)(1)(ii) and (d)(2) introductory text.

2. Removing the language ''district director'' in paragraphs (f)(2)(i), (f)(3)(ii), (f)(3)(iii), (f)(4)(i) and (g) *Examples 6, 7* and *8* and adding the language ''Internal Revenue Service office'' in its place in all locations.

3. Removing the language ''such'' in the second sentence of paragraph (g) *Example 9* and adding the language ''these'' in its place.

The revisions read as follows:

§ 301.7430–1 Exhaustion of administrative remedies.

* * * * *

(b) * * *

(1) * * *

(ii) * * *

(A) Requests an Appeals office conference in accordance with §§ 601.105 and 601.106 of this chapter or any successor published guidance; and

* * * * *

(d) * * *

(1) * * *

(i) The party follows all applicable Internal Revenue Service procedures for contesting the matter (including filing a written protest or claim, requesting an administrative appeal, and participating in an administrative hearing or conference); or

(ii) If there are no applicable Internal Revenue Service procedures, the party submits to the area director of the area having jurisdiction over the dispute a written claim for relief reciting facts and circumstances sufficient to show the nature of the relief requested and that the party is entitled to the requested relief; and the area director has denied the claim for relief in writing or failed to act on the claim within a reasonable period after the claim is received by the area director.

(2) For purposes of paragraph (d)(1)(ii) of this section, a *reasonable period* is—

* * * * *

Par. 4. Section 301.7430–2 is amended by:

1. Adding the language ''from the Internal Revenue Service'' at the end of the last sentence of paragraph (a).

2. Removing the language ''such'' in the fourth and fifth sentences of paragraph (b)(2) and adding the language ''these'' in its place in both locations.

3. Removing the '';'' at the end of paragraph (c)(3)(i)(B) and adding a ''.'' in its place.

4. Adding a new sentence at the end of paragraphs (c)(3)(i)(B), (c)(3)(i)(E) and (c)(7).

5. Revising paragraphs (c)(3)(ii)(C), (c)(5) and (e).

6. Adding new paragraph (c)(3)(iii)(C).

7. Removing the language ''which'' in the first sentence of paragraph (c)(4) and adding the language ''that'' in its place.

8. Removing the language ''such'' in the second sentence of paragraph (c)(6) and adding the language ''the'' in its place.

The additions and revisions read as follows:

§ 301.7430–2 Requirements and procedures for recovery of reasonable administrative costs.

* * * * *

(c) * * *

(3) * * *

(i) * * *

(B) * * * For costs incurred after January 18, 1999, if the taxpayer alleges that the United States has lost in courts of appeal for other circuits on substantially similar issues, the taxpayer must provide the full name of the case, volume and pages of the reporter in which the opinion appears, the circuit in which the case was decided, and the year of the opinion;

* * * * *

(E) * * * This statement must identify whether the representation is on a *pro bono* basis as defined in § 301.7430–4(d) and, if so, to whom payment should be made. Specifically, the statement must direct whether payment should be made to the taxpayer's representative or to the representative's employer.

(ii) * * *

(C) For costs incurred after January 18, 1999, if more than $125 per hour as adjusted for increases in the cost of living pursuant to § 301.7430–4(b)(3) is claimed for the fees of a representative in connection with the administrative proceeding, an affidavit stating that a special factor described in § 301.7430–4(b)(3) is applicable, such as the difficulty of the issues presented in the case or the lack of local availability of tax expertise. If a special factor is claimed based on specialized skills and distinctive knowledge as described in § 301.7430–4(b)(2)(ii), the affidavit must state—

(1) Why the specialized skills and distinctive knowledge were necessary in the representation;

(2) That there is a limited availability of representatives possessing these specialized skills and distinctive knowledge; and

(3) How the education and experience qualifies the representative as someone with the necessary specialized skills and distinctive knowledge.

(iii) * * *

(C) In cases of *pro bono* representation, time records similar to billing records, detailing the time spent and work completed must be submitted for the requested fees.

* * * * *

(5) *Period for requesting costs from the Internal Revenue Service.* To recover reasonable administrative costs pursuant to section 7430 and this section, the taxpayer must file a written request for costs within 90 days after the date the final adverse decision of the Internal Revenue Service with respect to all tax, additions to tax, interest, and penalties at issue in the administrative proceeding is mailed or otherwise furnished to the taxpayer. For purposes of this section, *interest* means the interest that is specifically at issue in the administrative proceeding independent of the taxpayer's objections to the underlying tax imposed. The final decision of the Internal Revenue Service for purposes of this section is the document that resolves the tax liability of the taxpayer with regard to all tax, additions to tax, interest, and penalties at issue in the administrative proceeding (such as a Form 870 or closing agreement), or a notice of assessment for that liability (such as the notice and demand under section 6303), whichever is earlier mailed or otherwise furnished to the taxpayer. For purposes of this section, if the 90th day falls on a Saturday, Sunday, or a legal holiday, the 90-day period shall end on the next succeeding day that is not a Saturday, Sunday, or a legal holiday as defined by section 7503.

* * * * *

(7) * * * If the notice of decision denying (in whole or in part) an award for reasonable administrative costs was mailed by the Internal Revenue Service via certified mail or registered mail, a taxpayer may obtain judicial review of that decision by filing a petition for review with the Tax Court prior to the 91st day after the mailing of the notice of decision.

* * * * *

(e) * * *

Example 1. Taxpayer A receives a notice of proposed deficiency (30-day letter). A requests and is granted Appeals office consideration. Appeals requests that A submit certain documents as substantiation for the tax matters at issue. Appeals determines that the information submitted is

insufficient. Appeals then issues a notice of deficiency. After receiving the notice of deficiency but before the 90-day period for filing a petition with the Tax Court has expired, A convinces Appeals that the information submitted during the review by Appeals is sufficient and, therefore, the notice of deficiency is incorrect and A owes no additional tax. Appeals then closes the case showing a zero deficiency and mails A a notice to this effect. Assuming that all of the other requirements of section 7430 are satisfied, A may recover reasonable administrative costs incurred after the date of the 30-day letter (the administrative proceeding date). To recover these costs, A must file a request for administrative costs with the Appeals office personnel who settled A's tax matter, or if that person is unknown to A, with the Area Director of the area that considered the underlying matter, within 90 days after the date of mailing of the Office of Appeals' final decision that A owes no additional tax.

Example 2. Taxpayer B files a request for an abatement of interest pursuant to section 6404 and the regulations thereunder. The Area Director issues a notice of proposed disallowance of the abatement request (akin to a 30-day letter). B requests and is granted Appeals office consideration. No agreement is reached with Appeals and the Office of Appeals issues a notice of disallowance of the abatement request. B does not file suit in the Tax Court, but instead contacts the Appeals office within 180 days after the mailing date of the notice of disallowance of the abatement request to attempt to reverse the decision. B convinces the Appeals office that the notice of disallowance is in error. The Appeals office agrees to abate the interest and mails the taxpayer a notification of this decision. The mailing date of the notification from Appeals of the decision to abate interest commences the 90-day period from which the taxpayer may request administrative costs. Assuming that all of the other requirements of section 7430 are satisfied, B may recover reasonable administrative costs incurred after the date of the notice of proposed disallowance of the abatement request (the administrative proceeding date). To recover these costs, B must file a request for costs with the Appeals office personnel who settled B's tax matter, or if that person is unknown to B, with the Area Director of the area that considered the underlying matter within 90 days after the date of mailing of the Office of Appeals' final decision that B is entitled to abatement of interest.

Example 3. Taxpayer C receives a notice of proposed adjustment and employment tax 30-day letter. C requests and is granted Appeals office consideration. Appeals requests that C submit certain documents to support C's position in the tax matters at issue. Appeals determines that the documents submitted are insufficient. Appeals then issues a notice of determination of worker classification. After receiving the notice of determination but before the 90-day period for filing a petition with the Tax Court has expired, C convinces Appeals that the documents submitted during the review by Appeals adequately support its position and, therefore, C owes no additional employment tax. Appeals then closes the case showing a zero tax adjustment and mails C a no-change letter. Assuming that all of the other requirements of section 7430 are satisfied, C may recover reasonable administrative costs incurred after the date of the notice of proposed adjustment and 30-day letter (the administrative proceeding date). To recover these costs, C must file a request for administrative costs with the Appeals office personnel who settled C's tax matter, or if that person is unknown to C, with the Area Director of the area that considered the underlying matter, within 90 days after the date of mailing of the Office of Appeals' final decision that C owes no additional tax.

Par. 5. Section 301.7430–3 is amended by:

1. Revising paragraphs (b), (c)(1), (c)(3) and (d).

2. Adding paragraph (c)(4).

The addition and revisions read as follows:

§ 301.7430–3 Administrative proceeding and administrative proceeding dates.

* * * * *

(b) *Collection action.* A collection action generally includes any action taken by the Internal Revenue Service to collect a tax (or any interest, additional amount, addition to tax, or penalty, together with any costs in addition to the tax) or any action taken by a taxpayer in response to the Internal Revenue Service's act or failure to act in connection with the collection of a tax (including any interest, additional amount, addition to tax, or penalty, together with any costs in addition to the tax). A collection action for purposes of section 7430 and this section includes any action taken by the Internal Revenue Service under Chapter 64 of Subtitle F to collect a tax. Collection actions also include collection due process hearings under sections 6320 and 6330 (unless the underlying tax liability is properly at issue), and those actions taken by a taxpayer to remedy the Internal Revenue Service's failure to release a lien under section 6325 or to remedy any unauthorized collection action as defined by section 7433, except those collection actions described by section 7433(e). An action or procedure directly relating to a claim for refund after payment of an assessed tax is not a collection action.

(c) *Administrative proceeding date*—(1) *General rule.* For purposes of section 7430 and the regulations thereunder, the term *administrative proceeding date* means the earlier of—

(i) The date of the receipt by the taxpayer of the notice of the decision of the Internal Revenue Service Office of Appeals;

(ii) The date of the notice of deficiency; or

(iii) The date on which the first letter of proposed deficiency that allows the taxpayer an opportunity for administrative review in the Internal Revenue Service Office of Appeals is sent.

(2) * * *

(3) *Notice of deficiency.* A notice of deficiency is a notice described in section 6212(a), including a notice rescinded pursuant to section 6212(d). For purposes of determining reasonable administrative costs under section 7430 and the regulations thereunder, the following will be treated as a notice of deficiency:

(i) A notice of final partnership administrative adjustment described in section 6223(a)(2).

(ii) A notice of determination of worker classification issued pursuant to section 7436.

(iii) A final notice of determination denying innocent spouse relief issued pursuant to section 6015.

(4) *First letter of proposed deficiency that allows the taxpayer an opportunity for administrative review in the Office of Appeals.* Generally, the first letter of proposed deficiency that allows the taxpayer an opportunity for administrative review in the Office of Appeals is the first letter issued to the taxpayer that describes the proposed adjustments and advises the taxpayer of the opportunity to contact the Office of Appeals. It also may be a claim disallowance or the first letter of determination that allows the taxpayer an opportunity for administrative review in the Office of Appeals.

(d) *Examples.* The provisions of this section are illustrated by the following examples:

Example 1. Taxpayer A receives a notice of proposed deficiency (30-day letter). A files a request for and is granted an Appeals office conference. At the Appeals conference no agreement is reached on the tax matters at issue. The Office of Appeals then issues a notice of deficiency. Upon receiving the notice of deficiency, A does not file a petition with the Tax Court. Instead, A pays the deficiency and files a claim for refund. The claim for refund is considered by the Internal Revenue Service and the Area Director issues a notice of proposed claim disallowance. A requests and is granted Appeals office consideration. A convinces Appeals that A's claim is correct and Appeals allows A's claim. A may recover reasonable administrative costs incurred on or after the date of the notice of proposed deficiency (30-day letter), but only if the other requirements of section 7430 and the regulations thereunder are satisfied. A cannot recover costs incurred prior to the date of the 30-day letter because these costs were incurred before the administrative proceeding date.

Example 2. Taxpayer B files an individual income tax return showing a balance due. No payment is made with the return and the Internal Revenue Service assesses the amount shown on the return. The Internal Revenue Service issues a notice of levy pursuant to section 6330. B requests and is granted a Collection Due Process (CDP) hearing. In connection with the CDP hearing, B enters into an installment agreement as a collection alternative. The costs that B incurred in connection with the CDP hearing were not incurred in an administrative proceeding, but rather in a collection action. Accordingly, B may not recover those costs as reasonable administrative costs under section 7430 and the regulations thereunder.

Par. 6. Section 301.7430–4 is amended by:

1. Removing the language ''such'' in the second and fifth sentences of paragraph (b)(2)(ii) and adding the language ''that'' in its place in both locations.

2. Revising paragraphs (b)(3)(i), (b)(3)(iii)(B), and (c)(4) *Examples 1* and *2*.

3. Removing the language ''$110'' from the first and second sentences in paragraph (b)(3)(ii) and adding the language ''$125'' in its place in both locations.

4. Revising the first sentence in paragraph (b)(3)(iii)(C).

5. Redesignating paragraph (b)(3)(iii)(D) as paragraph (b)(3)(iii)(F) and revising newly-designated paragraph (b)(3)(iii)(F).

6. Adding new paragraphs (b)(3)(iii)(D), (b)(3)(iii)(E) and (d).

7. Removing the language ''Such'' in the third sentence of paragraph (c)(2)(i) and adding the language ''These'' in its place.

8. Removing the language ''$110'' from the second and third sentences in paragraph (c)(2)(ii) and adding the language ''$125'' in its place in both locations.

9. Removing the language ''which'' in the fourth sentence of paragraph (c)(2)(i) and adding the language ''that'' in its place.

The additions and revisions read as follows:

§ 301.7430–4 Reasonable administrative costs.

* * * * *

(b) * * *

(3) *Limitation on fees for a representative*—(i) *In general.* Except as otherwise provided in this section, fees incurred after January 18, 1999, and described in paragraph (b)(1)(iv) of this section that are recoverable under section 7430 and the regulations thereunder as reasonable administrative costs may not exceed $125 per hour increased by a cost of living adjustment (and if appropriate, a special factor adjustment).

* * * * *

(iii) * * *

(B) *Special factor.* A *special factor* is a factor, other than an increase in the cost of living, that justifies an increase in the $125 per hour limitation of section 7430(c)(1)(B)(iii). The undesirability of the case, the work and the ability of counsel, the results obtained, and customary fees and awards in other cases, are factors applicable to a broad spectrum of litigation and do not constitute special factors for the purpose of increasing the $125 per hour limitation. By contrast, the limited availability of a specially qualified representative for the proceeding, the difficulty of the issues, and the limited local availability of tax expertise are special factors justifying an increase in the $125 per hour limitation.

(C) *Limited availability.* Limited availability of a specially qualified representative is established by demonstrating that a specially qualified representative for the proceeding is not available at the $125 per hour rate (as adjusted for an increase in the cost of living). * * *

(D) *Limited local availability of tax expertise.* Limited local availability of tax expertise is established by demonstrating that a representative possessing tax expertise is not available in the taxpayer's geographical area. Initially, this showing may be made by submission of an affidavit signed by the taxpayer, or by the taxpayer's counsel, that no representative possessing tax expertise practices within a reasonable distance from the taxpayer's principal residence or principal office. The hourly rate charged by representatives in the geographical area is not relevant in determining whether tax expertise is locally available. If the Internal Revenue Service challenges this initial showing, the taxpayer may submit additional evidence to establish the limited local availability of a representative possessing tax expertise.

(E) *Difficulty of the issues.* In determining whether the difficulty of the issues justifies an increase in the $125 per hour limitation on the applicable hourly rate, the Internal Revenue Service will consider the following factors:

(*1*) The number of different provisions of law involved in each issue.

(*2*) The complexity of the particular provision or provisions of law involved in each issue.

(*3*) The number of factual issues present in the proceeding.

(*4*) The complexity of the factual issues present in the proceeding.

(F) *Example.* The provisions of this section are illustrated by the following example:

Example. Taxpayer A is represented by B, a CPA and attorney with a LL.M. Degree in Taxation with Highest Honors and who regularly handles cases dealing with TEFRA partnership issues. B represents A in an administrative proceeding involving TEFRA partnership issues that is subject to the provisions of this section. Assuming the taxpayer qualifies for an award of reasonable administrative costs by meeting the requirements of section 7430, the amount of the award attributable to the fees of B may not exceed the $125 per hour limitation (as adjusted for the cost of living), absent a special factor. B is not a specially qualified representative because extraordinary knowledge of the tax laws does not constitute distinctive knowledge or a unique and specialized skill constituting a special factor. A special factor must be comprised of nontax expertise unless the taxpayer establishes the limited local availability of tax expertise.

* * * * *

(c) * * *

(4) * * *

Example 1. After incurring fees for representation during the Internal Revenue Service's examination of taxpayer A's income tax return, A receives a notice of proposed deficiency (30-day letter). A files a request for and is granted an Appeals office conference. At the conference no agreement is reached on the tax matters at issue. The Internal Revenue Service then issues a notice of deficiency. Upon receiving the notice of deficiency, A discontinues A's administrative efforts and files a petition with the Tax Court. A's costs incurred before the date of the mailing of the 30-day letter are not reasonable administrative costs because they were incurred before the administrative proceeding date. Similarly, A's costs incurred in connection with the preparation and filing of a petition with the Tax Court are litigation costs and not reasonable administrative costs.

Example 2. Assume the same facts as in *Example 1* except that after A receives the notice of deficiency, A recontacts Appeals and Appeals agrees with A. If A seeks administrative costs, A may recover costs incurred after the date of the mailing of the 30-day letter, costs incurred in recontacting Appeals after the issuance of the notice of deficiency, and costs incurred up to the time the Tax Court petition was filed, as reasonable administrative costs, but only if the other requirements of section 7430 and the regulations thereunder are satisfied. The costs incurred before the date of the mailing of the 30-day letter are not reasonable administrative costs because they were incurred before the administrative proceeding date, as set forth in § 301.7430–3(c)(1)(iii). A's costs incurred in connection with the filing of a petition with the Tax Court are not reasonable administrative costs because those costs are litigation costs. Similarly, A's costs incurred after the filing of the petition are not reasonable administrative costs, as they are litigation costs.

(d) *Pro bono services*—(1) *In general.* Fees recoverable under section 7430 and the regulations thereunder as reasonable administrative costs may exceed the attorneys' fees paid or incurred by the prevailing party if these fees are less than the reasonable attorneys' fees because an individual is representing the prevailing party on a *pro bono* basis. In addition to attorneys' fees, reasonable costs incurred or paid by the individual providing the *pro bono* services that are normally billed separately also may be recovered under this section.

(2) *Requirements. Pro bono* representation is established by demonstrating—

(i) Legal services were provided for no fee or for a fee that (taking into account all the facts and circumstances) constitutes a nominal fee;

(ii) The legal services were provided to or on behalf of either—

(A) Persons of limited financial means who meet the eligibility requirements for programs funded by the Legal Services Corporation as set forth in 45 CFR 1611; or

(B) Organizations operating primarily to address the needs of persons with limited means if payment of a standard legal fee would significantly deplete the person's financial resources; and

(iii) The service provider intended to perform services for no fee or for a nominal fee from the commencement of the representation. Intent to perform services for no fee or for a nominal fee may be demonstrated through documentation such as a retainer agreement. An individual will not be considered to have represented a client on a *pro bono* basis if the facts demonstrate that the individual anticipated a fee or provided services on a contingency fee basis. The fact that the service provider intended to seek recovery of fees under section 7430 will not prevent the service provider from satisfying this requirement.

(3) *Nominal fee.* A *nominal fee* is defined as one that is slight, inconsiderable or trifling (taking into account all the facts and circumstances).

(4) *Payment when services provided at no charge or for a nominal fee.* A prevailing party who receives legal services at no charge or for a nominal fee and who satisfies the requirements under this section is eligible to receive reasonable fees in excess of the fees actually paid or incurred and those otherwise meeting the requirements of this paragraph. Payment will be made to the representative or the representative's employer.

(5) *Recordkeeping.* Contemporaneous records must be maintained, demonstrating the work performed and the time allocated to each task. These records should contain similar information to billing records.

(6) *Hourly rate.* For purposes of this section, the hourly rate may not exceed the lesser of—

(i) The rate prescribed under section 7430(c)(1)(B); or

(ii) The hourly rate customarily charged by the representative in cases that are not handled on a *pro bono* basis.

(7) *Examples.* The provisions of this section are illustrated by the following examples:

Example 1. Taxpayer A, an attorney, files a petition with the Tax Court and pays a $60 filing fee. A appears pro se in the court proceeding. If A prevails, he will not be entitled to an award of reasonable litigation costs for his services. A is rendering services on his own behalf, not providing *pro bono* representation. His lost opportunity costs are not compensable under section 7430. A may recover the filing fee as a litigation cost, but only if the other requirements of section 7430 and the regulations thereunder are satisfied.

Example 2. Taxpayer retains attorney B with regard to the audit of taxpayer's individual income tax return. B agrees to represent taxpayer on a *pro bono* basis. Under this arrangement, taxpayer pays to attorney B a nominal fee. The customary hourly rate charged by B in cases not handled on a *pro bono* basis is less than the rate prescribed under section 7430(c)(1)(B). Any award paid to attorney B, or attorney B's employer, would be limited to attorney B's customary hourly rate. Thus, attorney B, or attorney B's employer, would receive the customary hourly rate charged in cases not handled by attorney B on a *pro bono* basis rather than the nominal fee actually paid or incurred by the taxpayer.

Example 3. Assume the same facts in *Example 2* except that attorney B's customary hourly rate exceeds the rate prescribed under section 7430(c)(1)(B). Any award paid to attorney B, or attorney B's employer, would be made at the rate prescribed under section 7430(c)(1)(B).

Example 4. Organization C, a low income taxpayer clinic within the meaning of section 7526, agrees to represent taxpayer on a *pro bono* basis. Attorneys employed by C do not have a customary hourly rate and work exclusively for C. Any award paid to C, for representation by its attorneys, would be limited to the rate prescribed under section 7430(c)(1)(B).

§ 301.7430–5 [Amended]

Par. 7. For each entry in the table, redesignate the paragraph designated in the ''Old Paragraph'' column as the new paragraph designation in the ''New Paragraph'' column to read as follows:

Old paragraph	New paragraph
301.7430–5(a)(1)	301.7430–5(a)(2)
301.7430–5(a)(2)	301.7430–5(a)(3)
301.7430–5(a)(3)	301.7430–5(a)(4)
301.7430–5(c)	301.7430–5(d)(1)
301.7430–5(c)(2)	301.7430–5(d)(6)
301.7430–5(c)(3)	301.7430–5(d)(7)
301.7430–5(d)	301.7430–5(e)
301.7430–5(e)	301.7430–5(f)(1)
301.7430–5(f)(1)	301.7430–5(g)(1)
301.7430–5(f)(2)	301.7430–5(g)(3)
301.7430–5(f)(3)	301.7430–5(g)(4)
301.7430–5(g)	301.7430–5(h)

Par. 8. Section 301.7430–5 is amended by:

1. Removing the language ''only if—'' at the end of the introductory text in paragraph (a) and adding the language ''(other than by reason of section 7430(c)(4)(E)) only if—'' in its place.

2. Adding new paragraphs (a)(1), (c), (d)(2), (d)(3), (d)(4), (d)(5), (g)(2) and (g)(5).

3. Revising paragraph (b).

4. Revising the third sentence and removing the language ''(c)(3)'' from the fourth sentence in newly-designated paragraph (d)(7) and adding the language ''(d)(7)'' in its place.

5. Revising the paragraph heading for newly-designated paragraph (f)(1) and adding new paragraph (f)(2).

6. Revising newly-designated paragraphs (g)(1) and (g)(3).

7. Removing the language ''Internal Revenue Code'' in the first sentence of newly-designated paragraph (g)(4) in both places.

8. Removing the language ''such'' in the first sentence of newly-designated paragraph (h) and adding the language ''an'' in its place.

9. Removing paragraph (h).

The additions and revisions read as follows:

§ 301.7430–5 Prevailing party.

(a) * * *

(1) At least one issue (other than recovery of administrative costs) remains in dispute as of the date that the Internal Revenue Service takes a position in the administrative proceeding, as described in paragraph (b) of this section;

* * * * *

(b) *Position of the Internal Revenue Service.* The position of the Internal Revenue Service in an administrative proceeding is the position taken by the Internal Revenue Service as of the earlier of—

(1) The date of the receipt by the taxpayer of the notice of the decision of the Internal Revenue Service Office of Appeals; or

(2) The date of the notice of deficiency or any date thereafter.

* * * * *

(c) *Examples.* The provisions of this section may be illustrated by the following examples:

Example 1. Taxpayer A receives a notice of proposed deficiency (30-day letter). A pays the amount of the proposed deficiency and files a claim for refund. A's claim is considered and a notice of proposed claim disallowance is issued by the Area Director. A does not request an Appeals office conference and the Area Director issues a notice of claim disallowance. A then files suit in a United States District Court. A cannot recover reasonable administrative costs because the notice of claim disallowance is not a notice of the decision of the Internal Revenue Service Office of Appeals or a notice of deficiency. Accordingly, the Internal Revenue Service has not taken a position in the administrative proceeding pursuant to section 7430(c)(7)(B).

Example 2. Taxpayer B receives a notice of proposed deficiency (30-day letter). B disputes the proposed adjustments and requests an Appeals office conference. The Appeals office determines that B has no additional tax liability. B requests administrative costs from the date of the 30-day letter. B is not the prevailing party and may not recover administrative costs because all of the proposed adjustments in the case were resolved as of the date that the Internal Revenue Service took a position in the administrative proceeding.

(d) * * *

(2) *Position in courts of appeal.* Whether the United States has won or lost an issue substantially similar to the one in the taxpayer's case in courts of appeal for circuits other than the one to which the taxpayer's case would be appealable should be taken into consideration in determining whether the Internal Revenue Service's position was substantially justified.

(3) *Example.* The provisions of this section are illustrated by the following example:

Example. The Internal Revenue Service, in the conduct of a correspondence examination of taxpayer A's individual income tax return, requests substantiation from A of claimed medical expenses. A does not respond to the request and the Service issues a notice of deficiency. After receiving the notice of deficiency, A presents sufficient information and arguments to convince a revenue agent that the notice of deficiency is incorrect and that A owes no tax. The revenue agent then closes the case showing no deficiency. Although A incurred costs after the issuance of the notice of deficiency, A is unable to recover these costs because, as of the date these costs were incurred, A had not presented relevant information under A's control and relevant legal arguments supporting A's position to the appropriate Internal Revenue Service personnel. Accordingly, the position of the Internal Revenue Service was substantially justified at the time the costs were incurred.

(4) *Included costs.* (i) An award of reasonable administrative costs shall only include costs incurred on or after the earliest of—

(A) The date of the receipt by the taxpayer of the notice of decision from Appeals;

(B) The date of the notice of deficiency; or

(C) The date on which the first letter of proposed deficiency that allows the taxpayer an opportunity for administrative review in the Office of Appeals is sent.

(ii) If the Internal Revenue Service takes a position in an administrative proceeding, as defined in paragraph (b) of this section, and the position is not substantially justified, the taxpayer may be permitted to recover costs incurred before the position was taken, but not before the dates set forth in this paragraph (d)(4).

(5) *Examples.* The provisions of this section may be illustrated by the following examples:

Example 1. Pursuant to section 6672, taxpayer D receives from the Area Director Collection Operations (Collection) a proposed assessment of trust fund taxes (Trust Fund Recovery Penalty). D requests and is granted Appeals office consideration. Appeals considers the issues and decides to uphold Collection's recommended assessment. Appeals notifies D of this decision in writing. Collection then assesses the tax and notice and demand is made. D timely pays the minimum amount required to commence a court proceeding, files a claim for refund, and furnishes the required bond. Collection disallows the claim, but Appeals, on reconsideration, reverses its original position, thus upholding D's position. If Appeals concedes its initial determination was not substantially justified, D may recover administrative costs incurred on or after the mailing of the proposed assessment of trust fund taxes, because the proposed assessment is the first determination letter that allows the taxpayer an opportunity for administrative review in the Internal Revenue Service Office of Appeals.

Example 2. Taxpayer E receives a notice of proposed deficiency (30-day letter). E pays the amount of the proposed deficiency and files a claim for refund. E's claim is considered and a notice of proposed disallowance is issued by the Area Director. E requests and is granted Appeals office consideration. No agreement is reached with Appeals and the Office of Appeals issues a notice of claim disallowance. E does not file suit in a United States District Court but instead contacts the Appeals office to attempt to reverse the decision. E convinces the Appeals officer that the notice of claim disallowance is in error. The Appeals officer then abates the assessment. E may recover reasonable administrative costs if the position taken in the notice of claim disallowance issued by the Office of Appeals was not substantially justified and the other requirements of section 7430 and the regulations thereunder are satisfied. If so, E may recover administrative costs incurred from the mailing date of the 30-day letter because the requirements of paragraph (c)(2) of this section are met. E cannot recover the costs incurred prior to the mailing of the 30-day letter because they were incurred before the administrative proceeding date.

* * * * *

(7) *Presumption.* * * * For purposes of this paragraph (d)(7), the term *applicable published guidance* means final or temporary regulations, revenue rulings, revenue procedures, information releases, notices and announcements published in the Internal Revenue Bulletin and, if issued to the taxpayer, private letter rulings, technical advice memoranda, and determination letters (§ 601.601(d)(2) of this chapter). * * *

* * * * *

(f) *Most significant issue or set of issues presented*—(1) *In general.* * * *

(2) *Example.* The provisions of this section may be illustrated by the following example:

Example. In the purchase of an ongoing business, Taxpayer F obtains from the previous owner of the business a covenant not to compete for a period of five years. On audit of F's individual income tax return for the year in which the business is acquired, the Internal Revenue Service challenges the basis assigned to the covenant not to compete and a deduction taken as a business expense for a seminar attended by F. Both parties agree that the covenant not to compete is amortizable over a period of five years; however, the Internal Revenue Service asserts that the proper basis of the covenant is $2X while F asserts the basis is $4X. The deduction for the seminar attended by F was reported on the return in question in the amount of $7X. The Internal Revenue Service determines that the deduction for the seminar should be disallowed entirely. In the notice of deficiency, the Internal Revenue Service adjusts the amortization deduction to reflect the change to the basis of the covenant not to compete, and disallows the seminar expense. Thus, of the two adjustments determined for the year under audit, the adjustment attributable to the disallowance of the seminar is larger than that attributable to the covenant not to compete. Due to the impact on the next succeeding four years, however, the covenant not to compete adjustment is objectively the most significant issue to both F and the Internal Revenue Service.

* * * * *

(g) *Net worth and size limitations*—(1) *Individuals.* A taxpayer who is a natural person meets the net worth and size limitations of this paragraph if the taxpayer's net worth does not exceed two million dollars. The net worth limitation shall be determined for individuals using the fair market value of the individual's assets as of the administrative proceeding date. For purposes of determining net worth, individuals filing a joint return shall be treated as separate individuals. Thus,

individuals filing a joint return will each be subject to a separate net worth limitation of two million dollars.

(2) *Estates and trusts.* An estate or a trust meets the net worth and size limitations of this paragraph if the taxpayer's net worth does not exceed two million dollars. The net worth of an estate shall be determined using the fair market value of the assets of the estate as of the date of the decedent's death provided the date of death is prior to the date the court proceeding is commenced. The net worth of a trust shall be determined using the fair market value of the assets of the trust as of the last day of the last taxable year involved in the proceeding.

(3) *Others.* (i) A taxpayer that is a partnership, corporation, association, unit of local government, or organization (other than an organization described in paragraph (g)(4) of this section) meets the net worth and size limitations of this paragraph if, as of the administrative proceeding date:

(A) The taxpayer's net worth does not exceed seven million dollars.; and

(B) The taxpayer does not have more than 500 employees.

(ii) A taxpayer who is a natural person and owns an unincorporated business is subject to the net worth and size limitations contained in paragraph (g)(3)(i) of this section if the tax at issue (or any interest, additional amount, addition to tax, or penalty, together with any costs in addition to the tax) relates directly to the business activities of the unincorporated business.

(4) * * *

(5) *Special rule for TEFRA partnership proceedings.* (i) In cases involving partnerships subject to the unified audit and litigation procedures of subchapter C of chapter 63 of the Internal Revenue Code (TEFRA partnership cases), the TEFRA partnership meets the net worth and size limitations requirements of this paragraph (g) if, on the administrative proceeding date—

(A) The partnership's net worth does not exceed seven million dollars; and

(B) The partnership does not have more than 500 employees.

(ii) In addition, each partner requesting fees pursuant to section 7430 must meet the appropriate net worth and size limitations set forth in paragraph (g)(1), (g)(2) or (g)(3) of this section. For example, if a partner is an individual, his or her net worth must not exceed two million dollars as of the administrative proceeding date. If the partner is a corporation, its net worth must not exceed seven million dollars and it must not have more than 500 employees.

Par. 9. Section 301.7430–6 is amended by revising the section heading and adding a new sentence at the end of the paragraph to read as follows:

§ 301.7430–6 Effective/applicability dates.

* * *Sections 301.7430–2(c)(3)(i)(B), (c)(3)(i)(E), (c)(3)(ii)(C), (c)(3)(iii)(C), (c)(5), (c)(7), (e); 301.7430–3(c)(1), (c)(4), (d); 301.7430–4(b)(3)(i), (b)(3)(iii)(B), (b)(3)(iii)(D), (b)(3)(iii)(E), (c)(4), (d); and 301.7430–5(a), (b), (c), (d)(2), (d)(3), (d)(4), (d)(5), (f)(2), (g)(1), (g)(2) and (g)(5), as proposed, apply to costs incurred and services performed as of the date of publication of a Treasury decision adopting these rules as final regulations in the **Federal Register**.

Par. 10. Section 301.7430–7 is amended by adding new paragraph (c)(8) and new *Examples 16* and *17* to paragraph (e) to read as follows:

§ 301.7430–7 Qualified offers.

* * * * *

(c) * * *

(8) *Interest as a contested issue.* To constitute a qualified offer, an offer must specify the offered amount of the taxpayer's liability (determined without regard to interest, unless interest is a contested issue in the proceeding), as provided in paragraphs (c)(1)(ii) and (c)(3) of this section. Therefore, a qualified offer generally may only include an offer to compromise tax, penalties, additions to the tax and additional amounts. Interest may only be included in a qualified offer if interest is a contested issue in the proceeding. For purposes of this section, interest is a contested issue in the proceeding only if the court in which the proceeding could be brought would have jurisdiction to determine the amount of interest due on the underlying tax, penalties, additions to the tax and additional amounts. Examples of proceedings in which interest might be a contested issue include proceedings in which the increased interest rate for large corporate underpayments under section 6621(c) is imposed by the Internal Revenue Service and interest abatement proceedings brought under section 6404. Interest is not a contested issue in the proceeding if the court that would have jurisdiction over the proceeding would not have jurisdiction to determine the amount or rate of interest, regardless of whether the taxpayer attempts to raise interest as an issue in the proceeding. Consequently, interest will not be a contested issue in the vast majority of tax cases because they merely involve the straight forward application of statutory interest under section 6601. Accordingly, in those cases, interest may not be included in the offer.

* * * * *

(e) * * *

Example 16. Qualified offer may not compromise interest unless it is a contested issue. Taxpayer J receives a notice of deficiency making an adjustment resulting in a deficiency in tax of $6,500 plus a penalty of $500. Interest is not a contested issue in the proceeding. Within the qualified offer period, J submits a written offer to settle the case for a deficiency of $1,000, including all taxes, penalties, and interest. The offer states that it is a qualified offer for purposes of section 7430(g) and that it will remain open for acceptance by the IRS for a period of 90 days. Section 7430(g)(2)(B) and paragraph (c)(3) of this section state that the amount of a qualified offer must be without regard to interest unless interest is at issue in the proceeding. Since J's offer attempts to compromise interest, which is not a contested issue in the proceeding, it is not a qualified offer.

Example 17. Qualified offer based on new defense or legal theory. Taxpayers K and L received a statutory notice of deficiency for tax year 2005, a tax year when they were married and filed a joint income tax return. Taxpayer K files a sole petition claiming innocent spouse relief and simultaneously submits an offer purporting to be a qualified offer. The offer states that K is entitled to innocent spouse relief and offers to settle the 2005 deficiency as to K in the amount of $1,000. K's innocent spouse claim was not raised during K and L's audit, nor was it raised during their appeals conference. Additionally, at no time prior to or contemporaneously with submitting the offer did K file with the IRS a Form 8857, Request for Innocent Spouse Relief, or otherwise provide the information specified in § 1.6015–5(a) of this chapter. K's offer is not a qualified offer because K did not file a Form 8857 or otherwise provide substantiation or legal and factual arguments necessary to allow for informed consideration of the merits of the innocent spouse claim as required by paragraph (c)(4) of this section, contemporaneously with the offer or prior to making the offer.

Linda E. Stiff,

Deputy Commissioner for Services and Enforcement.

[FR Doc. E9–27948 Filed 11–24–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE INTERIOR

National Park Service

36 CFR Part 9

RIN 1024–AD78

Minerals Management, Nonfederal Oil and Gas Development

AGENCY: National Park Service, Interior.

ACTION: Advance notice of proposed rulemaking.

SUMMARY: We are seeking comments to assist us in developing proposed a proposed rule to revise regulations governing nonfederal oil and gas development within the boundaries of units of the National Park System. The regulations have been in effect for over thirty years and have not been substantively updated during that period. The National Park Service (NPS) is seeking public input on how to bring exempted operations under the scope of the regulations, and on how to improve resource protection aspects of the regulations while accounting for advances in oil and gas technology and industry practices.

DATES: Comments must be received by January 25, 2010.

ADDRESSES: You may submit comments, identified by RIN 1024–AD78, by any of the following methods:

Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

Fax: 303–987–6792. Attn: 9B Rulemaking Team. Include RIN 1024–AD78 on cover page.

Mail: Department of the Interior; National Park Service; Attention: 9B Rulemaking Team, Geologic Resources Division, National Park Service, P.O. Box 25287, Denver, Colorado 80225–0287.

Instructions: All submissions received must include the agency name and docket number or Regulatory Information Number (RIN) for this rulemaking. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. For detailed instructions on submitting comments and additional information on the rulemaking process, see the ''Public Participation'' heading of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Carol McCoy, Chief, Planning, Evaluation & Permits Branch, Geologic Resources Division, National Park Service, (303) 969–2096; P.O. Box 25287, Denver, Colorado 80225–0287.

SUPPLEMENTARY INFORMATION:

Background

The NPS promulgated regulations at 36 CFR part 9, subpart B (''9B regulations'') governing nonfederal oil and gas development in units of the National Park System in December 1978, with a January 1979 effective date. The regulations control all activities associated with nonfederal oil and gas development inside park boundaries where access is on, across, or through federally owned or controlled lands or waters. As of the drafting of this Advance Notice of Proposed Rulemaking (ANPR), there are 693 nonfederal oil and gas operations that exist in a total of 13 units of the National Park System.

The legal authority for the NPS to promulgate the 9B regulations is derived from the Property Clause (art. IV, section 3, cl. 2) and the Commerce Clause (art. I, section 8, cl. 3) of the United States Constitution, and from various statutes enacted by Congress for the administration of the National Park System. Under sections 1 and 3 of the NPS Organic Act, Congress has given the NPS, through the Secretary of the Interior, the authority to promulgate regulations necessary for the administration and management of the National Park System, which includes the authority to regulate nonfederal oil and gas activities within park boundaries for the purpose of protecting park resources and values. In addition, the enabling statutes for several individual parks contain specific provisions authorizing the NPS to regulate such oil-and gas-related activities.

Not all parks with non-federal oil and gas development occurring within their boundaries have such specific direction within their enabling statutes. Whether or not specified in an individual park enabling act, the Organic Act authority alone is legally sufficient to authorize such regulations.

Non-Federal oil and gas rights are the result of a conveyance of an interest in real property from a grantor other than the United States and may be held by individuals, companies, nonprofit organizations, or state and local governments. Such rights are a form of real property and fall under the protection of the 5th Amendment of the U.S. Constitution (''No person shall be * * * deprived of * * * property, without due process of law; nor shall private property be taken for public use, without just compensation.''). The NPS nonetheless may regulate these rights pursuant to the authority stated above.

Under the existing 9B regulations, an entity seeking to undertake nonfederal oil and gas activities in a park generally must submit and obtain NPS approval of a proposed plan of operations before commencing operations inside a park. A plan is essentially a prospective operator's blueprint of all intended activities within the boundary of the park, including exploration, drilling, production, transportation, and reclamation. The regulations require the operator to provide documentation demonstrating that the operator is exercising a bona fide property right to non-federal oil and gas in the park unit. In a proposed plan, an operator must also identify those specific measures that will be undertaken to protect park resources and values. Finally, an operator must submit a performance bond for the principal purpose of ensuring that funds will be available to reclaim a site should an operator default on its obligations under a plan.

The plan of operations requirement is the primary tool for protecting park resources and values from potential adverse impacts associated with the exercise of nonfederal oil and gas rights inside park boundaries. In reviewing a proposed plan to determine whether the NPS can approve an operation, the NPS undertakes a variety of analyses required by federal statutes, such as the National Environmental Policy Act, the Endangered Species Act, and the National Historic Preservation Act, as well as the standards specified in the 9B regulations. In analyzing proposed plans, the NPS coordinates and consults with a variety of other regulatory agencies at the federal and state level. The NPS also works closely with the operator in order to have park protection concerns addressed through the incorporation of appropriate mitigation measures into plans.

Once the NPS has completed its review and environmental compliance responsibilities and determined that a given proposal meets applicable requirements and approval standards, the NPS will approve an operator's plan of operations. The approved plan authorizes the operator to conduct its operation in a unit of the National Park System.

During the life of an oil and gas operation in a park, park resource managers monitor activities at the operator's site to ensure compliance with the plan. The existing regulations also authorize the NPS to enforce the terms of the plan as may be necessary via such means as suspension of operations or revocation of the plan approval.

It is important to note that while nonfederal oil and gas operations in parks must also comply with state requirements, the 9B regulations differ from most state oil and gas regulations by focusing on the protection of the park's natural and cultural resources and visitors. State regulations may contain some surface use provisions but

mainly focus on conservation of the oil and gas resource, protection of the associated ownership interests, and protection of surface and groundwater.

Information Requested

The NPS is interested in ideas from the public on ways the NPS could improve the existing regulations. The NPS intends to use the input from the public to aid in developing a proposed rulemaking, which will then also be published in the **Federal Register** for comment. In particular, the NPS encourages the public to provide comments and suggestions related to the topics described in the body of this ANPR.

Please indicate which of the topics your comments address and which question you are responding to. If your comments cover issues outside of these topics, please identify them as ''other.''

Regulation of Exempt Operations

The existing regulations, as provided at § 9.30(a), apply where an operator's access is ''on across, or through federally owned or controlled lands or waters.'' As a result, 109 operations (17%) are currently exempt from the regulatory requirements even though the operations occur inside park boundaries. For example, oil and gas rights under privately owned lands just inside the boundary of a park unit, and for which access to those lands is solely maintained without crossing park owned or administered lands, are not subject to these regulations.

In addition, under § 9.33, operations covered by a valid state permit in existence at the time the regulations became effective are also exempt (i.e., 255 operations or 37%). Ultimately, as these operations change hands or state permits expire, the exemption no longer applies and operators must comply with the regulations. However, the rate of turnover and permit expiration has been much slower than anticipated by the original drafters of the 9B regulations, leaving a large number of this class of operations outside the scope of the Service's regulations.

Because of these two exemptions, 53% (364 wells) of the wells in parks today are not subject to the requirements of the regulations to protect park resources and values. These exemptions are not specified in any statute, but were an exercise of the NPS's discretion at the time the regulations were promulgated.

The NPS has identified the following factors to be considered in evaluating options for possibly revising the current approach to existing operations:

A. Existing exempt operations already have established site locations and associated access routes.

B. The operations may or may not have equipment on site that reflects current-day industry standards.

C. Most of the currently exempt operations exist in 3 out of the 13 parks with nonfederal oil and gas operations within their boundaries.

D. Limited park staff and fiscal resources exist in parks for carrying out a multitude of responsibilities, including the administration of the 9B regulatory program.

The NPS is considering requiring all previously exempt operations to comply with the 9B regulations. The following ideas for how such operations could be brought under the regulations have been discussed:

Option #1—Require presently exempt operators to submit plans of operations, comply with operating standards, and provide financial assurance by a set date.

Option #2—Same as Option #1, however, the submittal of a plan of operations, compliance with operating standards, and financial assurance would be under a phased timeframe.

Option #3—Instead of requiring the submittal of a plan of operations for approval, require operators with exempt operations to verify that their operations are being conducted in a manner that fulfills a defined set of operating standards which would be enforceable by park staff. Under this option, operators will also be required to provide documentation of the legal basis for their respective oil and gas activities within the park unit, and submit financial assurance.

Questions:

1. Taking into account the factors identified above, do any of the option(s) above have greater merit for bringing previously exempt operations under the 9B regulations, and if so, why?

2. Do you have another option that you would like to suggest?

Directional Drilling

Under the existing regulations at § 9.32(e), if an operator locates surface facilities outside the park and proposes to directionally drill from those surface facilities to reach its non-Federal oil and gas rights inside the park, the operator can apply for an exemption to the 9B regulatory requirements. This provision provides an incentive to operators to locate their surface facilities outside the park and thereby greatly reduce impacts to park resources and values.

The scope of § 9.32(e) addresses only those activities that are occurring within the external boundaries of a park; that is, the downhole operations that pass through Federal subsurface estate within the boundary of a park. Surface activities associated with directional drilling operations outside the park are not within the scope of the jurisdiction provided to the NPS under § 9.32(e), or under the 9B regulations in general. If granted an exemption, operators do not need to submit a proposed plan of operation or a bond covering the activities occurring in the park (i.e., the downhole activities) to the NPS for approval. Essentially, under this provision of the regulations if an operator meets the requirements, the NPS must determine that the 9B regulations do not apply to the operator's activities.

The Service's goal relative to non-Federal oil and gas operations is to protect parks by eliminating direct impacts to park resources and values. When an operator takes advantage of the directional drilling provision of the regulations and locates its surface facilities outside park boundaries, the operator has significantly reduced direct impacts to park resources and values. By so doing, the operator has deployed a major park protection mitigation measure. While potential indirect impacts of sight, sound, artificial light, odor, and spills may exist from drilling operations outside a park, they are usually much reduced relative to surface operations in a park. Such impacts are diminished even further once the operation progresses from the drilling to production phase.

In evaluating options for revising this section of the existing regulation, the NPS has identified the following factors:

A. The NPS wants to ensure that it retain incentives for operators to locate their surface facilities outside park boundaries, and, if possible, even enhance those incentives. The NPS realizes that the primary incentive for operators to locate facilities outside park boundaries is the ability to save time and money.

B. The NPS wants to ensure the protection of park resources and values from indirect effects potentially resulting from operations that are located outside park boundaries.

The NPS is evaluating how to address directional drilling operations for the proposed rulemaking. The following ideas have been discussed:

Option #1: Retain the scope of the existing regulatory provision governing directional drilling operations.

Option #2: Expand the regulation to cover all activities associated with directional drilling operations which may affect park resources and values, both the downhole operations in the

park and the surface location outside the park.

Option #3: Exempt directional drilling operations entirely from the scope of the 9B regulations.

Questions:

3. Taking into account the factors identified above, what option(s) do you recommend for addressing directional drilling operations under the 9B regulations?

4. Are there other options for addressing the potential indirect impacts from directional drilling operations that retain the incentive for operators to locate their well pad and surface access routes outside the boundary of a park?

Operating Standards

The existing regulations contain requirements that operators must meet in conducting their operations, such as using technologically feasible least damaging methods in their operations; locating facilities away from water courses, structures, and visitor and administrative developed areas; and maintaining sites in a safe and workmanlike manner. These operating standards are found throughout various sections of the existing regulations.

The NPS realizes that the formulation of the existing standards is 30 years old. The NPS is aware that in the intervening years other agencies and industry groups have developed effective standards (e.g., API and AGA Standards and Practices, BLM Gold Book, State operating standards) that the NPS could incorporate into its regulations.

Question:

5. Do you know of examples of effective, enforceable operating standards that the NPS should consider when it develops its own comprehensive list?

Financial Assurance

The existing 9B regulations require that an operator file a performance bond, or other acceptable method of financial assurance, for all types of nonfederal oil and gas operations and all phases of the operation(s). The objective of requiring a bond is to ensure that in the event an operator becomes insolvent or defaults on his/her obligations under an approved plan of operations, adequate funds will be available for the NPS to have a third party carry out the plugging and reclamation requirements. The existing regulations place a bonding cap of up to $200,000 per operator, per NPS unit. Therefore, if one operator has multiple wells in a park unit, the NPS can only require up to $200,000 financial assurance from that one operator.

The NPS is considering eliminating the bonding cap, which was established in 1978, and replacing it with a variable amount of financial assurance equal to the reasonable estimated cost of reclamation and liability today.

Questions:

6. Are there alternatives to the existing acceptable financial assurance instruments (e.g., performance bonds, irrevocable letters of credit, and cash) that will protect the taxpayer in the event an operator defaults on its responsibilities under its approved plan of operations?

7. If so, please describe the advantages or disadvantages of one type of instrument over another.

Access Fees

The current 9B regulations at § 9.50(a)(1) authorize the park to impose a registration fee for vehicles used in connection with oil and gas operations that are using existing roads administered by the NPS. While this fee provision applies to the use of existing roads administered by the NPS, it does not apply to an operator's construction of new roads across federally owned lands to reach their non-Federal oil and gas rights.

As a result, the NPS is considering eliminating the current registration fee and replacing it with an access fee. This fee would compensate the United States for an operator's access across federally owned surface estate in order to reach the operator's non-Federal oil and gas rights, be it on an existing road administered by the NPS, or across undisturbed federally owned lands. Because the operator generally has only a right to reasonably use the federally owned surface estate immediately above the non-federal oil and gas right, this fee would not apply to access within this area. It would also bring NPS practice with respect to access fees in line with what other agencies and private land owners are doing.

Both the BLM and USFS charge fees for access where the operator has no pre-existing right to cross Federal lands. Similarly, adjacent private land owners also require operators to pay a fee to cross their land to reach the operator's oil and gas rights. Such fees are generally recognized today by the oil and gas industry as a cost of doing business.

Questions:

8. Should the NPS calculate fees for the privilege of access across federally owned lands, and how?

9. Should the NPS use an appraisal, available data from other Federal agencies that calculate and compile fair market land values (such as the National Agricultural Statistics Service), or other means to determine fair compensation for such use?

Assessments for Non-Compliance

The Superintendent's current enforcement mechanisms for operations under an approved plan are limited to suspension or revocation of the plan. If an operator fails to comply with a suspension or revocation order, the NPS must request that the Department of Justice file a civil action in Federal court seeking an injunction or restraining order to halt operations. The Superintendent has no practical method for dealing with minor regulatory infractions that do not rise to the level of suspension, revocation, or judicial intervention. Examples of minor infractions include accumulation of oilfield debris onsite, slow response to small contained spills, and lack of maintenance on access roads.

The NPS is considering revising the regulations to allow the use of administrative assessments to address minor violations of the regulations or a term or condition of an approved permit. Whenever the NPS learns of a compliance issue associated with an operation in a park, the Service's first approach is always to work with operators to have them rectify the situation. If this approach is not successful, then the NPS issues a formal notice of non-compliance to the operator. The NPS is now considering authorizing park staff to issue administrative assessments upon the failure of an operator to comply with a notice of non-compliance. The assessment would be a monetary amount that an operator must pay to the park, based on an estimation of the cost of damages to park resources due to the operator's violation of a term or condition of an approved permit. An example of such an approach is found under BLM regulations at 43 CFR 3163.1, which gives BLM authority to assess a penalty of $500 per day for major violations, and $250 for minor violations.

Question:

10. Are there other more effective means beyond the imposition of an administrative assessment that the NPS can use to address minor infractions and to provide operators an incentive to comply with the regulations?

NPS seeks responses to the above noted questions from the public. Additionally, the NPS seeks any relevant comments to other issues regarding these regulations. Where options are presented, the NPS especially seeks comments as to which ones may be considered the most

effective and efficient approach to managing nonfederal oil and gas development inside park boundaries. After analyzing the comments received from this notice, the NPS intends to determine how to proceed with a proposed rulemaking.

Additional information about the NPS Non-Federal Oil and Gas Program is available at *http://www.nature.nps.gov/geology/oil_and_gas/index.cfm.*

Public Participation

All submissions received must include the agency name and RIN 1024–AD78 for this notice. Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

At this time, the NPS is not soliciting comments on environmental impacts. The NPS will do so as part of its environmental compliance under the National Environmental Policy Act.

Dated: October 2, 2009.

Will Shafroth,

Acting Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. E9–28248 Filed 11–24–09; 8:45 am]

BILLING CODE 4310–EH–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 86 and 600

[EPA–HQ–OAR–2005–0169; FRL–8982–2]

RIN 2060–A036

Fuel Economy Regulations for Automobiles: Technical Amendments and Corrections

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to amend and correct portions of its existing fuel economy regulations. There are three reasons for this action. First, some minor corrections and amendments are needed to EPA's December 27, 2006 final rule for fuel economy labeling requirements for cars and light trucks. Second, the Department of Transportation finalized new average fuel economy standards for 2008–2011 light trucks on April 6, 2006. Third, on March 30, 2009, NHTSA revised CAFE requirements for 2011 trucks and finalized new average fuel economy (CAFE) standards for 2011 passenger automobiles. In order for DOT to administer these new standards, EPA must make some conforming changes to its regulations. In addition, some minor conforming changes to EPA's regulations are needed for two other separate statutory and regulatory actions. None of the above amendments and corrections would have any direct impact on human health and the environment, but they would allow for the more effective administration of existing regulations. In the ''Rules and Regulations'' section of this **Federal Register,** we published the above actions as a direct final rule without a prior proposed rule. If we receive no adverse comment, we will not take further action on this proposed rule. If we receive adverse comment, we will withdraw the portions of the final rule receiving such comment and those portions will not take effect. We will address all public comments in a subsequent final rule based on this proposed rule. We will not institute a second comment period on this action. Any parties interested in commenting must do so at this time.

DATES: Written comments must be received by December 28, 2009.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–OAR–2005–0169, by one of the following methods:

- *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.
- *Fax:* (202) 566–1741.
- *Mail:* Environmental Protection Agency, EPA Docket Center (EPA/DC), Air and Radiation Docket, Mail Code 6102T, 1200 Pennsylvania Avenue, NW., Washington, DC 20460, Attention Docket ID No. EPA–HQ–OAR–2005–0169. In addition, please mail a copy of your comments on the information collection provisions to the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), *Attn:* Desk Officer for EPA, 725 17th St., NW., Washington, DC 20503.''
- *Hand Delivery:* Docket Center, (EPA/DC) EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC, Attention Docket ID No. OAR–2005–0169. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–HQ–OAR–2005–0169. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.* For additional instructions on submitting comments, go to Section VII of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: All documents in the docket are listed in the www.regulations.gov index. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in www.regulations.gov or in hard copy at the EPA Docket Center, EPA/DC, EPA West, Room B102, 1301 Constitution Ave., NW., Washington, DC. This Docket Facility is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The EPA Docket Center telephone number is (202) 566–1742. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number

for the Public Reading Room is (202) 566–1744.

FOR FURTHER INFORMATION CONTACT: Christine Mikolajczyk, Office of Transportation and Air Quality, Compliance and Innovative Strategies Division, Environmental Protection Agency, 2000 Traverwood Drive, Ann Arbor, MI 48105; *telephone number:* (734) 214–4403; *fax number:* (734) 214–4053; *e-mail address: mikolajczyk.christine@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Why Is EPA Issuing This Proposed Rule?

This document proposes to take action on minor amendments and corrections to EPA's existing emission and fuel economy regulations, located at 40 CFR Part 86 and Part 600. This proposal clarifies that special test procedures, calculation methods and label formats may be used for fuel economy labels and CAFE calculations of advanced technology vehicles. Advanced technology vehicles include, but are not limited to electric vehicles, fuel cell vehicles, plug-in hybrid vehicles and vehicles equipped with hydrogen-fueled internal combustion engines. This proposal also includes technical amendments to the fuel economy label regulations, including changes to the minivan definition, van definition, interior volume measurements of passenger vehicles, and special purpose class of vehicles. Today's action also proposes to correct some typographical errors and make other minor modifications to ensure accurate interpretation of the regulations. The changes to the EPA CAFE regulations are being proposed to conform to the NHTSA regulations, and include adding new reporting provisions that would enable EPA to provide NHTSA with the data it needs to determine compliance with the 2008–2011 CAFE standards for passenger automobiles and trucks.

In addition, two conforming changes are being proposed to align the EPA CAFE regulations with a 2007 Energy Independence and Security Act (EISA) amendment extending the alternative fuel vehicle CAFE credits to 2019, and to align the EPA CAFE regulations with a previous NHTSA rulemaking which eliminated the requirement to report separate CAFE values for domestic and imported trucks.

We have published a direct final rule which amends the Fuel Economy and Emission Regulation requirements in the ''Rules and Regulations'' section of this **Federal Register** because we view this as a noncontroversial action and anticipate no adverse comment. We have explained our reasons for this action in the preamble to the direct final rule. This proposal incorporates by reference all of the reasoning, explanation, and regulatory text for this proposal. Please refer to the direct final rule that is located in the ''Rules and Regulations'' section of this **Federal Register** publication. The direct final rule will be effective on January 25, 2010 unless we receive adverse comment by December 28, 2009.

If we receive no adverse comment, we will not take further action on this proposed rule. If we receive adverse comment, we will withdraw the direct final rule and it will not take effect. We would address all public comments in any subsequent final rule based on this proposed rule. If we receive adverse comment on a distinct provision of this rulemaking, we will publish a withdrawal in the **Federal Register** indicating which provisions we are withdrawing. The provisions that are not withdrawn will become effective on the date set out above, notwithstanding adverse comment on any other provision.

We do not intend to institute a second comment period on this action. Any parties interested in commenting must do so at this time. For further information, please see the information provided in the **ADDRESSES** section of this document.

II. Does This Action Apply to Me?

This action applies to manufacturers of new passenger cars and light trucks, including medium-duty passenger vehicles.[1] Regulated categories and entities include:

Category	NAICS codes [a]	Examples of potentially regulated entities
Industry	336111, 336112	Motor vehicle manufacturers.
Industry	811112, 811198, 541514.	Commercial Importers of Vehicles and Vehicle Components.

[a] North American Industry Classification System (NAICS).

III. What Should I Consider as I Prepare My Comments for EPA?

A. Submitting CBI

Do not submit this information to EPA through *http://www.regulations.gov* or e-mail. Clearly mark the part or all of the information that you claim to be CBI. For CBI information in a disk or CD ROM that you mail to EPA, mark the outside of the disk or CD ROM as CBI and then identify electronically within the disk or CD ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

B. Tips for Preparing Your Comments

When submitting comments, remember to:

- Identify the rulemaking by docket number and other identifying information (subject heading, **Federal Register** date and page number).
- Follow directions—The agency may ask you to respond to specific questions or organize comments by referencing a Code of Federal Regulations (CFR) part or section number.
- Explain why you agree or disagree; suggest alternatives and substitute language for your requested changes.
- Describe any assumptions and provide any technical information and/or data that you used.
- If you estimate potential costs or burdens, explain how you arrived at your estimate in sufficient detail to allow for it to be reproduced.
- Provide specific examples to illustrate your concerns, and suggest alternatives.
- Explain your views as clearly as possible, avoiding the use of profanity or personal threats.

[1] ''Passenger car,'' ''light truck,'' and ''medium-duty passenger vehicle'' are defined in 40 CFR 600.002–08. Generally, the term ''light truck'' means a pick-up truck, sport-utility vehicle, or minivan of up to 8,500 lbs gross vehicle weight rating, and ''medium-duty passenger vehicle'' means a sport-utility vehicle or passenger van from 8,500 to 10,000 lbs gross vehicle weight rating. Medium-duty passenger vehicles do not include pick-up trucks.

• Make sure to submit your comments by the comment period deadline identified.

C. Docket Copying Costs

You may be charged a reasonable fee for photocopying docket materials, as provided in 40 CFR Part 2.

IV. What Are the Administrative Requirements of This Proposed Rule?

A. Executive Order 12866: Regulatory Planning and Review

Under Executive Order (EO) 12866 (58 FR 51735, October 4, 1993), this action is a ''significant regulatory action'' because it has the potential to raise novel legal or policy issues. Accordingly, EPA submitted this action to the Office of Management and Budget (OMB) for review under EO 12866 and any changes made in response to OMB recommendations have been documented in the docket for this action.

B. Paperwork Reduction Act

This action does not impose any substantive new information collection burden under the provisions of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.* for the changes to the minivan definition, the requirements to include medium-duty passenger vehicles (MDPVs) in CAFE calculations, the additional CAFE footprint reporting requirements, or any other certification, fuel economy labeling and CAFE changes contained in this direct final rule. Burden is defined at 5 CFR 1320.3(b). Note that the data submittal requirements to include MDPVs in 2011 and later CAFE data and to report footprint information for reformed CAFE have already been established by NHTSA in its final rules for new passenger automobile and truck CAFE standards,[2] and the accompanying NHTSA ICR (OMB 2127–00019).

The revision to the minivan definition in today's action has a de minimis impact; however, if anything, the revision is expected to reduce manufacturers' information collection burden. For example, manufacturers were previously required to calculate and report to EPA the total interior volume of each style of minivan and full-sized van to determine whether the van was at or below 180 cubic feet in interior volume. Today's action eliminates the 180 cubic feet interior volume specification from the minivan definition, thus slightly reducing manufacturers' reporting and recordkeeping burden.

Regarding the MDPV requirements for 2011 and later CAFE, the following statement was made in EPA's Information Collection Request (ICR) for the 2008 Fuel Economy Labeling rule (71 FR 77872, December 27, 2006):

> Also beginning with model year 2011, medium-duty passenger vehicles (MDPVs) will be included in the labeling program. MDPVs essentially include SUVs and passenger vans that are between 8,500 and 10,000 lbs. ''GVWR'' (gross vehicle weight ratings). This change is congruent with the National Highway Traffic Safety Administration's (NHTSA's) expansion of the Corporate Average Fuel Economy (CAFE) program to include MDPVs beginning the same model year (71 FR 17565; April 6, 2006). Because more vehicle testing is required under CAFE than under labeling, the impacts of increased testing for MDPVs will be in the ICR for the rule to implement EPA's role in the CAFE program, which will be finalized in a separate action, in time for model year 2011, *or in the appropriate fuel economy program information collection renewal.*[3] (Emphasis added.)

Thus, in the 2008 FE Label rulemaking EPA indicated we would either include the MDPV information collection requirements in an ICR for today's rulemaking or include it in the EPA's emission and fuel economy ICR renewal request to OMB (which occurs every three years). EPA elected the latter approach, and has included the additional MDPV testing, reporting and recordkeeping burden for fuel economy labeling and CAFE purposes in ICR 0783.54 (OMB 2060–0320), the renewal of the Motor Vehicle Emissions and Fuel Economy Compliance ICR which was submitted to OMB for review on October 23, 2008. Since EPA MDPV ICR requirements have been previously submitted to OMB and because they were also included in NHTSA's ICR (OMB 2127–00019), they are not included in today's action.

Regarding footprint information, the reporting requirements for footprint information and related data were not specifically addressed in the ICR for EPA's Fuel Economy Labeling Rule (ICR 0783.51, OMB 2060–0104) because any change in burden was considered to be negligible and within the margin of error for the information technology estimate in that ICR; and because the information collection burden was partially included in the NHTSA ICR (OMB 2127–00019). The information collection burden for footprint information is currently included in EPA's ICR 0783.54 (OMB 2060–0320), the renewal of the Motor Vehicle Emissions and Fuel Economy Compliance ICR, which was submitted to OMB for review on October 23, 2008.

Additionally, the footprint information reported to EPA for final CAFE reports (wheelbase, track width and sales information) is essentially the same information which will have been previously reported to NHTSA when manufacturers submitted their preliminary CAFE (PCAFE) and mid-model year CAFE reports to NHTSA. [Note that manufacturers are not required to submit PCAFE or mid-model year reports to EPA.] Reporting footprint information to EPA with final sales data is expected to be a minimal burden because manufacturers will have already established company business practices to track footprint and sales information for NHTSA and because manufacturers have been reporting CAFE final sales information to EPA since 1978.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) generally requires an agency to prepare a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements under the Administrative Procedure Act or any other statute unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small organizations, and small governmental jurisdictions.

For purposes of assessing the impacts of this proposed rule on small entities, a small entity is defined as: (1) A small business as defined by the Small Business Administration (SBA) regulations at 13 CFR 121.201; (2) a small governmental jurisdiction that is a government of a city, county, town, school district or special district with a population of less than 50,000; and (3) a small organization that is any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.

After considering the economic impacts of this action on small entities, I certify that this action will not have a significant economic impact on a substantial number of small entities. Based on Small Business Administration size standards, small businesses in the automobile manufacturing industry are defined as those having less than 1000 employees per firm. Additionally, they are identified using the North America Industrial Classification System (NAICS) by NAICS code 336111. Out of a total of approximately 80 automotive manufacturers subject to this action,

[2] *See* 49 CFR 537.7(c)(4), as amended by 71 FR 17678, April 6, 2006 and 74 FR 14196, March 30, 2009.

[3] *See* 71 FR 77872, December 27, 2006.

EPA estimates that approximately 10 of these could be classified as small entities based on SBA size standards. No new burden for fuel economy labeling is being imposed by this action. The new reporting requirement for the reform CAFE footprint data has already been established by NHTSA in its final rule for new truck CAFE standards,[4] and thus this action imposes no additional burden.

D. Unfunded Mandates Reform Act

This rule does not contain a Federal mandate that may result in expenditures of $100 million or more for State, local, and tribal governments, in the aggregate, or the private sector in any one year. This action simply makes minor amendments, clarifications, and corrections that will allow for the more effective administration of existing regulations. Thus, this rule is not subject to the requirements of sections 202 or 205 of the Unfunded Mandates Reform Act. This rule is also not subject to the requirements of section 203 of the Unfunded Mandates Reform Act because it contains no regulatory requirements that might significantly or uniquely affect small governments. This action imposes no enforceable duty on any State, local or tribal governments.

E. Executive Order 13132: Federalism

Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999), requires EPA to develop an accountable process to ensure ''meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications.'' ''Policies that have federalism implications'' is defined in the Executive Order to include regulations that have ''substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.''

This proposed rule does not have federalism implications. It will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132. Thus, Executive Order 13132 does not apply to this rule.

F. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This action does not have tribal implications, as specified in Executive Order 13175 (65 FR 67249, November 9, 2000). The impacts of this proposed rule are limited to the regulated entities: the automotive manufacturing industry. Thus, Executive Order 13175 does not apply to this action. EPA specifically solicits additional comment on this proposed action from tribal officials.

G. EO 13045 ''Protection of Children From Environmental Health Risks and Safety Risks''

Executive Order 13045: ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997) applies to any rule that: (1) Is determined to be ''economically significant'' as defined under Executive Order 12866, and (2) concerns an environmental health or safety risk that EPA has reason to believe may have a disproportionate effect on children. If the regulatory action meets both criteria, the Agency must evaluate the environmental health or safety effects of the planned rule on children, and explain why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the Agency.

EPA interprets EO 13045 (62 FR 19885, April 23, 1997) as applying only to those regulatory actions that concern health or safety risks, such that the analysis required under section 5–501 of the EO has the potential to influence the regulation. This action is not subject to EO 13045 because it does not establish an environmental standard intended to mitigate health or safety risks.

H. Executive Order 13211 (Energy Effects)

This rule is not a ''significant energy action'' as defined in Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001) because it is not likely to have a significant adverse effect on the supply, distribution, or use of energy. Further, we have concluded that this rule is not likely to have any adverse energy effects.

I. National Technology Transfer Advancement Act

Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (''NTTAA''), Public Law 104–113, 12(d) (15 U.S.C. 272 note) directs EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

This action does not involve technical standards. Therefore, EPA did not consider the use of any voluntary consensus standards.

J. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

Executive Order (EO) 12898 (59 FR 7629, Feb. 16, 1994) establishes federal executive policy on environmental justice. Its main provision directs federal agencies, to the greatest extent practicable and permitted by law, to make environmental justice part of their mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of their programs, policies, and activities on minority populations and low-income populations in the United States.

EPA has determined that this proposed rule will not have disproportionately high and adverse human health or environmental effects on minority or low-income populations because it does not affect the level of protection provided to human health or the environment. This action simply makes minor amendments, clarifications, and corrections that will allow for the more effective administration of existing regulations without impacting the current fuel economy and emission control measures.

V. Statutory Provisions and Legal Authority

Statutory authority for the fuel economy labeling program and for corporate average fuel economy can be found in the Clean Air Act, 42 U.S.C. 7401–7671q, 49 U.S.C. 32901–32919, and Public Law 109–58. Statutory authority for vehicle emission control program is found in the Clean Air Act, as amended 42 U.S.C. 7401 *et seq.,* in particular sections 202 and 206 of the Act, 42 U.S.C. 7521 and 7525.

List of Subjects

40 CFR Part 86

Administrative practice and procedure, Confidential business

[4] *See* 49 CFR 537.7(c)(4), as amended by 71 FR 17678, Apr. 6, 2006.

information, Incorporation by reference, Labeling, Motor vehicle pollution, Reporting and recordkeeping requirements.

40 CFR Part 600

Administrative practice and procedure, Electric power, Fuel economy, Incorporation by reference, Labeling, Reporting and recordkeeping.

Dated: November 9, 2009.

Lisa P. Jackson,

Administrator.

[FR Doc. E9–27943 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2008–0020; Internal Agency Docket No. FEMA–B–1080]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Proposed rule.

SUMMARY: Comments are requested on the proposed Base (1% annual-chance) Flood Elevations (BFEs) and proposed BFE modifications for the communities listed in the table below. The purpose of this notice is to seek general information and comment regarding the proposed regulatory flood elevations for the reach described by the downstream and upstream locations in the table below. The BFEs and modified BFEs are a part of the floodplain management measures that the community is required either to adopt or show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, these elevations, once finalized, will be used by insurance agents, and others to calculate appropriate flood insurance premium rates for new buildings and the contents in those buildings.

DATES: Comments are to be submitted on or before February 23, 2010.

ADDRESSES: The corresponding preliminary Flood Insurance Rate Map (FIRM) for the proposed BFEs for each community is available for inspection at the community's map repository. The respective addresses are listed in the table below.

You may submit comments, identified by Docket No. FEMA–B–1080, to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) proposes to make determinations of BFEs and modified BFEs for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed BFEs and modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities. These proposed elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

Comments on any aspect of the Flood Insurance Study and FIRM, other than the proposed BFEs, will be considered. A letter acknowledging receipt of any comments will not be sent.

National Environmental Policy Act. This proposed rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Executive Order 12866, Regulatory Planning and Review. This proposed rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866, as amended.

Executive Order 13132, Federalism. This proposed rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This proposed rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR part 67 is proposed to be amended as follows:

PART 67—[AMENDED]

1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.4 [Amended]

2. The tables published under the authority of § 67.4 are proposed to be amended as follows:

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Cherokee County, Alabama, and Incorporated Areas				
Coosa River	Approximately 1,080 feet downstream of State Highway 35.	None	+575	Town of Gaylesville.
	Approximately 2.0 miles upstream of State Highway 35.	None	+579	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Weiss Lake	Entire shoreline of Weiss Lake	None	+573	Town of Cedar Bluff.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Town of Cedar Bluff
Maps are available for inspection at 3420 Spring Street, Cedar Bluff, AL 35959.

Town of Gaylesville
Maps are available for inspection at 4740 Main Street, Gaylesville, AL 35973.

Appling County, Georgia, and Incorporated Areas

Sweet Water Creek	Approximately 400 feet upstream of Satilla Church Road.	None	+166	City of Baxley.
	Approximately 0.97 mile upstream of Satilla Church Road.	None	+169	
Tributary B	Approximately 150 feet upstream of confluence with Sweet Water Creek.	None	+169	City of Baxley.
	Approximately 150 feet downstream of State Highway 15.	None	+194	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Baxley
Maps are available for inspection at 282 East Parker Street, Baxley, GA 31513.

Burke County, Georgia, and Incorporated Areas

McIntosh Creek	Approximately 260 feet downstream of State Highway 121.	None	+210	City of Waynesboro.
	Approximately 420 feet upstream of Highway 121	None	+213	
Savannah River	Approximately 1.54 mile downstream of confluence with McBean Creek.	None	+107	Unincorporated Areas of Burke County.
	Approximately 6.84 miles upstream of confluence with McBean Creek.	+115	+112	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Waynesboro
Maps are available for inspection at 628 Myrick Street, Waynesboro, GA 30830.

Unincorporated Areas of Burke County
Maps are available for inspection at 602 North Liberty Street, Waynesboro, GA 30830.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Effingham County, Georgia, and Incorporated Areas				
Dasher Creek	Approximately 0.51 mile upstream of North Carolina Avenue.	None	+47	City of Rincon, Unincorporated Areas of Effingham County.
	Approximately 2.14 miles upstream of McCall Road	None	+62	
Sweigoffer Creek	Approximately 90 feet upstream of Seaboard Coast Line Railroad.	+43	+39	Unincorporated Areas of Effingham County.
	Approximately 0.91 mile upstream of Georgia Southern Railway.	None	+57	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Rincon

Maps are available for inspection at 302 South Columbia Avenue, Rincon, GA 31326.

Unincorporated Areas of Effingham County

Maps are available for inspection at 601 North Laurel Street, Springfield, GA 31329.

Emanuel County, Georgia, and Incorporated Areas				
Crooked Creek	Approximately 200 feet downstream of Old Nunez Road.	None	+200	Unincorporated Areas of Emanuel County.
	Approximately 1,400 feet downstream of Meadowlake Parkway.	None	+241	
Holloway Pond/Yam Grandy Creek Tributary.	Entire shoreline of Holloway Pond	None	+251	Unincorporated Areas of Emanuel County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Emanuel County

Maps are available for inspection at 101 North Main Street, Swainsboro, GA 30401.

Tattnall County, Georgia, and Incorporated Areas				
Ohoopee River	At Georgia Central Railroad	None	+109	Unincorporated Areas of Tattnall County.
	Approximately 2.66 miles upstream of State Highway 292/Sixth Avenue.	None	+118	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

ADDRESSES

Unincorporated Areas of Tattnall County

Maps are available for inspection at the County Courthouse, 108 Brazwell Street, Reidsville, GA 30453.

Calhoun County, Illinois, and Incorporated Areas

Illinois River	Approximately Springfield Street extended (Calhoun/Jersey county boundary approximately river mile 1.2).	+440	+439	Unincorporated Areas of Calhoun County, Village of Hardin, Village of Kampsville.
	Approximately 1,500 feet downstream of Bee Creek Road extended (Calhoun/Pike county boundary approximately river mile 38.9).	+442	+441	
Mississippi River	Approximately Springfield Street extended (Calhoun/Jersey county boundary approximately river mile 219.15).	+440	+439	Unincorporated Areas of Calhoun County, Village of Hamburg.
	Approximately 1.0 mile upstream of Lock and Dam No. 24 (approximately river mile 274.43).	+458	+457	
Pohlman Creek	Approximately 75 feet downstream of Main Street in the Village of Brussels, IL.	None	+454	Unincorporated Areas of Calhoun County.
	Approximately 20 feet upstream of Main Street in the Village of Brussels, IL.	None	+456	

* National Geodetic Vertical Datum.

+ North American Vertical Datum.

Depth in feet above ground.

^ Mean Sea Level, rounded to the nearest 0.1 meter.

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Calhoun County

Maps are available for inspection at the Calhoun County Courthouse, 102 South County Road, Hardin, IL 62047.

Village of Hamburg

Maps are available for inspection at the Village Hall, 211 Washington Street, Hamburg, IL 62045.

Village of Hardin

Maps are available for inspection at the Village Hall, 100 Main Street, Hardin, IL 62047.

Village of Kampsville

Maps are available for inspection at the Village Hall, 210 Oak Street, Kampsville, IL 62053.

Vanderburgh County, Indiana, and Incorporated Areas

Bluegrass Creek	At Heckel Road	+385	+384	Unincorporated Areas of Vanderburgh County.
	Approximately 1.5 mile upstream of Boonville-New Harmony Road.	None	+387	
Crawford-Brandeis Ditch	Upstream side of Norfolk Southern Railroad	+385	+386	Unincorporated Areas of Vanderburgh County.
Dry Run Lower	At the confluence with Pigeon Creek	+379	+378	City of Evansville.
	Approximately 100 feet upstream of 1st Avenue	None	+381	
Dry Run Upper	At the confluence with Dry Run Lower	None	+378	City of Evansville.
	Approximately 0.3 mile upstream of Cross Gate Drive	None	+407	
Greenbriar Hills Tributary	Approximately 600 feet upstream of the confluence with Little Pigeon Creek.	None	+381	Unincorporated Areas of Vanderburgh County.
	Approximately 800 feet upstream of Greendale Drive	None	+413	
Harper Ditch	At the confluence with Hirsch Ditch	None	+381	City of Evansville.
	At the confluence with Pigeon Creek	+382	+381	
Hirsch Ditch	At the confluence with Harper Ditch	None	+381	Unincorporated Areas of Vanderburgh County, City of Evansville.
	At the confluence of Crawford-Brandeis, Lockwood, and Stockfleith Ditches.	+385	+386	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Little Pigeon Creek	At the confluence with Pigeon Creek	None	+378	Unincorporated Areas of Vanderburgh County, City of Evansville.
	Approximately 2,250 feet upstream of the confluence with Pigeon Creek.	None	+378	
Lockwood Ditch	At the confluence of Crawford-Brandeis, Stockfleith, and Hirsch Ditches.	+385	+386	Unincorporated Areas of Vanderburgh County.
	At county boundary	+385	+387	
Mill Road Tributary	At the confluence with Little Pigeon Creek	None	+378	City of Evansville.
	Approximately 725 feet upstream of Inwood Drive	None	+407	
Nurenbern Ditch	At the confluence with Lockwood Ditch	+385	+387	Unincorporated Areas of Vanderburgh County.
	At State Route 66	None	+389	
Ohio River	Approximately 7.3 miles upstream of Vanderburgh/Posey county boundary (extended).	+375	+374	Unincorporated Areas of Vanderburgh County, City of Evansville.
	Approximately 1.5 miles downstream of Vanderburgh/Warrick county boundary (extended).	+380	+381	
Pigeon Creek	Approximately 1,200 feet downstream of North Fulton Avenue.	+379	+378	Unincorporated Areas of Vanderburgh County, City of Evansville.
	At Green River Road	+384	+383	
Schlensker Ditch	At Green River Road	+385	+389	Unincorporated Areas of Vanderburgh County.
	Approximately 2,000 feet upstream of Browning Road	None	+441	
Schlensker Ditch Tributary	At the confluence with Schlensker Ditch	None	+405	Unincorporated Areas of Vanderburgh County.
	Approximately 0.5 mile upstream of the confluence with Schlensker Ditch.	None	+409	
Stockfleith Ditch	At the confluence with Hirsch, Lockwood, and Crawford-Brandeis Ditches.	+385	+386	Unincorporated Areas of Vanderburgh County.
	At State Route 66	None	+388	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Evansville

Maps are available for inspection at the Civic Center Complex, Building Commission Department, 1 Northwest Martin Luther King Jr. Boulevard, Room 310, Evansville, IN 47708.

Unincorporated Areas of Vanderburgh County

Maps are available for inspection at the Civic Center Complex, Building Commission Department, 1 Northwest Martin Luther King Jr. Boulevard, Room 310, Evansville, IN 47708.

Barren County, Kentucky, and Incorporated Areas

Barren River Lake	Entire shoreline	None	+590	Unincorporated Areas of Barren County.
Barren River Tributary 32.1 (Backwater effects from Barren River Lake).	From the confluence with Barren River Lake to approximately 0.2 mile upstream of the confluence with Barren River Lake.	None	+590	Unincorporated Areas of Barren County.
Beaver Creek (Backwater effects from Barren River Lake).	From the confluence with Barren River Lake to approximately 4.0 miles upstream of the confluence with Barren River Lake.	None	+590	Unincorporated Areas of Barren County.
Beaver Creek Tributary 1 (Backwater effects from Barren River Lake).	From the confluence with Barren River Lake to approximately 0.7 mile upstream of the confluence with Barren River Lake.	None	+590	Unincorporated Areas of Barren County.
Beaver Creek Tributary 1.4 (Backwater effects from Barren River Lake).	From the confluence with Beaver Creek Tributary 1 to approximately 1.5 mile upstream of the confluence with Beaver Creek Tributary 1.	None	+590	Unincorporated Areas of Barren County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Beaver Creek Tributary 47 (Backwater effects from Barren River Lake).	From the confluence with Beaver Creek to approximately 0.3 mile upstream of the confluence with Beaver Creek.	None	+590	Unincorporated Areas of Barren County.
Coon Creek (Backwater effects from Barren River Lake).	From the confluence with Barren River Lake to approximately 0.8 mile upstream of the confluence with Barren River Lake.	None	+590	Unincorporated Areas of Barren County.
Dry Creek (Backwater effects from Barren River Lake).	From the confluence with Barren River Lake to approximately 1.0 mile upstream of the confluence with Barren River Lake.	None	+590	Unincorporated Areas of Barren County.
Peter Creek (Backwater effects from Barren River Lake).	From the confluence with Barren River Lake to approximately 2.2 miles upstream of the confluence with Barren River Lake.	None	+590	Unincorporated Areas of Barren County.
Rose Creek (Backwater effects from Barren River Lake).	From the confluence with Skaggs Creek to approximately 1.6 mile upstream of the confluence with Skaggs Creek.	None	+590	Unincorporated Areas of Barren County.
Skaggs Creek (Backwater effects from Barren River Lake).	From the confluence with Barren River Lake to approximately 2.3 miles upstream of the confluence with Barren River Lake.	None	+590	Unincorporated Areas of Barren County.
South Fork Beaver Creek (Backwater effects from Barren River Lake).	From the confluence with Beaver Creek to approximately 0.4 mile upstream of the confluence with Beaver Creek.	None	+590	Unincorporated Areas of Barren County.
South Glover Creek (Backwater effects from Barren River Lake).	From the confluence with Barren River Lake to approximately 1.5 mile upstream of the confluence with Barren River Lake.	None	+590	Unincorporated Areas of Barren County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Barren County

Maps are available for inspection at 117 North Public Square, Suite 3A, Glasgow, KY 42141.

Vernon Parish, Louisiana, and Incorporated Areas

Bayou Castor	Approximately 1 mile downstream of Highway 466	None	+225	City of Leesville, Unincorporated Areas of Vernon Parish.
	Approximately 700 feet upstream of the confluence with Stream No. 1.	None	+231	
Sabine River	Approximately 2.67 miles downstream of Neal Loop	None	+85	Unincorporated Areas of Vernon Parish.
	Approximately 2.3 miles upstream of Parish Road 113	None	+115	
Stream No. 1	At the confluence with Stream No. 2	None	+231	City of Leesville, Unincorporated Areas of Vernon Parish.
	Just downstream of Herring Street	None	+237	
Stream No. 2	At the confluence with Stream No. 1	None	+231	City of Leesville.
	Just downstream of 5th Street	None	+244	
Stream No. 3	Approximately 780 feet upstream of Franklin Avenue	None	+224	City of Leesville.
	Just downstream of West Texas Street	None	+253	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

ADDRESSES

City of Leesville
Maps are available for inspection at City Hall, 101 West Lee Street, Leesville, LA 71446.

Unincorporated Areas of Vernon Parish
Maps are available for inspection at the Police Jury, 602 Alexandria Highway, Leesville, LA 71446.

Cass County, Nebraska, and Incorporated Areas

Missouri River	Approximately 8,140 feet southeast of Eaton Lane	*940	+943	Unincorporated Areas of Cass County, City of Plattsmouth.
	Approximately 13,800 feet downstream of Interstate 75.	*966	+969	
Platte River	Approximately 13,800 feet downstream of Interstate 75.	*966	+969	Unincorporated Areas of Cass County, City of Plattsmouth, Village of Cedar Creek, City of Louisville, Village of South Bend.
	Approximately 9,200 feet upstream of Interstate 80	*1059	+1061	
Weeping Water Creek	Approximately 2,800 feet downstream of 48th Street	None	+993	Village of Nehawka.
	Approximately 2,600 feet upstream of 48th Street	None	+998	
Weeping Water Creek	Just upstream of Scenic Road	None	+1061	Unincorporated Areas of Cass County, City of Weeping Water.
	Approximately 2,815 feet downstream of State Highway 50.	None	+1094	
	Approximately 215 feet upstream of State Highway 50	None	+1111	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Louisville
Maps are available for inspection at City Hall, 210 Main Street, Louisville, NE 68037.

City of Plattsmouth
Maps are available for inspection at City Hall, 136 North 5th Street, Plattsmouth, NE 68048.

City of Weeping Water
Maps are available for inspection at City Hall, 203 West Eldora, Weeping Water, NE 68463.

Unincorporated Areas of Cass County
Maps are available for inspection at the County Courthouse, 346 Main Street, Plattsmouth, NE 68048.

Village of Cedar Creek
Maps are available for inspection at the Village Office, 200 East B Street, Cedar Creek, NE 68016.

Village of Nehawka
Maps are available for inspection at the Village Office, 713 Elm Street, Nehawka, NE 68413.

Village of South Bend
Maps are available for inspection at the Village Hall, 300 Spruce Street, South Bend, NE 68058.

Huron County, Ohio, and Incorporated Areas

East Branch Huron River	Approximately 50 feet downstream of Norfolk and Western Railroad.	None	+666	Unincorporated Areas of Huron County.
	Approximately 0.5 mile downstream of West Main Street.	None	+672	
	Approximately 50 feet downstream of West Main Street.	None	+674	
	Just downstream of State Highway 61	None	+677	
Norwalk Creek	Just downstream of State Highway 61	None	+677	Unincorporated Areas of Huron County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Norwalk Creek	Approximately 1,800 feet upstream of State Highway 61.	None	+680	Unincorporated Areas of Huron County, City of Norwalk.
	Approximately 700 feet downstream of Southwest Street.	+687	+688	
	Approximately 400 feet downstream of East Elm Street.	+708	+709	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Norwalk
Maps are available for inspection at 38 Whittlesey Avenue, Norwalk, OH 44857.

Unincorporated Areas of Huron County
Maps are available for inspection at 8 Fair Road, Norwalk, OH 44857.

Cherokee County, Texas, and Incorporated Areas

Gum Creek	Just upstream of Lakeshore Drive	None	+429	City of Jacksonville.
	Approximately 1,700 feet upstream of Lakeshore Drive.	None	+439	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Jacksonville
Maps are available for inspection at 301 East Commerce Street, Jacksonville, TX 75766.

Jasper County, Texas, and Incorporated Areas

Pin Oak Creek	Approximately 550 feet downstream of Lanier Street	None	+99	Unincorporated Areas of Jasper County.
	Approximately 1,000 feet upstream of County Road 404.	None	+110	
Sandy Creek	Just upstream of the Burlington Northern Santa Fe Corporation Railroad.	None	+214	Unincorporated Areas of Jasper County.
	Approximately 0.5 mile upstream of the Burlington Northern Santa Fe Corporation Railroad.	None	+217	
Trotti Creek	Just upstream of Farm-to-Market 2799	None	+198	Unincorporated Areas of Jasper County.
	Just downstream of County Road 128	None	+204	
	Approximately 450 feet upstream of Farm-to-Market 2800.	None	+240	
	Approximately 0.7 mile upstream of Farm-to-Market 2800.	None	+244	
Trout Creek	Approximately 481 feet downstream of the confluence with Pin Oak Creek.	None	+99	Unincorporated Areas of Jasper County.
	Approximately 0.72 mile upstream of Highway 96	None	+105	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Jasper County

Maps are available for inspection at 121 North Austin, Room 106, Jasper, TX 75951.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Deborah S. Ingram,

Acting Deputy Assistant Administrator for Mitigation, Mitigation Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–28311 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2008–0020; Internal Agency Docket No. FEMA–B–1076]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Proposed rule.

SUMMARY: Comments are requested on the proposed Base (1% annual-chance) Flood Elevations (BFEs) and proposed BFE modifications for the communities listed in the table below. The purpose of this notice is to seek general information and comment regarding the proposed regulatory flood elevations for the reach described by the downstream and upstream locations in the table below. The BFEs and modified BFEs are a part of the floodplain management measures that the community is required either to adopt or show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, these elevations, once finalized, will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents in those buildings.

DATES: Comments are to be submitted on or before February 23, 2010.

ADDRESSES: The corresponding preliminary Flood Insurance Rate Map (FIRM) for the proposed BFEs for each community is available for inspection at the community's map repository. The respective addresses are listed in the table below.

You may submit comments, identified by Docket No. FEMA–B–1076, to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) proposes to make determinations of BFEs and modified BFEs for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed BFEs and modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities. These proposed elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

Comments on any aspect of the Flood Insurance Study and FIRM, other than the proposed BFEs, will be considered. A letter acknowledging receipt of any comments will not be sent.

National Environmental Policy Act. This proposed rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Executive Order 12866, Regulatory Planning and Review. This proposed rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866, as amended.

Executive Order 13132, Federalism. This proposed rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This proposed rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR part 67 is proposed to be amended as follows:

PART 67—[AMENDED]

1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.4 [Amended]

2. The tables published under the authority of § 67.4 are proposed to be amended as follows:

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Greene County, Georgia, and Incorporated Areas				
Oconee River	Approximately 0.79 mile downstream of the Oglethorpe/Greene County Border.	None	+459	Unincorporated Areas of Greene County.
	At the Oglethorpe/Greene County border	None	+462	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Greene County

Maps are available for inspection at the Greene County Administration Building, 1034 Silver Drive, Suite 104, Greensboro, GA 30642.

Twiggs County, Georgia, and Incorporated Areas				
Ocmulgee River	Approximately 0.5 mile southwest of the intersection of Alfred Bond Drive and Cochran Short Route.	None	+277	Unincorporated Areas of Twiggs County.
	Approximately 1.3 mile northwest of the intersection of Alfred Bond Drive and Cochran Short Route.	None	+278	
Stone Creek	Approximately 600 feet downstream of the downstream-most Twiggs-Bibb County Boundary.	None	+357	Unincorporated Areas of Twiggs County.
	Approximately 300 feet upstream of the upstream-most Twiggs-Bibb County Boundary.	None	+373	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Twiggs County

Maps are available for inspection at the Twiggs County Courthouse, 425 Railroad Street North, Jefferson, GA 31044.

City and County of Honolulu, Hawaii				
Pacific Ocean	Approximately 1,275 feet north of the intersection of Lihue Drive and Plantation Road.	None	^1	City and County of Honolulu.
	Approximately 5,025 feet southeast of the intersection of Poipu Drive and Nawiliwili Street.	None	^51	
Pacific Ocean/Pearl Harbor	Approximately 700 feet east of the intersection of Wasp Boulevard and Lexington Boulevard.	None	#2	City and County of Honolulu.
	Approximately 600 feet south of the intersection of Lehua Avenue and Coral Avenue.	None	#2	
	Approximately 880 feet northwest of intersection of Kamehameha Street and Kalaloa Street.	None	#1	
	Approximately 325 feet southeast of the intersection of Ibis Avenue and Heron Avenue.	None	#2	
	Approximately 3,250 feet southwest of the intersection of Plantation Road and Waipio Point Access Road.	None	#2	

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	
	Approximately 450 feet east of the intersection of 101st Street and Heron Avenue.	None	^1	
	Approximately 1,775 feet southwest of the intersection of Signer Boulevard and Second Street.	None	^11	
	Approximately 1,565 feet south of the intersection of Signer Boulevard and Second Street.	None	#2	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Local Tidal Datum.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City and County of Honolulu

Maps are available for inspection at the Honolulu City and County Emergency Management Department, 650 South King Street, Basement, Honolulu, HI 96813.

Lake County, Indiana, and Incorporated Areas

Dyer Ditch	Just upstream of 213th Street	+624	+619	Unincorporated Areas of Lake County, Town of Dyer, Town of Schererville.
	Just upstream of 77th Avenue	None	+638	
Hart Ditch	At the confluence with Little Calumet River	+599	+596	Town of Dyer, Town of Munster.
	Approximately 1,650 feet upstream of Hart Street	+636	+637	
Lake Michigan	Eastern Lake County Border	+584	+585	City of East Chicago, City of Gary, City of Hammond, City of Whiting.
	At Indiana/Illinois State Boundary	+584	+585	
Main Beaver Dam Ditch	Just downstream of Broadway	None	+684	Town of Merrillville.
	Approximately 1,000 feet upstream of Broadway	None	+684	
	Approximately 1,600 feet downstream of 91st Avenue	None	+689	
	Just downstream of 91st Avenue	None	+689	
Main Beaver Dam Ditch	Approximately 730 feet west of Clark Road	None	+690	Town of Schererville.
Main Beaver Dam Ditch South Tributary.	Approximately 425 feet downstream of US 231	None	+694	Unincorporated Areas of Lake County.
	Just downstream of 113th Avenue	None	+695	
McConnel Ditch	Approximately 1,280 feet downstream of Morse Street	None	+674	Town of Lowell.
	Just downstream of Morse Street	None	+678	
Niles Ditch	Just upstream of 101st Avenue	None	+676	Town of Merrillville.
	Approximately 150 feet upstream of 101st Avenue	None	+676	
Seberger Ditch	Just upstream of East Main Street	+621	+620	Town of Griffith, Town of Schererville.
	Approximately 200 feet upstream of Redar Drive	+634	+633	
Spring Street Ditch	Approximately 0.5 mile east of Kennedy Avenue	None	+622	Town of Griffith.
	Just upstream of railroad	None	+622	
Turkey Creek	Approximately 500 feet upstream of I–65	+613	+614	Unincorporated Areas of Lake County, Town of Merrillville, Town of Schererville.
	Approximately 150 feet upstream of 85th Street	None	+670	
Unnamed Tributary (Backwater from West Creek).	Just upstream of Conrail Railroad	None	+674	Unincorporated Areas of Lake County.
	Just downstream of Louisville and Nashville Railroad	None	+674	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of East Chicago
Maps are available for inspection at 4444 Railroad Avenue, East Chicago, IN 46312.

City of Gary
Maps are available for inspection at 401 West Broadway, Gary, IN 46402.

City of Hammond
Maps are available for inspection at 5925 Calumet Avenue, Hammond, IN 46322.

City of Whiting
Maps are available for inspection at 1443 119th Street, Whiting, IN 46394.

Town of Dyer
Maps are available for inspection at 1 Town Square, Dyer, IN 46311.

Town of Griffith
Maps are available for inspection at 111 North Broad Street, Griffith, IN 46319.

Town of Lowell
Maps are available for inspection at 501 East Main Street, Lowell, IN 46356.

Town of Merrillville
Maps are available for inspection at 7820 Broadway, Merrillville, IN 46410.

Town of Munster
Maps are available for inspection at 1005 Ridge Road, Munster, IN 46321.

Town of Schererville
Maps are available for inspection at 10 East Joliet Street, Schererville, IN 46375.

Unincorporated Areas of Lake County
Maps are available for inspection at 2293 North Main Street, Crown Point, IN 46307.

Adair County, Kentucky, and Incorporated Areas

Bryant Creek (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 1.3 mile upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Adair County.
Casey Creek (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 3.4 miles upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Adair County.
Casey Creek Tributary 10 (Backwater effects from Green River Lake).	From the confluence with Casey Creek to approximately 1.1 mile upstream of the confluence with Casey Creek.	None	+713	Unincorporated Areas of Adair County.
Casey Creek Tributary 8 (Backwater effects from Green River Lake).	From the confluence with Casey Creek to approximately 0.6 mile upstream of the confluence with Casey Creek.	None	+713	Unincorporated Areas of Adair County.
Crooked Creek (Backwater effects from Green River Lake).	From the confluence with Casey Creek to approximately 2.1 miles upstream of the confluence with Casey Creek.	None	+713	Unincorporated Areas of Adair County.
Crooked Creek Tributary 10 (Backwater effects from Green River Lake).	From the confluence with Crooked Creek to approximately 0.2 mile upstream of the confluence with Crooked Creek.	None	+713	Unincorporated Areas of Adair County.
Denton Branch (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 0.6 mile upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Adair County.
Green River (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 3.5 miles upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Adair County.
Green River Lake	Entire shoreline of Green River Lake	None	+713	Unincorporated Areas of Adair County.
North White Oak Creek (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 1.1 mile upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Adair County.
Snake Creek (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 1.4 mile upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Adair County.

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Spout Springs Branch (Backwater effects from Green River Lake).	From the confluence with Green River to approximately 2.1 miles upstream of the confluence with Green River.	None	+713	Unincorporated Areas of Adair County.
West Butler Creek (Backwater effects from Green River Lake).	From the confluence with Green River Lake to approximately 0.9 mile upstream of the confluence with Green River Lake.	None	+713	Unincorporated Areas of Adair County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Adair County

Maps are available for inspection at 424 Public Square, Suite 1, Columbia, KY 42728.

Lafayette County, Mississippi, and Incorporated Areas

Burney Branch	Approximately 0.5 mile downstream from Veterans Drive.	None	+350	City of Oxford.
	Approximately 1,727 feet upstream of Sisk Avenue	None	+454	
Davidson Creek	Approximately 0.4 mile downstream of College Hill Road.	+357	+355	City of Oxford.
	Approximately 1,444 feet downstream of College Hill Road.	+360	+359	
Enid Lake/Yocona River	Just downstream of County Road 387	None	+274	Unincorporated Areas of Lafayette County.
	Approximately 1 mile downstream of State Highway 315.	None	+274	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Oxford

Maps are available for inspection at the City Hall, 107 Courthouse Square, Oxford, MS 38655.

Unincorporated Areas of Lafayette County

Maps are available for inspection at the County Courthouse, 1 Courthouse Square, Oxford, MS 38655.

Chenango County, New York (All Jurisdictions)

Canasawacta Creek	At the confluence with Chenango River	+991	+990	City of Norwich, Town of Norwich.
	Approximately 825 feet upstream of the confluence with Chenango River.	+991	+990	

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Chenango River	At downstream county boundary	+900	+899	City of Norwich, Town of Greene, Town of North Norwich, Town of Norwich, Town of Oxford, Town of Preston, Town of Sherburne, Town of Smyrna, Village of Earlville, Village of Greene, Village of Oxford, Village of Sherburne.
	At upstream county boundary	None	+1074	
Kelsey Brook	At the confluence with Susquehanna River	+969	+972	Village of Afton.
	Approximately 995 feet upstream of Main Street/State Route 7.	+971	+972	
Susquehanna River	At downstream county boundary	+963	+965	Town of Afton, Town of Bainbridge, Village of Afton, Village of Bainbridge.
	At upstream county boundary	+985	+987	
Unadilla River	At the confluence with Susquehanna River	None	+987	Town of Bainbridge, Town of Guilford, Town of New Berlin, Town of Norwich, Village of New Berlin.
	Approximately 1.7 miles upstream of State Highway 80.	None	+1101	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Norwich
Maps are available for inspection at the Norwich City Hall, 1 City Plaza, Norwich, NY 13814.

Town of Afton
Maps are available for inspection at the Afton Town Hall, 169 Main Street, Afton, NY 13730.

Town of Bainbridge
Maps are available for inspection at the Bainbridge Town Hall, 15 North Main Street, Bainbridge, NY 13733.

Town of Greene
Maps are available for inspection at the Greene Town Hall, 51 Genesee Street, Greene, NY 13778.

Town of Guilford
Maps are available for inspection at the Town Hall, 223 Marble Road, Guilford, NY 13780.

Town of New Berlin
Maps are available for inspection at the New Berlin Town Hall, 30 North Main Street, New Berlin, NY 13411.

Town of North Norwich
Maps are available for inspection at the Town Hall, 188 County Road 23, North Norwich, NY 13814.

Town of Norwich
Maps are available for inspection at the Norwich Town Hall, 157 County Road 32A, Norwich, NY 13815.

Town of Oxford
Maps are available for inspection at the Oxford Town Hall, 20 Lafayette Park, Oxford, NY 13830.

Town of Preston
Maps are available for inspection at the Preston Town Barn, 671 Tamarack Road, Oxford, NY 13830.

Town of Sherburne
Maps are available for inspection at the Sherburne Town Hall, 1 Canal Street, Sherburne, NY 13460.

Town of Smyrna
Maps are available for inspection at the Town Clerk's Office, 1893 State Highway 80, Smyrna, NY 13464.

Village of Afton

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	

Maps are available for inspection at the Afton Village Hall, 105 Main Street, Afton, NY 13730.

Village of Bainbridge

Maps are available for inspection at the Bainbridge Village Office, 33 West Main Street, Bainbridge, NY 13733.

Village of Earlville

Maps are available for inspection at the Village Hall, 8 North Main Street, Earlville, NY 13332.

Village of Greene

Maps are available for inspection at the Greene Village Hall, 49 Genesee Street, Greene, NY 13778.

Village of New Berlin

Maps are available for inspection at the New Berlin Village Hall, 13 South Main Street, New Berlin, NY 13411.

Village of Oxford

Maps are available for inspection at the Oxford Village Hall, 20 Lafayette Park, Oxford, NY 13830.

Village of Sherburne

Maps are available for inspection at the Sherburne Village Hall, 15 West State Street, Sherburne, NY 13460.

Delaware County, New York (All Jurisdictions)

Bear Brook	From the confluence with Sands Creek	None	+938	Town of Hancock.
	To approximately 150 feet upstream of County Route 67.	None	+946	
Beaver Kill	From the confluence with East Branch Delaware River Reach 1.	+1,011	+1008	Town of Hancock, Town of Colchester.
	To approximately 0.9 mile upstream of State Route 17 at county boundary.	None	+1257	
Charlotte Creek	From the confluence with Susquehanna River	+1101	+1102	Town of Davenport, Town of Harpersfield.
	To approximately 1.1 mile upstream of Johnson Road	None	+1327	
Delaware River	From approximately 5.7 miles downstream of Lordville Road.	+840	+841	Town of Hancock, Village of Hancock.
	To the confluence of East Branch Delaware River and West Branch Delaware River.	+903	+904	
East Branch Delaware River Reach 1.	From the confluence with Delaware River and East Branch Delaware River Reach 1.	+903	+904	Town of Hancock, Town of Colchester, Village of Hancock.
	To approximately 1,550 feet upstream of State Route 30.	+1103	+1107	
East Branch Delaware River Reach 2.	From approximately 0.6 mile downstream of Fair Street.	None	+1308	Town of Middletown, Village of Margaretville.
	To approximately 0.5 mile downstream of Fair Street	None	+1308	
East Brook	From the confluence with West Branch Delaware River.	+1213	+1212	Village of Walton, Town of Walton.
	To approximately 0.9 mile upstream of Brook Dam Road.	+1287	+1288	
Little Delaware River	From the confluence with West Branch Delaware River.	+1344	+1346	Town of Delhi.
	To approximately 220 feet downstream of Arbor Hill Road.	+1345	+1346	
Ouleout Creek	From approximately 1.56 mile upstream of East Sidney Lake Dam.	None	+1198	Town of Franklin.
	To approximately 1.6 mile upstream of East Sidney Lake Dam.	None	+1198	
Sands Creek	From the confluence with West Branch Delaware River.	+911	+913	Village of Hancock, Town of Hancock.
	To the confluence with Bear Brook	None	+938	
Steele Brook	From the confluence with West Branch Delaware River.	+1356	+1358	Village of Delhi.
	To approximately 630 feet downstream of Elm Street	+1357	+1358	
Susquehanna River	From approximately 0.7 mile downstream of State Route 8.	+985	+987	Village of Sidney, Town of Davenport, Town of Sidney.
	To approximately 0.6 mile downstream of County Highway 47.	+1101	+1102	
Third Brook	From the confluence with West Brook	+1206	+1208	Village of Walton, Town of Walton.
	To approximately 1.1 mile upstream of Ogden Street	+1390	+1391	

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Vly Creek	Approximately 2,625 feet downstream of County Route 37.	None	+1558	Village of Fleischmanns.
	To approximately 2,550 feet downstream of County Route 37.	None	+1559	
West Branch Delaware River	From the confluence with Delaware River	+903	+904	Town of Hancock, Town of Delhi, Town of Deposit, Town of Hamden, Town of Kortright, Town of Tompkins, Town of Walton, Village of Delhi, Village of Hancock, Village of Walton.
	To approximately 1.1 mile upstream of Hoag Cross Road.	None	+1410	
West Brook	From the confluence with West Branch Delaware River.	+1206	+1208	Village of Walton, Town of Walton.
	To approximately 1.4 mile upstream of Walton-Sidney Road.	None	+1368	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Town of Colchester
Maps are available for inspection at the Colchester Town Building Department, 72 Tannery Road, Downsville, NY 13755.

Town of Davenport
Maps are available for inspection at the Town Hall, 11790 State Highway 23, Davenport Center, NY 13751.

Town of Delhi
Maps are available for inspection at the Delhi Town Building Code Office, 3 Elm Street, Delhi, NY 13753.

Town of Deposit
Maps are available for inspection at the Town Hall, 3 Elm Street, Deposit, NY 13754.

Town of Franklin
Maps are available for inspection at the Town Hall, 554 Main Street, Franklin, NY 13775.

Town of Hamden
Maps are available for inspection at the Town Hall, Route 10 and Covert Hollow Road, Hamden, NY 13782.

Town of Hancock
Maps are available for inspection at the Hancock Town Hall, 661 West Main Street, Hancock, NY 13783.

Town of Harpersfield
Maps are available for inspection at the Town Hall, 25399 State Highway 23, Harpersfield, NY 13786.

Town of Kortright
Maps are available for inspection at the Kortright Town Hall, 51702 State Highway 10, Bloomville, NY 13739.

Town of Middletown
Maps are available for inspection at the Middletown Town Hall, 42339 State Highway 28, Margaretville, NY 12455.

Town of Sidney
Maps are available for inspection at the Sidney Town Civic Center, 21 Liberty Street, Suite 1, Sidney, NY 13838.

Town of Tompkins
Maps are available for inspection at the Tompkins Town Hall, 148 Bridge Street, Trout Creek, NY 13847.

Town of Walton
Maps are available for inspection at the Walton Town Hall, 129 North Street, Walton, NY 13856.

Village of Delhi
Maps are available for inspection at the Delhi Village Building Enforcement Office, 9 Court Street, Delhi, NY 13753.

Village of Fleischmanns
Maps are available for inspection at the Village Hall, 1017 Main Street, Fleischmanns, NY 12430.

Village of Hancock
Maps are available for inspection at the Hancock Village Hall, 85 East Front Street, Hancock, NY 13783.

Village of Margaretville
Maps are available for inspection at the Village Hall, 773 Main Street, Margaretville, NY 12445.

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	

Village of Sidney
Maps are available for inspection at the Sidney Village Hall, 21 Liberty Street, Sidney, NY 13838.

Village of Walton
Maps are available for inspection at the Walton Village Hall, 21 North Street, Walton, NY 13856.

Onondaga County, New York (All Jurisdictions)

Deruyter Reservoir	Shoreline of Deruyter Reservoir within Onondaga County.	None	+1282	Town of Fabius.
Geddes Brook	Approximately 245 feet downstream of Gere Lock Road.	None	+381	Village of Solvay.
	At Gere Lock Road bridge	None	+396	
Otisco Lake	Entire shoreline of Otisco Lake within the Towns of Marcellus, Spafford, and Otisco.	None	+789	Town of Marcellus, Town of Otisco, Town of Spafford.
Thompson Brook	At South Bay Road Bridge	None	+382	Village of North Syracuse.
	Approximately 265 feet upstream of I–481 ramp	None	+383	
Tully Lake	Shoreline of Tully Lake within Onondaga County	None	+1195	Town of Tully.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Town of Fabius
Maps are available for inspection at the Town Hall, 7891 Main Street, Fabius, NY 13063.

Town of Marcellus
Maps are available for inspection at the Town Hall, 24 East Main Street, Marcellus, NY 13108.

Town of Otisco
Maps are available for inspection at the Otisco Town Hall, 1924 Barker Street, Tully, NY 13159.

Town of Spafford
Maps are available for inspection at the Spafford Town Hall, 1984 Route 174, Skaneateles, NY 13152.

Town of Tully
Maps are available for inspection at the Town Hall, 5833 Meetinghouse Road, Tully, NY 13159.

Village of North Syracuse
Maps are available for inspection at the Village Hall, 600 South Bay Road, North Syracuse, NY 13212.

Village of Solvay
Maps are available for inspection at the Village Hall, 1100 Woods Road, Solvay, NY 13209.

Schoharie County, New York (All Jurisdictions)

Cobleskill Creek	Approximately 490 feet downstream of New York State Route 10/7.	+918	+919	Town of Richmondville, Town of Cobleskill, Village of Richmondville.
	Approximately 600 feet upstream of I–88 Exit 20 Ramp.	None	+1013	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Town of Cobleskill
Maps are available for inspection at 2668 State Route 7, Suite 13, Cobleskill, NY 12043.

Flooding source(s)	Location of referenced elevation	*Elevation in feet (NGVD) +Elevation in feet (NAVD) #Depth in feet above ground ^Elevation in meters (MSL)		Communities affected
		Effective	Modified	

Town of Richmondville
Maps are available for inspection at the Richmondville Town Hall, 340 Main Street, Richmondville, NY 12149.

Village of Richmondville
Maps are available for inspection at the Richmondville Village Hall, 295 Main Street, Richmondville, NY 12149.

Alleghany County, Virginia, and Incorporated Areas

Jackson River	Approximately 1.1 mile downstream of State Route 18	+1188	+1187	City of Covington.
	Approximately 1,200 feet upstream of the confluence of Dry Run Branch.	+1247	+1246	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Covington
Maps are available for inspection at City Hall, 333 West Locust Street, Covington, VA 24426.

Botetourt County, Virginia, and Incorporated Areas

Cowpasture River Reach 1	At county boundary	None	+1014	Unincorporated Areas of Botetourt County.
	At confluence with James River	+1015	+1014	
Cowpasture River Reach 2	Approximately 1,300 feet downstream of downstream county boundary.	None	+1030	Unincorporated Areas of Botetourt County.
	At upstream county boundary	None	+1042	
Jackson River	At confluence with James River	+1015	+1014	Unincorporated Areas of Botetourt County.
	At county boundary	+1021	+1014	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Botetourt County
Maps are available for inspection at the County Courthouse, 1 West Main Street, Fincastle, VA 24090.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Deborah S. Ingram,

Acting Deputy Assistant Administrator for Mitigation, Mitigation Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–28312 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket ID FEMA–2008–0020; Internal Agency Docket No. FEMA–B–1078]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Proposed rule.

SUMMARY: Comments are requested on the proposed Base (1% annual-chance) Flood Elevations (BFEs) and proposed BFE modifications for the communities listed in the table below. The purpose of this notice is to seek general information and comment regarding the proposed regulatory flood elevations for the reach described by the downstream and upstream locations in the table below. The BFEs and modified BFEs are a part of the floodplain management measures that the community is required either to adopt or show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, these elevations, once finalized, will be used by insurance agents, and others to calculate appropriate flood insurance premium rates for new buildings and the contents in those buildings.

DATES: Comments are to be submitted on or before February 23, 2010.

ADDRESSES: The corresponding preliminary Flood Insurance Rate Map (FIRM) for the proposed BFEs for each community is available for inspection at the community's map repository. The respective addresses are listed in the table below.

You may submit comments, identified by Docket No. FEMA–B–1078, to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–2820, or (e-mail) *kevin.long@dhs.gov.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) proposes to make determinations of BFEs and modified BFEs for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed BFEs and modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities. These proposed elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

Comments on any aspect of the Flood Insurance Study and FIRM, other than the proposed BFEs, will be considered. A letter acknowledging receipt of any comments will not be sent.

National Environmental Policy Act. This proposed rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Executive Order 12866, Regulatory Planning and Review. This proposed rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866, as amended.

Executive Order 13132, Federalism. This proposed rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This proposed rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

Accordingly, 44 CFR part 67 is proposed to be amended as follows:

PART 67—[AMENDED]

1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.;* Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.4 [Amended]

2. The tables published under the authority of § 67.4 are proposed to be amended as follows:

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Jackson County, Florida, and Incorporated Areas				
Buck Pelt Creek	Just upstream of Fillmore Drive	None	+83	Unincorporated Areas of Jackson County.
	Approximately 0.4 mile upstream of State Highway 73	None	+137	
Chipola River	Approximately 1,450 feet upstream of County Highway 162.	None	+88	Unincorporated Areas of Jackson County.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
	At the confluence with Marshall Creek	None	+93	
Chipola River Tributary 7	Approximately 0.4 mile downstream of Jefferson Street.	None	+83	Unincorporated Areas of Jackson County, City of Marianna
	Approximately 1.6 mile upstream of Penn Avenue	None	+134	
Dry Creek	Approximately 2.7 miles upstream of the confluence with Chipola River.	None	+74	Unincorporated Areas of Jackson County.
	Just downstream of Mill Road	None	+97	
Dry Creek Tributary 11	At the confluence with Dry Creek	None	+74	Unincorporated Areas of Jackson County.
	Approximately 1.5 mile upstream of the confluence with Dry Creek.	None	+74	
Little Creek	Just downstream of Ezell Road	None	+147	Unincorporated Areas of Jackson County.
	Approximately 590 feet downstream of Ezell Road	None	+147	
Long Branch	At the confluence with Dry Creek	None	+74	Unincorporated Areas of Jackson County.
	Approximately 0.8 mile upstream of Interstate 10	None	+132	
Long Branch Tributary 2	At the confluence with Long Branch	None	+78	Unincorporated Areas of Jackson County.
	Approximately 0.7 mile upstream of the confluence with Long Branch.	None	+98	
Long Branch Tributary 3	At the confluence with Long Branch	None	+87	Unincorporated Areas of Jackson County.
	Approximately 1.3 mile upstream of Thompson Road	None	+129	
Unnamed Stream 59	At the confluence with Unnamed Stream 59–1	None	+77	Unincorporated Areas of Jackson County.
	Approximately 1.1 mile upstream of the confluence with Unnamed Stream 59–1.	None	+96	
Unnamed Stream 59–1	At the confluence with Unnamed Stream 59	None	+77	Unincorporated Areas of Jackson County.
	Approximately 0.5 mile upstream of Bright Prospect Road.	None	+108	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Marianna

Maps are available for inspection at City Hall, 2898 Green Street, Marianna, FL 32446.

Unincorporated Areas of Jackson County

Maps are available for inspection at the Chamber of Commerce, 4318 Lafayette Street, Marianna, FL 32446.

Bacon County, Georgia, and Incorporated Areas

Hurricane Creek	Approximately 1,650 feet upstream of State Highway 32.	None	+143	Unincorporated Areas of Bacon County.
	Approximately 575 feet upstream of U.S. Highway 1	None	+149	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

ADDRESSES

Unincorporated Areas of Bacon County

Maps are available for inspection at 502 West 12th Street, Alma, GA 31510.

Baldwin County, Georgia, and Incorporated Areas

Fishing Creek	approximately 0.4 mile downstream of U.S. Highway 441.	None	+276	City of Milledgeville.
	Approximately 1.9 mile upstream of Blandy Road	None	+297	
Fishing Creek (backwater area).	Approximately 0.5 mile southwest of Blandy Road and railroad.	None	+289	Unincorporated Areas of Baldwin County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Milledgeville

Maps are available for inspection at the Water Department, 119 East Hancock Street, Milledgeville, GA 31061.

Unincorporated Areas of Baldwin County

Maps are available for inspection at the County Commissioner's Office, 121 North Wilkinson Street, Suite 314, Milledgeville, GA 31061.

Candler County, Georgia, and Incorporated Areas

Lotts Creek	At Candler/Bulloch county boundary	None	+165	Unincorporated Areas of Candler County.
	Approximately 300 feet upstream of Candler/Bulloch county boundary.	None	+165	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Candler County

Maps are available for inspection at the County Courthouse, 705 North Lewis Street, Metter, GA 30439.

Jackson County, Georgia, and Incorporated Areas

Middle Oconee River	At downstream Jackson and Athens-Clarke county boundary.	+619	+621	Unincorporated Areas of Jackson County.
	Downstream side of State Highway 330	+650	+651	
Mulberry River	Approximately 0.54 mile southwest of the intersection of Etheridge Road and Cedar Grove Church Road.	None	+696	Unincorporated Areas of Jackson County.
	Approximately 0.86 mile southwest of the intersection of Etheridge Road and Cedar Grove Church Road.	None	+701	
Walton Creek	At downstream Jackson and Athens-Clarke county boundary.	None	+651	Unincorporated Areas of Jackson County.
	At upstream Jackson and Athens-Clarke county boundary.	None	+656	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Jackson County

Maps are available for inspection at the County Administration Building, 67 Athens Street, Jefferson, GA 30549.

Lanier County, Georgia, and Incorporated Areas

Big Creek	Approximately 1,550 feet upstream of East Main Street.	None	+159	Unincorporated Areas of Lanier County.
	Approximately 1,700 feet downstream of East Main Street.	None	+159	
	Approximately 2,990 feet upstream from Brantley Street/State Highway 135.	None	+167	
	Approximately 3,150 feet upstream from Brantley Street/State Highway 135.	None	+167	
Mill Creek	Approximately 4,000 feet upstream from North Pecan Street.	None	+176	Unincorporated Areas of Lanier County
	Approximately 4,090 feet upstream from North Pecan Street.	None	+176	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Lanier County

Maps are available for inspection at the County Courthouse, 100 Main Street, Lakeland, GA 31635.

Laurens County, Georgia, and Incorporated Areas

Ford Branch	Approximately 400 feet upstream of Shamrock Drive	None	+205	Unincorporated Areas of Laurens County.
	Approximately 1,170 feet upstream of Shamrock Drive.	None	+206	
Hunger and Hardship Creek	At confluence with Oconee River	None	+181	Unincorporated Areas of Laurens County.
	Approximately 79 feet upstream of Parker Dairy Road	None	+182	
Long Branch	At confluence with Oconee River	None	+176	Unincorporated Areas of Laurens County.
	Approximately 1,880 feet upstream of Brown Road	None	+220	
Oconee River	At confluence with Long Branch	None	+176	Unincorporated Areas of Laurens County, Town of East Dublin.
	At confluence with Hunger and Hardship Creek	None	+181	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

ADDRESSES

Town of East Dublin

are available for inspection at 116 Savannah Avenue, East Dublin, GA 31027

Unincorporated Areas of Laurens County

Maps are available for inspection at 101 East Jackson Street, Dublin, GA 31021.

Wayne County, Georgia, and Incorporated Areas

Little McMillen Creek	Approximately 2,800 feet upstream of Bethlehem Road.	+46	+48	City of Jesup
	Approximately 3,050 feet downstream of Grantham Road.	+51	+49	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Jesup

Maps are available for inspection at City Hall, 162 East Cherry Street, Jesup, GA 31546

Carroll County, Illinois, and Incorporated Areas

Mississippi River	Approximately Birch Road extended (approximately 526.6 miles upstream of the confluence with Ohio River).	None	+594	Village of Thomson.
	Approximately Main Street extended (approximately 527 miles upstream of the confluence with Ohio River).	None	+594	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Village of Thomson

Maps are available for inspection at the Village Hall, 800 Main Street, Thomson, IL 61285.

Ogle County, Illinois, and Incorporated Areas

Kyte River	Approximately 525 feet upstream of Jack Dame Drive	None	+773	Unincorporated Areas of Ogle County, City of Rochelle.
	Approximately 120 feet downstream of Treatment Plant Road.	+777	+777	
Lake Mistake Drain	Just above the confluence with Gale Creek (railroad)	None	+703	Unincorporated Areas of Ogle County.
	Approximately 0.68 mile upstream of Pines Road	None	+703	
Rock River	Approximately 0.97 mile downstream of State Route 64.	None	+672	City of Oregon.
	Approximately 0.89 mile upstream of State Route 64	None	+677	
Rock River	Approximately 0.61 mile downstream of the confluence with Stillman Creek.	+685	+686	City of Byron.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
South Branch Kishwaukee River.	Approximately 500 feet upstream of the confluence with Stillman Creek.	+685	+686	Unincorporated Areas of Ogle County.
	Upstream side of East Edson Road	None	+733	
	Approximately 1,200 feet upstream of East Line Road	None	+733	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Byron
Maps are available for inspection at City Hall, 232 West 2nd Street, Byron, IL 61010.
City of Oregon
Maps are available for inspection at City Hall, 115 North 3rd Street, Oregon, IL 61061.
City of Rochelle
Maps are available for inspection at City Hall, 420 North 6th Street, Rochelle, IL 61068.
Unincorporated Areas of Ogle County
Maps are available for inspection at the Zoning Administrator's Office, Ogle County Courthouse Annex, 106 South 5th Street, Oregon, IL 61061.

Scott County, Iowa, and Incorporated Areas

Mississippi River	Approximately 13.4 miles downstream of Lock & Dam #15.	+560	+561	City of Buffalo, City of Bettendorf, City of Davenport, City of Le Claire, City of Princeton, City of Riverdale, Unincorporated Areas of Scott County.
	Approximately 13.7 miles upstream of Lock & Dam #14.	+586	+585	
Mississippi River backwater effect on Moore Creek.	From the confluence with Mississippi River to a point approximately 0.4 mile upstream.	None	+562	City of Buffalo.
Mississippi River backwater effect on Oak Hill School Creek.	From the confluence with Mississippi River to a point approximately 0.5 mile upstream.	None	+561	City of Buffalo.
Mississippi River backwater affected area #1 (Downstream).	Approximately 0.4 mile downstream of intersection of Buffalo Road and State Route 22.	None	+562	City of Buffalo.
	Approximately 0.5 mile upstream of intersection of Dodge Street and State Route 22.	None	+562	
Mississippi River backwater affected area #2 (Upstream).	Approximately 875 feet downstream of intersection of 115th Avenue and State Route 22.	None	+562	City of Buffalo.
	Approximately 250 feet upstream of intersection of Buffalo Road and State Route 22.	None	+562	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Bettendorf
Maps are available for inspection at 1609 State Street, Bettendorf, IA 52722.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

City of Buffalo
Maps are available for inspection at 329 Dodge Street, Buffalo, IA 52728.

City of Davenport
Maps are available for inspection at 226 West 4th Street, Davenport, IA 52801.

City of Le Claire
Maps are available for inspection at 325 Wisconsin Street, Le Claire, IA 52753.

City of Princeton
Maps are available for inspection at 311 3rd Street, Princeton, IA 52768.

City of Riverdale
Maps are available for inspection at 110 Manor Drive, Bettendorf, IA 52722.

Unincorporated Areas of Scott County
Maps are available for inspection at 600 West 4th Street, Davenport, IA 52801.

Republic County, Kansas, and Incorporated Areas

Republic River	Approximately 4,475 feet downstream of U.S. Route 36.	None	+1434	Unincorporated Areas of Republic County.
	Approximately 1,475 feet upstream of U.S. Route 36	None	+1438	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Republic County
Maps are available for inspection at the County Courthouse, 1815 M Street, Belleville, KS 66935.

Allen County, Kentucky, and Incorporated Areas

Barren River Lake	Entire shoreline of Barren River Lake from just upstream of Barren River Dam to approximately 0.5 mile upstream of Brownsfield Road.	None	+590	Unincorporated Areas of Allen County.
Barren River Tributary 20 (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 0.8 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Barren River Tributary 23 (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 0.4 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Barren River Tributary 26 (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 1,900 feet upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Barren River Tributary 28 (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 0.4 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Barren River Tributary 29 (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 0.4 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Bear Creek (Backwater effects from Barren River Lake).	From confluence with Rhoden Creek Lake to approximately 0.7 mile upstream of confluence with Rhoden Creek.	None	+590	Unincorporated Areas of Allen County.
Hurricane Creek (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 0.7 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Hurricane Creek Tributary 3 (Backwater effects from Barren River Lake).	From confluence with Hurricane Creek to approximately 1,000 feet upstream of confluence with Hurricane Creek.	None	+590	Unincorporated Areas of Allen County.
	From confluence with Barren River Lake to approximately 1,900 feet upstream of confluence with Barren River Lake.	None	+590	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Hurricane Creek Tributary 4 (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 0.4 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Manley Branch (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 1 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Manley Branch Tributary 3 (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 0.8 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Rhoden Creek (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 1.4 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Trace Creek (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 1 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Walnut Creek (Backwater effects from Barren River Lake).	From confluence with Barren River Lake to approximately 1.1 mile upstream of confluence with Barren River Lake.	None	+590	Unincorporated Areas of Allen County.
Walnut Creek Tributary 7 (Backwater effects from Barren River Lake).	From confluence with Walnut Creek Lake to approximately 1.1 mile upstream of confluence with Walnut Creek.	None	+590	Unincorporated Areas of Allen County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Allen County

Maps are available for inspection at 201 West Main Street, Scottsville, KY 42164.

Clay County, Minnesota, and Incorporated Areas

Buffalo River	At the confluence with the Red River of the North	+882	+883	Unincorporated Areas of Clay County, City of Georgetown.
	Just downstream of U.S. Highway 10 (1st Crossing)	+947	+948	
County Ditch No. 20 (Connecting Reach/Upper Reach).	At the convergence with the Red River of the North	+892	+893	Unincorporated Areas of Clay County.
	Approximately 2,500 feet downstream of Wall Street Avenue North/County Highway 22.	+895	+896	
County Ditch No. 20 (Lower Reach).	At the convergence with the Red River of the North	+889	+888	Unincorporated Areas of Clay County.
	At divergence from County Ditch No. 20 (Connecting Reach/Upper Reach).	+892	+893	
County Ditch No. 41	Approximately 5,645 feet downstream of Main Street South/County Highway 78.	None	+908	Unincorporated Areas of Clay County, City of Moorhead.
	Approximately 320 feet downstream of Burlington Northern & Santa Fe Railway.	None	+911	
County Ditch No. 50	At 34th Street North	None	+903	City of Dilworth.
	Approximately 2,590 feet upstream of U.S. Highway 10/Center Avenue East.	+912	+911	
County Drain No. 51	At confluence with Buffalo River	None	+891	Unincorporated Areas of Clay County.
	Approximately 3,900 feet upstream of 90th Avenue North/County Highway 26.	None	+902	
Glyndon Tributary	Approximately 1,700 feet downstream of U.S. Highway 10/State Street.	+915	+916	Unincorporated Areas of Clay County, City of Glyndon.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Red River of the North	At 110th Street South/County Highway 71	None	+926	Unincorporated Areas of Clay County, City of Georgetown, City of Moorhead.
	At the Norman County boundary	+878	+879	
	At the Wilkin County boundary	+916	+919	
South Branch Buffalo River ..	At confluence with Buffalo River	+914	+915	Unincorporated Areas of Clay County.
	Approximately 200 feet downstream of 180th Avenue South.	+943	+942	
South Branch Wild Rice River.	Backwater area approximately 1,450 feet downstream of Burlington Northern & Santa Fe Railway/State Highway 32.	None	+1119	City of Ulen.
Stony Creek	At confluence with South Branch Buffalo River	+925	+924	Unincorporated Areas of Clay County.
	Approximately 100 feet upstream of the confluence with South Branch Buffalo River.	+925	+924	
Unnamed Tributary to Whisky Creek.	At 165th Avenue South	None	+993	Unincorporated Areas of Clay County.
	Approximately 3,110 feet upstream of Front Street South/County Highway 52.	None	+1030	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Dilworth
Maps are available for inspection at 21st Avenue Southeast, Dilworth, MN 56529.

City of Georgetown
Maps are available for inspection at 127 Main Street, Georgetown, MN 56546.

City of Glyndon
Maps are available for inspection at 36 3rd Street Southeast, Glyndon, MN 56547.

City of Moorhead
Maps are available for inspection at 500 Center Avenue, Moorhead, MN 56561.

City of Ulen
Maps are available for inspection at 201 1st Street Northwest, Ulen, MN 56585.

Unincorporated Areas of Clay County
Maps are available for inspection at 807 11th Street North, Moorhead, MN 56560.

Rice County, Minnesota, and Incorporated Areas

Cannon River	Approximately 4,460 feet downstream of Hester Street/County Highway 1.	None	+912	City of Morristown, City of Northfield, Unincorporated Areas of Rice County.
	At State Highway 60/Morristown Boulevard	None	+1003	
Spring Creek	Approximately 60 feet upstream of North Dennison Road/County Highway 28.	None	+945	City of Northfield, Unincorporated Areas of Rice County.
	Approximately 740 feet upstream of Ford Street	None	+970	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Morristown

Maps are available for inspection at City Hall, 402 Central Avenue, Morristown, MN 55052.

City of Northfield

Maps are available for inspection at City Hall, 801 Washington Street, Northfield, MN 55057.

Unincorporated Areas of Rice County

Maps are available for inspection at the County Government Services Building, 320 Northwest 3rd Street, Faribault, MN 55021.

Cedar County, Missouri, and Incorporated Areas

Stockton Lake	Shorelines of Stockton Lake	None	+887	City of Stockton, Unincorporated Areas of Cedar County.

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Stockton

Maps are available for inspection at 201 South High, Stockton, MO 65785.

Unincorporated Areas of Cedar County

Maps are available for inspection at 113 South Street, Stockton, MO 65785.

Otero County, New Mexico, and Incorporated Areas

Cherokee Bill Canyon	Approximately 2.71 miles downstream of the intersection of U.S. Highway 70 and White Tail Road.	None	+6699	Muscalero Apache Indian Reservation.
	Approximately 2.61 miles downstream of the intersection of U.S. Highway 70 and White Tail Road.	None	+6716	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Muscalero Apache Indian Reservation

Maps are available for inspection at 1000 New York Ave, Alamogordo, NM 88310.

Crawford County, Ohio, and Incorporated Areas

Sandusky River	Approximately 0.8 mile downstream of Gay Street	None	+970	Unincorporated Areas of Crawford County.
	Approximately 0.6 mile downstream of U.S. Highway 30.	None	+985	
Zuber Ditch	Approximately 0.6 mile upstream of the confluence with Olentangy River.	None	+1131	Unincorporated Areas of Crawford County.
	Approximately 900 feet downstream of North Market Street.	None	+1131	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	

Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Crawford County

Maps are available for inspection at the County Administration Building, 112 East Mansfield Street, Bucyrus, OH 44820.

Noble County, Ohio, and Incorporated Areas

Salt Run	Approximately 460 feet downstream of State Route 78 in the Village of Caldwell.	None	+726	Unincorporated Areas of Noble County, Village of Caldwell.
	Approximately 280 feet upstream of State Route 564	None	+738	
West Fork Duck Creek	Approximately 0.41 mile upstream of Township Highway 330.	None	+734	Unincorporated Areas of Noble County, Village of Belle Valley.
	Approximately 0.6 mile upstream of Main Street in the Village of Belle Valley.	None	+746	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Noble County

Maps are available for inspection at the County Auditor's Office, 200 Courthouse Square, Caldwell, OH 43724.

Village of Belle Valley

Maps are available for inspection at the County Auditor's Office, 200 Courthouse Square, Caldwell, OH 43724.

Village of Caldwell

Maps are available for inspection at the County Auditor's Office, 200 Courthouse Square, Caldwell, OH 43724.

Kent County, Rhode Island (All Jurisdictions)

Maskerchugg River	Approximately 750 feet downstream of State Route 1 (Boston Post Road).	+13	+15	City of Warwick, Town of East Greenwich.
	Approximately 45 feet upstream of Division Street	+69	+75	
North Branch Pawtuxet River (Upper Reach).	Approximately 530 feet downstream of State Route 115 (located in Providence County).	None	+183	Town of Coventry.
	Approximately 240 feet downstream of State Route 116 (located in Providence County).	None	+185	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

City of Warwick

Maps are available for inspection at the City Hall-Annex Building, Planning Department, 3275 Post Road, Warwick, RI 02286.

Town of Coventry

Maps are available for inspection at the Public Works Department, 1675 Flat River Road, Coventry, RI 02816.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground ^ Elevation in meters (MSL)		Communities affected
		Effective	Modified	
Town of East Greenwich				
Maps are available for inspection at the Department of Public Works, 111 Pierce Street, East Greenwich, RI 02818.				
Van Zandt County, Texas, and Incorporated Areas				
Mill Creek	Approximately 400 feet upstream of State Highway 64	None	+457	Unincorporated Areas of Van Zandt County.
	Just downstream of State Highway 243	None	+467	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.
^ Mean Sea Level, rounded to the nearest 0.1 meter.
** BFEs to be changed include the listed downstream and upstream BFEs, and include BFEs located on the stream reach between the referenced locations above. Please refer to the revised Flood Insurance Rate Map located at the community map repository (see below) for exact locations of all BFEs to be changed.

Send comments to Kevin C. Long, Acting Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472.

ADDRESSES

Unincorporated Areas of Van Zandt County

Maps are available for inspection at 121 East Dallas Street, Room 204, Canton, TX 75103.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Deborah S. Ingram,

Acting Deputy Assistant Administrator for Mitigation, Mitigation Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–28314 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

49 CFR Part 214

[Docket No. FRA–2008–0059, Notice No. 3]

RIN 2130–AB96

Railroad Workplace Safety; Adjacent-Controlled-Track On-Track Safety for Roadway Workers

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: FRA proposes to amend its regulations on railroad workplace safety to reduce further the risk of serious injury or death to roadway workers. In particular, FRA proposes to require that railroads adopt specified on-track safety procedures to protect certain roadway work groups from the movement of trains or other on-track equipment on ''adjacent controlled track.'' FRA proposes to define ''adjacent controlled track'' to mean ''a controlled track whose track center is spaced 19 feet or less from the track center of the occupied track.'' These on-track safety procedures would be required for each adjacent controlled track when a roadway work group with at least one of the roadway workers on the ground is engaged in a common task with an on-track roadway maintenance machine or coupled equipment on an occupied track. FRA also proposes to require that railroads, contractors to railroads, and roadway workers comply with these procedures. The NPRM issued as ''Notice No. 1'' under this same docket number and published July 17, 2008 (73 FR 41214), was withdrawn by ''Notice No. 2'' published August 13, 2008 (73 FR 47124).

DATES: (1) Written comments must be received no later than January 25, 2010. Comments received after that date will be considered to the extent possible without incurring additional expense or delay.

(2) FRA anticipates being able to resolve this rulemaking without a public, oral hearing. However, if FRA receives a specific request for a public, oral hearing prior to December 28, 2009, one will be scheduled and FRA will publish a supplemental notice in the **Federal Register** to inform interested parties of the date, time, and location of any such hearing.

ADDRESSES: *Comments:* You may submit comments on this NPRM, identified by Docket No. FRA–2008–0059, Notice No. 3, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Follow the online instructions for submitting comments.
- *Mail:* Docket Management Facility, U.S. Department of Transportation, West Building, Ground Floor, M–33, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- *Hand Delivery or Courier:* Docket Management Facility, U.S. Department of Transportation, West Building, Ground Floor, M–33, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal holidays.
- *Fax:* 202–493–2251.

Instructions: For detailed instructions on submitting comments, and additional information on the rulemaking process, see the ''Public Participation'' heading of the **SUPPLEMENTARY INFORMATION** section of this preamble. Note that all comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. Please see the ''Privacy Act'' subheading under the ''Regulatory Impact and Notices''

heading, below, in Section VIII.I. of this preamble.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov* anytime, or to the Docket Management Facility, U.S. Department of Transportation, West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal holidays. Follow the online instructions for accessing the docket.

FOR FURTHER INFORMATION CONTACT: Kenneth Rusk, Staff Director, Track Division, Office of Safety Assurance and Compliance, FRA, 1200 New Jersey Avenue, SE., RRS–15, Mail Stop 25, Washington, DC 20590 (telephone 202–493–6236); or Anna Winkle, Trial Attorney, Office of Chief Counsel, FRA, 1200 New Jersey Avenue, SE., RCC–12, Mail Stop 10, Washington, DC 20590 (telephone 202–493–6166 or 202–493–6052).

SUPPLEMENTARY INFORMATION:

Table of Contents for Supplementary Information

I. Impetus for Rulemaking
II. Overview of the Existing Roadway Worker Protection (RWP) Rule
  A. Applicability and Basic Definitions
  B. Authorized Methods of Establishing On-Track Safety
  C. Existing On-Track Safety Requirements for Roadway Work Groups With Respect to Adjacent Tracks
III. Notice of Safety Advisory 2004–01
IV. Recent Roadway Worker Accidents (1997–2008)
V. Joint Petition to FRA for an Emergency Order
VI. Current Rulemaking To Revise the RWP Rule
  A. Overview of the RSAC [Railroad Safety Advisory Committee]
  B. Proceedings in This Rulemaking to Date Generally
  C. Proceedings concerning On-Track Safety Procedures for Adjacent Tracks, Including Response to Comments on the July 17, 2008 NPRM
  1. Joint Comments of BMWED and BRS
  2. Draft Comments of AAR
  3. Comments of Additional Interested Parties
VII. Section-by-Section Analysis
VIII. Regulatory Impact and Notices
  A. Executive Order 12866 and DOT Regulatory Policies and Procedures
  B. Regulatory Flexibility Act and Executive Order 13272
  C. Paperwork Reduction Act
  D. Federalism Implications
  E. Environmental Impact
  F. Unfunded Mandates Reform Act of 1995
  G. Energy Impact
  H. Trade Impact
  I. Privacy Act

I. Impetus for Rulemaking

As will be detailed in this NPRM, the recent increase in roadway worker fatalities that have occurred on an adjacent track (*i.e.,* under the existing rule, any track within 25 feet of the centerline of the track to which the roadway work group was assigned to perform one or more roadway worker duties) has caused considerable concern at FRA and throughout the industry, even prompting the filing of a joint petition for emergency order under 49 U.S.C. 20104 on April 11, 2008. *See* 49 CFR part 214, subpart C (''Roadway Worker Protection Rule'' or ''RWP Rule''). FRA had issued a notice of safety advisory to address this same issue in May of 2004; however, it appears that the salutary effects of the safety advisory, which produced a period of 16 months with no fatalities on an adjacent track, were not long-lasting, as four fatalities have since occurred on an adjacent track where a roadway work group, with at least one of the roadway workers on the ground, was engaged in a common task with an on-track roadway maintenance machine or coupled equipment on an occupied track. These proposed amendments to the Roadway Worker Protection Rule are based on the consensus language developed through the Roadway Worker Protection (RWP) Working Group of FRA's Railroad Safety Advisory Committee (RSAC), which is comprised of various representatives of the groups that are affected by this rule (including railroad management, railroad labor organizations, and contractors). Because incidents involving adjacent controlled tracks appear to present clear evidence of significant risk that is not effectively addressed by the current regulation, FRA has concluded that moving forward with this proposal in advance of the other proposals contained in the RSAC consensus [1] is necessary and appropriate.

II. Overview of the Existing RWP Rule

A. Applicability and Basic Definitions

The RWP Rule requires each railroad that operates rolling equipment on track that is part of the general railroad system of transportation to ''adopt and implement a program that will afford on-track safety to all roadway workers whose duties are performed on that railroad.'' *See* 49 CFR 214.3, 214.303(a).[2] ''On-track safety'' is defined as ''a state of freedom from the danger of being struck by a moving railroad train or other railroad equipment, provided by operating and safety rules that govern track occupancy by personnel, trains and on-track equipment.'' *See* § 214.7. The roadway workers that must be afforded on-track safety are any employees of a railroad, or of a contractor to a railroad, whose duties include ''inspection, construction, maintenance or repair of railroad track, bridges, roadway, signal and communication systems, electric traction systems, roadway facilities or roadway maintenance machinery on or near track or with the potential of fouling a track, and flagmen and watchmen/lookouts . * * *'' *See* § 214.7, ''Roadway worker.''

B. Authorized Methods of Establishing On-Track Safety

Several methods are authorized to be used to provide on-track safety for roadway workers, and many of those methods involve establishing ''working limits,'' which is defined in part as ''a segment of track with definite boundaries established in accordance with [part 214] upon which trains and engines may move only as authorized by the roadway worker having control over that defined segment of track.'' *See* §§ 214.7 and 214.319. Working limits may be established on controlled track (*i.e.,* ''track upon which the railroad's operating rules require that all movements of trains must be authorized by a train dispatcher or a control operator'') through exclusive track occupancy (§ 214.321), foul time (§ 214.323), or train coordination (§ 214.325). *See* §§ 214.7 and 214.319. Regardless of which method is chosen, the working limits are only permitted to be under the control of a qualified roadway worker in charge, and all affected roadway workers must be notified and either clear of the track or provided on-track safety through train approach warning (in accordance with § 214.329) before the working limits are released to permit the operation of trains or other on-track equipment through the working limits. *See id.*

Train approach warning is another common method of establishing on-

[1] While the consensus language relating to adjacent track issues that was developed through the RSAC was originally intended to be published as part of a larger NPRM, FRA has decided to propose these adjacent-track-related provisions in this separate NPRM so that an appropriate provision will be in effect in a more timely fashion than if the provision were one of many in the larger rulemaking that would need to undergo internal review and approval and public notice and comment. The remaining provisions not related to adjacent track will be proposed in a separate NPRM at a later date, as part of the larger RWP rulemaking.

[2] All references in this preamble to a section or other provision of a regulation are to a section, part or, other provision in title 49, Code of Federal Regulations unless otherwise specified.

track safety in which a trained and qualified watchman/lookout provides warning to roadway worker(s) of the approach of a train or on-track equipment in sufficient time to enable each roadway worker to move to and occupy a previously arranged place of safety not less than 15 seconds before a train moving at the maximum speed authorized on that track would arrive at the location of the roadway worker. *See* §§ 214.329 and 214.7 ''Watchman/lookout.'' Train approach warning is sometimes used as a temporary form of on-track safety when a roadway worker in charge needs to nullify the on-track safety previously established by working limits in order to permit a train or piece of on-track equipment to enter the roadway work group's working limits. Train approach warning permits the roadway workers to continue working for longer (than if working limits were the only form of on-track safety in effect) if the working limits span several miles and the train or equipment will not be passing by the work area for some time due to a speed restriction, the distance away, or the train or equipment halting its movement. It should be noted that switching temporarily to ''train approach warning'' is permissible only if the change was previously discussed in detail with the roadway work group either in the on-track safety job briefing prior to beginning work or in an updated on-track safety job briefing pursuant to § 214.315(d). *See* § 214.315.

C. Existing On-Track Safety Requirements for Roadway Work Groups With Respect to Adjacent Tracks

Section 214.335(c) of the RWP Rule currently requires that roadway work groups engaged in ''large-scale maintenance or construction'' be provided with on-track safety in the form of ''train approach warning'' for train or equipment movements on adjacent tracks if the adjacent tracks are not already included within the working limits. Under the current definition of ''adjacent tracks,'' on-track safety as discussed above is required for any tracks with track centers spaced less than 25 feet apart from the track center of the track to which a roadway work group is assigned to perform large-scale maintenance or construction. *See* §§ 214.7, 214.335(c). The track to which the roadway work group is assigned to perform the large-scale maintenance or construction is commonly referred to as the ''occupied track.'' Thus, in triple-main track territory, if a roadway work group is occupying the middle track (*e.g.,* Main Track No. 2) in order to perform large-scale maintenance or construction, and the track centers of the tracks on either side of the occupied track are within 25 feet of the track center of the occupied track, then on-track safety is required to be established on both adjacent tracks (*e.g.,* Main Track Nos. 1 and 3). In some yards or territories, where track centers may be spaced only 12 feet apart, an occupied track (*e.g.,* Yard Track No. 3) may have up to four adjacent tracks (*e.g.,* Yard Track Nos. 1, 2, 4, and 5). In such cases, the current rule requires on-track safety to be established on all four adjacent tracks, in addition, of course, to the on-track safety required for the occupied track itself. *See* §§ 214.335(c) and 214.337(a).

Although the term ''large-scale maintenance or construction'' is not specifically defined in the regulation, FRA noted in the preamble to the 1996 final rule establishing the RWP Rule that the principle behind the reference to large-scale maintenance or construction ''is the potential for distraction, or the possibility that a roadway worker or roadway maintenance machine might foul the adjacent track and be struck by an approaching or passing train,'' and further stated that ''conditions in which the risk of distraction is significant'' require measures to provide on-track safety on adjacent tracks.'' *See* 61 FR 65959, 65971 (December 16, 1996). To further clarify what was meant by the term ''large-scale maintenance or construction,'' FRA adopted the recommendation of the Roadway Worker Safety Advisory Committee, which described large-scale track maintenance and/or renovations, such as but not limited to, ''rail and tie gangs, production in-track welding, ballast distribution, and undercutting.'' *See id.* Under such guidance, many railroads were not providing on-track safety on adjacent tracks for surfacing operations, small tie renewal operations, or similar maintenance operations that, while smaller in scale, still included one or more on-track roadway maintenance machines or coupled equipment. Fatalities occurred on the adjacent track during such operations when on-track safety was not established on the adjacent track or had been temporarily or permanently nullified or suspended to permit the passage of a train or other on-track equipment.

III. Notice of Safety Advisory 2004–01

After the occurrence of five roadway worker fatalities in one calendar year (2003), including one on an adjacent track, FRA responded on April 27, 2004, by issuing Notice of Safety Advisory 2004–01, which was later published in the **Federal Register** on May 3, 2004. *See* 69 FR 24220. FRA issued this safety advisory to recommend certain safety practices, to review existing requirements for the protection of roadway workers from traffic on adjacent tracks, and to heighten awareness to prevent roadway workers from inadvertently fouling a track when on-track safety is not provided. *See id.*

The safety advisory explained that the requirements of the RWP Rule, including the requirement to provide adjacent track on-track safety for large-scale maintenance or construction in § 214.335(c), are only minimum standards. The advisory emphasized that railroads and railroad contractors are free to prescribe additional or more-stringent standards consistent with the rule. *See id.* at 24222 and § 214.301(b).

FRA recommended that railroads and contractors to railroads develop and implement basic risk assessment procedures for use by roadway workers to determine the likelihood that a roadway worker or equipment would foul an adjacent track prior to initiating work activities, regardless of whether those activities were ''large-scale'' or ''small-scale.'' The advisory provided examples of relevant factors to consider in making such an assessment. These factors included whether the work could be conducted by individuals positioned between the rails of a track on which on-track safety has been established, as opposed to being on the field side of such a track toward an adjacent track; whether there was a structure between the tracks to prevent intrusion (such as a fence between the tracks at a passenger train station and the tall beam of a through-plate girder bridge); the track-center distance, to ensure that the adjacent track would not be fouled if a worker were to inadvertently trip and fall; the nature of the work (inspection or repair); the sight distances; and the speed of trains on the adjacent track. *See* 69 FR 24222. FRA further noted that, upon completion of an on-site risk assessment, the on-track safety briefing required by § 214.315(a) would be the ideal instrument to implement preventive measures concerning adjacent tracks. *See id.*

In addition to the above recommendation concerning basic risk assessment, FRA recommended that railroads and contractors to railroads consider taking the following actions:

- Use of working limits for activities where equipment could foul adjacent track (whether large-scale or small-scale activities);
- Use rotation stops to mitigate the dangers associated with on-track

equipment and trains passing on adjacent tracks;

- Review procedures for directing trains through adjacent track working limits, and enhance such procedures when necessary;
- Install adjacent track warning signs/devices in the operating cab of on-track machines to remind roadway maintenance machine operators to not inadvertently depart the equipment onto a track where there may be trains and other on-track equipment passing;
- Provide additional training and monitoring to employees, emphasizing the need to cross tracks in a safe manner (i.e., single file and after looking in both directions);
- Reinforce to individual roadway workers that it is critical not to foul a track except in the performance of duty and only when on-track safety has been established. This training could be accomplished through training sessions, as well as daily job briefings; and
- Institute peer-intervention measures by which workers are encouraged to intervene when observing another roadway worker engaging in potentially non-compliant and unsafe activity.

See id.

IV. Recent Roadway Worker Accidents (1997–2008)

In the twelve years since the RWP Rule went into effect on January 15, 1997, there have been nine roadway worker fatalities on an adjacent track. Seven of those fatalities have occurred on a controlled track that was adjacent to the track on which a roadway work group, with at least one of the roadway workers on the ground, was engaged in a common task with an on-track roadway maintenance machine or coupled equipment. FRA notes that there has been only one adjacent-track fatality where a roadway work group had been engaged in a common task with a lone hi-rail vehicle, defined in § 214.7 as ''a roadway maintenance machine that is manufactured to meet Federal Motor Vehicle Safety Standards and is equipped with retractable flanged wheels so that the vehicle may travel over the highway or on railroad tracks.'' [3] In addition, there have been no adjacent-track fatalities where a roadway work group had been engaged in a common task with a catenary maintenance tower car on the occupied track. This is likely because the duties normally performed by an employee operating a hi-rail or a catenary maintenance tower car tend to be less distracting to on-ground roadway workers and produce less dust and noise than a typical on-track roadway maintenance machine. Given the above, FRA proposes that adjacent-track on-track safety not be required for roadway work groups engaged in a common task with a hi-rail or a catenary maintenance tower car, as discussed in the section-by-section analysis of paragraphs (b)(2) and (b)(3), respectively, in new proposed § 214.336.

Of the seven fatalities that occurred under the circumstances described above and which this rule proposes to address, three occurred during the period after the effective date of the rule and before the publication of the safety advisory on May 3, 2004, and four have occurred since that period. In the four-year period prior to May of 2004 (May 1, 2000—April 30, 2004), there has been one adjacent-track fatality known to have occurred under such circumstances, for a rate of .25 per year. In the four-year period since (May 1, 2004—April 30, 2008), there have been four adjacent-track fatalities, for a rate of one per year, which is four times the rate of the previous four-year period. While FRA recognizes that even one death can make rates change dramatically when the total number of deaths is small, the increase in the rate of these deaths despite the safety advisory leads FRA to conclude that regulatory action is needed to avert an escalating number of deaths. Moreover, given the extensive participation in developing these consensus regulatory provisions by representatives of all of the key interests involved in this issue, it is contrary to the public interest to wait for all of the other issues in the larger RWP rulemaking to be resolved or to engage in lengthy periods for notice and public comment before acting to prevent more deaths.

The following is a brief summary of the results of FRA's investigations of the four most recent incidents that resulted in these unfortunate fatalities:

- *October 5, 2005:* A roadway surfacing gang tamper operator, with 28 years of service, was walking up to the front of the tamper to put away the light buggies as his surfacing gang, having just completed its work, was getting ready to travel to clear the number two main track. The operator was walking east on the side of the tamper between the two main tracks when he was struck by a westbound train on the adjacent track. The track centers were spaced approximately 13 feet apart, and the train was traveling at an estimated speed of 40 miles per hour (mph).
- *March 12, 2007:* A surfacing gang was occupying the number one main track in a double-main territory. The surfacing gang foreman (the roadway worker in charge), who earlier had notified the other members of the gang of pending movement on the adjacent track, was standing in the gage of the same adjacent track when he was struck by a train. It remains unclear why he was fouling the adjacent track at the time of the incident. The track centers were spaced approximately 13 feet, 6 inches apart, and the maximum authorized speed on the adjacent track was 50 mph. The foreman was the only roadway worker on the ground at the time of the incident.
- *February 10, 2008:* A train struck a roadway worker inside an interlocking on a triple-main track territory. The worker was part of a gang that consisted of approximately 10 workers that were engaged in the repair of a crossover on the middle main track with a tamper. Foul time was being used as adjacent-track on-track protection, but this protection was removed by the roadway worker in charge, who gave permission to the dispatcher to permit a train to operate on the adjacent track through the roadway work group working limits. As the train entered the interlocking on a limited clear signal indication for a crossover move past the work area, one of the roadway workers attempted to cross the track in front of the train and was struck. The track centers were spaced approximately 13 feet apart, and the maximum authorized speed for the train on the adjacent track was 45 mph.
- *March 27, 2008:* A surfacing gang was working on double-main track territory. The surfacing gang foreman was standing in the foul of the adjacent track while his surfacing crew worked on the number two main track (the occupied track). A train operating on the adjacent track struck the foreman. No on-track safety was in effect on the adjacent track involved at the time of the incident. The track centers were spaced approximately 14 feet, 7 inches apart, and the maximum authorized speed on the adjacent track was 70 mph. The foreman was the only roadway worker on the ground at the time of the incident.

While the above discussion focuses on those fatalities that have occurred on an adjacent track where a roadway work group, with at least one of the roadway workers on the ground, was engaged in a common task with an on-track roadway maintenance machine or coupled equipment on an occupied track, it is important to discuss some of the common circumstances in all nine of the fatalities that have occurred on an

[3] In that case, the roadway workers were under the impression that adjacent-track on-track safety was in effect, but it was not, due to a miscommunication.

adjacent track since the rule went into effect, as these circumstances were considered by FRA in its decision to issue this NPRM. The first common circumstance is the type of track. All nine of the fatalities occurred on ''controlled'' track, rather than ''non-controlled'' track. This was taken into consideration in writing FRA's proposed definition of ''adjacent controlled track,'' which would be included in proposed new § 214.336(a)(3) and would be limited to controlled tracks whose track centers are spaced 19 feet or less from the track center of the occupied track. The term would only be applicable to § 214.336 and would not replace the broader term ''adjacent tracks,'' which is defined in § 214.7.

Second, all nine of the fatalities occurred on an adjacent track that was quite closely-spaced to the track that the roadway work group was occupying. Six of the adjacent tracks had track centers that were spaced approximately 14 feet or less from the respective track centers of the tracks that the roadway work groups were occupying, and all nine of the adjacent tracks were spaced 15 feet or less from the track centers of the respective occupied tracks. This common circumstance was also taken into consideration in FRA's proposed definition of ''adjacent controlled track,'' which would have a narrower applicability for purposes of proposed § 214.336 than the term ''adjacent tracks,'' because it would not include tracks with track centers that were spaced more than 19 feet (but less than 25 feet) away from the track center of the occupied track.

The third common circumstance of the nine fatalities on adjacent track is the time of year. Four of the fatalities occurred during the first quarter (January–March), none of the fatalities occurred in the second and third quarters of the year (April–June and July–September, respectively), and the other five fatalities occurred during the fourth quarter (October–December). As noted earlier in Section I., above, because incidents involving adjacent controlled tracks appear to present clear evidence of significant risk that is not effectively addressed by the current regulation, FRA has concluded that moving forward with this proposal in advance of the other proposals contained in the RSAC consensus is necessary and appropriate in order to reduce the risk of additional fatalities on adjacent track that are likely to occur late this year or early next year in the absence of further regulatory action.

V. Joint Petition to FRA for an Emergency Order

On April 11, 2008, the Brotherhood of Maintenance of Way Employes Division (BMWED) and the Brotherhood of Railroad Signalmen (BRS) filed a joint petition requesting that FRA issue an emergency order under 49 U.S.C. 20104(a) requiring adjacent-track protection for roadway work groups. The petition noted that similar requests, which were filed on October 7, 2005, November 7, 2003, and December 21, 1999, were denied by FRA. The petitioners expressed their belief that, under the existing provisions of the rule, roadway workers will continue to suffer preventable serious injuries and death. The petitioners asserted that FRA should require railroads and their contractors to establish on-track safety on adjacent tracks (''adjacent-track on-track safety'') for a wider range of work activities. In FRA's January 5, 2006 denial of the October 2005 petition, FRA noted that the RSAC working group tasked to review and revise the RWP Rule (''RWP Working Group'') was ''committed to presenting comprehensive draft language * * * that would more closely tailor the solution to the problem.'' And while the RWP Working Group did in fact draft this language, and both the Working Group and the full RSAC were able to reach consensus on such language, BMWED and BRS were concerned that the language, which has not been published as an NPRM, would not become a final rule for a considerable period of time, leaving the possibility for further preventable fatalities. BMWED and BRS urged FRA to issue an emergency order that would adopt the adjacent-track consensus language of the RWP RSAC.

On April 18, 2008, the American Train Dispatchers Association (ATDA) filed a letter in support of the BMWED and BRS joint petition. In the letter, ATDA agreed that preventable injuries and deaths continue to occur because of a lack of positive regulation mandating adjacent-track on-track safety and urged FRA to issue an emergency order based upon the RSAC-approved and consensus-based replacement language for § 214.235(c), as indicated in the joint petition.

As an emergency order does not require prior notice to the affected party or an opportunity to be heard prior to issuance of the order, Congress declared that such an order may be invoked only where an unsafe condition or practice ''causes an emergency situation involving a hazard of death or personal injury.'' 49 U.S.C. 20104. By letter dated June 4, 2008, FRA denied the joint petition for emergency order, noting that the increased rate of adjacent-track-related fatalities cited in the joint petition makes a strong case for regulatory action, but does not constitute an emergency situation ''that has developed suddenly and unexpectedly in which the danger is immediate.'' To address this serious safety concern, FRA decided to issue a separate NPRM with an abbreviated comment period, as further discussed in Section VI.C., below.

VI. Current Rulemaking To Revise the RWP Rule

A. Overview of the RSAC

In March 1996, FRA established RSAC, which provides a forum for developing consensus recommendations to FRA's Administrator on rulemakings and other safety program issues. The Committee includes representation from all of the agency's major stakeholder groups, including railroads, labor organizations, suppliers and manufacturers, and other interested parties. A list of member groups follows:

- American Association of Private Railroad Car Owners (AARPCO);
- American Association of State Highway and Transportation Officials (AASHTO);
- American Chemistry Council;
- American Petroleum Institute;
- American Public Transportation Association (APTA);
- American Short Line and Regional Railroad Association (ASLRRA);
- ATDA;
- Association of American Railroads (AAR);
- Association of Railway Museums;
- Association of State Rail Safety Managers (ASRSM);
- Brotherhood of Locomotive Engineers and Trainmen (BLET);
- BMWED;
- BRS;
- Chlorine Institute;
- Federal Transit Administration (FTA)*;
- Fertilizer Institute;
- High Speed Ground Transportation Association (HSGTA);
- Institute of Makers of Explosives;
- International Association of Machinists and Aerospace Workers;
- International Brotherhood of Electrical Workers (IBEW);
- Labor Council for Latin American Advancement*;
- League of Railway Industry Women*;
- National Association of Railroad Passengers (NARP);
- National Association of Railway Business Women*;

- National Conference of Firemen & Oilers;
- National Railroad Construction and Maintenance Association (NRC);
- National Railroad Passenger Corporation (Amtrak);
- National Transportation Safety Board (NTSB)*;
- Railway Supply Institute (RSI);
- Safe Travel America (STA);
- Secretaria de Comunicaciones y Transporte*;
- Sheet Metal Workers International Association (SMWIA);
- Tourist Railway Association, Inc.;
- Transport Canada*;
- Transport Workers Union of America (TWU);
- Transportation Communications International Union/BRC (TCIU/BRC);
- Transportation Security Administration (TSA)*; and
- United Transportation Union (UTU).

* Indicates associate, non-voting membership.

When appropriate, FRA assigns a task to RSAC, and after consideration and debate, RSAC may accept or reject the task. If the task is accepted, RSAC establishes a working group that possesses the appropriate expertise and representation of interests to develop recommendations to FRA for action on the task. These recommendations are developed by consensus. A working group may establish one or more task forces to develop facts and options on a particular aspect of a given task. The individual task force then provides that information to the working group for consideration. If a working group comes to unanimous consensus on recommendations for action, the package is presented to the full RSAC for a vote. If the proposal is accepted by a simple majority of RSAC, the proposal is formally recommended to FRA. FRA then determines what action to take on the recommendation. Because FRA staff play an active role at the working group level in discussing the issues and options and in drafting the language of the consensus proposal, FRA is often favorably inclined toward the RSAC recommendation. However, FRA is in no way bound to follow the recommendation, and the agency exercises its independent judgment on whether the recommended rule achieves the agency's regulatory goal, is soundly supported, and is in accordance with policy and legal requirements. Often, FRA varies in some respects from the RSAC recommendation in developing the actual regulatory proposal or final rule. Any such variations would be noted and explained in the rulemaking document issued by FRA. If the working group or RSAC is unable to reach consensus on a recommendation for action, FRA moves ahead to resolve the issue through traditional rulemaking proceedings.

B. Proceedings in This Rulemaking to Date Generally

On January 26, 2005, the RSAC formed the RWP Working Group (''Working Group'') to consider specific actions to advance the on-track safety of employees of covered railroads and their contractors engaged in maintenance-of-way activities throughout the general system of railroad transportation, including clarification of existing requirements. The assigned task was to review the existing rule, technical bulletins, and a safety advisory dealing with on-track safety. The Working Group was to consider implications and, as appropriate, consider enhancements to the existing rule. The Working Group would report to the RSAC any specific actions identified as appropriate, and would report planned activity to the full Committee at each scheduled Committee meeting, including milestones for completion of projects and progress toward completion.

The Working Group is comprised of members from the following organizations:

- Amtrak;
- APTA;
- ASLRRA;
- ATDA;
- AAR, including members from BNSF Railway Company (BNSF), Canadian National Railway Company (CN), Canadian Pacific Railway, Limited (CP), Consolidated Rail Corporation (Conrail), CSX Transportation, Inc. (CSXT), Kansas City Southern (KCS), Norfolk Southern Corporation (NS), and Union Pacific Railroad Company (UP);
- Belt Railroad of Chicago;
- BLET;
- BMWED;
- BRS;
- Federal Railroad Administration (FRA);
- Indiana Harbor Belt Railroad (IHB);
- Long Island Rail Road (LIRR);
- Metro-North Commuter Railroad Company (Metro-North);
- Montana Rail Link;
- NRC;
- Northeast Illinois Regional Commuter Railroad Corporation (Metra);
- RailAmerica, Inc.;
- Southeastern Pennsylvania Transportation Authority (SEPTA);
- UTU; and
- Western New York and Pennsylvania Railroad (WNY&P).

The Working Group held 12 multi-day meetings. The group worked diligently and was able to reach consensus on 32 separate items.

C. Proceedings Concerning On-Track Safety Procedures for Adjacent Tracks, Including Response to Comments on the July 17, 2008 NPRM

One of the items on which the Working Group was able to reach consensus dealt specifically with the adjacent-track on-track safety issue in § 214.335 On-track safety procedures for roadway work groups. The consensus language developed by the Working Group for this topic, which was approved by the full RSAC and formally recommended to FRA for paragraphs (c), (d), and (e), is as follows:

For paragraph (c)—''On-track safety is required for adjacent controlled track within 19 feet of the centerline of the occupied track when roadway work group(s) consisting of roadway workers on the ground and on-track self-propelled or coupled equipment are engaged in a common task on an occupied track.

- ''Except as provided by paragraph (c)(3) of this section, when trains are cleared through working limits on an adjacent controlled track, or when watchman/lookout warning in accordance with § 214.329 is the form of adjacent on-track safety, roadway workers shall occupy a predetermined place of safety and all on-ground work and equipment movement activity within the fouling space of the occupied track shall cease upon notification of pending adjacent track movement (working limits) or upon receiving the watchman/lookout warning.
- ''When single or multiple movements are cleared through adjacent controlled track working limits, on-ground work and equipment movement on the occupied track may resume only after all such movements on adjacent track have passed each component of the Roadway Work Group(s). If the train stops before passing all roadway workers, the employee in charge shall communicate with the engineer prior to allowing the work to resume.
- ''When single or multiple movements are cleared through adjacent controlled track working limits at a speed no greater than 25 mph, work performed exclusively between the rails of the occupied track, or to the field side of the occupied track with no adjacent track, may continue upon notification of each roadway worker of movement on adjacent track. On-ground work shall not be performed within 25 feet to the front or 25 feet to the rear of roadway maintenance machine(s) on the

occupied track during such adjacent track movement.''

For paragraph (d), the Working Group recommended ''Equipment may not foul an adjacent controlled track unless protected by working limits and there are no movements authorized through the working limits by the roadway worker in charge.''

And for paragraph (e), the Working Group recommended ''The mandatory provisions for adjacent controlled track protection under this subpart are not applicable to work activities involving—

- ''A hi-rail vehicle as defined in § 214.7, provided such hi-rail vehicle is not coupled to railroad cars. Where multiple hi-rail vehicles are engaged in a common task, the on-track safety briefing shall include discussion of the nature of the work to be performed to determine if adjacent controlled track protection is necessary. Nothing in this subpart prohibits the roadway worker in charge of the hi-rail vehicle from establishing adjacent controlled track protection, as he/she deems necessary.
- ''On-ground roadway workers exclusively performing work on the field side of the occupied track.
- ''Catenary maintenance tower cars with roadway workers positioned on the ground within the gage of the occupied track for the sole purpose of applying or removing grounds. Nothing in this subpart prohibits the roadway worker in charge of the catenary maintenance tower car from establishing adjacent track protection, as he/she deems necessary.''

Upon reviewing the joint petition of the BRS and BMWED for an emergency order, the consensus language of the Working Group quoted above, and the relevant accident data concerning roadway workers fouling adjacent tracks, FRA decided to issue a separate NPRM [4] to lower the safety risk associated with roadway workers fouling adjacent tracks. Although FRA's safety advisory may have had an initial effect and have raised awareness enough to help keep the number of all categories of roadway worker fatalities in 2004 and through almost six months in 2005 at zero, the effect was not sustained enough to combat the rise of roadway worker fatality incidents since late June of 2005, when the first roadway worker fatality occurred after the issuance of the safety advisory, or since October of 2005, when the first adjacent track roadway worker fatality occurred.

In light of recent roadway worker fatality trends, FRA determined that the agency must propose a more prescriptive approach to prevent further fatalities. The need to mandate adjacent-track on-track safety was recognized by FRA, members of the Working Group, and members of the full RSAC. The consensus language developed by the Working Group and recommended by the full RSAC is expected to reduce the risk of roadway worker fatalities due to fouling an adjacent track while working in conjunction with on-track equipment on an occupied track. As part of the process in drafting the NPRM in the larger RWP rulemaking, FRA circulated the consensus rule text concerning adjacent track and other items for errata review. Both AAR and BMWED submitted comments on this provision. To address these issues, and other potential ambiguities discovered upon a closer review of the rule text, FRA reorganized and modified the consensus text in issuing an NPRM.

FRA published an NPRM addressing adjacent-track on-track safety on July 17, 2008 (73 FR 41214), but formally withdrew the notice on August 13, 2008 (73 FR 47124). The withdrawal stated, in part—''[i]n crafting the NPRM, FRA presented the RSAC consensus language in the preamble verbatim and transparently explained its rationale for all changes it made to the consensus language. As this was an NPRM, FRA sought comment on the entire proposal, including those portions that FRA sought to clarify.

''FRA recognizes that inadvertent errors do sometimes occur in formulating a proposal and expects that interested parties would provide comments to both FRA and all other interested parties through the established comment process detailed in the NPRM. Given the alleged discrepancies between the consensus language and the proposed rule, the need to clarify the essential issues and move toward resolution of the safety concern at hand, and the ex parte communications regarding this proposed rule, FRA has decided to withdraw this rulemaking and will take such further regulatory steps as safety requires.''

Id. Due to the inherent dangers of roadway workers working in multiple-track territories among machines, FRA has decided to revisit the issues and language of the withdrawn NPRM in light of the comments received, formal and informal, and issue this revised NPRM. In accordance with the Department of Transportation's Policy (Order No. 2100.2 (1970)), all communications (including emails) between FRA employees and other parties since the publication of the July 17, 2008 NPRM and prior to its withdrawal were reduced to writing and placed in the public docket. While some comments were marked ''draft'' or received after the withdrawal of the NPRM, FRA has decided to post them to the docket, since they were still taken into consideration in drafting this NPRM. A summary of the comments received follows, below.

1. Joint Comments of BMWED and BRS

BMWED and BRS filed a joint request to extend the comment period to 60 days on July 28, 2008, as well as preliminary joint comments detailing their concerns with the substance of FRA's initial NPRM on August 10, 2008 (just after FRA issued the withdrawal notice, but prior to the publication of the notice in the **Federal Register**). FRA has considered all of the comments submitted by BMWED and BRS, formal and informal, and recognizes areas where the initial proposed rule text could be adjusted to address their concerns with FRA's initial proposal, while still addressing FRA's concerns with the consensus language that was recommended to FRA by RSAC. While BMWED also commented on the rule through ex parte communications, as posted to the docket, FRA believes that the joint initial comments address these same concerns, as well as those summarized in the joint request to extend the comment period, in one document; thus, FRA will be referencing the comments made in the preliminary joint comments, rather than those made through ex parte communications and the joint request to extend the comment period.

The first issue raised in the joint comments was the proposed removal of the definition of the term ''Adjacent tracks'' in § 214.7. BMWED and BRS stated that the removal of the definition in § 214.7 would remove tens of thousands of miles of non-controlled track from the scope of the regulation. FRA disagrees with this interpretation of the NPRM, since the proposed removal of the definition is not what would have removed non-controlled track from the scope of adjacent-track on-track safety; rather, it was the substantive provision itself that the RSAC recommended and that formed the basis for FRA's proposal that would have removed it. Since the term was no longer being used anywhere else in part 214, it would have caused confusion to have a definition that included non-

[4] As noted in Section I. of this document, the provisions related to adjacent-controlled-track on-track safety were originally intended to be published as part of a larger NPRM concerning part 214, but have been proposed here as a separate NPRM to expedite the effective date of such provisions.

controlled tracks within 25 feet of the occupied track and controlled tracks greater than 19 feet, but less than 25 feet from the occupied track, without any relevance to a substantive provision. BMWED and BRS believe that leaving the definition in would give the roadway worker in charge the necessary discretion to establish on-track safety on an adjacent track, even when on-track safety is not mandated by FRA. FRA believes that this concern may be addressed by adjusting the proposed section concerning the on-track safety job briefing (§ 214.315) to use the term ''adjacent tracks'' [5] and adding language to that section regarding the roadway worker in charge, and by modifying the language in § 214.336 to make it clear that the new requirement does not prohibit the roadway worker in charge from establishing additional on-track safety on one or more adjacent tracks as he or she deems necessary.

The joint comments also describe a concern with the withdrawn NPRM's proposed language in § 214.336(a)(1)(ii) that would have permitted a component of a roadway work group to resume all on-ground work and equipment movement after the ''head-end'' of a movement passed by the component's location when trains are cleared through working limits at speeds greater than 25 mph. The joint comments insist that the RSAC Working Group's intent was for work to stop for the entire movement, not just the head-end.

While drafting this section in the withdrawn NPRM, FRA made a good faith determination of the meaning of the consensus language and could not distinguish whether the Working Group meant ''head-end'' or entire ''movement.'' (This determination is reflected in the preamble, and comments were requested.) Based on AAR's errata review comments and FRA's review of the January 10–11, 2006 Working Group meeting minutes, it appeared possible that an error was made, with respect to the ''head-end only'' requirement, by the Working Group in creating the final draft of the consensus language that was eventually presented to the full RSAC for approval. The draft being discussed at the January meeting allowed work to commence at the head-end during movement at 30 mph, but required that the entire movement pass before allowing work to commence at speeds greater than 30 mph. The Working Group reached consensus on the ''concepts of the proposal'' for this item at its February 1–2, 2006 meeting.[6] While it was clear from the Working Group meeting minutes that the speed threshold of 30 mph was being negotiated (railroad management proposed that it be raised to 40 mph, while railroad labor proposed that it be lowered to 10 mph), the meeting minutes did not clearly capture the discussion that led to the use of the term ''movement,'' rather than ''head-end'' or ''entire movement.''

Upon reviewing other documents from that meeting, FRA has determined that railroad management's proposal that included the 40-mph threshold also appears to have conceded that the entire movement must pass before permitting work to resume, regardless of speed. While it is possible that the concession of the entire movement passing was conditioned upon railroad labor accepting railroad management's proposal as a whole (including the 40-mph threshold), FRA did not receive any further comments from AAR or any of its members on this issue, despite the request for comments on this issue in the July 17, 2008 NPRM. Since the consensus language eventually approved by the full RSAC most closely resembled that which railroad labor proposed to the Working Group, FRA has decided to edit the language in this NPRM to require that all work not subject to an exception be permitted to resume only after the entire movement (*i.e.,* the trailing-end of the movement) has passed by the location of the roadway work group component. This requirement would apply regardless of the speed of the movement.

Regarding the limited work activities that would be permitted to continue under FRA's initial proposal when trains are passing on an adjacent controlled track at speeds of 25 mph or less, BMWED and BRS note that the language proposed by FRA in paragraph (a)(2) differed from the consensus language in paragraph (c)(3) (indicating that work conducted ''exclusively between the rails of the occupied track, or to the field side of the occupied track with no adjacent track'' would be permitted to continue, provided that the work was not conducted within 25 feet of the front or rear of any roadway maintenance machine). BMWED and BRS expressed their concern that it would be unsafe to permit work to the field side if working limits are not specifically required on any adjacent track on that side.

While paragraph (c)(3) of the consensus language permitted all work to continue to the field side of the occupied track only if there was no adjacent track present, the consensus language did not impose such a limitation in the broad exception for on-ground work on the field side of the occupied track in paragraph (e)(2) (now proposed paragraph (e)(1)). FRA's original proposal would have permitted certain work to continue to the field side, provided that on-track safety (including train approach warning) had been established in accordance with this subpart on any adjacent track on that side.

In consideration of the concern raised by BMWED and BRS in their joint comments, FRA has adjusted the language originally proposed so as to better ensure the safety of the workers on that side of the occupied track. In addition to permitting work to continue while exclusively positioned on the field side of an occupied track that has no adjacent track on that side, the new proposal would also permit work to continue while exclusively positioned on the field side of an occupied track that has an adjacent track on that side provided that working limits have been established on the closest adjacent track on that side and there are no movements authorized through the working limits by the roadway worker in charge on that adjacent track. The above proposed conditions for conducting work while positioned on the field side have been summarized in the definition of a new term, ''clear side,'' in § 214.336(a)(3), so as to avoid having to repeat these conditions in the rule text proposed in paragraphs (c) and (e)(1) of this section. In applying the exception in proposed paragraph (e)(1), FRA notes that the ''clear side'' portion of the proposal would have the effect of requiring that working limits be established on an adjacent track (on the field side where the on-ground roadway workers are exclusively positioned) that is non-controlled and whose centerline is 25 feet from the centerline of the occupied track, while no form of on-track safety (*i.e.,* working limits or train approach warning) would be required on the adjacent controlled track that is located on the other side of the occupied track

[5] The consensus language stated ''information about any tracks adjacent to the track to be occupied.'' One could interpret this language to have included a discussion of adjacent tracks without regard to a set distance, since the term limiting the distance to 25 feet was not used. The term ''adjacent tracks'' would thus limit the discussion to those within 25 feet.

[6] On page 13 of the meeting minutes, the facilitator ''reminded the group that the vote would be on the concepts of the proposal and the language may change and be simplified when finalized.'' A representative of AAR then asked if everyone agreed on ''the principles of the write-up.'' At the March 15–16, 2006 meeting, the ''RWP Working Group Table'' included the language that was eventually approved by the full RSAC (except that ''employee in charge'' was changed to ''roadway worker in charge'' in paragraph (d)) and indicated ''Consensus 02/02/06. Draft language from 02/02/06 revised by consolidating the exceptions.''

and whose centerline is within 12 feet of the occupied track. FRA seeks comment as to the frequency with which these, or similar, circumstances would occur, and whether the ''clear side'' portion of the exception in proposed paragraph (e)(1) imposes an unreasonable burden.

Another issue that BMWED and BRS would like FRA to reconsider is the proposed requirement for railroads to provide training or issue a bulletin with the proposed new requirements for adjacent-track on-track safety. The proposed requirement that railroads issue a bulletin or other document to the roadway workers was intended as a stop-gap measure, together with extended on-track safety job briefings, since most railroads provide their employees with annual training at the beginning of the calendar year. This was not a new concept, as the proposal was based on a similar provision in Emergency Order No. 24, and because FRA believes that this, in conjunction with job briefings on the issue, is the approach most railroads take to train their employees when an operating rule change goes into effect mid-year. BMWED and BRS, however, noted in their joint comments that this was not adequate training, and expressed their fear that that this would shift the burden for effective training from the employer to unsuspecting employees. They also noted a concern that the proposed requirement for the employers to obtain a written receipt or acknowledgement may also affect their memberships' legal rights under the Federal Employers' Liability Act. Because of the timing of the withdrawal of the NPRM, FRA believes that it can coordinate this NPRM and final rule to correspond with the railroad's annual training cycle for roadway worker protection, thus making the requirement to issue a bulletin unnecessary as a stop-gap measure.

Finally, the joint comments note that FRA's initial proposal also differs from the RSAC consensus language because FRA proposed to move the section of the rule that pertains to adjacent-track on-track safety from § 214.335(c) to a new proposed § 214.336. FRA does not agree with these comments and denies that moving language from one section to another, for clarification purposes, changes the substance and intent of the provision. Currently, § 214.335 of the existing regulation for on-track safety for roadway work groups contains only one short provision that is applicable to adjacent track protection, that is, paragraph (c). The RSAC recognized that this provision is vague as to what circumstances mandate adjacent-track on-track safety, and this was the very reason for the RSAC's recommendation to amend it. Because of the complex revisions to the regulation with respect to adjacent-track on-track safety, and to avoid having too many levels of subparagraphs in the rule text, FRA believes it is necessary to create a new section. A new section would not change the substance or application of the regulation in any way, and additions to regulations often require the restructuring of subsections in order to promote clear, concise interpretation.

2. Draft Comments of AAR

AAR submitted draft comments to FRA on September 16, 2008. Although the draft comments were received after the date that the NPRM was formally withdrawn, FRA has decided to post them to the docket and discuss them in this NPRM, in an effort to continue FRA's transparency in these proceedings as well as to encourage an open discussion and resolution of the related issues at this NPRM stage, rather than at the later, final rule stage.

The first issue concerns the applicability of proposed § 214.336(a) to ''a roadway work group with at least *one of the roadway workers on the ground*'' (emphasis added). AAR urges FRA to return to the consensus language, which applied ''when roadway work group(s) consisting of *roadway workers on the ground* and on-track self-propelled equipment are engaged in a common task on an occupied track'' (*emphasis added*). AAR is concerned that this subtle change would bring several work activities into the scope of the rule that were not intended to be covered by the Working Group consensus language. Specifically, AAR is concerned about work activities such as ''an employee remaining within the gage of the occupied track fueling a machine; getting off equipment to load anchors, spikes, or other equipment; deploying a laser device for a tamping machine; and checking cross level.'' AAR proposes that FRA amend part of the first sentence of § 214.336(a) from ''with at least one of the roadway workers on the ground'' to ''with more than one roadway worker on the ground,'' and make further conforming amendments by deleting the phrase ''one or more'' in paragraphs (b)(1), (2), and (3).

FRA had proposed to amend this portion of the consensus language for clarity, since the consensus language (''when roadway work group(s) consisting of roadway workers on the ground and on-track self-propelled or coupled equipment are engaged in a common task on an occupied track'') contained the words ''roadway work group(s)'' and ''equipment,'' both of which could be interpreted as plural and result in confusion concerning how many roadway workers needed to be on the ground before this section would apply. FRA specifically chose the clarifying words ''one or more roadway workers on the ground'' because FRA believed that this was the intent of the Working Group, since there was no safety rationale for excluding roadway work groups that consist of only two roadway workers. In choosing this language, FRA assumed that in a two-person roadway work group, one roadway worker was assigned to operate the equipment, and the other was assigned to perform duties on the ground in a common task with the machine and presumably its operator. The potential for distraction of the one roadway worker on the ground in a roadway work group consisting of only two roadway workers is the same as for each of the two roadway workers on the ground in a roadway work group consisting of three roadway workers. Moreover, FRA analysis of the agency's accident investigations of these types of incidents has revealed that four [7] of the seven fatalities on an adjacent track occurred with only one of the roadway workers on the ground that had been engaged in a common task with an on-track roadway maintenance machine.

AAR also requested that the exception for hi-rails in proposed § 214.336(b)(2) of the former NPRM be expanded to include rail-bound geometry and detection equipment, since the level of distraction posed by this equipment is similar to that of hi-rails. AAR suggests that the language in that section be amended by adding ''or self-propelled track geometry or detector car.'' FRA notes that while a rail-bound geometry car tends to be much larger than a hi-rail, it seems that the level of distraction is similar for a roadway worker on the ground who is field-verifying a measurement behind a geometry car and a roadway worker on the ground who is replacing a bolt behind a hi-rail; nonetheless, FRA seeks comment as to whether this type of equipment should be added to the exception.

The comments further request that an exception be added (*i.e.,* that no adjacent-controlled-track on-track safety be required) when there is a physical barrier between the occupied track and the adjacent controlled track. AAR indicates that there are several locations where there is a physical barrier, such as a fence, between tracks operated by

[7] The dates and locations of those incidents were October 9, 1999 (Juniata, NE), October 30, 2003 (Argyle, IA), March 12, 2007 (Piketon, OH), and March 27, 2008 (Emporia, KS).

different railroads, especially where the corridor is shared by both freight and passenger railroads. AAR believes that this barrier is sufficient to protect against movements on an adjacent track located on the other side of the barrier, and suggests that a fourth exception be added as follows: ''Work on occupied track where there is a physical barrier such as a fence between the occupied track and the adjacent track.'' While FRA agrees that a continuous permanent or semi-permanent barrier could be sufficient to prevent accidental fouling of an adjacent controlled track located on the other side of the barrier, FRA is concerned that the language that AAR has suggested is overly broad and could be interpreted to allow orange construction cones or barrels connected with flimsy plastic ''fences'' to be sufficient. FRA seeks comment on whether a fourth exception should be added and, if so, whether it should be limited to where there is a continuous permanent or semi-permanent physical barrier of a certain height, such as a chain-linked fence at least 4′ in height or a concrete barrier of at least 32″ in height, between the occupied track and the adjacent controlled track.

AAR also recommended that FRA permit the machine operator to perform work on the ground within 25 feet of the front or rear of the roadway maintenance machine that he or she is operating, during adjacent-controlled-track movements of 25 mph or less. It would be impractical not to allow the operator to step off of his machine and walk directly behind it. Accordingly, AAR suggests that the proposed paragraph 214.336(a)(2)(i) (now proposed as § 214.336(c)) be amended by adding after the word ''movement'' the phrase ''unless the employee is operating the machine.'' FRA believes that the phrase ''unless the employee is the assigned operator of the machine'' would better address AAR's concerns, since presumably the employee would place the machine in the idle position and set the brakes before alighting and, therefore, would not be operating or moving the machine from the ground. FRA seeks comment as to whether this amendment should be added.

Finally, AAR requested that FRA reconsider the proposed training and recordkeeping requirements in the initial NPRM. While recognizing that training is vital, AAR urges FRA to make the effective date for training on the new requirements consistent with the railroads' training schedules. Regarding the proposed recordkeeping requirements, AAR notes that the requirement for a written acknowledgment is ''burdensome, unwarranted, and violates both Congressional and OMB mandates,'' and requests that FRA permit railroads to use electronic signatures in lieu of handwritten signatures. While FRA is not opposed to permitting electronic signatures under the circumstances proposed in the initial NPRM, the proposed recordkeeping requirement has been deleted from this NPRM, making this a moot point.

3. Comments of Additional Interested Parties

FRA received a number of brief comments. The July 30, 2008 joint comments submitted by ATDA, BLET, and UTU, expressed support for the BMWED and BRS' joint request to extend the comment period on the initial NPRM to 60 days. Other brief comments raised different concerns, which have been summarized, below.

Three general comments were submitted to the docket. The first general comment was submitted by John Walsh. He indicates that while part 214 is intended to provide for the safety of railroad workers, it also preempts State laws concerning the railroads. As such, he believes that FRA's regulations should also require railroads to provide for the protection of emergency workers, including firefighters, emergency medical technicians (EMTs), and those working under their direction and control. He recommends that railroads annually notify every firefighting agency with tracks in their jurisdiction of whom to contact whenever the firefighters or EMTs are operating within the railroad's right of way, and that railroads have procedures in place to restrict train traffic in the area until the firefighters' or EMTs' incident commander grants the railroad permission to allow trains to pass through the incident area. As Mr. Walsh's comments are outside the scope of part 214, it appears that this request would be more appropriate if filed in the form of a petition for a new rulemaking under 49 CFR 211.11.

The second general comment was submitted by Michael McGinley, who indicates that he is a retiree from the Southern California Regional Rail Authority (Metrolink) engineering department. He states that the weakest link is the widespread failure of locomotive engineers to comply with sounding warning signals upon seeing roadway workers, and expressed his belief that this may be due to the part 214 requirements being taught to the engineering department employees and not to the transportation department employees. He recommends that the application of the present regulations be reinforced through the operating practices perspective and focus on the locomotive engineers. While FRA is not proposing to amend the section that relates to audible warning (§ 214.339) in this NPRM, FRA notes that this is one of the most common violations cited under part 214, and many railroads have taken steps to reinforce and raise awareness of these requirements through increased training and efficiency testing. Thus, FRA does not believe that this section should be amended at this time.

The third general comment was submitted by Frederic W. Yocum, who is a retired railroader who served on RSAC. He suggests that FRA amend the language to add the phrase ''or desirable'' to the language proposed in the initial NPRM so as to read ''nothing in this section prohibits the roadway worker in charge from establishing adjacent-track on-track safety as he or she deems necessary *or desirable'' (emphasis added).* He notes that there are probably occasions on which the roadway worker in charge would want to increase safety by establishing adjacent-track on-track safety, but would not meet the standard of ''necessary'' if taken literally. FRA recognizes that the roadway worker in charge needs the flexibility to establish on-track safety as he or she deems necessary for completion of the work, but is mindful not to provide unfettered discretion, which could result if the words ''or desirable'' were to be added. If the nature of the work that is being performed by the roadway work group will likely cause one of the roadway workers in the group to foul an adjacent track, then additional on-track safety is necessary. FRA has added language to the new proposed section to ensure that the roadway worker in charge has the discretion to establish on-track safety on one or more adjacent tracks (regardless of whether the track is controlled or non-controlled) as necessary, consistent with both the purpose and requirements of subpart C of part 214.

In addition to these comments, FRA also received comments from Todd Cotie, Health and Safety Coordinator for the United Steelworkers Local 2004, representing 3,200 track maintenance workers across Canada. He recommends that trains be ordered to reduce their speed to a maximum of 30 mph when passing in proximity to workers on adjacent mainline tracks, since a slower train would allow engineers and work crews more time to notice and react to various situations that occur from the passing train. This recommendation is based on various rules, including the speed restriction for trains passing in

proximity to occupied on-track living accommodations (boarding cars) that are eight feet away on the adjacent track, just as roadway workers would be. As another example, Mr. Cotie submitted a copy of a February 7, 2008 letter from CN regarding the train clearing guidelines for the protection of employees who work under Canadian Rail Operating Rules (CROR) Rule 42. These guidelines appear to require that trains be instructed by the Rule 42 foreman to proceed through limits at a speed not exceeding 30 mph if the employees cannot clear to a location at least 19 feet away from the nearest rail of the track on which the train is approaching. Mr. Cotie believes that the few minutes of delay that would result in slowing a 60-mph freight or 100-mph passenger train to 30 mph when passing work crews is well worth assuring the security of the workers. FRA believes that its proposal in this NPRM assures the security of the roadway workers while taking into consideration the productivity costs to the railroads. A detailed analysis of this balancing is discussed in the regulatory evaluation, which has been posted to the docket.

VII. Section-by-Section Analysis

Proposed Amendments to 49 CFR Part 214, Railroad Workplace Safety

Subpart C—Roadway Worker Protection

Section 214.315 Supervision and Communication

Given the importance of an on-track safety job briefing in roadway workers' understanding of the nature of the work they will be conducting and the conditions under which they will conduct it, FRA thinks that the existing requirements in § 214.315 for a job briefing ''when an employer assigns duties to a roadway worker that call for that employee to foul a track'' should also be expanded to cover the new proposed procedures for adjacent-controlled-track on-track safety in § 214.336 if such procedures are required for that assignment or if adjacent-track on-track safety is deemed necessary by the roadway worker in charge. With a few minor changes, the text concerning the additional components of an on-track safety job briefing that is proposed in this NPRM was consensus language developed by the Working Group and recommended by the full RSAC. The consensus language relating to adjacent tracks was proposed as a new paragraph (a)(2) in § 214.315, to read: ''Information about any tracks adjacent to the track to be occupied, on-track safety for such tracks, and identification of roadway maintenance machines that will foul any adjacent track. In such cases, the briefing shall include procedural instructions addressing the nature of the work to be performed and the characteristics of the work location to ensure compliance with this part.''

On December 18, 2007, FRA emailed the Working Group members and requested an errata review of a document in which FRA had compiled all of the consensus items. In its errata review comments, AAR requested that FRA clarify that the provision is not intended to require a discussion on the on-track safety of an adjacent track unless on-track safety is required on that track by part 214. FRA agrees that this is not the intent of the proposed requirement, and has added the language ''if required by this subpart or deemed necessary by the roadway worker in charge'' to the consensus rule text, which has been proposed as new paragraph (a)(3). The language concerning the roadway worker in charge's discretion was added to emphasize that the roadway worker in charge would still be permitted to establish on-track safety on an adjacent track, regardless of whether it is controlled or non-controlled, if it is reasonably necessary given the nature of the work that is to be performed. This proposed section would still require the on-track safety job briefing to include information concerning any ''adjacent tracks'' (as defined in § 214.7), so as to serve as a warning to each roadway worker of the potential danger in fouling such a track, even if no on-track safety is required for that particular track because it does not meet the definition of ''adjacent controlled track'' in proposed § 214.336(a)(3). While the second sentence of the consensus language began with the phrase ''in such cases,'' FRA has deleted that language, and proposes to move the rest of the language into a new paragraph (a)(4), since the on-track safety job briefing must always address the nature of the work to be performed and the characteristics of the work location to ensure compliance with this subpart, regardless of whether there is an adjacent track present.

FRA has further clarified in a proposed revision to introductory paragraph (a) that this section lists only the minimum items that must be discussed in an on-track safety briefing. The words ''at a minimum'' were added, and the rest of existing paragraph (a) has been moved to proposed paragraphs (a)(1) and (a)(2).

Section 214.335 On-Track Safety Procedures for Roadway Work Groups, General

FRA proposes to amend this section by deleting paragraph (c) and creating new requirements in a separate section to address adjacent-controlled-track on-track safety procedures for certain roadway work groups, § 214.336, for the reasons discussed below. Existing paragraph (c) reads: ''Roadway work groups engaged in large-scale maintenance or construction shall be provided with train approach warning in accordance with § 214.327 for movements on adjacent tracks that are not included within working limits.''

The proposal would also amend the heading of § 214.335 to reflect the general nature of the remaining requirements in that section.

Section 214.336 Adjacent-Controlled-Track On-Track Safety Procedures for Certain Roadway Work Groups

Paragraph (a), Procedures; General

As discussed in Section II.C., above, § 214.335(c) currently requires adjacent-track on-track safety for a roadway work group only if such a work group is engaged in ''large-scale maintenance or construction.'' Under this criterion and the limited guidance provided in the preamble to the final rule, many railroads have not been providing on-track safety on adjacent tracks for surfacing operations, small tie-renewal operations, or similar maintenance operations that, while smaller in scale, still include on-track, self-propelled equipment. This proposed new section seeks to eliminate this interpretive issue by establishing new, more objective criteria for determining whether adjacent-track on-track safety is required for a roadway work group. Fatalities have occurred in connection with such operations, which many believe the existing language should be interpreted to cover.

In developing language to address the increasing number of roadway worker fatalities on an adjacent track, the Working Group considered that most of the fatalities on an adjacent track occurred when a roadway work group with at least one of the roadway workers on the ground, was engaged in a common task with on-track, self-propelled equipment on an occupied track. In those circumstances, the potential for a roadway worker in the group to be distracted from the danger of an oncoming train was great due to the noise and dust generated by operation of the roadway maintenance machines, the need to avoid entanglement in the operation of those

machines, and the need to monitor the quality of the work being performed. This set of factual circumstances became the basis for the proposed new criteria for triggering the requirement to establish adjacent-track on-track safety in introductory paragraph (c)(1) of the consensus language, and in paragraph (a)(1) of proposed new § 214.336, which, as a general rule, would require that on-track safety be established for each adjacent controlled track when a roadway work group with at least one of the roadway workers on the ground, is engaged in a common task with an on-track roadway maintenance machine or coupled equipment on an occupied track. In particular, the on-track safety would have to be provided in accordance with § 214.319 (Working limits, generally) (which includes § 214.321 (Exclusive track occupancy), § 214.323 (Foul time), and § 214.325 (Train coordination)), or § 214.329 (Train approach warning provided by watchmen/lookouts).

The general rule would be set forth in paragraph (a), which would also direct the reader to the three exceptions described in proposed paragraph (e). The more specific procedures for adjacent-controlled-track on-track safety would be set forth in paragraphs (b) and (c), concerning movements on an adjacent controlled track at over 25 mph, and at 25 mph or less, respectively. Paragraph (a)(2) provides that if an occupied track has two adjacent controlled tracks, and one of these adjacent controlled tracks has one or more movements authorized at 25 mph or less, and the other adjacent controlled track has one or more concurrent movements authorized at over 25 mph, the more restrictive procedures in paragraph (b) would apply. This would require that all work (*i.e.,* both on-ground work and roadway maintenance machine or coupled equipment movement) on or fouling the occupied track or either of the adjacent controlled tracks cease, since, as will be further discussed below, there would be no ''clear side'' on which to continue even on-ground work on the field side. *See* proposed § 214.336(e)(1).

Paragraph (a)(3) would add definitions of three new terms used exclusively in § 214.336 (''adjacent controlled track,'' ''clear side,'' and ''occupied track''), and one existing term (''adjacent tracks'') that is defined in § 214.7, but which would be repeated in this section to ensure that the reader is aware that two similar terms are being used in this section, with different meanings. For purposes of this section, ''adjacent controlled track'' would mean ''a controlled track whose track center is spaced 19 feet or less from the track center of the occupied track.'' In contrast, the definition of ''adjacent tracks'' (in § 214.7) includes any tracks, controlled or non-controlled, whose track centers are spaced less than 25 feet apart. FRA proposes to adopt this narrower definition of ''adjacent controlled track'' based on the roadway worker fatality data discussed above in ''IV. Recent Roadway Worker Accidents (1997–2008),'' which show that the adjacent tracks on which the roadway worker fatalities occurred were all controlled tracks and that the track centers of these controlled tracks were within 15 feet of the track centers of the occupied track. In light of these data, the Working Group agreed that 19 feet would be a reasonable and safe threshold to trigger the requirement to establish on-track safety on an adjacent track and that it would be reasonable to cover controlled tracks within that 19-foot zone but to exclude non-controlled tracks. FRA notes that the lack of fatalities on non-controlled adjacent tracks may be attributable to the reduced operating speeds on non-controlled tracks, where railroad operating rules generally require that movements must stop short of obstructions within half the range of vision. The Working Group discussed, and the full RSAC recommended for inclusion in § 214.335(c), that on-track safety be required for ''adjacent controlled track within 19 feet of the centerline of the occupied track'' for certain work activities. FRA agrees with this analysis and has reflected it in the proposed definition of ''adjacent controlled track.'' Note, however, that this section also uses the broader term ''adjacent track'' or ''adjacent tracks'' in paragraphs (c)(2)(i), (e)(1), and (f), as further discussed, below.

The third proposed definition in § 214.336(a) is for the term ''clear side.'' FRA proposes to define the term for purposes of § 214.336 to mean ''the field side of the occupied track that either has no adjacent track on that side, or has an adjacent track or tracks on that side and working limits have been established in accordance with this subpart on the closest adjacent track on that side and there are no movements authorized through the working limits by the roadway worker in charge on that adjacent track.'' This term was added so that the above language would not need to be included in the rule text in proposed paragraphs (c) and (e)(1) of this section. It should be noted that there are two field sides to each occupied track, beginning at each rail and continuing outward and away from the track center of the occupied track. One or both field sides may meet the definition of ''clear'' at some point during the work period (depending on the presence of an adjacent track on one or both sides and the method and circumstances of the on-track safety established on the adjacent track or tracks), but since the term is only used when making the determination as to whether work must cease due to one or more movements on an adjacent-controlled track, there could be only one ''clear side'' at the time of that determination.

FRA believes that the work permitted to continue under the circumstances described in proposed paragraphs (c) and (e)(1) should not be limited to only those situations where there is no adjacent track present. While paragraph (c)(3) of the consensus language (pertaining to single or multiple adjacent-track movements at a speed of 25 mph or less) permitted all work to continue to the field side of the occupied track only if there was no adjacent track present during such movements, the consensus language did not impose such a limitation in the broad exception for on-ground work on the field side of the occupied track in paragraph (e)(2) (now proposed paragraph (e)(1)). FRA's original proposal would have permitted certain work to continue, provided that on-track safety (including train approach warning) had been established in accordance with this subpart on any adjacent track on that side. In consideration of the joint comments submitted by BMWED and BRS, FRA has adjusted the language originally proposed so as to better ensure the safety of the workers on that side of the occupied track.

Specifically, under the proposed sections that use the term ''clear side,'' certain work would be permitted to continue on the field side furthest from the adjacent controlled track if working limits (including those established by making the track inaccessible per § 214.327 if the adjacent track is non-controlled) have been established on that track, and the roadway worker in charge has not authorized any movements through the working limits of that adjacent track. This proposal would allow the roadway worker in charge to better monitor and control the on-track safety of roadway workers performing work in triple-track territory, especially since the designated place of safety during an adjacent-controlled-track movement may very well be the field side towards another adjacent track on which no movement is occurring. Train approach warning would not be

permitted, since a train would be free to move on the adjacent track on that side without the roadway worker in charge's permission or knowledge. FRA believes that this new language addresses the safety concern raised in the joint comments.

The fourth proposed definition to be used for purposes of § 214.336 is ''occupied track.'' FRA proposes to define the term ''occupied track'' to mean the track on which a roadway maintenance machine or coupled equipment is located while engaged in a common task with a roadway work group. FRA replaced the consensus language of ''on-track, self-propelled or coupled equipment'' with ''on-track roadway maintenance machine or coupled equipment'' so as to use a term that is already defined in part 214. It should be noted that while the language that would trigger the requirement to establish adjacent-controlled-track on-track safety contains the term ''on-track roadway maintenance machine'' (which excludes hi-rails), the proposed definition of ''occupied track'' contains the broader term ''roadway maintenance machine'' (which includes hi-rails), since a roadway work group that is engaged in a common task with a hi-rail would still be ''occupying'' the track, regardless of whether adjacent-track on-track safety would be required during that task. The language in RSAC-recommended paragraph (a) was also modified in light of the proposed new definition of ''adjacent controlled track,'' namely by moving the reference to the 19-foot track center distance and placing it in the definition.

Paragraphs (b), Procedures for Adjacent-Controlled-Track Movements Over 25 mph; and (c), Procedures for Adjacent-Controlled-Track Movements 25 mph or Less

In an effort to make the section easier to understand, FRA has reorganized the section into proposed paragraph (b), which lists the procedures to follow for one or more adjacent-controlled-track movements over 25 mph (*i.e.*, if a train or other on-track equipment is authorized to move on an adjacent controlled track at a speed greater than 25 mph), and proposed paragraph (c), which lists the procedures to follow when one or more adjacent-controlled-track movements are authorized at a speed of 25 mph or less.[8] As noted above in the discussion of paragraph (a)(2), if an occupied track has two adjacent controlled tracks, and one of these adjacent controlled tracks has one or more movements authorized at 25 mph or less, and the other adjacent controlled track has one or more concurrent movements authorized at over 25 mph, the more restrictive procedures in paragraph (b) would apply.

Proposed paragraph (b)(1) would generally require that each roadway worker in the roadway work group stop any work on the ground and stop the movement of any roadway maintenance machine or coupled equipment in the fouling space of the occupied track and the adjacent controlled track, and occupy a predetermined place of safety. If on-track safety has been established on the adjacent controlled track through train approach warning in accordance with § 214.329 (either as the sole method of on-track safety or in addition to working limits), all work would have to cease upon receiving a watchman/lookout warning. *See* § 214.336(b)(1)(ii). On the other hand, if working limits have been established on the adjacent controlled track and the roadway work group has not been assigned a watchman/lookout, all work would have to cease upon receiving notification that the roadway worker in charge intends to authorize one or more train movements or other on-track equipment movements through the working limits on an adjacent controlled track. *See* § 214.336(b)(1)(i). This notification would have to occur before the roadway worker in charge releases the working limits, in order to comply with existing § 214.319(c).

FRA notes that the language in proposed paragraph (b)(1) that would generally require roadway workers to cease all on-ground work within the fouling space of the occupied track could potentially be interpreted by some as conflicting with the language in proposed paragraph (e)(1), which would permit on-ground work on the clear (field) side, a portion of which would be within the fouling space of the occupied track. While proposed paragraphs (a) and (e) both contain language indicating, directly or indirectly, that paragraph (e) would apply notwithstanding any conflicting language in proposed paragraphs (a) through (c), to ensure that there is no confusion as to the interrelation of these sections, FRA has added the phrase ''except as provided in paragraph (e) of this section'' at the beginning of proposed paragraph (b)(1) and seeks comment regarding whether this was the intent of the consensus language. FRA does not believe that this same clarification would be necessary in proposed paragraph (c), since proposed paragraph (c) refers the reader to proposed paragraph (b).

In its errata review comments on the FRA document compiling all of the Working Group consensus language, AAR requested that FRA clarify whether work would be permitted to resume at a particular location after the head-end of the movement had passed or after the entire train had passed, under the RSAC-recommended § 214.335(c)(2). As discussed in section VI.C.1., above, upon an extensive review of all related meeting documents, FRA has determined that railroad management's proposal appears to have conceded that the entire movement must pass before permitting work to resume, regardless of speed. While it is possible that the concession of the entire movement passing was conditioned upon railroad labor accepting railroad management's proposal as a whole (including the proposal of a 40-mph threshold), FRA did not receive any further comments from AAR or any of its members on this issue, despite the request for comments on this issue in the July 17, 2008 NPRM. FRA did, however, receive joint comments from BMWED and BRS on this issue. The joint comments noted the hazards presented to roadway workers by abnormal consist conditions (*e.g.,* ''shifted loads/shifted ladings, loose banding, dragging chains/binders, loose brake piping, loose/swinging boxcar doors, [and] fragmented brake shoes'') and by ''dust, rust, debris, stone, and track construction/maintenance materials'' which may become airborne while trains pass roadway workers. Given these potential hazards and the information available in the related meeting documents, FRA proposes to require that all work not subject to an exception be permitted to resume only after the entire movement (the trailing-end of the movement) has passed by the location of the roadway work group component. *See* proposed § 214.336(b)(2). This would apply regardless of the speed of the movement, since the procedures for adjacent-controlled-track movements at 25 mph or less are the same as for those

[8] If a roadway worker in charge, in his or her discretion, authorizes a train through working limits on an adjacent controlled track at 30 mph, but the train is actually traveling at a speed of only 20 mph, the procedures in proposed paragraph (b), regarding adjacent-controlled-track movements over 25 mph, would still apply. Where exclusive track occupancy is the method of on-track safety established on the adjacent controlled track, FRA notes that existing § 214.321(d) provides that movements of trains and roadway maintenance machines within working limits shall be made only under the direction of the roadway worker having control over the working limits, and further notes that such movements shall be at restricted speed unless a higher speed has been specifically authorized by the roadway worker in charge of the working limits.

at over 25 mph, unless the work being performed is subject to an exception. *See* proposed § 214.336(c).

In modifying the language in consensus paragraphs (c)(2) (concerning when work would be permitted to resume) and (c)(3) (concerning which work would be permitted to continue during adjacent-controlled-track movements of 25 mph or less) for inclusion in its proposal, FRA realized that these same paragraphs did not address situations where train approach warning was the established method of adjacent-controlled-track on-track safety (either as the sole method, or in combination with working limits). Where train approach warning is the sole method of adjacent-controlled-track on-track safety, there are no working limits established on the adjacent controlled track, and trains are not being ''cleared through adjacent-controlled-track working limits'' by the roadway worker in charge. Regarding consensus paragraph (c)(3) (concerning which work would be permitted to continue during adjacent-controlled-track movements of 25 mph or less), this simply means that this type of work would always be permitted so long as train approach warning was in effect, since a train or other on-track equipment would not be authorized to exceed 25 mph. Regarding consensus paragraph (c)(2) (concerning when work would be permitted to resume), this means that the watchman/lookout may not know (depending on the span of the working limits and the available sight distance) how many movements at any given time are operating within the same segment of track on the adjacent-controlled-track as that of the working limits established on the occupied track. Thus, it would be reasonable for work to resume after the trailing-end of a train passes unless and until the watchman/lookout provides a warning for a subsequent train. To address these oversights, FRA made adjustments to the consensus language in paragraphs (c)(2) and (c)(3) in proposed §§ 214.336(b)(2)(i) and 214.336(c), respectively.

As the roadway workers are presented with similar safety risks and would still receive notification of the train or other on-track equipment movements, regardless of the method of adjacent-track on-track safety established, FRA has decided to adopt language in proposed § 214.336(b)(2)(i), that would clarify that a component of a roadway work group may resume on-ground work and movement of any roadway maintenance machine or coupled equipment on the occupied track only after the trailing-end of all trains or other on-track equipment moving on the adjacent controlled track (for which a notification or warning has been received in accordance with paragraph (b)(1) of this section) has passed and remains ahead of[9] that component of the roadway work group. Thus, if there are three trains cleared through the working limits by the roadway worker in charge, and there is no watchman/lookout assigned, the roadway workers would not, under this proposal, be permitted to resume work until the trailing-end of all three trains had passed by (and remained ahead of) that component of the roadway work group. However, if there are three trains operating within the same segment of track on the adjacent-controlled-track as that of the working limits established on the occupied track, and there is sufficient space between each of the trains to provide adequate warning to clear the track, the watchman/lookout may provide a warning for the first train, and work would be permitted to resume after the trailing-end of that train passed by (and remained ahead of) that component of the roadway work group, until such time as the watchman/lookout provided a warning for the second train, and so forth.

On the other hand, if the train or other on-track equipment were to stop before its trailing-end passed all of the roadway workers in the roadway work group, then the work to be performed on or while fouling the occupied track ahead of the trailing-end of the train or other on-track equipment on the adjacent controlled track would be permitted to resume only if adjacent-controlled-track on-track safety has been established. *See* proposed § 214.336(b)(2)(ii). In most cases, this would likely mean that on-track safety through train approach warning (§ 214.329) has been established on the adjacent track. *See* proposed § 214.336(b)(2)(ii)(A). In the remaining cases, this would mean that the roadway worker in charge has communicated with the train engineer or equipment operator and established that such train or other on-track equipment shall move only under his or her direction. *See* proposed § 214.336(b)(2)(ii)(B).

It should be noted that the train approach warning option provided in proposed § 214.336(b)(2)(ii)(A) would not be permitted alongside the train (or for a certain distance on the occupied track ahead of the location of the train on the adjacent controlled track), since the train, if it were traveling at the ''maximum speed authorized on that track'' would already be at the roadway worker's location (or, at certain distances, would be able to reach the roadway worker's location sooner than 15 seconds) and would not permit the roadway worker any (or sufficient) time to clear. Under such circumstances, work would not be permitted to resume until the conditions proposed in § 214.336(b)(2)(ii)(B) have been met, or until the train resumes its movement and its trailing-end passes the roadway worker's location, whichever comes first.

The proposed procedures to be followed for adjacent-track movements of 25 mph or less are the same as those procedures for adjacent-track movements over 25 mph, except that work would be permitted to continue in certain circumstances without regard to when the trailing-end passed the roadway work group's location, due to the low speed of the movements. In proposed paragraph (a)(2), FRA makes clear that if an occupied track has two adjacent controlled tracks, and one of the tracks has one or more adjacent-controlled-track movements authorized at 25 mph or less, and the other has one or more concurrent adjacent-controlled-track movements authorized at over 25 mph, the more restrictive procedures in paragraph (b) would apply.

The circumstances under which work may continue during low-speed movements on adjacent controlled tracks have been included in proposed paragraph (c). Unless the work falls under one of the exceptions in proposed paragraph (e), the work that would be permitted to continue after receiving a warning or notification of an adjacent-controlled-track movement would have to be performed more than 25 feet in front of or behind any roadway maintenance machine that is on or fouling the occupied track. While existing § 214.341(a)(5) requires each employer to include in its on-track safety program specific provisions addressing spacing ''between machines and roadway workers to prevent personal injury,'' the rule does not prescribe a specific distance, as certain work activities may require a roadway worker to work closer to a machine than others. Many railroads that subscribe to the General Code of Operating Rules (''GCOR''), for example, have adopted a 15-foot work zone in which roadway workers are not permitted to enter without first communicating with the

[9] The language ''and remains ahead of'' was added to this section to ensure that a roadway worker who has been passed (*e.g.,* at milepost 10) would not be permitted to then move up (*e.g.,* by hi-rail or walking to milepost 11) and perform work on the occupied track at a point alongside of (or ahead of) a train that has stopped on the adjacent controlled track (*e.g.,* with its trailing-end located at milepost 10.9 and its head-end located at milepost 11.2).

operator of the equipment and establishing safe work procedures. *See* GCOR Rule 136.7.3. The Working Group proposed a larger work zone of 25 feet to help lessen the distraction and danger posed by a roadway maintenance machine working on or fouling an occupied track, as both an on-ground roadway worker and an operator of a roadway maintenance machine will be performing work with the additional distraction of one or more adjacent-controlled-track movements. FRA proposes to adopt this recommendation as one of the circumstances for permitting work to continue as described in proposed paragraph (c).

FRA believes that the intent of the consensus language regarding the 25-foot zone in paragraph (c) was to ensure that roadway workers were not performing on-ground work within 25 feet of the forward or rearward path of a moving machine; thus, workers would still be permitted to work alongside a machine on a clear side (to verify the quality of the work being performed by that machine, for example). A roadway worker that is performing duties alongside a roadway maintenance machine would, of course, need to be mindful of the machine's footprint (which would include any brooms or wings of a machine, if extended) in deciding where to position himself or herself in performing such duties. FRA believes that the procedures addressing spacing ''between machines and roadway workers to prevent personal injury'' that are required by existing § 214.341(a)(5) should adequately address the risk of working alongside a machine (under any circumstance, not just during movements on adjacent controlled track); however, FRA seeks comment regarding the adequacy of these procedures.

Proposed paragraph (c) would permit work to continue that is performed ''exclusively while positioned on or between the rails of the occupied track or to the clear side'' of the occupied track, provided it is performed outside of the 25-foot work zone discussed above. The rationale for permitting work to continue while positioned between the rails is that a roadway worker who is positioned between the rails of the occupied track is in little danger of fouling the adjacent controlled track. This proposed condition is similar to an existing provision in § 214.103(d) that permits bridge workers to perform minor repair work exclusively between the rails (so long as the weight-bearing portion of the roadway worker's body is between the rails) without any fall protection. As this condition has worked well in the bridge worker area, FRA proposes to adopt the RSAC-recommended condition in the roadway worker area.

The other set of circumstances in proposed paragraph (c) for permitting work to continue when a movement on the adjacent controlled track is authorized at 25 mph or less is when work is performed to the ''clear side'' of the occupied track, provided that it is performed outside of the 25-foot work zone. As discussed above in the analysis of proposed paragraph (a)(3) of this section, the ''clear side'' means ''the field side of the occupied track that either has no adjacent track on that side, or has an adjacent track or tracks on that side and working limits have been established in accordance with this subpart on the closest adjacent track on that side and there are no movements authorized through the working limits by the roadway worker in charge on that adjacent track.'' Both the Working Group and FRA recognize that if there is little danger of a roadway worker fouling an adjacent controlled track (*e.g.,* Main Track No. 1) while positioned between the rails of the occupied track (*e.g.,* Main Track No. 2), a roadway worker is in even less danger of fouling that adjacent controlled track if he or she is positioned on the field side of the occupied track furthest from the adjacent controlled track. If, however, there is another adjacent track present (*e.g.,* Main Track No. 3, whether controlled or non-controlled) on the field side farthest from the adjacent controlled track on which a train or other on-track equipment movement has been authorized (*e.g.,* Main Track No. 1), then the roadway worker would potentially be in danger of fouling the other adjacent track (*e.g.,* Main Track No. 3). FRA makes clear that even if on-track safety in the form of working limits had been established on the other adjacent track (*e.g.,* Main Track No. 3), the roadway worker would still be in potential danger if he or she were to foul that adjacent track if the protection had in effect been nullified by the roadway worker in charge authorizing a train or other on-track equipment movement through the working limits on that other adjacent track. This is why FRA is proposing that work would be permitted on that side only if it truly is a ''clear side.''

Given the potential danger posed by concurrent movements on two adjacent controlled tracks, it is important to note that while proposed § 214.336 would apply to each adjacent controlled track individually, the impact on the type of work that would be permitted to continue on the occupied track must be examined as a whole. Thus, where a roadway worker receives notification of adjacent-controlled-track movements authorized at 25 mph or less that are occurring concurrently on both adjacent tracks, FRA proposes that the roadway worker would not be permitted to work on either field side of the occupied track, as the movement on one adjacent controlled track would not permit any work on the field side closest to it, and the movement on the other adjacent (controlled or non-controlled) track would not permit any work on the field side closest to it. *See* proposed paragraph (c)(2). Under these circumstances, there would be no ''clear side'' on which to perform even on-ground work as provided in the general exception in proposed paragraph (e)(1).

It should also be noted that paragraph (c) only directly addresses the types of work that a component of a roadway work group may continue performing while waiting for the trailing-end of an adjacent-controlled-track movement to pass by that component's location. It does not directly address when all other work (*i.e.,* work that paragraph (c) does not cover) may resume. Thus, roadway workers who are assigned to perform work not covered by paragraph (c) must look to the procedures in paragraph (b)(2) for guidance. For example, since on-ground work that would be performed between the rails and near a roadway maintenance machine (*i.e.,* in the 25-foot zone in front of or behind a machine that is on or fouling the occupied track) is not covered by paragraph (c), such work would not be permitted to resume until the conditions in paragraph (b)(2) had been fulfilled. That is to say, such work (as well as all other work that must cease as noted in paragraph (b) that is not permitted to continue by paragraph (c) and not subject to one of the general exceptions in paragraph (e)) would be permitted to resume only after the trailing-end of all movements (for which a notification or warning has been received in accordance with paragraph (b)(1) of this section) have passed by (and remain ahead of) the roadway work group component's location. Paragraph (d), Procedures for a roadway maintenance machine or coupled equipment fouling an adjacent controlled track.

Regarding the prohibition in consensus paragraph (d) against ''equipment'' fouling an adjacent controlled track unless protected by working limits, FRA has changed the term to ''roadway maintenance machine'' to clarify that this prohibition is meant to be broad and would include hi-rails that are part of the roadway work group or otherwise working within the same working limits as the roadway

work group. *See* proposed §§ 214.336(d) and 214.336(e)(2). While a hi-rail alone would not trigger the requirement to establish adjacent-controlled-track on-track safety, once a hi-rail has become part of a roadway work group involving at least one roadway worker on the ground and ''an on-track roadway maintenance machine or coupled equipment,'' the hi-rail would be subject to this prohibition against fouling, as well as to the machine spacing requirement in consensus paragraph (c). *See* proposed §§ 214.336(c), 214.336(d), and 214.336(e)(2). Further, FRA clarifies that the prohibition was not meant to be so broad that a roadway worker would not be permitted to use readily portable tools or equipment similar to a jackhammer, such as a pneumatic tamping gun or a spike driver, on an adjacent controlled track while afforded on-track safety through train approach warning. FRA would urge that employers and employees use common sense in determining which tools or equipment they would permit to be used or use under train approach warning. If there is any doubt as to whether the equipment could be readily removed, the employee must not foul the track with those tools or equipment under watchman/lookout (*i.e.,* train approach warning) protection.

Paragraph (e), Exceptions to the Requirement for Adjacent-Controlled-Track On-Track Safety

The Working Group also discussed, and the RSAC recommended, three exceptions when adjacent-controlled-track on-track safety would not have to be established at all. *See* consensus paragraphs (e)(1)–(e)(3). FRA proposes to adopt all three exceptions in this NPRM. *See* proposed § 214.336(e).

The first proposed exception to the requirement for adjacent-controlled-track on-track safety would be for one or more on-ground roadway workers performing work while exclusively positioned on the clear (field) side of the occupied track, provided that there should essentially be no danger posed by any other adjacent track. In particular, there would be no danger posed by any other adjacent track either because there is no adjacent track on the field side of the occupied track or, even though there is an adjacent track on the field side of the occupied track, working limits have been established in accordance with this subpart on the closest adjacent track on that side and there are no movements authorized through the working limits on that adjacent track. Regarding the language ''while exclusively positioned on the clear side,'' FRA notes that this language refers to the positioning of the weight-bearing portion of the roadway worker's body. This interpretation is consistent with FRA's interpretation of a similar provision in the bridge worker area (*see* § 214.103(d)) and also with the working group's intent that the exception in proposed paragraph (e)(1) be written so as to permit an on-ground roadway worker to change out a stone on a rail grinder, which may require that part of his or her body (*e.g.,* his or her hands) be within the gage of the occupied track.

As noted above in the discussion of proposed paragraphs (b)(1) and (c), this exception would apply notwithstanding any conflicting language in proposed paragraphs (a) through (c). Thus, on-ground work within the fouling space of the occupied track on the clear (field) side would still be permitted to continue during adjacent-controlled-track movements occurring on the other field side of the occupied track, regardless of the speed of those movements. Moreover, this on-ground work would not be subject to the condition that the on-ground work permitted to continue must be conducted more than 25 feet in front of or behind any roadway maintenance machine on or fouling the occupied track. FRA seeks comment as to whether the 25-foot zone should apply to the work performed in paragraph (e)(1) as well.

The second exception to the requirement for adjacent-controlled-track on-track safety would be for a hi-rail vehicle on the occupied track, provided such hi-rail vehicle is not coupled to any equipment and not operating on the same occupied track and within working limits of a roadway work group as described in paragraph (a) of this section. *See* proposed § 214.336(e)(2). As discussed in Section IV. of this preamble, there has been only one adjacent-track fatality where a roadway work group had been engaged in a common task with a hi-rail vehicle as defined in § 214.7, and the roadway workers in that case were under the impression that adjacent-track on-track safety was in effect when, due to a miscommunication, it was not. Given the circumstances of the one fatality and because the duties normally performed by an employee operating a hi-rail tend to be less distracting to on-ground roadway workers and produce less dust and noise than a typical on-track roadway maintenance machine, FRA proposes that adjacent-track on-track safety not be required for roadway work groups engaged in a common task with a hi-rail.

The consensus language for this second exception also included language indicating that where multiple hi-rails are engaged in a common task, the on-track safety briefing shall include discussion of the nature of the work to be performed to determine if ''adjacent controlled track protection'' is necessary. FRA has added a cross-reference to proposed § 214.315(a)(4) to this language in its proposal because the roadway worker in charge must always consider the nature of the work to be performed to determine the appropriate level of on-track safety. In fact, the consensus language emphasizes that nothing in this subpart prohibits the roadway worker in charge from establishing adjacent controlled track protection as he or she deems necessary. Consensus paragraph (e)(1) (now proposed paragraph (e)(2)) was also amended to remove the words ''as defined in § 214.7,'' since each time that a term defined in § 214.7 is used in part 214, FRA intends the term to be interpreted in the manner in which it is defined in § 214.7, unless otherwise noted. As discussed in section VI.C.2., above, FRA seeks comment as to whether this proposed exception should be expanded to include rail-bound geometry and detection equipment.

The third proposed exception to the requirement for adjacent-controlled-track on-track safety is for a catenary maintenance tower car with one or more roadway workers positioned on the ground exclusively within the gage of the occupied track for the sole purpose of applying or removing grounds. As discussed in Section IV. of this preamble, there have been no adjacent-track fatalities where a roadway work group had been engaged in a common task with a catenary maintenance tower car on the occupied track and the duties normally performed by an employee operating a catenary maintenance tower car tend to be less distracting to on-ground roadway workers and produce less dust and noise than a typical on-track roadway maintenance machine. FRA proposes to add this exception, with the same caveat added as for hi-rails, which is that once the catenary maintenance tower car is operating on the same occupied track and within the working limits of a roadway work group as described in paragraph (a) of this section, the exception would no longer apply.

As discussed in section VI.C.2., above, AAR is requesting that a fourth exception be added when there is a physical barrier between the occupied track and the adjacent controlled track. FRA seeks comment on whether a fourth exception should be added, and if so, whether it should be limited to ''where there is a continuous permanent

or semi-permanent physical barrier of a certain height, such as a chain-linked fence of at least 4′ in height or a concrete barrier of at least 32″ in height, between the occupied track and the adjacent controlled track.''

Paragraph (f), Discretion of Roadway Worker in Charge

In BMWED's errata review comments on the FRA document compiling all of the Working Group consensus language that was recommended to FRA by the RSAC, BMWED noted that from the manner in which the consensus exceptions (paragraphs (e)(1)-(e)(3)) were constructed, one could interpret that the roadway worker in charge of on-ground roadway workers exclusively performing work on the field side of the occupied track described in consensus paragraph (e)(2) would not be afforded the same right to establish a greater level of adjacent-track on-track safety as the roadway worker in charge of the hi-rail vehicle or catenary maintenance tower car described in paragraphs (e)(1) and (e)(3), respectively. FRA agrees that the provisions should be consistent. The section has been reorganized so that the language in paragraph (e)(3) stating that ''[n]othing in this subpart prohibits the roadway worker in charge of the catenary maintenance tower car from establishing adjacent track protection, as he/she deems necessary'' has been removed from paragraph (e)(3) (along with similar language in paragraph (e)(1)) and slightly reworded and moved into a new paragraph (f) so as to apply generally to proposed § 214.336, including all three exceptions in proposed paragraphs (e)(1)–(e)(3). Proposed paragraph (f) reads—''*Discretion of roadway worker in charge.* Nothing in this subpart prohibits the roadway worker in charge from establishing on-track safety on one or more adjacent tracks as he or she deems necessary consistent with both the purpose and requirements of this subpart.''

VIII. Regulatory Impact and Notices

A. Executive Order 12866 and DOT Regulatory Policies and Procedures

This NPRM has been evaluated in accordance with existing policies and procedures, and determined to be significant under both Executive Order 12866 and DOT policies and procedures. *See* 44 FR 11034 (Feb. 26, 1979). FRA has prepared and placed in the docket a regulatory evaluation addressing the economic impact of this NPRM. Document inspection and copying facilities are available at the Federal Docket Management Facility, U.S. Department of Transportation, West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590. Docket material is also available for inspection on the Internet at *http://www.regulations.gov*. Photocopies may also be obtained by submitting a written request to the FRA Docket Clerk at Office of Chief Counsel, Mail Stop 10, Federal Railroad Administration, 1200 New Jersey Avenue, SE., Washington, DC 20590; please refer to Docket No. FRA–2008–0059, Notice No. 3.

Certain of the requirements reflect current industry practice, or restate existing regulations, or both. As a result, in calculating the costs of this NPRM, FRA has neither included the costs of those actions that would be performed voluntarily in the absence of a regulation, nor has FRA included the costs of those actions that would be required by an existing regulation.

This evaluation includes quantitative measurements and qualitative discussions of implementation costs for this proposed rule. The costs would primarily be imposed by a small increase in job briefing time and additional resources spent to provide on-track safety for the safe conduct of other than large-scale maintenance and construction of track located adjacent to (and within a certain distance of) one or more controlled tracks on which train movements may be occurring. Training costs would also accrue. The benefits would primarily accrue from a reduction in roadway worker casualties (fatalities and injuries). Business benefits stemming from avoided train delays and property damages would also accrue.

FRA estimates that the present value (PV, 7%) of the total 20-year costs that the industry would be expected to incur to comply with the requirements in this NPRM would be $130.7 million. FRA also estimates that the PV (7%) of the total 20-year benefits accruing to society from the implementation of the requirements would be $131.9 million. The following table includes a summary of the regulatory impact analysis (RIA) costs and benefits, broken down by section of the rule and benefit category, respectively:

COST AND BENEFIT SUMMARY

Costs (by section of rule)	Reference: section of RIA	Total: PV, 7% (in millions—rounded)
Section 214.315—Job Briefings	9.2	$1.21
Section 214.335—On Track	9.4	127.59
Other (Signalmen, Lone Workers)	9.4	1.70
Section 214.336—Training	9.4	0.16
COST Total for NPRM		*130.65*
Benefits (by benefit category)	**Reference: section of RIA**	**Total: PV, 7% (in millions—rounded)**
Casualty Mitigation—Fatality	10.1	$49.16
Casualty Mitigation—Injury	10.2	30.83
Nonfatal Injury Prevention	10.3	5.65
Adjacent Track Revision	10.4	6.04
Damage Reduction	10.5	0.64
Reporting and Recordkeeping—Cost Savings	10.6	0.01
Business Industry Benefit	10.7	39.60
BENEFIT Total for NPRM		*131.94*

FRA believes that taking into account non-quantifiable benefits, including reduced train delays and property damages resulting from roadway worker incidents, the benefits associated with this proposed rule would justify the implementation costs. FRA requests comment on all of the assumptions used in the regulatory evaluation to calculate the costs and benefits.

B. Regulatory Flexibility Act and Executive Order 13272

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) and Executive Order 13272 require a review of proposed and final rules to assess their impact on small entities. FRA has prepared and placed in the docket a Small Entity Impact Assessment and Evaluation that assesses the small entity impact of this NPRM. Document inspection and copying facilities are available at the Docket Management Facility, U.S. Department of Transportation, West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590. Docket material is also available for inspection on the Internet at *http://www.regulations.gov*. Photocopies may also be obtained by submitting a written request to the FRA Docket Clerk at Office of Chief Counsel, Mail Stop 10, Federal Railroad Administration, 1200 New Jersey Avenue, SE., Washington, DC 20590; please refer to Docket No. FRA–2008–0059, Notice No. 3.

This Small Entity Impact Assessment and Evaluation concludes that this proposed rule would not have a significant economic impact on a substantial number of small entities. In order to determine the significance of the economic impact for the final rule's Regulatory Flexibility Act (RFA) requirements, FRA invites comments from all interested parties concerning data and information regarding the potential economic impact caused by this proposed rule, during the comment period.

The U.S. Small Business Administration (SBA) stipulates in its ''Size Standards'' that a ''for profit'' railroad business firm may not have more than ''1,500 employees for ''Line-Haul Operating'' Railroads and 500 employees for ''Switching and Terminal Establishments'' to be considered as a ''small entity.''[10] ''Small entity'' is defined in 5 U.S.C. 601 as a small business concern that is independently owned and operated and is not dominant in its field of operation. SBA's ''size standards'' may be altered by Federal agencies upon consultation with SBA and in conjunction with public comment.

Pursuant to that authority, FRA has published a final policy that classifies ''small entities'' as, inter alia, being railroads that meet the line haulage revenue requirements of a Class III railroad.[11] 49 CFR part 209, appendix C. Currently, the revenue requirements are 20 million inflation-adjusted dollars or less in annual operating revenue. The 20-million limit is based on the Surface Transportation Board's threshold of a Class III railroad carrier, which is adjusted by applying the railroad revenue deflator adjustment.[12] The same dollar limit on revenues is established to determine whether a railroad shipper or contractor is a small entity. FRA is using this definition of ''small entity'' for regulatory flexibility purposes in this rulemaking.

There are approximately 665 small railroads.[13] Potentially all small railroads could be impacted by this proposed regulation. However, because of certain characteristics that these railroads typically have, there should not be any impact on the majority of them. Most have only single-track operations. Some small railroads such as the tourist and historic railroads, operate across the lines of other railroads that would bear the burden or impact of the proposed rules requirements. Finally, other small railroads, if they do have more than a single track, typically have operations that are light enough such that the railroads have generally always performed the pertinent trackside work with the track and right-of-way taken out of service, or conducted the work during hours that the track is not used.

In addition, FRA is not aware of any commuter railroads that qualify as small entities. This is likely because commuter railroad operations in the United States are part of larger governmental entities whose jurisdictions exceed 50,000 in population. *See* 49 CFR part 209, appendix C.

FRA is uncertain as to the number of contractors that would be affected by this proposed rule. FRA is aware that some railroads hire contractors to conduct some of the functions of roadway workers on their railroads. However, most of the costs associated with the burdens from this rulemaking would ultimately get passed on to the pertinent railroad. Most likely, the contracts would be written to reflect that, and the contractor would bear no additional burden for the proposed requirements. In addition, FRA is uncertain as to the number of contractors that would be considered to be small entities. FRA requests any information during the rulemaking comment period related to contractors and the burdens that might impact them as a result of this proposed rulemaking.

No other small businesses (non-railroads) are expected to be impacted by this proposed rulemaking.

The impacts from this regulation are primarily a result of the proposed requirements for roadway work groups to be provided on-track safety when working on a track within close proximity of an adjacent track that is controlled. Again, since small railroads either do not have any adjacent track or conduct track work on the occupied track with an adjacent track when the adjacent track is out of service, there is no impact for small railroads. Since FRA does not anticipate that this proposed rule would impose any burdens on small entities, there is no alternative treatment proposed for small entities.

Having made these determinations, FRA certifies that this NPRM is not expected to have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act or Executive Order 13272.

C. Paperwork Reduction Act

The information collection requirements in this proposed rule have been submitted for approval to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 *et seq.* The sections that contain the new and current information collection requirements, and the estimated time to fulfill each requirement are as follows:

[10] ''Table of Size Standards,'' U.S. Small Business Administration, January 31, 1996, 13 CFR part 121.

[11] *See* 68 FR 24891 (May 9, 2003).

[12] For further information on the calculation of the specific dollar limit, please reference 49 CFR part 1201.

[13] 715 railroads—50 (large freight, medium freight, passenger, and commuter railroads) = 665 small railroads.

CFR section (if applicable)	Respondent universe	Total annual responses	Average time per response	Total annual burden hours
Form FRA F 6180.119—Part 214 Railroad Workplace Safety Violation Report.	350 Safety Inspectors ..	150 forms	4 hours	600
214.303—Railroad On-Track Safety Programs				
—Amendments to Programs	60 Railroads	20 amend. + 584 amend.	20 hours; 4 hrs.	2,736
—Subsequent Years: New Programs	5 New Railroads	5 new prog.	250 hours	1,250
214.313—Good Faith Challenges to On-Track Safety Rules.	20 Railroads	80 challenges	4 hours per challenge ..	320
214.315/335—Supervision and Communication				
—Job Briefings	50,000 Roadway Workers.	16,350,000 briefings	2 minutes per briefing ..	545,000
—Adjacent-Track Safety Briefings (New Requirement).	24,500 Roadway Workers.	2,403,450 briefings	30 seconds per briefing	20,029
214.321—Exclusive Track Occupancy—Working Limits.	8,583 Roadway Workers.	700,739 written authorities.	1 minute	11,679
214.325—Train Coordination				
—Establishing Working Limits through Communication.	50,000 Roadway Workers.	36,500 communications	15 seconds	152
214.327—Inaccessible Track				
—Working Limits on Non-Controlled Track: Notifications.	718 Railroads	50,000 notifications	10 minutes	8,333
214.336—*Procedures for Adjacent-Controlled-Track Movements Over 25 mph* (New Requirements)				
—Notifications/Watchmen/Lookout Warnings	100 Railroads	10,000 notific.	15 seconds	42
—Roadway Worker Communication with Train Engineers or Equipment Operators.	100 Railroads	3,000 comm.	1 minute	50
Procedures for Adjacent-Controlled-Track Movements 25 mph or Less				
—Notifications/Watchmen/Lookout Warnings	100 Railroads	3,000 notific.	15 seconds	13
—Roadway Worker Communication with Train Engineers or Equipment Operators.	100 Railroads	1,500 comm.	1 minute	25
214.337—On-Track Safety Procedures for Lone Workers: Statements by Lone Workers.	718 Railroads	2,080,000 statements ..	30 seconds	17,333
214.343/345/347/349/351/353/355—Training Requirements.	50,000 Roadway Workers.	50,000 tr. Empl	4.5 hours	225,000
—Additional On-Track Safety Training (New Requirement).	35,000 Roadway Workers.	35,000 tr. Empl	5 minutes	2,917
—Records of Training	50,000 Roadway Workers.	50,000 records	2 minutes	1,667
214.503—Good Faith Challenges; Procedures for Notification and Resolution				
—Notifications for Non-Compliant Roadway Maintenance Machines or Unsafe Condition.	50,000 Roadway Workers.	125 notifications	10 minutes	21
—Development of Resolution Procedures ...	644 Railroads	10 procedures	2 hours	20
214.505—Required Environmental Control and Protection Systems for New On-Track Roadway Maintenance Machines with Enclosed Cabs.	644 Railroads	10 lists	1 hour	10
214.507—As-Built Light Weight on New On-Track Roadway Maintenance Machines.	644 Railroads	1,000 stickers	5 minutes	83
214.511—Required Audible Warning Devices for New On-Track Roadway Maintenance Machines.	644 Railroads	3,700 identified mechanisms.	5 minutes	308
214.513—Retrofitting of Existing On-Track Roadway Maintenance Machines.				
—Identification of Triggering Mechanism—Horns.	703 Railroads	200 mechanisms	5 minutes	17
214.515—Overhead Covers for Existing On-Track Roadway Maintenance Machines.	644 Railroads	500 requests + 500 responses.	10 minutes; 20 minutes	250
214.517—Retrofitting of Existing On-Track Roadway Maintenance Machines Manufactured on or after Jan. 1, 1991.	644 Railroads	500 stencils	5 minutes	42
214.518—Safe and Secure Position for Riders				
—Positions Identified by Stencils/Markings/Notices.	644 Railroads	1,000 stencils	5 minutes	83
214.523—Hi-Rail Vehicles	644 Railroads	2,000 records	60 minutes	2,000
—Non-Complying Conditions	644 Railroads	500 tags + 500 reports	10 min.; 15 min	208
214.527—Inspection for Compliance; Repair Schedules.	644 Railroads	550 tags + 550 reports	5 min.; 15 min	184

CFR section (if applicable)	Respondent universe	Total annual responses	Average time per response	Total annual burden hours
214.533—Schedule of Repairs; Subject to Availability of Parts.	644 Railroads	250 records	15 minutes	63

All estimates include the time for reviewing instructions; searching existing data sources; gathering or maintaining the needed data; and reviewing the information. Pursuant to 44 U.S.C. 3506(c)(2)(B), FRA solicits comments concerning whether these information collection requirements are necessary for the proper performance of the functions of FRA, including whether the information has practical utility; the accuracy of FRA's estimates of the burden of the information collection requirements; the quality, utility, and clarity of the information to be collected; and whether the burden of collection of information on those who are to respond, including through the use of automated collection techniques or other forms of information technology, may be minimized. For information or a copy of the paperwork package submitted to OMB, contact Mr. Robert Brogan, Information Clearance Officer, at 202–493–6292, or Ms. Nakia Jackson at 202–493–6073.

Organizations and individuals desiring to submit comments on the collection of information requirements should direct them to Mr. Robert Brogan or Ms. Nakia Jackson, Federal Railroad Administration, 1200 New Jersey Avenue, SE., 3rd Floor, Washington, DC 20590. Comments may also be submitted via e-mail to Mr. Brogan or Ms. Jackson at the following addresses: *robert.brogan@dot.gov* or *nakia.jackson@dot.gov.*

OMB is required to make a decision concerning the collection of information requirements contained in this proposed rule between 30 and 60 days after publication of this document in the **Federal Register.** Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. The final rule will respond to any OMB or public comments on the information collection requirements contained in this proposal.

FRA is not authorized to impose a penalty on persons for violating information collection requirements which do not display a current OMB control number, if required. FRA intends to obtain current OMB control numbers for any new information collection requirements resulting from this rulemaking action prior to the effective date of the final rule. The OMB control number, when assigned, will be announced by separate notice in the **Federal Register.**

D. Federalism Implications

FRA has analyzed this NPRM in accordance with the principles and criteria contained in Executive Order 13132, issued on August 4, 1999, which directs Federal agencies to exercise great care in establishing policies that have federalism implications. *See* 64 FR 43255. This NPRM will not have a substantial direct effect on the States, on the relationship between the National government and the States, or on the distribution of power and responsibilities among various levels of government.

One of the fundamental federalism principles, as stated in Section 2(a) of Executive Order 13132, is that ''Federalism is rooted in the belief that issues that are not national in scope or significance are most appropriately addressed by the level of government closest to the people.'' Congress expressed its intent that there be national uniformity of regulation concerning railroad safety matters when it enacted 49 U.S.C. 20106. As amended to date, that section provides that all regulations prescribed by the Secretary of Transportation with respect to railroad safety matters and the Secretary of Homeland Security with respect to railroad security matters preempt any State law, regulation, or order covering the same subject matter, except a provision necessary to eliminate or reduce an essentially local safety or security hazard that is not incompatible with a Federal law, regulation, or order and that does not unreasonably burden interstate commerce. Nothing in this NPRM proposes to alter the preemptive effect of the RWP Rule so these provisions, once adopted as a final rule, would have the same preemptive effect as the current RWP Rule in accordance with the statute.

FRA notes that the above factors have been considered throughout the development of this NPRM both internally and through discussions within the RSAC forum, as described in Sections VI and VII of this preamble. The full RSAC, which, prior to the publication of this NPRM, reached consensus on proposed rule text and recommended the proposal to FRA, has as permanent voting members two organizations representing State and local interests: AASHTO and ASRSM. As such, these State organizations concurred with the proposed requirements, which differ in only limited respects from the requirements contained in this NPRM. The RSAC regularly provides recommendations to the FRA Administrator for solutions to regulatory issues that reflect significant input from its State members. To date, FRA has received no indication of concerns about the Federalism implications of this rulemaking from these representatives or from any other representative.

For the foregoing reasons, FRA believes that this NPRM is in accordance with the principles and criteria contained in Executive Order 13132.

E. Environmental Impact

FRA has evaluated this NPRM in accordance with its ''Procedures for Considering Environmental Impacts'' (FRA's Procedures) (*see* 64 FR 28545 (May 26, 1999)) as required by the National Environmental Policy Act (*see* 42 U.S.C. 4321 *et seq.*), other environmental statutes, Executive Orders, and related regulatory requirements. FRA has determined that this NPRM is not a major FRA action (requiring the preparation of an environmental impact statement or environmental assessment) because it is categorically excluded from detailed environmental review pursuant to section 4(c)(20) of FRA's Procedures. *See* 64 FR 28547 (May 26, 1999). In accordance with section 4(c) and (e) of FRA's Procedures, the agency has further concluded that no extraordinary circumstances exist with respect to this regulation that might trigger the need for a more detailed environmental review. As a result, FRA finds that this NPRM is not a major Federal action significantly affecting the quality of the human environment.

F. Unfunded Mandates Reform Act of 1995

Pursuant to Section 201 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4, 2 U.S.C. 1531), each Federal agency ''shall, unless otherwise prohibited by law, assess the effects of Federal regulatory actions on State, local, and tribal governments, and the private sector (other than to the extent that such regulations incorporate

requirements specifically set forth in law).'' Section 202 of the Act (2 U.S.C. 1532) further requires —''[b]efore promulgating any general notice of proposed rulemaking that is likely to result in the promulgation of any rule that includes any Federal mandate that may result in expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (annually adjusted for inflation) in any 1 year, and before promulgating any final rule for which a general notice of proposed rulemaking was published, the agency shall prepare a written statement. * * *''

The written statement must detail the effect on State, local, and tribal governments and the private sector. This NPRM will not result in the expenditure, in the aggregate, of $141,300,000 in any one year, and thus preparation of such a statement is not required.

G. Energy Impact

Executive Order 13211 requires Federal agencies to prepare a Statement of Energy Effects for any ''significant energy action.'' *See* 66 FR 28355 (May 22, 2001). Under the Executive Order, a ''significant energy action'' is defined as any action by an agency (normally published in the **Federal Register**) that promulgates or is expected to lead to the promulgation of a final rule or regulation, including notices of inquiry, advance notices of proposed rulemaking, and notices of proposed rulemaking: (1)(i) that is a significant regulatory action under Executive Order 12866 or any successor order, and (ii) is likely to have a significant adverse effect on the supply, distribution, or use of energy; or (2) that is designated by the Administrator of the Office of Information and Regulatory Affairs as a significant energy action. FRA has evaluated this NPRM in accordance with Executive Order 13211. FRA has determined that this NPRM is not likely to have a significant adverse effect on the supply, distribution, or use of energy. Consequently, FRA has determined that this regulatory action is not a ''significant energy action'' within the meaning of Executive Order 13211.

H. Trade Impact

The Trade Agreements Act of 1979 (Pub. L. 96–39, 19 U.S.C. 2501 *et seq.*) prohibits Federal agencies from engaging in any standards setting or related activities that create unnecessary obstacles to the foreign commerce of the United States. Legitimate domestic objectives, such as safety, are not considered unnecessary obstacles. The statute also requires consideration of international standards and, where appropriate, that they be the basis for U.S. standards.

FRA has assessed the potential effect of this NPRM on foreign commerce and believes that its requirements are consistent with the Trade Agreements Act. The requirements imposed are safety standards, which, as noted, are not considered unnecessary obstacles to trade.

I. Privacy Act

Anyone is able to search the electronic form of all comments received into any of FRA's dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477–78), or you may visit *http://DocketsInfo.dot.gov*.

List of Subjects in 49 CFR Part 214

Occupational safety and health, Penalties, Railroad safety.

The Proposed Rule

In consideration of the foregoing, FRA proposes to amend part 214 of chapter II, subtitle B of title 49, Code of Federal Regulations, as follows:

PART 214—[AMENDED]

1. The authority citation for part 214 is revised to read as follows:

Authority: 49 U.S.C. 20102–20103, 20107, 21301–21302, 21304; 28 U.S.C. 2461, note; and 49 CFR 1.49.

Subpart C—Roadway Worker Protection

2. Section 214.315 is amended by revising paragraph (a) to read as follows:

§ 214.315 Supervision and communication.

(a) When an employer assigns a duty to a roadway worker that calls for that employee to foul a track, the employer shall provide the employee with an on-track safety job briefing that, at a minimum, includes the following:

(1) Information on the means by which on-track safety is to be provided for each track identified to be fouled;

(2) Instruction on each on-track safety procedure to be followed;

(3) Information about any adjacent tracks, on-track safety for such tracks, if required by this subpart or deemed necessary by the roadway worker in charge, and identification of any roadway maintenance machines that will foul such tracks; and

(4) A discussion of the nature of the work to be performed and the characteristics of the work location to ensure compliance with this subpart.

* * * * *

3. Section 214.335 is amended by removing paragraph (c) and revising the section heading to read as follows:

§ 214.335 On-track safety procedures for roadway work groups, general.

* * * * *

4. New § 214.336 is added to read as follows:

§ 214.336 Adjacent-controlled-track on-track safety procedures for certain roadway work groups.

(a) *Procedures; general.* (1) Except as provided in paragraph (e) of this section, on-track safety is required for each adjacent controlled track when a roadway work group with at least one of the roadway workers on the ground is engaged in a common task with an on-track roadway maintenance machine or coupled equipment on an occupied track. The required on-track safety shall be established through working limits (§ 214.319) or train approach warning provided by watchmen/lookouts (§ 214.329) and as more specifically described in this section.

(2) If an occupied track has two adjacent controlled tracks, and one of these adjacent controlled tracks has one or more adjacent-controlled-track movements authorized at 25 mph or less, and the other adjacent controlled track has one or more concurrent adjacent-controlled-track movements authorized at over 25 mph, the more restrictive procedures in paragraph (b) of this section apply.

(3) As used in this section—

''*Adjacent controlled track''* means a controlled track whose track center is spaced 19 feet or less from the track center of the occupied track.

''*Adjacent tracks''* means two or more tracks with track centers spaced less than 25 feet apart.

''*Clear side''* means the field side of the occupied track that either has no adjacent track on that side or has an adjacent track or tracks on that side and working limits have been established in accordance with this subpart on the closest adjacent track on that side and there are no movements authorized through the working limits by the roadway worker in charge on that adjacent track.

''*Occupied track''* means the track on which a roadway maintenance machine or coupled equipment is located while engaged in a common task with a roadway work group.

(b) *Procedures for adjacent-controlled-track movements over 25*

mph. Except as provided in paragraph (e) of this section, if a train or other on-track equipment is authorized to move on an adjacent controlled track at a speed greater than 25 mph, each roadway work group to which this section applies must comply with the following procedures:

(1) *Ceasing work and occupying a place of safety.* Each roadway worker in the roadway work group shall cease any on-ground work and movement of any roadway maintenance machine or coupled equipment in the fouling space of the occupied track and the adjacent controlled track, and occupy a predetermined place of safety upon receiving—

(i) A notification in accordance with § 214.319(c) indicating that the roadway worker in charge intends to authorize one or more train or other on-track equipment movements through the working limits on the adjacent controlled track, if adjacent-controlled-track on-track safety has been established through working limits alone; or

(ii) A watchman/lookout warning, if on-track safety through train approach warning (§ 214.329) has been established on the adjacent controlled track either as the sole method of on-track safety or in addition to working limits.

(2) *Resuming work.* (i) A component of a roadway work group may resume on-ground work and movement of any roadway maintenance machine or coupled equipment on or fouling the occupied track only after the trailing-end of all trains or other on-track equipment moving on the adjacent controlled track (for which a notification or warning has been received in accordance with paragraph (b)(1) of this section) has passed and remains ahead of that component of the roadway work group.

(ii) If the train or other on-track equipment stops before its trailing-end has passed all of the roadway workers in the roadway work group, the work to be performed on or fouling the occupied track ahead of the trailing-end of the train or other on-track equipment on the adjacent controlled track may resume only—

(A) If on-track safety through train approach warning (§ 214.329) has been established on the adjacent controlled track; or

(B) After the roadway worker in charge has communicated with the train engineer or equipment operator and established that further movements of such train or other on-track equipment shall be made only as permitted by the roadway worker in charge.

(c) *Procedures for adjacent-controlled-track movements 25 mph or less.* If a train or other on-track equipment is authorized to move on an adjacent controlled track at a speed of 25 mph or less, each roadway work group to which this section applies must comply with the procedures listed in paragraph (b) of this section, except that work that is performed exclusively while positioned on or between the rails of the occupied track or on the clear side may continue, provided that any on-ground work is performed more than 25 feet in front of or behind any roadway maintenance machine on or fouling the occupied track during such adjacent-controlled-track movement.

(d) *Procedures for a roadway maintenance machine or coupled equipment fouling an adjacent controlled track.* A roadway maintenance machine or coupled equipment shall not foul an adjacent controlled track unless working limits have been established on the adjacent controlled track and there are no movements authorized through the working limits by the roadway worker in charge.

(e) *Exceptions to the requirement for adjacent-controlled-track on-track safety.* The procedures for adjacent-controlled-track on-track safety in paragraphs (a) through (c) of this section do not apply to the following work activities:

(1) One or more on-ground roadway workers performing work while exclusively positioned on the clear side of the occupied track.

(2) A hi-rail vehicle on or fouling an occupied track while engaged in a common task with one or more roadway workers on the ground, provided that such hi-rail vehicle is not coupled to one or more railroad cars or operating on the same occupied track and within the working limits of a roadway work group as described in paragraph (a) of this section. In accordance with § 214.315(a)(3), where multiple hi-rail vehicles are engaged in a common task, the on-track safety briefing shall include discussion of the nature of the work to be performed to determine if adjacent-controlled-track on-track safety is necessary.

(3) A catenary maintenance tower car on or fouling an occupied track that is engaged in a common task with one or more roadway workers positioned on the ground within the gage of the occupied track for the sole purpose of applying or removing grounds, provided that such catenary maintenance tower car is not operating on the same occupied track and within the working limits of a roadway work group as described in paragraph (a) of this section.

(f) *Discretion of roadway worker in charge.* Nothing in this subpart prohibits the roadway worker in charge from establishing on-track safety on one or more adjacent tracks as he or she deems necessary consistent with both the purpose and requirements of this subpart.

Issued in Washington, DC, on November 16, 2009.

Karen J. Rae,

Deputy Administrator.

[FR Doc. E9–27974 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–06–P

Notices

Federal Register
Vol. 74, No. 226
Wednesday, November 25, 2009

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.

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

[Doc. No. AMS–LS–09–0054]

Results of Soybean Request for Referendum

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Notice.

SUMMARY: The results of the Agricultural Marketing Service's (AMS) Request for Referendum indicate that too few soybean producers wanted a referendum on the Soybean Promotion and Research Order (Order) for one to be conducted. The Request for Referendum was conducted from May 4, 2009, through May 29, 2009, at the Department of Agriculture's (USDA) Farm Service Agency county offices. To trigger a referendum, 58,918 soybean producers needed to complete a Request for Referendum. The number of soybean producers requesting a referendum was 759.

FOR FURTHER INFORMATION CONTACT: Kenneth R. Payne, Chief, Marketing Programs Branch, Livestock and Seed Program, AMS, USDA, Room 2628–S, STOP 0251, 1400 Independence Avenue, SW., Washington, DC 20250–0251; Telephone 202/720–1115; Fax 202/720–1125; or e-mail to *Kenneth.Payne@ams.usda.gov.*

SUPPLEMENTARY INFORMATION: Pursuant to the Soybean Promotion, Research, and Consumer Information Act (Act) (7 U.S.C. 6301 *et seq.*), every 5 years the Secretary of Agriculture (Secretary) gives soybean producers the opportunity to request a referendum on the Order. If the Secretary determines that at least 10 percent of U.S. producers engaged in growing soybeans (not in excess of one-fifth of which may be producers in any one State) support the conduct of a referendum, the Secretary must conduct a referendum within 1 year of that determination. If these requirements are not met, a referendum is not conducted.

A notice of opportunity to Request a Soybean Referendum was published in the **Federal Register** (74 FR 9382) on March 4, 2009. To be eligible to participate in the Request for Referendum, producers or the producer entity that they are authorized to represent must provide supporting documentation showing that they or the producer entity they represent paid an assessment sometime during the representative period between January 1, 2007, and December 31, 2008. Based on USDA data, there are 589,182 soybean producers in the United States. This information was published in the **Federal Register** (74 FR 9047) on March 2, 2009, to establish the number of producers eligible to request a referendum.

A total of 759 valid Requests for Referendum were completed by eligible soybean producers. This number does not meet the requisite number of 58,918. Therefore, based on the Request for Referendum results, a referendum will not be conducted. In accordance with the provisions of the Act, soybean producers will be provided another opportunity to request a referendum in 5 years.

The following is the State-by-State results of the Request for Referendum:

State	Valid ballots
Alabama	2
Alaska	0
Arizona	0
Arkansas	1
California	0
Colorado	0
Connecticut	0
Delaware	2
Florida	1
Georgia	1
Hawaii	0
Idaho	0
Illinois	112
Indiana	112
Iowa	102
Kansas	15
Kentucky	5
Louisiana	0
Maine	0
Maryland	11
Massachusetts	0
Michigan	31
Minnesota	71
Mississippi	0
Missouri	62
Montana	0
Nebraska	27
Nevada	0
New Hampshire	0
New Jersey	0
New Mexico	0
New York	10
North Carolina	13
North Dakota	3
Ohio	87
Oklahoma	3
Oregon	0
Pennsylvania	3
Rhode Island	0
South Carolina	3
South Dakota	38
Tennessee	7
Texas	4
Utah	0
Vermont	0
Virginia	6
Washington	0
West Virginia	2
Wisconsin	25
Wyoming	0

Authority: 7 U.S.C. 6301–6311.

Dated: November 19, 2009.

Rayne Pegg,

Administrator, Agricultural Marketing Service.

[FR Doc. E9–28233 Filed 11–24–09; 8:45 am]

BILLING CODE 3410–02–P

COMMISSION ON CIVIL RIGHTS

Sunshine Act Notice

AGENCY: United States Commission on Civil Rights.

ACTION: Notice of meeting.

DATE AND TIME: Friday, December 4, 2009; 9:30 a.m. EST.

PLACE: 624 9th St., NW., Room 540, Washington, DC 20425.

Meeting Agenda

This meeting is open to the public.

I. Approval of Agenda.

II. Program Planning.

- Update on Status of 2010 Enforcement Report.
- Update on Status of Title IX Project.
- Approval of Briefing Report on Covert Wiretapping in the War on Terror.
- Approval of MEPA Briefing Report.

III. Management & Operations.

- Update Regarding Special Assistant GS Level.

IV. Approval of September 24, October 8, October 15, October 30, and November 20 Meeting Minutes.
V. Staff Director's Report.
VI. Adjourn.

CONTACT PERSON FOR FURTHER INFORMATION: Lenore Ostrowsky, Acting Chief, Public Affairs Unit (202) 376–8591. TDD: (202) 376–8116.

Persons with a disability requiring special services, such as an interpreter for the hearing impaired, should contact Pamela Dunston at least seven days prior to the meeting at 202–376–8105. TDD: (202) 376–8116.

Dated: November 23, 2009.

David Blackwood,

General Counsel.

[FR Doc. E9–28423 Filed 11–23–09; 4:15 pm]

BILLING CODE 6335–01–P

DEPARTMENT OF COMMERCE

Submission for OMB Review; Comment Request

The Department of Commerce will submit to the Office of Management and Budget (OMB) for clearance the following proposal for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

Agency: National Oceanic and Atmospheric Administration (NOAA).

Title: Northeast Region Permit Family of Forms.

OMB Control Number: 0648–0202.

Form Number(s): NA.

Type of Request: Regular submission.

Number of Respondents: 21,554.

Average Hours per Response: Permit applications or renewals, 30 minutes to 1 hour; vessel replacement/upgrade requests, 3 hours; requests for lobster or gillnet tags, exemption requests and notifications, 5 minutes; and proposed sector allocation proposal and plan of operations, 50 hours each.

Burden Hours: 26,832.

Needs and Uses: The participants in the marine fishing industry, including vessel owners, vessel operators, and fish dealers, who wish to participate in regulated Northeast Regional fisheries must apply for, and obtain, permits. Persons obtaining permits may also be subject to notification, tagging, and other requirements. This request affects collections associated with the Atlantic Herring, Atlantic Mackerel, Atlantic Sea Scallop, Black Sea Bass, Bluefish, Illex Squid, Loligo Squid, Butterfish, Monkfish, Northeast (NE) Multispecies, Ocean Quahog, Scup, Spiny Dogfish, Summer Flounder, Surf Clam, Tilefish, Deep-sea Red Crab, NE Skates, and American Lobster Fishery Management Plans, developed under the authority of the Magnuson-Stevens Fishery Conservation and Management Act.

Affected Public: Business or other for-profit organizations.

Frequency: Annually and on occasion.

Respondent's Obligation: Mandatory.

OMB Desk Officer: David Rostker, (202) 395–3897.

Copies of the above information collection proposal can be obtained by calling or writing Diana Hynek, Departmental Paperwork Clearance Officer, (202) 482–0266, Department of Commerce, Room 7845, 14th and Constitution Avenue, NW., Washington, DC 20230 (or via the Internet at *dHynek@doc.gov*).

Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to David Rostker, OMB Desk Officer, FAX number (202) 395–7285, or *David_Rostker@omb.eop.gov.*

Dated: November 19, 2009.

Gwellnar Banks,

Management Analyst, Office of the Chief Information Officer.

[FR Doc. E9–28212 Filed 11–24–09; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–908]

First Antidumping Duty Administrative Review of Sodium Hexametaphosphate from the People's Republic of China: Extension of Time Limit for the Preliminary Results

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

EFFECTIVE DATE: November 25, 2009.

FOR FURTHER INFORMATION CONTACT: Paul Walker, AD/CVD Operations, Office 9, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–0413.

SUPPLEMENTARY INFORMATION:

Background

On April 27, 2009, the Department of Commerce (''Department'') published in the **Federal Register** a notice of initiation of an administrative review of sodium hexametaphosphate from the People's Republic of China (''PRC''), covering the period September 14, 2007 - February 28, 2009. *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Request for Revocation in Part*, 74 FR 19042 (April 27, 2009) (''*Initiation*''). From May 26, 2009 to October 28, 2009, the respondent in this review submitted responses to the Department's antidumping duty questionnaires. The preliminary results of this administrative review are currently due on December 1, 2009.

Extension of Time Limit for the Preliminary Results

Section 751(a)(3)(A) of the Tariff Act of 1930, as amended (''the Act''), requires the Department to issue the preliminary results of an administrative review within 245 days after the last day of the anniversary month of an order for which a review is requested. If it is not practicable to complete the review within the time period, section 751(a)(3)(A) of the Act allows the Department to extend this deadline to a maximum of 365 days.

The Department determines that completion of the preliminary results of this review within the statutory time period is not practicable, given the extraordinarily complicated nature of the proceeding. The Department requires more time to gather and analyze a significant amount of information pertaining to the respondent's corporate structure and ownership, sales practices, and manufacturing methods. The Department also requires additional time to analyze the questionnaire responses and conduct verification. Therefore, given the number and complexity of issues in this case, and in accordance with section 751(a)(3)(A) of the Act, we are extending the time period for issuing the preliminary results of review by 60 days until January 30, 2010. The final results continue to be due 120 days after the publication of the preliminary results.

This notice is published pursuant to sections 751(1)(3)(A) and 777(i)(1) of the Act and 19 CFR 351.213(h)(2).

Dated: November 19, 2009.

John M. Andersen,

Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. E9–28269 Filed 11–24–09; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[A–549–502]

Circular Welded Carbon Steel Pipes and Tubes from Thailand: Extension of Time Limit for Preliminary Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce

EFFECTIVE DATE: November 25, 2009.

FOR FURTHER INFORMATION CONTACT: Jacqueline Arrowsmith, AD/CVD Operations, Office 6, Import Administration, International Trade Administration, Department of Commerce, Room 7866, 14th Street and Constitution Avenue, NW, Washington DC 20230; telephone: (202) 482–5255.

SUPPLEMENTARY INFORMATION:

Background

On April 27, 2009, the Department published the initiation of the administrative review of the antidumping duty order on circular welded carbon steel pipes and tubes (pipes and tubes) from Thailand for the period March 1, 2008 through February 28, 2009. *See Initiation of Antidumping and Countervailing Duty Administrative Reviews and Request for Revocation in Part* 74 FR FR 19042 (April 27,2009) (*Initiation Notice*). This review covers the respondent, Saha Thai Steel Pipe (Public) Co., Ltd. (Saha Thai), a producer/exporter of the subject merchandise to the United States.

Extension of Time Limit for the Preliminary Results

Section 751(a)(3)(A) of the Tariff Act of 1930, as amended (the Act), and section 351.213(h)(1) of the Department's regulations require the Department to issue the preliminary results of a review within 245 days after the last day of the anniversary month of the order or suspension agreement for which the administrative review was requested, and final results of the review within 120 days after the date on which the notice of the preliminary results is published in the **Federal Register**. However, if the Department determines that it is not practicable to complete the review within the aforementioned specified time limits, section 751(a)(3)(A) of the Act and section 351.213(h)(2) of the Department's regulations allow the Department to extend the 245-day period to 365 days and to extend the 120-day period to 180 days.

The Department requires additional time to evaluate Saha Thai's questionnaire responses in order to conduct a thorough analysis of all information on the record. Specifically, the Department needs more time to analyze respondent's cost information and to consider whether to use quarterly costs as Saha Thai has requested. The Department, therefore, finds that it is not practicable to complete the preliminary results of this review within the original time limit and is extending the deadline for completion of the preliminary results of this administrative review of the antidumping duty order on circular welded carbon steel pipes and tubes from Thailand by 120 days, from December 1, 2009 to March 31, 2010.

This notice is issued and published pursuant to sections 751(a)(3)(A) and 777(i)(1) of the Act.

Dated: November 18, 2009.

John M. Andersen,

Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. E9–28275 Filed 11–24–09; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[Docket 52–2009]

Foreign-Trade Zone 61—San Juan, Puerto Rico; Application for Expansion

An application has been submitted to the Foreign-Trade Zones (FTZ) Board (the Board) by the Puerto Rico Trade and Export Company, grantee of FTZ 61, requesting authority to expand its zone to include additional sites in the San Juan, Puerto Rico area, in and adjacent to the San Juan Customs and Border Protection port of entry. The application was submitted pursuant to the provisions of the Foreign-Trade Zones Act, as amended (19 U.S.C. 81a–81u), and the regulations of the Board (15 CFR Part 400). It was formally filed on November 17, 2009.

FTZ 61 was approved on October 20, 1980 (Board Order No. 165, 45 FR 71408, 10/28/80) and expanded on September 28, 2007 (Board Order No. 1528, 72 FR 56723, 10/04/07). The zone project currently consists of the following sites: *Site 1* (244 acres) *Parcel A* (192 acres)—International Trade Center Grounds, Highway 165, km. 2.4; *Parcel B* (23 acres)—tract of undeveloped land, intersection of State Road 22 and State Road 28; *Parcel C* (12 acres)—tract of developed land, at Highway 28 and Cano Avenue; *Parcel D* (5 acres)—Amelia Distribution Center, intersection of Highway 165 and Calle Amelia; *Parcel E* (5 acres)—warehouse building, within the Centro Mercantil Internacional Complex, West Street, at the International Trade Center Grounds, Guaynabo; *Parcel F* (7 acres)—warehouse building (expires 11/1/11) located at Road #5, Km. 4.0, Barrio Palmas, Catano; *Site 2* (11 acres)—North Distribution Center, located at km. 1.1 on Highway 869, Catano; *Site 3* (15 acres)—Catano Equipment and Storage Complex, intersection of Highway 165 and Las Palmas Avenue, Catano; *Site 4* (2 acres)—Bayamon Logistics, Storage and Distribution Center, intersection of Calle C and Highway 28, Bayamon; *Site 5* (3 acres)—Corujo Industrial Park, located at Road 866, Km. 1.7, Hato Tejas; *Site 6* (4 acres)—warehouse facilities located on the north side of Highway 2, one mile east of Highway 165, Toa Baja; *Site 7* (2 acres)—Baldorioty de Castro Warehouse and Distribution Center, located at Km. 10.3, Marginal de la Avenida de Baldorioty de Castro at the intersection of Mercedez Drive, Carolina; *Site 8* (5 acres)—Manati chemical warehouse, intersection of Highways 686 and 670, Manati; *Site 9* (7 acres)—warehouse facilities located at km. 28.6 on Highway 1, Caguas; *Site 10* (14 acres)—storage complex at Km. 3.9, Marginal de J.F. Kennedy Avenue at the intersection of Blay Street, San Juan; *Site 11* (32 acres)—Mayaguez Regional Distribution Center, located at 201 Algarrobo Avenue, Mayaguez; *Site 12* (307 acres, 2 parcels)—Yabucoa Industrial Park, at the intersection of Highway 901 and Highway 53, Yabucoa; and, *Site 13* (3 acres)—warehouse facility, located at State Road 3, Km. 77.2, Barrio Abajo, Humacao.

The applicant is requesting authority to expand Sites 1, 5 and 10 to include additional acreage and to include 3 additional sites in the San Juan area:

—Expand Site 1 which will include temporary Site 1 Parcel F (7 acres) on a permanent basis (expires 11/01/11) and to restore to Site 1 Parcel B (19 acres) which had been removed for minor boundary modifications (new overall Site 1 total acreage-263 acres);

—Expand Site 5 to include an additional eight acres (new total-11 acres) (within the 350-acre Corujo Industrial Park);

—Expand Site 10 to include an additional acre (new total-15 acres);

—*Proposed Site 14* (6 acres)—Angora Industrial Park, Rd. #1, Km. 32.6, Bairoa Avenue, Caguas;

—*Proposed Site 15* (9 acres)—Royal Industrial Park, Rd. #869, Km. 2.8, Barrio Palmas, Catano; and,

—*Proposed Site 16* (1 acre)—Benitez commercial complex, Rd. #1, Km. 32.9, Bairoa Avenue, Caguas.

The sites will provide public warehousing and distribution services to area businesses. No specific manufacturing authority is being requested at this time. Such requests would be made to the Board on a case-by-case basis.

In accordance with the Board's regulations, Kathleen Boyce of the FTZ Staff is designated examiner to evaluate and analyze the facts and information presented in the application and case record and to report findings and recommendations to the Board.

Public comment on the application is invited from interested parties. Submissions (original and 3 copies) shall be addressed to the Board's Executive Secretary at the address listed below. The closing period for their receipt is January 25, 2010. Rebuttal comments in response to material submitted during the foregoing period may be submitted during the subsequent 15-day period (to February 8, 2010).

A copy of the application will be available for public inspection at the Office of the Executive Secretary, Foreign-Trade Zones Board, Room 2111, U.S. Department of Commerce, 1401 Constitution Avenue, NW., Washington, DC 20230–0002, and in the ''Reading Room'' section of the Board's Web site, which is accessible via *http://www.trade.gov/ftz.*

For further information, contact Kathleen Boyce at *Kathleen_Boyce@ita.doc.gov* or (202) 482–1346.

Dated: November 17, 2009.

Andrew McGilvray,

Executive Secretary.

[FR Doc. E9–28267 Filed 11–24–09; 8:45 am]

BILLING CODE P

DEPARTMENT OF COMMERCE

International Trade Administration

Initiation of Antidumping and Countervailing Duty Administrative Reviews

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: The Department of Commerce (''the Department'') has received requests to conduct administrative reviews of various antidumping duty orders and findings with October anniversary dates. In accordance with the Department's regulations, we are initiating those administrative reviews.

EFFECTIVE DATE: November 25, 2009.

FOR FURTHER INFORMATION CONTACT: Sheila E. Forbes, Office of AD/CVD Operations, Customs Unit, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230, telephone: (202) 482–4697.

SUPPLEMENTARY INFORMATION:

Background

The Department has received timely requests, in accordance with 19 CFR 351.213(b), for administrative reviews of various antidumping duty orders and findings with October anniversary dates.

Notice of No Sales

Under 19 CFR 351.213(d)(3), the Department may rescind a review where there are no exports, sales, or entries of subject merchandise during the respective period of review (''POR'') listed below. If a producer or exporter named in this notice of initiation had no exports, sales, or entries during the POR, it should notify the Department within 30 days of publication of this notice in the **Federal Register**. The Department will consider rescinding the review only if the producer or exporter, as appropriate, submits a properly filed and timely statement certifying that it had no exports, sales, or entries of subject merchandise during the POR. All submissions must be made in accordance with 19 CFR 351.303 and are subject to verification in accordance with section 782(i) of the Tariff Act of 1930, as amended (''the Act''). Six copies of the submission should be submitted to the Assistant Secretary for Import Administration, International Trade Administration, Room 1870, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230. Further, in accordance with 19 CFR 351.303(f)(1)(i), a copy of each request must be served on every party on the Department's service list.

Respondent Selection

In the event the Department limits the number of respondents for individual examination for administrative reviews, the Department intends to select respondents based on U.S. Customs and Border Protection (''CBP'') data for U.S. imports during the POR. We intend to release the CBP data under Administrative Protective Order (''APO'') to all parties having an APO within five days of publication of this initiation notice and to make our decision regarding respondent selection within 20 days of publication of this **Federal Register** notice. The Department invites comments regarding the CBP data and respondent selection within 10 calendar days of publication of this **Federal Register** notice.

Separate Rates

In proceedings involving non–market economy (''NME'') countries, the Department begins with a rebuttable presumption that all companies within the country are subject to government control and, thus, should be assigned a single antidumping duty deposit rate. It is the Department's policy to assign all exporters of merchandise subject to an administrative review in an NME country this single rate unless an exporter can demonstrate that it is sufficiently independent so as to be entitled to a separate rate.

To establish whether a firm is sufficiently independent from government control of its export activities to be entitled to a separate rate, the Department analyzes each entity exporting the subject merchandise under a test arising from the *Final Determination of Sales at Less Than Fair Value: Sparklers from the People's Republic of China*, 56 FR 20588 (May 6, 1991), as amplified by *Final Determination of Sales at Less Than Fair Value: Silicon Carbide from the People's Republic of China*, 59 FR 22585 (May 2,1994). In accordance with the separate–rates criteria, the Department assigns separate rates to companies in NME cases only if respondents can demonstrate the absence of both *de jure* and *de facto* government control over export activities.

All firms listed below that wish to qualify for separate–rate status in the administrative reviews involving NME countries must complete, as appropriate, either a separate–rate application or certification, as described below. For these administrative reviews, in order to demonstrate separate–rate eligibility, the Department requires entities for whom a review was requested, that were assigned a separate rate in the most recent segment of this proceeding in which they participated, to certify that they continue to meet the criteria for obtaining a separate rate. The Separate Rate Certification form will be available on the Department's website at http://www.trade.gov/ia on the date of publication of this **Federal Register** notice. In responding to the certification, please follow the ''Instructions for Filing the Certification'' in the Separate Rate Certification. Separate Rate Certifications are due to the Department no later than 30 calendar days after publication of this **Federal Register** notice. The deadline and requirement for submitting a Certification applies

equally to NME–owned firms, wholly foreign–owned firms, and foreign sellers who purchase and export subject merchandise to the United States.

For entities that have not previously been assigned a separate rate, to demonstrate eligibility for such, the Department requires a Separate Rate Status Application. The Separate Rate Status Application will be available on the Department's website at http://www.trade.gov/ia on the date of publication of this **Federal Register** notice. In responding to the Separate Rate Status Application, refer to the instructions contained in the application. Separate Rate Status Applications are due to the Department no later than 60 calendar days of publication of this **Federal Register** notice. The deadline and requirement for submitting a Separate Rate Status Application applies equally to NME–owned firms, wholly foreign–owned firms, and foreign sellers that purchase and export subject merchandise to the United States.

For exporters and producers who submit a separate–rate status application or certification and subsequently are selected as mandatory respondents, these exporters and producers will no longer be eligible for separate–rate status *unless* they respond to all parts of the questionnaire as mandatory respondents.

INITIATION OF REVIEWS:

In accordance with 19 CFR 351.221(c)(1)(i), we are initiating administrative reviews of the following antidumping duty orders and findings. We intend to issue the final results of these reviews not later than October 31, 2010.

Antidumping Duty Proceedings	Period to be Reviewed
THE PEOPLE'S REPUBLIC OF CHINA: Certain Helical Spring Lock Washers[1].	
A–570–822	10/1/08 - 9/30/09
Hangzhou Spring Washer Co., Ltd..	
THE PEOPLE'S REPUBLIC OF CHINA: Steel Wire Garment Hangers[2].	
A–570–918	3/25/08 - 9/30/09
Acrowell International Logistics.	
Acx Logistics (China) Ltd..	
Agility Logistics (Shanghai) Ltd..	
Ahlers Vina Logistics.	
Alcon Express Corp..	
Alpi Trading Service Co., Ltd..	
Amerasian Shipping Logistics Corp..	
Anc Service Co., Ltd..	
Angang Clothes Rack Manufacture Co..	
Anhui Whywin International Co., Ltd..	
Apex Holding Group Limited.	
Apex Maritime Co. Ltd..	
Apl Logistics China, Ltd..	
Arturo Huizar Velazquez.	
Ate Logistics Co., Ltd..	
Beijing Kang Jie Kong Cargo Agent Co., Ltd..	
Biz Sources Inc. (Biz Sources PTY Ltd.).	
Brilliant Globe Logistics Inc..	
Canada Cleaning Supply Corp..	
Centurion Logistics Services Ltd..	
China Coast Freight Co., Ltd..	
China Container Line (Shanghai) Ltd..	
China International Freight Co., Ltd..	
China Ocean Shipping Agency (Ningbo).	
City Ocean Logistics Co., Ltd..	
Cixi K&J International Co., Ltd..	
Cohesion Freight (HK) Ltd..	
Cohesion Freight Agency Ltd. (Shanghai).	
Cong Ty Duoc Thao.	
Cong Ty Trach Nhiem (CTN Co., Ltd.).	
De Well Container Shipping Corp..	
Diep Son Hangers One Member Co., Ltd..	
Direct Service Inc..	
Distribution Rsjo Inc..	
Dma Logistics Inc..	
Dong Nam A Co., Ltd..	
Dragon Trading Shipping Co., Ltd..	
Dynamic Network Container Line Ltd..	
Evergreen Logistics Vietnam Co., Ltd..	
Expeditors China.	
Far Go Express Company Limited.	
Fastic Transportation Co., Ltd..	
Focus Shipping Corp..	
For You Beautiful Industrial Co., Ltd..	
Fortune Freight International Co., Ltd..	
Ge Li Commerce Co., Ltd..	
General Merchandise Consolidators, Inc..	
Giant Choice Co., Ltd..	
Gle Logistics Co., Ltd..	
Globe Express Services S.a.r.L. Co., Ltd..	
Goldever International Logistics Co..	
Good Wonder Limited.	

Antidumping Duty Proceedings	Period to be Reviewed
Guangdong Provincial Taoyue Mfg. Co., Ltd..	
Guangxi Shengfeng Import and Export Co., Ltd..	
Guangzhou Yanglei–Packing Co., Ltd..	
Guilin Yc Enterprise Co., Ltd..	
Hangzhou Rico Homeware and Apparel Ltd..	
Hanhen Shipping (China) Co., Ltd..	
Hanjin (Shenzhen) Co., Ltd..	
Hanjin Logistics (Shanghai) Co., Ltd..	
Hcmc General Import and Export Investment Joint Stock Company (IMexico).	
Hecny Shipping Limited.	
Hippo Logistics Co., Ltd..	
HongKong Wells Limited.	
Honour Lane Logistics Co., Ltd..	
Honour Lane Shipping Limited.	
Huada Fashion Enterprise, Inc..	
Huguang Huojia Factory.	
Intercontinental Shipping Co., Ltd..	
Jiangmen Hongjun Hardware & Elect.	
Jiangsu Globe Logistics Limited Co..	
Jiangyin Hongji Metal Products Co., Ltd..	
Jianxing Boyi Medical Device Co., Ltd..	
Jr Metal Products Shanghai.	
Ju Fu Co., Ltd..	
Kaiping Youming Hardware & Plastic Products Co., Ltd..	
KB Steel.	
Kingly Industry (Canada) Corp..	
Korea Laundry Industry Co., Ltd..	
Kuehne & Nagel Ltd..	
Kyung Dong Industrial Co., Ltd..	
Laidlaw Company LLC.	
Laidlaw Metal Products Co., Ltd..	
Laidlaw Shanghai.	
Lights Out Machinery Co., Ltd..	
Limpiaduria Zaragoza Huizar.	
Link & Link Shipping Ltd..	
Maple Hangers Inc..	
Mico Mit Co., Ltd..	
Moc Viet Manufacture Co., Ltd..	
Multi–Sander Tech. Co., Ltd..	
N2j Co., Ltd..	
Nanchang Tuhai Industry Co., Ltd..	
Ningbo Dasheng Hanger Ind. Co., Ltd..	
Ningbo Eidz Holding Ltd..	
Ningbo Jude Trading Co., Ltd..	
Ningbo Peacebird Import & Export Co., Ltd..	
Ningbo Yifan International Forwarding Agency Co., Ltd..	
NV Hanger Co., Ltd..	
Ocean Star International Logistics Co., Ltd..	
Odyssey International (China) Ltd..	
Oec Freight Worldwide Co., Ltd..	
Orient Express Container Co., Ltd..	
Orient Star Shipping Pte..	
Orient Star Transport International Ltd..	
Oriental Dragon Co., Ltd..	
Oriental Logistics Group Ltd..	
P T Transportation Ltd..	
Pacific Star Express Corporation.	
Pacific Star International Logistics (China) Co., Ltd..	
Phoenix International Freight Services Ltd..	
Pingye Foreign Transportation Co., Ltd..	
Post–Pop Art Co., Ltd..	
Price Group Ltd..	
Prolim De Baja California.	
Pu Jiang County Command Metal Products Co., Ltd..	
Pudong Trans USA, Inc..	
Quyky–yanglei International Co., Ltd..	
RDD Freight International Inc..	
Rich Shipping Company Limited.	
Rising Trade Inc..	
Royal Cargo Combined Logistics, Inc..	
Royal McGoun Inc..	
Schenker China Ltd..	
Sea Bright International Industrial.	
Seamaster Logistics Inc..	

Antidumping Duty Proceedings	Period to be Reviewed
Shanghai Air Sea Transport Inc..	
Shanghai Channel International Logistics.	
Shanghai Fanyuan Freight Forwarding.	
Shanghai Garment Group Import/Export Corp..	
Shanghai Jianhai International Trade Co., Ltd..	
Shanghai Light Industry and Textile Group Co., Ltd..	
Shanghai T.H.I Transport Co., Ltd..	
Shanghai Wells Hanger Co., Ltd..	
Shangyu Baoxiang Metal Manufactured Co., Ltd..	
Shaoguang International Trade Co..	
Shaoxing Andrew Metal Manufactured Co., Ltd..	
Shaoxing Dingli Metal Clotheshorse Co., Ltd..	
Shaoxing Gangyuan Metal Manufactured Co., Ltd..	
Shaoxing Guochao Metallic Products Co., Ltd..	
Shaoxing Leiluo Metal Manufactured.	
Shaoxing Liangbao Metal Manufactured Co., Ltd..	
Shaoxing Meideli Metal Hanger Co., Ltd..	
Shaoxing Shunji Metal Clotheshorse Co., Ltd..	
Shaoxing Tongzhou Metal Manufactured Co., Ltd..	
Shaoxing Zhongbao Metal Manufactured Co., Ltd..	
Shenzhen Center Link International.	
Shenzhen Pacific–Net Logistics Inc..	
Shipping & Distribution Ltd..	
Sino Connections Logistics Inc..	
Sinobo International Logistics Co., Ltd..	
Sinotrans Zhejiang Co., Ltd..	
Sirius Global Logistics Co., Ltd..	
Smart Concept Trading Limited.	
Star Glory Ltd..	
Summit Logistics International Inc..	
Sun Vn Transport Corp. (Sunvn Transport Corporation).	
Tay Ruey Enterprise Co..	
Thanh Hieu Manufacturing Trading Co., Ltd..	
The Houjie Town Yongxiang/Hardware Processing Plant.	
Tianjin Hongtong Metal Manufacture Co., Ltd..	
Top Harvest Metal Co. Ltd..	
Top Shipping Logistics Co., Ltd..	
Topocean Consolidation Service (China) Ltd..	
Topocean Vietnam.	
Translink Shipping Inc..	
Transworld Transportation Co., Ltd..	
Twt–Transworld Transportation Co., Ltd..	
U.S. United Logistics Inc..	
Unique Logistics International (HK) Ltd..	
Unitex International Forwarding (HK) Ltd..	
Ups Scs Ltd..	
Vantage Logistics Corporation.	
Viet Anh Import–Export Joint Stock Company.	
Vietnam Hangers Joint Stock Company.	
Wiexin Cargo Services Co., Ltd..	
Whale Logistics Company Ltd..	
Winwell Industrial Limited.	
Wuhu Rising International Trade Co., Ltd..	
Xin Chang Heng Xin Yi Jia Factory.	
Yiwu Ao–Si Metal Products Co., Ltd..	
Zhejiang Hailiang Co., Ltd..	
Zhejiang King Merchandise Industrial.	
Zhejiang Lucky Cloud Hanger Co., Ltd..	
Zhejiang Peace Industry and Trade Inc..	
Zownzi Hardware Hanger Fty Ltd..	
Zynpak Packaging Products Inc..	
Countervailing Duty Proceedings.	
None..	
Suspension Agreements.	
None..	

[1] If the above-named company does not qualify for a separate rate, all other exporters of Certain Helical Spring Lock Washers from the People's Republic of China (''PRC'') who have not qualified for a separate rate are deemed to be covered by this review as part of the single PRC entity of which the named exporter is a part.

[2] If one of the above-named companies does not qualify for a separate rate, all other exporters of Steel Wire Garment Hangers from the PRC who have not qualified for a separate rate are deemed to be covered by this review as part of the single PRC entity of which the named exporter is a part.

During any administrative review covering all or part of a period falling between the first and second or third and fourth anniversary of the publication of an antidumping duty order under 19 CFR 351.211 or a determination under 19 CFR 351.218(f)(4) to continue an order or suspended investigation (after sunset review), the Secretary, if requested by a domestic interested party within 30 days of the date of publication of the notice of initiation of the review, will determine, consistent with *FAG Italia v. United States*, 291 F.3d 806 (Fed Cir. 2002), as appropriate, whether antidumping duties have been absorbed by an exporter or producer subject to the review if the subject merchandise is sold in the United States through an importer that is affiliated with such exporter or producer. The request must include the name(s) of the exporter or producer for which the inquiry is requested.

For the first administrative review of any order, there will be no assessment of antidumping or countervailing duties on entries of subject merchandise entered, or withdrawn from warehouse, for consumption during the relevant provisional–measures ''gap'' period, of the order, if such a gap period is applicable for the POR.

Interested parties must submit applications for disclosure under APO in accordance with 19 CFR 351.305. On January 22, 2008, the Department published *Antidumping and Countervailing Duty Proceedings: Documents Submission Procedures; APO Procedure*s, 73 FR 3634 (January 22, 2008). Those procedures apply to administrative reviews included in this notice of initiation. Parties wishing to participate in any of these administrative reviews should ensure that they meet the requirements of these procedures (*e.g.*, the filing of separate letters of appearance as discussed in 19 CFR 351.103(d)).

These initiations and this notice are in accordance with section 751(a) of the Tariff Act of 1930, as amended (19 U.S.C. 1675(a)), and 19 CFR 351.221(c)(1)(i).

Dated: November 19, 2009.

John M. Andersen,

Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. E9–28271 Filed 11–24–09; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Hydrographic Services Review Panel Meeting

AGENCY: National Ocean Service, National Oceanic and Atmospheric Administration (NOAA), Department of Commerce.

ACTION: Notice of public meeting (via conference call) on December 16, 2009.

SUMMARY: The Hydrographic Services Review Panel (HSRP), a Federal Advisory Committee, will be holding a public meeting via teleconference on December 16, 2009. The purpose of the meeting is to discuss and vote on proposed revisions to an updated version of the Hydrographic Services Review Panel Federal Advisory Committee Special Report 2007, ''HSRP Most Wanted Hydrographic Services Improvements.''

Date and Time: The conference call will commence at 2 p.m. Eastern Standard Time on Wednesday, December 16, 2009, and will end by 4 p.m. Eastern Standard Time, if not earlier. Agenda topics and times are subject to change. For the most current meeting agenda, refer to the HSRP Web site: *http://www.nauticaicharts.noaa.gov/ocs/hsrp/hsrp.htm.*

Public Participation: The meeting is open to the public and will be held via conference call with documents reviewed by meeting participants via WebEx. To register for the meeting and participate in the conference call and on-line document review, contact Rebecca Arenson at *Hydroservices.panel@noaa.gov* or 301–713–2780 x158. Register for the meeting by Friday, December 11, 2009. Please note that there are a limited number of access lines for WebEx participation, with participation available on a first-come, first served basis. For more information on meeting topics, refer to the HSRP Web site at: *http://www.nauticaicharts.noaa.gov/ocs/hsrp/hsrp.htm.* A public comment period will be scheduled during the meeting. The public comment period will be part of the final agenda that will be published before the meeting date on the HSRP Web site (*http://www.nauticaicharts.noaa.gov/ocs/hsrp/hsrp.htm*). Written public comments should be submitted to Rebecca Arenson no later than December 11, 2009. Those individuals planning to provide oral comments are requested to inform Rebecca Arenson no later than December 11, 2009. The time period for oral comments may be limited. Please contact Rebecca Arenson via e-mail: *Hydroservices.panel@noaa.gov* or phone: 301–713–2780 x158.

FOR FURTHER INFORMATION CONTACT: Rebecca Arenson, NOAA, Office of Coast Survey, National Ocean Service (NOS), NOAA (N/CS), 1315 East West Highway, Silver Spring, Maryland 20910; Telephone: 301–713–2780 x158, e-mail: *Hydroservices.panel@noaa.gov* or visit the NOAA HSRP Web site at *http://www.nauticaicharts.noaa.gov/ocs/hsrp/hsrp.htm.*

SUPPLEMENTARY INFORMATION:

The Hydrographic Services Review Panel (HSRP) was established by the Secretary of Commerce to advise the Under Secretary of Commerce for Oceans and Atmosphere on matters related to the responsibilities and authorities set forth in section 303 of the Hydrographic Services Improvement Act of 1998, its amendments, and such other appropriate matters that the Under Secretary refers to the Panel for review and advice.

The HSRP conference call is open to the public; participation is available on a first-come, first-served basis, and may be limited.

Items on the meeting agenda include: (1) Proposed revisions to an updated version of the Hydrographic Services Review Panel Federal Advisory Committee Special Report 2007, ''HSRP Most Wanted Hydrographic Services Improvements,'' and (2) other topics. Agenda topics and times are subject to change. For the most current meeting agenda, refer to the HSRP Web site: *http://www.nauticaicharts.noaa.gov/ocs/hsrp/hsrp.htm.*

Dated: November 9, 2009.

John E. Lowell, Jr.,

Director, Office of Coast Survey, National Ocean Service, National Oceanic and Atmospheric Administration.

[FR Doc. E9–28215 Filed 11–24–09; 8:45 am]

BILLING CODE 3510–JE–M

DEPARTMENT OF COMMERCE

Bureau of Industry and Security

Regulations and Procedures Technical Advisory Committee; Notice of Partially Closed Meeting

The Regulations and Procedures Technical Advisory Committee (RPTAC) will meet December 9, 2009, 9 a.m., Room 3884, in the Herbert C. Hoover Building, 14th Street between Constitution and Pennsylvania Avenues, NW., Washington, DC. The Committee advises the Office of the

Assistant Secretary for Export Administration on implementation of the Export Administration Regulations (EAR) and provides for continuing review to update the EAR as needed.

Agenda

Public Session

1. Opening remarks by the Chairman.

2. Presentation of papers or comments by the Public.

3. Opening remarks by Bureau of Industry and Security.

4. Export Enforcement update.

5. Regulations update.

6. Working group reports.

7. Automated Export System (AES) update.

Closed Session

8. Discussion of matters determined to be exempt from the provisions relating to public meetings found in 5 U.S.C. app. 2 section 10(a)(1) and 10(a)(3).

The open session will be accessible via teleconference to 20 participants on a first come, first serve basis. To join the conference, submit inquiries to Ms. Yvette Springer at *Yspringer@bis.doc.gov* no later than December 2, 2009.

A limited number of seats will be available for the public session. Reservations are not accepted. To the extent that time permits, members of the public may present oral statements to the Committee. The public may submit written statements at any time before or after the meeting. However, to facilitate the distribution of public presentation materials to the Committee members, the Committee suggests that presenters forward the public presentation materials prior to the meeting to Ms. Springer via e-mail.

The Assistant Secretary for Administration, with the concurrence of the delegate of the General Counsel, formally determined on March 23, 2009, pursuant to Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. app. 2 section (10)(d)), that the portion of the meeting dealing with matters the disclosure of which would be likely to frustrate significantly implementation of an agency action as described in 5 U.S.C. 552b(c)(9)(B) shall be exempt from the provisions relating to public meetings found in 5 U.S.C. app. 2 section 10(a)1 and 10(a)(3). The remaining portions of the meeting will be open to the public.

For more information, call Yvette Springer at (202) 482–2813.

Dated: November 18, 2009.

Yvette Springer,

Committee Liaison Officer.

[FR Doc. E9–28195 Filed 11–24–09; 8:45 am]

BILLING CODE 3510–JT–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XT11

Western Pacific Fishery Management Council; Public Meetings

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of public meeting.

SUMMARY: This notice advises the public that the Western Pacific Fishery Management Council (Council) will convene a meeting of its Advisory Panel.

DATES: The Advisory Panel meeting will be held December 15–17, 2009. For the specific time and agenda for the meeting see **SUPPLEMENTARY INFORMATION**.

ADDRESSES: The meeting of the Advisory Panel will be held at the Council office at 1164 Bishop Street, Suite 1400, Honolulu, HI 96813.

FOR FURTHER INFORMATION CONTACT: Kitty M. Simonds, Executive Director; telephone: (808) 522–8220.

SUPPLEMENTARY INFORMATION: The date, time and agenda for each meeting are as follows:

Tuesday, December 15, 2009, 9 a.m. - 5 p.m.

1. Welcome and Introductions
2. Review and approval of agenda
3. Reports on fishery and community issues, American Samoa, Guam, CNMI and Hawaii
4. Status of Council programs
5. New directions
   a. Council process
   b. Administrative initiatives
   c. Leveraging Council family resources and networks
   d. Other initiatives
6. Guest presentation on effects of El Nino in the Western Pacific Region
7. Breakout session on how the Advisors can help implement Council programs
   a. Improving communication
   b. Public engagement strategies
8. Review and discussion on breakout outcomes

Wednesday, December 16, 2009 9 a.m. - 5 p.m.

9. Hawaii Institute of Marine Biology site visit and guest presentations on (1) Using genetics and life history to track spread of introduced taape, roi and toau in Hawaii; (2) Recent advances in population resolution with examples from Hawaii; and (3) Complex population structure and management of migratory marine animals.
10. Council issues and actions
   a. Catch shares
   b. Annual Catch Limits
   c. Collecting fishing information
   i. Report on data workshop
   ii. Non-commercial federal permit and reporting
   iii. Voluntary data collection
   d. Marine spatial planning
   i. Offshore aquaculture options
   ii. Hawaii bottomfish essential fish habitat and habitat of particular concern options
   iii. Monuments
   iv. Marine protected area policy
   v. Buoys and Moorings
   vi. Other
   e. Community programs
   i. Cooperative research
   ii. Marine Education and Training
   iii. Community networking
   iv. Fish aggregation devices
   v. Marine Conservation Plan community development project
   vi. Traditional Ecological Knowledge Summit
   f. Federal/agency presentations
   i. Status of Western Pacific Region sea turtles
   ii. Coral reef assessments
11. Breakout session to discuss fishery and program issues
   a. Develop recommendations on action items as presented
   b. Develop strategy and plan to further discuss issues with the public
12. Reconvene plenary
   a. Review breakout outcomes
   b. Summarize recommendations
   c. Consider region-wide recommendations

Thursday, December 17, 2009, 9 a.m. - noon

13. Guest presentation - TBD
14. 2010 Calendar of meeting and events
   a. Council meetings, workshops and events
   b. Other meetings and events
15. Review and finalize outcomes
   a. Recap recommendations and plans by island area
   b. Consider additional actions
16. Other issues

The order in which agenda items are addressed may change. Public comment

periods will be provided throughout each agenda. The Advisory Panel will meet as late as necessary to complete scheduled business.

Although non-emergency issues not contained in this agenda may come before this group for discussion, in accordance with the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act), those issues may not be the subject of formal action during these meetings. Actions will be restricted to those issues specifically identified in this notice and any issues arising after publication of this notice that require emergency action under Section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Kitty M. Simonds, (808) 522–8220 (voice) or (808) 522–8226 (fax), at least 5 days prior to the meeting date.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: November 20, 2009.

Tracey L. Thompson,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E9–28251 Filed 11–24–09; 8:45 am]

BILLING CODE 3510–22–S

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

Proposed Information Collection; Comment Request

AGENCY: Corporation for National and Community Service.

ACTION: Notice.

SUMMARY: The Corporation for National and Community Service (hereinafter the ''Corporation''), as part of its continuing effort to reduce paperwork and respondent burden, conducts a pre-clearance 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 (PRA95) (44 U.S.C. 3506(c)(2)(A)). This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirement on respondents can be properly assessed.

Currently, the Corporation is soliciting comments on the Service-Learning Evaluation Study Feasibility Questionnaire. In this process, State Education Agencies will be asked about the type of service-learning within their state and the feasibility of the Service-Learning Evaluation Study. This information will be used to help determine the recruitment strategy for the Service-Learning Evaluation Study.

Copies of the information collection requests can be obtained by contacting the office listed in the **ADDRESSES** section of this notice.

DATES: Written comments must be submitted to the individual and office listed in the **ADDRESSES** section by January 25, 2010.

ADDRESSES: You may submit comments, identified by the title of the information collection activity, by any of the following methods:

(1) *By mail sent to:* Corporation for National and Community Service, Office of Research and Policy Development; Attention Carla Fletcher, Policy Analyst, Room 10913B; 1201 New York Avenue, NW., Washington, DC 20525.

(2) By hand delivery or by courier to the Corporation's mailroom at Room 8100 at the mail address given in paragraph (1) above, between 9 a.m. and 4 p.m. Monday through Friday, except Federal holidays.

(3) *By fax to:* (202) 606–3464, Attention Carla Fletcher, Policy Analyst.

(4) *Electronically through the Corporation's e-mail address system: cfletcher@cns.gov.*

FOR FURTHER INFORMATION CONTACT: Carla Fletcher, (202) 606–6720, or by e-mail at *cfletcher@cns.gov.*

SUPPLEMENTARY INFORMATION: The Corporation is particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Corporation, including whether the information will have practical utility;
- 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;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are expected to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology (*e.g.,* permitting electronic submissions of responses).

Background

The Corporation is developing a Service-Learning Evaluation in response to the Edward M. Kennedy Serve America Act (H.R. 1388) legislative mandate to assess the impact of the activities carried out under the Learn and Serve America Program. In developing the recruitment plan, the Corporation would like to work with the State Education Agencies to develop an effective strategy and begin to identify states that are able to participate in the study.

Current Action

The Corporation seeks to collect new information on the feasibility of a Service-Learning Evaluation Study in order to identify an effective recruitment strategy and potential states that could participate in the Service-Learning Evaluation.

Type of Review: New.

Agency: Corporation for National and Community Service.

Title: Service-Learning Evaluation Study Feasibility Questionnaire.

OMB Number: None.

Agency Number: None.

Affected Public: State Education Agencies.

Total Respondents: 59.

Frequency: One time.

Average Time per Response: Averages 60 minutes.

Estimated Total Burden Hours: 59 hours.

Total Burden Cost (capital/startup): None.

Total Burden Cost (operating/maintenance): None.

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 information collection request; they will also become a matter of public record.

Dated: November 19, 2009.

Robert Grimm,

Director, Office of Research and Policy Development.

[FR Doc. E9–28292 Filed 11–24–09; 8:45 am]

BILLING CODE 6050–$$–P

DELAWARE RIVER BASIN COMMISSION

Notice of Commission Meeting and Public Hearing

Notice is hereby given that the Delaware River Basin Commission will

hold an informal conference followed by a public hearing on Wednesday, December 9, 2009. The hearing will be part of the Commission's regular business meeting. The conference session and business meeting both are open to the public and will be held at the Commission's office building, located at 25 State Police Drive, West Trenton, New Jersey.

The conference among the commissioners and staff will begin at 10:30 a.m. and will consist of a presentation by a spokesperson for New York City regarding temporary closure of the Delaware Aqueduct; a report by the chair of the Toxics Advisory Committee; a report by the chair of the Water Quality Advisory Committee; and a presentation on the Pocono Creek Watershed Sustainability Study.

The subjects of the public hearing to be held during the 1 p.m. business meeting include the dockets listed below:

1. *Melody Lakes, D–1980–079–3.* An application for renewal of the applicant's 0.072 mgd WWTP discharge. The project WWTP will continue to discharge to Tohickon Creek, a tributary of the Delaware River at River Mile 157.00—26.16 (Delaware River—Tohickon Creek) in Richland Township, Bucks County, Pennsylvania. The project WWTP is located in the drainage area of the section of the non-tidal Delaware River known as the Lower Delaware, which is classified as Special Protection Waters.

2. *Schering Corporation, D–1986–004–2.* An application to modify Schering Corporation's industrial waste treatment plant (IWTP) docket to approve an existing discharge of 0.04 mgd of treated industrial wastewater from Outfall No. 001A (approved by Docket D–1986–4) and a 0.02 mgd discharge of cooling tower blowdown and HVAC condensate from Outfall No. DSN002A. Outfalls Nos. 001A and DSN002A will continue to discharge to an Unnamed Tributary of the Paulins Kill at River Mile 207.0—33.8—0.3 (Delaware River—Paulins Kill—unnamed tributary), in Lafayette Township, Sussex County, New Jersey. The project IWTP is located in the drainage area of the section of the non-tidal Delaware River known as the Lower Delaware, which is classified as Special Protection Waters.

3. *Lower Perkiomen Valley Regional Sewer Authority, D–2001–042 CP–3.* An application for approval to renew a discharge of up to 14.25 mgd from the existing Oaks Wastewater Treatment Plant (WWTP). The Oaks WWTP discharges to the Schuylkill River at River Mile 92.47—32.35 (Delaware River—Schuylkill River), in Upper Providence Township, Montgomery County, Pennsylvania.

4. *Delaware County Solid Waste Authority, D–89–18 CP–4.* An application for approval of the modification and expansion from 0.08 mgd to 0.115 mgd of the Delaware County Solid Waste Authority's (DCSWA) Rolling Hills leachate treatment plant (LTP). Modifications include the addition of a clarifier, new ozone system, additional blowers, new pumps, and new boilers to ensure the treatment process complies with permit limitations such as color, ammonia, and TDS. The LTP treats leachate from the Rolling Hills landfill and discharges to the Manatawny Creek at River Mile 92.47—54.15—12.2 (Delaware River—Schuylkill River—Manatawny Creek) through a diffused outfall. The project LTP is located in Earl Township, Berks County, Pennsylvania.

5. *Gloucester County Utilities Authority D–1990–074 CP–3.* An application for the continued approval of a 27 mgd discharge of treated wastewater from the Gloucester County Utilities Authority (GCUA) wastewater treatment plant (WWTP). On May 6, 2009, the DRBC approved Docket No. D–2008–27–1 for the West Deptford Energy Station (WDES), allowing WDES to withdraw up to 7.5 mgd of GCUA's effluent for cooling water purposes and to discharge approximately 2.0 mgd of contact cooling water (CCW) back to GCUA's effluent stream. As a result of the WDES approval, a TDS and thermal mixing zone are required for existing GCUA Outfall No. DSN004A at the Delaware River. This application includes a thermal mixing zone of 164 feet and a TDS mixing zone of 105 feet for Outfall No. DSN004A. The project WWTP is located in Water Quality Zone 4 at River Mile 89.7 (Delaware River), in West Deptford Township, Gloucester County, New Jersey.

6. *Aqua Pennsylvania—Chalfont System, D–1993–083 CP–2.* An application for approval of a groundwater withdrawal project for which the Commission's approval has expired, to continue a withdrawal of 39 mg/30 days to supply the applicant's public water supply system from five existing wells. The project is located in the Stockton Formation in the Neshaminy, Pine Run and Cooks Run watersheds in Chalfont and New Britain boroughs, Montgomery County, Pennsylvania within the Southeastern Pennsylvania Ground Water Protected Area (GWPA). The project wells are located in three sub-basins of the Neshaminy Creek Basin, as defined by the GWPA Regulations: North Branch Neshaminy Creek, Pine Run Basin and Doylestown Sub-basin Neshaminy Creek.

7. *The Upper Hanover Authority and The Red Hill Water Authority, D–2002–10 CP–3.* An application for a groundwater withdrawal project to increase the withdrawal from 43.113 mg/30 days to 56.88 mg/30 days from six existing wells and one existing spring water withdrawal (Kemmerer Spring) to supply the applicant's public water supply. The 13.767 mg/30 days increase would be obtained from existing Wells Nos. TUHA–1 and TUHA–2. The project is located in the Brunswick, Leithsville and Hardyston Formations. The increased allocation is requested in order to meet 10-year projected increases in service area demand. The project is located in the Perkiomen Creek and Macoby Creek watersheds in Upper Hanover, Hereford and Upper Milford Townships, Montgomery, Berks and Lehigh Counties, Pennsylvania and is located in the Southeastern Pennsylvania Ground Water Protected Area (GWPA). The project wells are in the Upper Reach Perkiomen Creek and Perkiomen-Macoby Run sub-basins as defined by the GWPA Regulations.

8. *Yukiguni Maitake Manufacturing Corporation of America, D–2003–026–1.* An application for approval of a groundwater withdrawal project to supply up to 13.14 mg/30 days of water to the applicant's mushroom facility from new Well No. 001. The project is located in the Lower Devonian and Sulurian Formations in the Basher Kill Watershed in Mamakating Township, Sullivan County, New York. The site is located within the drainage area to the section of the non-tidal Delaware River known as the Upper Delaware, which is designated as Special Protection Waters.

9. *Inversand Company, D–2007–015–1.* An application for approval of a groundwater withdrawal project to supply up to 15.5 mg/30 days of water to the applicant's glauconite mining operations from new Wells Nos. 1 and 2 and a mining pit. The project is located in the Mt. Laurel-Wenonah and Potomac-Raritan-Magothy formations in the Mantua Creek Watershed in Mantua Township, Gloucester County, New Jersey.

10. *Yukiguni Maitake Manufacturing Corporation of America, D–2008–035–1.* An application for approval to construct wastewater treatment facilities for the Yukiguni Maitake Mushroom Growing Facility and to construct three land discharges from a pilot-scale growing facility (1-story, 44,100 square foot building) on the site. Two of the proposed discharges are to a three-bay infiltration basin system, whereas the

third is to an on-site septic tank discharging to a leach field. The three-bay infiltration basin system will accept up to 55,000 gpd, 51,000 gpd of which will be from a geothermal system (Outfall No. 005) and the remaining 4,000 gpd from process water (Outfall No. 002). The on-site septic tank and leach field are proposed to receive up to 1,000 gpd of sanitary wastewater (Outfall No. 001). The project is located in the Basher Kill Watershed in Mamakating Township, Sullivan County, New York, within the drainage area to the section of the non-tidal Delaware River known as the Upper Delaware, which is designated as Special Protection Waters.

11. *UMH Properties Inc., D–2009–021–1.* An application for approval of the Highland Estates Mobile Home Park WWTP. The existing WWTP discharges treated sewage effluent at an average annual daily flow rate of 0.08325 mgd to an unnamed tributary of Mill Creek, which is a tributary of the Schuylkill River. The facility is located in Greenwich Township, Berks County, Pennsylvania.

12. *White Manor Country Club, D–2009–022–1.* An application for approval of a new ground and surface water withdrawal project to supply up to 7.02 mg/30 days of water to the applicant's irrigation process from existing Well No. 1 and existing Intakes 1 and 2. The project well and intakes are located in the Felsic Gneiss, granulite facies in the Crum Creek Watershed in Willistown Township, Chester County, Pennsylvania and is located in the Southeastern Pennsylvania Ground Water Protected Area.

13. *Camp Lohikan, D–2009–024–1.* An application for approval of the proposed Camp Lohikan Spray Irrigation Sewage Disposal System. The proposed WWTP is comprised of an aerated lagoon system designed to provide secondary treatment and disinfection, followed by land application via spray irrigation. The hydraulic design capacity of the facility is 0.03 million gallons per day (mgd). The proposed project is located in the Equinunk Creek Watershed in Buckingham Township, Wayne County, Pennsylvania, within the drainage area to the section of the non-tidal Delaware River known as the Upper Delaware, which is classified as Special Protection Waters.

14. *Lehigh Carbon Community College, D–2009–025 CP–1.* An application for approval to install two new final clarifiers and aerobic digesters at the existing 36,225 gallons per day (gpd) WWTP of the Lehigh Carbon Community College. No change in hydraulic design is proposed. The project is located in North Whitehall Township, Lehigh County, Pennsylvania, within the drainage area of the section of the non-tidal Delaware River known as the Lower Delaware, which is classified as Special Protection Waters. The WWTP discharges to an unnamed tributary of Jordan Creek, a High Quality-Cold Water Fishery, Migrating Fishery (HQ–CWF, MF) at River Mile 183.66—16.25—13.79—1.26 (Delaware River—Lehigh River—Jordan Creek—Unnamed Tributary).

In addition to the standard business meeting items, including adoption of the Minutes of the Commission's previous (October 22, 2009) business meeting; announcements of upcoming advisory committee meetings and events of interest; a report on hydrologic conditions; a report by the Executive Director; and a report by the Commission's General Counsel, the business meeting also will include public hearings and consideration by the Commission of resolutions: (a) Extending Docket No. D–69–210 CP Final (Revision 12) for the Limerick Generating Station Water Supply Modification Demonstration Project and Wadesville Mine Pool Withdrawal and Streamflow Augmentation Demonstration Project for a period of one year or until the Commission approves a revised docket, whichever occurs first; (b) authorizing the Executive Director to modify Docket D–71–86–2 for DuPont's Edge Moor Titanium Dioxide Facility Industrial Wastewater Discharge to provide additional time and to establish an approved schedule for installation of a diffuser by January 31, 2010; (c) approving the Commission's FY 2010–2015 Water Resources Program; (d) approving guidance consisting of a DRBC ''penalty matrix'' to assist regulated entities and DRBC staff in reaching negotiated settlements for suspected violations of DRBC regulations; (e) authorizing and directing the Executive Director to enter into a revised administrative agreement with the State of New Jersey for the submission and review of projects under Section 3.8 of the Compact; and (f) approving the DRBC fiscal year 2011 operating and capital budgets. An opportunity for public dialogue will be provided at the end of the meeting.

Draft dockets scheduled for public hearing on December 9, 2009 can be accessed through the Notice of Commission Meeting and Public Hearing on the Commission's Web site, drbc.net, ten days prior to the meeting date. Additional public records relating to the dockets may be examined at the Commission's offices. Please contact William Muszynski at 609–883–9500, extension 221, with any docket-related questions.

Note that conference items are subject to change and items scheduled for hearing are occasionally postponed to allow more time for the Commission to consider them. Please check the Commission's website, drbc.net, closer to the meeting for changes that may be made after the deadline for filing this notice.

Individuals in need of an accommodation as provided for in the Americans with Disabilities Act who wish to attend the informational meeting, conference session or hearings should contact the commission secretary directly at 609–883–9500 ext. 203 or through the Telecommunications Relay Services (TRS) at 711, to discuss how the Commission can accommodate your needs.

Dated: November 17, 2009.

Pamela M. Bush,

Commission Secretary.

[FR Doc. E9–28238 Filed 11–24–09; 8:45 am]

BILLING CODE 6360–01–P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Acting Director, Information Collection Clearance Division, Regulatory Information Management Services, Office of Management invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before December 28, 2009.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, *Attention:* Education Desk Officer, Office of Management and Budget, 725 17th Street, NW., Room 10222, New Executive Office Building, Washington, DC 20503, be faxed to (202) 395–5806 or send e-mail to *oira_submission@omb.eop.gov.*

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public

participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Acting Director, Regulatory Information Management Services, Office of Management, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g. new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: November 20, 2009.

James Hyler,

Acting Director, Information Collection Clearance Division, Regulatory Information Management Services, Office of Management.

Office of Special Education and Rehabilitative Services

Type of Review: Revision.

Title: Report of Dispute Resolution Under Part C of the Individuals with Disabilities Education Act.

Frequency: Annually.

Affected Public: State, local, or tribal gov't.

Reporting and Recordkeeping Hour Burden:

Responses: 56.

Burden Hours: 3,360.

Abstract: This package provides instructions and forms necessary for States to report the number of written, signed complaints; mediation requests; and hearing requests and the status of these actions with regards to children served under Part C of IDEA initiated during the reporting year. The form satisfies reporting requirements and is used by OSEP to monitor SEAs and for Congressional reporting.

Requests for copies of the information collection submission for OMB review may be accessed from *http://edicsweb.ed.gov,* by selecting the ''Browse Pending Collections'' link and by clicking on link number 4145. When you access the information collection, click on ''Download Attachments '' to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue, SW., LBJ, Washington, DC 20202–4537. Requests may also be electronically mailed to the Internet address *ICDocketMgr@ed.gov* or faxed to 202–401–0920. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be electronically mailed to *ICDocketMgr@ed.gov*. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. E9–28252 Filed 11–24–09; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Acting Director, Information Collection Clearance Division, Regulatory Information Management Services, Office of Management invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before December 28, 2009.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Education Desk Officer, Office of Management and Budget, 725 17th Street, NW., Room 10222, New Executive Office Building, Washington, DC 20503, be faxed to (202) 395–5806 or send email to *oira_submission@omb.eop.gov.*

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Acting Director, Regulatory Information Management Services, Office of Management, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g. new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: November 20, 2009.

James Hyler,

Acting Director, Information Collection Clearance Division, Regulatory Information Management Services, Office of Management.

Office of Special Education and Rehabilitative Services

Type of Review: Revision.

Title: Report of Children and Toddlers Receiving Early Intervention Services in accordance with Part C, Report of Program Settings Where Early Intervention Services are Provided to Children with Disabilities and Their Families in Accordance with Part C; Report on Infants and Toddlers Exiting Part C.

Frequency: Annually.

Affected Public: State, Local, or Tribal Gov't.

Reporting and Recordkeeping Hour Burden:

Responses: 56.

Burden Hours: 5,987.

Abstract: This package provides instructions and forms necessary for States to report the number of children receiving early intervention services under Part C of IDEA, the settings in which these children are provided services, and the reasons by which these children exit Part C of IDEA. The form satisfies reporting requirements and is used by OSEP to monitor State agencies and for Congressional reporting.

Requests for copies of the information collection submission for OMB review may be accessed from *http://edicsweb.ed.gov,* by selecting the ''Browse Pending Collections'' link and by clicking on link number 4144. When you access the information collection, click on ''Download Attachments '' to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue, SW., LBJ, Washington, DC 20202–4537. Requests may also be electronically mailed to the Internet address *ICDocketMgr@ed.gov* or faxed to 202–401–0920. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be electronically mailed to *ICDocketMgr@ed.gov*. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal

Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. E9–28253 Filed 11–24–09; 8:45 am]
BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Acting Director, Information Collection Clearance Division, Regulatory Information Management Services, Office of Management invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before December 28, 2009.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Education Desk Officer, Office of Management and Budget, 725 17th Street, NW., Room 10222, New Executive Office Building, Washington, DC 20503, be faxed to (202) 395–5806 or send email to *oira_submission@omb.eop.gov.*

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Acting Director, Regulatory Information Management Services, Office of Management, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, *e.g.* new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: November 20, 2009.

James Hyler,

Acting Director, Information Collection Clearance Division, Regulatory Information Management Services, Office of Management.

Office of Special Education and Rehabilitative Services

Type of Review: Extension.
Title: State Plan for Independent Living (SPIL).
Frequency: Every three years.
Affected Public: Federal Government, not-for-profit institutions; private sector; State, Local, or Tribal Gov't.
Reporting and Recordkeeping Hour Burden:
Responses: 56.
Burden Hours: 3,360.
Abstract: States wishing to receive funding under the State Independent Living Services (SILS) and Centers for Independent Living (CIL) programs must submit an approvable three-year State Plan for Independent Living (SPIL) to the Rehabilitation Services Administration (RSA). The purpose of these programs is to promote the independent living philosophy—based on consumer control, peer support, self-help, self-determination, equal access and individual and systems advocacy—to maximize the leadership, empowerment, independence and productivity of individuals with significant disabilities and to promote and maximize the integration and full inclusion of individuals with significant disabilities into the mainstream of American society. The SPIL encompasses the activities planned by the State to achieve its specified independent living objectives and reflects the State's commitment to comply with all applicable statutory and regulatory requirements during the three years covered by the plan.

Requests for copies of the information collection submission for OMB review may be accessed from *http://edicsweb.ed.gov,* by selecting the ''Browse Pending Collections'' link and by clicking on link number 4133. When you access the information collection, click on ''Download Attachments '' to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue, SW., LBJ, Washington, DC 20202–4537. Requests may also be electronically mailed to the Internet address *ICDocketMgr@ed.gov* or faxed to 202–401–0920. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be electronically mailed to *ICDocketMgr@ed.gov*. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. E9–28254 Filed 11–24–09; 8:45 am]
BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

November 19, 2009.

Take notice that the Commission received the following exempt wholesale generator filings:

Docket Numbers: EG10–9–000.
Applicants: Nacogdoches Power, LLC.
Description: Self Certification Notice of Nacogdoches Power, LLC.
Filed Date: 11/18/2009.
Accession Number: 20091118–5043.
Comment Date: 5 p.m. Eastern Time on Wednesday, December 9, 2009.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER98–2782–016.
Applicants: Power City Partners LP.
Description: Power City Partners, LP submits notice of change in status in compliance with the requirements of Section 35.42 of the regulations of the FERC *etc.*
Filed Date: 11/17/2009.
Accession Number: 20091118–0104.
Comment Date: 5 p.m. Eastern Time on Tuesday, December 8, 2009.

Docket Numbers: ER05–757–005.
Applicants: Victoria International LTD.
Description: Amendment to Application of Victoria International LTD.
Filed Date: 11/18/2009.
Accession Number: 20091118–5094.
Comment Date: 5 p.m. Eastern Time on Wednesday, December 9, 2009.

Docket Numbers: ER09–1556–000; ER09–1556–001; ER09–1557–000; ER09–1557–001; ER09–1619–000.
Applicants: Midwest Independent Transmission System Operator, Inc.
Description: The Midwest Independent Transmission System Operator, Inc submits response to the Commission's letter dated 10/20/09 seeking additional information re the filing dated 8/7/09 *etc.*
Filed Date: 11/04/2009.
Accession Number: 20091106–0062.
Comment Date: 5 p.m. Eastern Time on Wednesday, November 25, 2009.

Docket Numbers: ER10–34–001.

Applicants: Energy Consulting Services.

Description: Energy Consulting Services, LLC submits the Petition for Acceptance of Initial Tariff, Waivers and Blanket Authority, FERC Electric Tariff, Original Volume 1.

Filed Date: 11/09/2009.

Accession Number: 20091112–0094.

Comment Date: 5 p.m. Eastern Time on Monday, November 30, 2009.

Docket Numbers: ER10–71–001.

Applicants: Elmwood Park Power LLC.

Description: Elmwood Park Power LLC submits sub. tariff sheets to reflect the Elmwood is a Category 1 seller in all regions other than the Northwest region *etc.*

Filed Date: 11/17/2009.

Accession Number: 20091118–0105.

Comment Date: 5 p.m. Eastern Time on Tuesday, December 8, 2009.

Docket Numbers: ER10–266–001.

Applicants: Trans Bay Cable LLC.

Description: Trans Bay Cable LLC submits Substitute Original Sheet 20 reflecting the deletion in Section 5.1 as well as a blackline of Sheet 20 to show the change.

Filed Date: 11/16/2009.

Accession Number: 20091118–0107.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–281–000.

Applicants: Southwest Power Pool, Inc., E.ON U.S. LLC.

Description: Southwest Power Pool, Inc *et al.* submits joint of notice of termination of the ITO Agreement.

Filed Date: 10/26/2009.

Accession Number: 20091117–0080.

Comment Date: 5 p.m. Eastern Time on Friday, November 27, 2009.

Docket Numbers: ER10–285–000.

Applicants: Carolina Power & Light Company.

Description: Carolina Power & Light Company submits revised Power Supply Agreement, Sixth Revised Rate Schedule FERC No 134 with North Carolina Electric Membership Corp.

Filed Date: 11/17/2009.

Accession Number: 20091118–0108.

Comment Date: 5 p.m. Eastern Time on Tuesday, December 8, 2009.

Take notice that the Commission received the following electric securities filings:

Docket Numbers: ES10–9–000.

Applicants: Southern Power Company.

Description: Application for financing authority of Southern Power Company.

Filed Date: 11/18/2009.

Accession Number: 20091118–5093.

Comment Date: 5 p.m. Eastern Time on Wednesday, December 9, 2009.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. 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. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed dockets(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. E9–28281 Filed 11–24–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Comined Notice of Filings #1

November 18, 2009.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER97–870–016.

Applicants: Sunoco Power Marketing LLC.

Description: Sunoco Power Marketing, LLC submits an amended Order 697 Compliance Filing and Request for Category I Status.

Filed Date: 11/16/2009.

Accession Number: 20091118–0003.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER97–3359–016.

Applicants: Florida Power & Light Company.

Description: Florida Power & Light Company Notice of Change in Status.

Filed Date: 11/16/2009.

Accession Number: 20091116–5126.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER04–879–001.

Applicants: Sunoco Power Generation, LLC.

Description: Sunoco Power Generation, LLC submits an amended Order 697 Compliance Filing and Request for Category I Status.

Filed Date: 11/16/2009.

Accession Number: 20091118–0002.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER04–449–021.

Applicants: New York Independent System Operator, Inc.

Description: New York Independent System Operator, Inc *et al.* submit amendments to the New York Independent System Operator, Inc's Open Access Transmission Tariff to implement a funding mechanism for recovery *etc.*

Filed Date: 11/13/2009.

Accession Number: 20091117–0059.

Comment Date: 5 p.m. Eastern Time on Friday, December 4, 2009.

Docket Numbers: ER08–1297–005; ER01–1071–016; ER08–1293–005; ER08–1294–005; ER06–9–011; ER03–34–015; ER06–1261–010; ER03–1105–012; ER03–1104–012; ER09–138–003; ER09–988–004; ER09–989–004; ER09–832–003; ER98–2076–018; ER98–4222–016; ER08–250–006; ER08–197–009; ER08–1300–005; ER08–1296–005; ER07–174–010.

Applicants: Ashtabula Wind, LLC; Badger Windpower LLC; Crystal Lake

Wind, LLC; Crystal Lake Wind II, LLC; FPL Energy Burleigh County Wind, LLC; FPL Energy Hancock County Wind, LLC; FPL Energy Mower County, LLC; FPL Energy North Dakota Wind II, LLC; FPL Energy North Dakota Wind, LLC; FPL Energy Oliver Wind I, LLC; NextEra Energy Duane Arnold, LLC; NextEra Energy Point Beach, LLC; NextEra Energy Power Marketing, LLC; Hawkeye Power Partners, LLC; Lake Benton Power Partners II LLC; Langdon Wind, LLC; FPL Energy Oliver Wind II, LLC; Story Wind, LLC; Osceola Windpower II, LLC; Osceola Windpower, LLC.

Description: NextEra Energy Entities Notification of Non-material Change in Status regarding their market-based rate authorizations in the Central Region.

Filed Date: 11/17/2009.

Accession Number: 20091117–5089.

Comment Date: 5 p.m. Eastern Time on Tuesday, December 8, 2009.

Docket Numbers: ER09–1723–004.

Applicants: Dry Lake Wind Power, LLC.

Description: Dry Lake Wind Power, LLC submits supplemental information in support of its application for market-based rate authorizations.

Filed Date: 11/10/2009.

Accession Number: 20091112–0137.

Comment Date: 5 p.m. Eastern Time on Tuesday, December 1, 2009.

Docket Numbers: ER09–1736–001.

Applicants: Southwest Power Pool, Inc.

Description: Southwest Power Pool, Inc submits revised tariff pages incorporating American Electric Power Service Corp formula rate template originally filed on 9/23/09.

Filed Date: 11/16/2009.

Accession Number: 20091117–0084.

Comment Date: 5 p.m. Eastern Time on Monday, November 23, 2009.

Docket Numbers: ER10–43–001.

Applicants: E.ON U.S. LLC.

Description: E.ON US, LLC submits substitute Network Integration Transmission Service Agreement and Network Operating Agreement for service to Kentucky Municipal Power Agency.

Filed Date: 11/16/2009.

Accession Number: 20091117–0083.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–151–000.

Applicants: New York Independent System Operator, Inc.

Description: New York Independent System Operator, Inc. *et al.* submit an amended and restated engineering, procurement, and construction agreement among New York Independent System Operator, Inc. *et al.* and request for waiver.

Filed Date: 10/29/2009.

Accession Number: 20091030–0110.

Comment Date: 5 p.m. Eastern Time on Thursday, November 19, 2009.

Docket Numbers: ER10–256–000.

Applicants: FPL Energy Stateline II, Inc.

Description: FPL Energy Stateline II, Inc's request for authorization to sell energy and capacity at market-based rates and Waiver of the 60-day notice requirement.

Filed Date: 11/16/2009.

Accession Number: 20091118–0077.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–269–000.

Applicants: 3Degrees Group, Inc.

Description: 3Degrees Group, Inc submits for filing the Petition for Acceptance of Initial Tariff, Waivers and Blanket Authority.

Filed Date: 11/17/2009.

Accession Number: 20091117–0090.

Comment Date: 5 p.m. Eastern Time on Tuesday, December 8, 2009.

Docket Numbers: ER10–270–000.

Applicants: NorthWestern Corporation.

Description: NorthWestern Corporation submits an executed non-conforming Firm Point to Point Service Agreement between NorthWestern et al designated as Service Agreement19–SD under its Open Access Transmission Tariff, etc.

Filed Date: 11/16/2009.

Accession Number: 20091117–0061.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–271–000.

Applicants: PJM Interconnection, L.L.C.

Description: PJM Interconnection, LLC submits an executed Wholesale Market Participation Agreement entered into among PJM *et al.* executed on 10/15/09.

Filed Date: 11/16/2009.

Accession Number: 20091117–0060.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–272–000.

Applicants: New York Independent System Operator, Inc.

Description: New York Independent System Operator, Inc submits revisions to its Open Access Transmission Tariff and its Market Administration and Control Area Services Tariff.

Filed Date: 11/16/2009.

Accession Number: 20091117–0051.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–273–000.

Applicants: Southwest Power Pool Inc.

Description: Southwest Power Pool, Inc submits revised pages to its Open Access Transmission Tariff intended to implement rate changes etc.

Filed Date: 11/16/2009.

Accession Number: 20091117–0052.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–274–000.

Applicants: Entergy Services, Inc.

Description: Entergy Arkansas, Inc submits amended rate schedule providing for power coordination and interchange services to East Texas Electric Cooperative, Inc.

Filed Date: 11/16/2009.

Accession Number: 20091117–0053.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–276–000.

Applicants: Rolling Thunder I Power Partners, LLC.

Description: Rolling Thunder I Power Partners, LLC submits its proposed FERC Electric Tariff, Original Volume 1, pursuant to which Rolling Thunder I may make wholesale sales of electric capacity *et al.*

Filed Date: 11/17/2009.

Accession Number: 20091118–0076.

Comment Date: 5 p.m. Eastern Time on Tuesday, December 8, 2009

Docket Numbers: ER10–277–000.

Applicants: Midwest Independent Transmission System Operator, Inc.

Description: Midwest Independent Transmission System Operator, Inc submits five copies of a proposed revision to its Open Access Transmission Energy and Operating Reserve Market Tariff *etc.*

Filed Date: 11/16/2009.

Accession Number: 20091117–0085.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–278–000.

Applicants: NationalGrid USA.

Description: Request of National Grid USA for Expedited Consideration and Temporary Waiver of Qualification Process Reimbursement Deposit Due Date under Section III.13.1.9.3 of the ISO–NE Tariff.

Filed Date: 11/17/2009.

Accession Number: 20091117–5034.

Comment Date: 5 p.m. Eastern Time on Wednesday, November 25, 2009.

Docket Numbers: ER10–279–000.

Applicants: Midwest Independent Transmission System Operator, Inc.

Description: Midwest Independent Transmission System Operator, Inc submits the proposed revisions to its Open Access Transmission, Energy and Operating Reserve Markets Tariff etc.

Filed Date: 11/16/2009.

Accession Number: 20091117–0086.

Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Docket Numbers: ER10–280–000.
Applicants: Laidlaw Berlin BioPower, LLC.
Description: Stinson Morrison Hecker LLP submits Request of Laidlaw Berling BioPower, LLC for Limited Waiver of Qualification Process Cost Reimbursement Deposit Deadline under Transmission *et al.*
Filed Date: 11/17/2009.
Accession Number: 20091117–0081.
Comment Date: 5 p.m. Eastern Time on Wednesday, November 25, 2009.

Docket Numbers: ER10–282–000.
Applicants: PJM Interconnection, LLC.
Description: PJM Interconnection, LLC submits an executed interconnection agreement with Meadow Lake Wind Farm, LLC *et al.*
Filed Date: 11/17/2009.
Accession Number: 20091117–0089.
Comment Date: 5 p.m. Eastern Time on Tuesday, December 8, 2009.

Docket Numbers: ER10–284–000.
Applicants: Southern California Edison Company.
Description: Southern California Edison Company submits a letter agreement between Southern California Edison Company and First Solar Development, Inc.
Filed Date: 11/16/2009.
Accession Number: 20091117–0088.
Comment Date: 5 p.m. Eastern Time on Monday, December 7, 2009.

Take notice that the Commission received the following electric securities filings:

Docket Numbers: ES09–59–001.
Applicants: National Grid USA.
Description: Amendment to Application of National Grid USA, Request for Shortened Comment Period, and Request for Expedited Action.
Filed Date: 11/16/2009.
Accession Number: 20091116–5143.
Comment Date: 5 p.m. Eastern Time on Friday, November 27, 2009.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. 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. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed dockets(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. E9–28282 Filed 11–24–09; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–8977–7; Docket ID No. EPA–HQ–ORD–2009–0816]

A Framework for Categorizing the Relative Vulnerability of Threatened and Endangered Species to Climate Change

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of public comment period.

SUMMARY: EPA is announcing a 30-day public comment period for the draft document titled, ''A Framework for Categorizing the Relative Vulnerability of Threatened and Endangered Species to Climate Change'' (EPA/600/R–09/011). The document was prepared by the National Center for Environmental Assessment within EPA's Office of Research and Development. This draft document describes an evaluative framework that may be used to categorize the relative vulnerability of species to climate change. To illustrate the use of this framework, it was applied to five U.S. threatened and endangered species: The golden-cheeked warbler, the salt marsh harvest mouse, the Mount Graham red squirrel, the Lahontan cutthroat trout, and the desert tortoise. A sixth species, the bald eagle which is no longer listed as threatened or endangered, except for the southwest population, was also evaluated.

An external peer review of this report has been completed. The public comment period and the external peer review are separate processes. The public comment period provides an opportunity for all interested parties to comment on the document. When finalizing the draft document, EPA will consider any public comments received in accordance with this notice.

EPA is releasing this draft document solely for the purpose of pre-dissemination review and comment under applicable information quality guidelines. This document has not been formally disseminated by EPA and does not represent and should not be construed to represent any Agency policy or determination. The first draft of this report was reviewed in 2002 by the U.S. Fish and Wildlife Service within the Department of the Interior. This final draft is being released to the public as well as to other federal agencies who may wish to comment.

DATES: The 30-day public comment period begins November 25, 2009, and ends December 28, 2009. Technical comments should be in writing and must be received by EPA by December 28, 2009.

ADDRESSES: The draft ''A Framework for Categorizing the Relative Vulnerability of Threatened and Endangered Species to Climate Change'' is available primarily via the Internet on the National Center for Environmental Assessment's home page under the Recent Additions and the Data and Publications menus at *http://www.epa.gov/ncea.* A limited number of paper copies are available from the Information Management Team, NCEA; telephone: 703–347–8561; facsimile: 703–347–8691. If you are requesting a paper copy, please provide your name, your mailing address, and the document title, ''A Framework for Categorizing the Relative Vulnerability of Threatened and Endangered Species to Climate Change.''

Comments may be submitted electronically via *http://www.regulations.gov,* by mail, by facsimile, or by hand delivery/courier. Please follow the detailed instructions provided in the **SUPPLEMENTARY INFORMATION** section of this notice.

FOR FURTHER INFORMATION CONTACT: For information on the public comment period, contact the Office of Environmental Information Docket; telephone: 202–566–1752; facsimile: 202–566–1753; or e-mail: *ORD.Docket@epa.gov.*

For technical information, contact Susan Julius, NCEA; telephone: 703–347–8619; facsimile: 703–347–8694; or e-mail: *julius.susan@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Information About the Project/ Document

The document, ''A Framework for Categorizing the Relative Vulnerability of Threatened and Endangered Species to Climate Change'' describes an evaluative framework that may be used to categorize the relative vulnerability of species to climate change. It is intended that the results of applying the framework be regarded as indications of the comparative vulnerabilities of species, not estimates of a species' absolute vulnerability to climate change. Four modules compose this framework: Module 1 categorizes baseline vulnerability to extinction or major population reduction by scoring those elements of the species' life history, demographics, and conservation status that influence the likelihood of its survival or extinction (excluding climatic changes); Module 2 scores the likely vulnerability of a species to future climate change, including the species' potential physiological, behavioral, demographic, and ecological response to climate change; Module 3 combines the results of Modules 1 and 2 into a matrix to produce an overall score of the species' vulnerability to climate change, which maps to an adjectival category, such as ''critically vulnerable,'' ''highly vulnerable,'' ''less vulnerable,'' and ''least vulnerable;'' Module 4 is a qualitative determination of uncertainty of overall vulnerability (high, medium, and low) based on evaluations of uncertainty done in each of the first 3 modules.

To illustrate the use of this framework, it was applied to six U.S. species that were listed as threatened or endangered at the time the framework was developed. Based on the framework, four of those species were categorized as ''critically vulnerable'' to climate change: The golden-cheeked warbler (*Dendroica chrysoparia*), the salt marsh harvest mouse (*Reithrodontomys raviventris*), the Mount Graham red squirrel (*Tamiasciurus hudsonicus grahamensis*), and the Lahontan cutthroat trout (*Oncorhyncus clarki henshawi*). The desert tortoise (*Gopherus agassizii*) was characterized as ''highly vulnerable'' and the bald eagle (*Haliaeetus leucocephalus*) was categorized as ''less vulnerable.'' Certainty scores in Module 4 ranged between medium and high and reflect the amount and quality of information available.

This framework was developed by EPA's Global Change Research Program and is offered as one of a number of potential approaches for prioritizing those species most vulnerable to climate change. It is not intended to serve as a tool for determining whether a species is endangered or threatened under the Section 4 listing process of the Endangered Species Act.

EPA's Global Change Research is an assessment-oriented program committed to developing frameworks and tools to assist decision-makers in evaluating the impacts of climate change to air quality, water quality and ecosystems.

II. How To Submit Technical Comments to the Docket at http://www.regulations.gov.

Submit your comments, identified by Docket ID No. EPA–HQ–ORD 2009–0816, by one of the following methods:

- *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.
- *E-mail: ORD.Docket@epa.gov.*
- *Fax:* 202–566–1753.
- *Mail:* Office of Environmental Information (OEI) Docket (Mail Code: 2822T), U.S. Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460. The phone number is 202–566–1752.
- *Hand Delivery:* The OEI Docket is located in the EPA Headquarters Docket Center, Room 3334 EPA West Building, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center's Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is 202–566–1744. Such deliveries are only accepted during the docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

If you provide comments by mail or hand delivery, please submit three copies of the comments. For attachments, provide an index, number pages consecutively with the comments, and submit an unbound original and three copies.

Instructions: Direct your comments to Docket ID No. EPA–HQ–ORD–2009–0816. Please ensure that your comments are submitted within the specified comment period. Comments received after the closing date will be marked ''late,'' and may only be considered if time permits. It is EPA's policy to include all comments it receives in the public docket without change and to make the comments available online at *http://www.regulations.gov,* including any personal information provided, unless a comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov*, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

Docket: Documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other materials, such as copyrighted material, are publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the OEI Docket in the EPA Headquarters Docket Center.

Dated: October 21, 2009.

Rebecca Clark,

Director, National Center for Environmental Assessment.

[FR Doc. E9–28294 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2003–0004; FRL–8799–8]

Access to Confidential Business Information by Computer Sciences Corporation and Its Identified Subcontractors

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: EPA has authorized contractor, Computer Sciences Corporation (CSC) of Chantilly, VA and its subcontractors, to access information which has been submitted to EPA under all sections of the Toxic Substances Control Act (TSCA). Some of the information may be claimed or determined to be Confidential Business Information (CBI).

DATES: Access to the confidential data will occur no sooner than December 2, 2009.

FOR FURTHER INFORMATION CONTACT: *For general information contact*: Colby Lintner, Regulatory Coordinator, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 554–1404; e-mail address: *TSCA-Hotline@epa.gov*.

For technical information contact: Scott Sherlock, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 564–8257; fax number: (202) 564–8251; e-mail address: *sherlock.scott@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Notice Apply to Me?

This action is directed to the public in general. This action may, however, be of interest to all who manufacture, process or distribute industrial chemicals. Since other entities may also be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the technical person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Get Copies of this Document and Other Related Information?

EPA has established a docket for this action under docket identification (ID) number EPA–HQ–OPPT–2003–0004. All documents in the docket are listed in the docket index available at *http://www.regulations.gov*. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available electronically at *http://www.regulations.gov*, or, if only available in hard copy, at the OPPT Docket. The OPPT Docket is located in the EPA Docket Center (EPA/DC) at Rm. 3334, EPA West Bldg., 1301 Constitution Ave., NW., Washington, DC. The EPA/DC Public Reading Room hours of operation are 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding Federal holidays. The telephone number of the EPA/DC Public Reading Room is (202) 566–1744, and the telephone number for the OPPT Docket is (202) 566–0280. Docket visitors are required to show photographic identification, pass through a metal detector, and sign the EPA visitor log. All visitor bags are processed through an X-ray machine and subject to search. Visitors will be provided an EPA/DC badge that must be visible at all times in the building and returned upon departure.

II. What Action is the Agency Taking?

Under Contract Number GS00T99ALD0203, Task Order Number EP10H000097, contractors CSC of 15000 Conference Center Drive, Chantilly, VA and its subcontractors Apex Systems, Inc. of 5430 Wade Park Blvd, Raleigh, NC; APPTIS Systems, Inc. of 4800 Westfields Blvd, Chantilly, VA; Berrett and Associates, Inc. of P.O. Box 2891, Sterling, VA; Digital Intelligence Systems Corp. of 4151 Lafayette Center Dr, Suite 600, Chantilly, VA; Excel Management Systems, Inc. of P.O. Box 8280, Columbus, OH; General Dynamics Advanced Information Systems of 10560 Arrowhead Dr., Fairfax, VA; KForce, Inc. of 12010 Sunset Hills Road, Suite 200, Reston, VA; and Paloma Systems, Inc. of 11250 Waples Mill Road, Suite 300, Fairfax, VA will assist the Office of Pollution Prevention and Toxics (OPPT) in the Local Technology Service (LTS) support task; provide Information Technology (IT) services in support of EPA's program offices; provide the EPA community with voice, data, and video technologies that meet their needs and requirements. The contractors will also provide engineering, operational, consulting, and/or development support services as requested by the TSCA CBI office. Finally, the contractor team will manage each project from start to completion and provide follow-on support when applicable.

In accordance with 40 CFR 2.306(j), EPA has determined that under Contract Number GS00T99ALD0203, Task Order Number EP10H000097, CSC and its subcontractors will require access to CBI submitted to EPA under all sections of TSCA to perform successfully the duties specified under the contract. CSC and its subcontractors' personnel will be given access to information submitted to EPA under all sections of TSCA.

EPA is issuing this notice to inform all submitters of information under all sections of TSCA that EPA may provide CSC and its subcontractors access to these CBI materials on a need-to-know basis only. All access to TSCA CBI under this contract will take place at EPA Headquarters and the Research Triangle Park, NC facilities in accordance with EPA's TSCA CBI Protection Manual.

Access to TSCA data, including CBI, will continue until March 30, 2010. If the contract is extended, this access will also continue for the duration of the extended contract without further notice.

CSC and its subcontractors' personnel will be required to sign nondisclosure agreements and will be briefed on appropriate security procedures before they are permitted access to TSCA CBI.

List of Subjects

Environmental Protection, Confidential Business Information.

Dated: November 18, 2009.

Matthew Leopard,

Acting Director, Information Management Division, Office of Pollution Prevention and Toxics.

[FR Doc. E9–28156 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2003–0004; FRL–8799–7]

Access to Confidential Business Information by Science Applications International Corporation

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: EPA has authorized its contractor, Science Applications International Corporation (SAIC)], to access information which has been submitted to EPA under sections 4, 5, 8, 12, and 13 of the Toxic Substances Control Act (TSCA). Some of the information may be claimed or determined to be Confidential Business Information (CBI).

DATES: Access to the confidential data will occur no sooner than December 2, 2009.

FOR FURTHER INFORMATION CONTACT: *For general information contact*: Colby Lintner, Regulatory Coordinator, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 554–1404; e-mail address: *TSCA-Hotline@epa.gov*.

For technical information contact: Scott Sherlock, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 564–8257; fax number: (202) 564–8251; e-mail address: *Scott Sherlock@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Notice Apply to Me?

This action is directed to the public in general. This action may, however, be of interest to all who manufacture, process, or distribute industrial chemicals. Since other entities may also be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the technical person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Get Copies of this Document and Other Related Information?

Docket. EPA has established a docket for this action under docket identification (ID) number EPA–HQ–OPPT–2003–0004. All documents in the docket are listed in the docket index available at *http://www.regulations.gov*. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available electronically at *http://www.regulations.gov*, or, if only available in hard copy, at the OPPT Docket. The OPPT Docket is located in the EPA Docket Center (EPA/DC) at Rm. 3334, EPA West Bldg., 1301 Constitution Ave., NW., Washington, DC. The EPA/DC Public Reading Room hours of operation are 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding Federal holidays. The telephone number of the EPA/DC Public Reading Room is (202) 566–1744, and the telephone number for the OPPT Docket is (202) 566–0280. Docket visitors are required to show photographic identification, pass through a metal detector, and sign the EPA visitor log. All visitor bags are processed through an X-ray machine and subject to search. Visitors will be provided an EPA/DC badge that must be visible at all times in the building and returned upon departure.

II. What Action is the Agency Taking?

Under Contract Number EP–W–09–032, contractor SAIC of 10260 Campus Point Drive, San Diego, CA, will assist the Office of Pollution Prevention and Toxics (OPPT) and the Office of Civil Enforcement (OCE) Core TSCA enforcement program by targeting facilities for inspections and investigations; inspecting and investigating facilities; case reviews and case development of activities relating to the manufacture, processing, distribution in commerce and disposal of toxic substances; developing and implementing data systems for internal enforcement tracking; and information collection from businesses that may request TSCA-CBI claims. SAIC may work in conjunction with the Information Management Division, Chemical Control Division, Economics, Exposure and Technology Division, and the Risk Assessment Division in OPPT. SAIC may work with data contained in the OPPT data systems, such as CICIS (TSCA Public Inventory), CCID (TSCA Confidential Inventory), CUS (Chemical Update System), CBITS (Confidential Business Information Tracking System), and MITS (Management Information Tracking System), to obtain information to support OCE's enforcement activities. All CBI claims requested when conducting investigations and inspections, issuing warrants or delivering subpoenas from which information collected and reviewed determines compliance, will be handled in accordance to the CBI Procedures. SAIC will administer a CBI documents tracking system beginning when the initial control number is assigned until the document is transferred to the EPA DCO, other SAIC DCO, returned to the company by the DCO, or destroyed by the DCO as required.

In accordance with 40 CFR 2.306(j), EPA has determined that under Contract Number EP–W–09–032, SAIC will require access to CBI submitted to EPA under sections 4, 5, 8, 12, and 13 of TSCA to perform successfully the duties specified under the contract. SAIC personnel will be given access to information submitted to EPA under sections 4. 5, 8, 12, and 13 of TSCA.

EPA is issuing this notice to inform all submitters of information under sections 4, 5, 8, 12, and 13 of TSCA that EPA may provide SAIC access to these CBI materials on a need-to-know basis only. All access to TSCA CBI under this contract will take place at EPA Headquarters and SAIC's sites located at the Energy, Environment and Infrastructure Business Unit, 12100 Sunset Hills Road, Reston, VA and 405 Urban Street, Suite 400, Lakewood, CO. However, no CBI storage or access will take place at the facilities until after an inspection has taken place and the Agency is satisfied that the sites meet the specifications for the use and storage of TSCA CBI materials.

Access to TSCA data, including CBI, will continue until September 30, 2014. If the contract is extended, this access will also continue for the duration of the extended contract without further notice.

SAIC personnel will be required to sign nondisclosure agreements and will be briefed on appropriate security procedures before they are permitted access to TSCA CBI.

List of Subjects

Environmental Protection, Confidential Business Information.

Dated: November 18, 2009.

Matthew Leopard,

Acting Director, Information Management Division, Office of Pollution Prevention and Toxics.

[FR Doc. E9–28172 Filed 11–24–09; 8:45 a.m.]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–RCRA–2009–0319, FRL–8984–8]

Agency Information Collection Activities; Submission to OMB for Review and Approval; Comment Request; Part B Permit Application, Permit Modifications, and Special Permits (Renewal), EPA ICR Number 1573.12, OMB Control Number 2050–0009

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*), this document announces that an Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval. This is a request to renew an existing approved collection. The ICR, which is abstracted below, describes the nature of the information collection and its estimated burden and cost.

DATES: Additional comments may be submitted on or before December 28, 2009.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA–HQ–RCRA–2009–0319, to (1) EPA, either online using *http://www.regulations.gov* (our preferred method), or by e-mail to *rcra-docket@epa.gov,* or by mail to: RCRA Docket (28221T), U.S. Environmental Protection Agency, 1200 Pennsylvania Avenue, NW., Washington, DC 20460; and (2) OMB, by mail to: Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Toshia King, Office of Resource Conservation and Recovery, mailcode 5303P, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460; telephone number: 703–308–7033; fax number: 703–308–8617; e-mail address: *king.toshia@epa.gov.*

SUPPLEMENTARY INFORMATION: EPA has submitted the following ICR to OMB for review and approval according to the procedures prescribed in 5 CFR 1320.12. On May 27, 2009 (74 FR 25236) EPA sought comments on this ICR pursuant to 5 CFR 1320.8(d). EPA received no comments. Any additional comments on this ICR should be submitted to EPA and OMB within 30 days of this notice.

EPA has established a public docket for this ICR under Docket ID No EPA–HQ–RCRA–2009–0319, which is available for online viewing at *http://www.regulations.gov,* or in person viewing at the Resource Conservation and Recovery Act (RCRA) Docket in the EPA Docket Center (EPA/DC), EPA West, Room 3334, 1301 Constitution Ave., NW., Washington, DC. The EPA/DC Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Reading Room is (202) 566–1744, and the telephone number for the RCRA Docket is (202) 566–0270.

Use EPA's electronic docket and comment system at *http://www.regulations.gov,* to submit or view public comments, access the index listing of the contents of the docket, and to access those documents in the docket that are available electronically. Once in the system, select ''docket search,'' then key in the docket ID number identified above. Please note that EPA's policy is that public comments, whether submitted electronically or in paper, will be made available for public viewing at *http://www.regulations.gov* as EPA receives them and without change, unless the comment contains copyrighted material, confidential business information (CBI), or other information whose public disclosure is restricted by statute. For further information about the electronic docket, go to *http://www.regulations.gov.*

Title: Part B Permit Application, Permit Modifications, and Special Permits (Renewal).

ICR numbers: EPA ICR No. 1573.12, OMB Control No. 2050–0009.

ICR Status: This ICR is scheduled to expire on November 30, 2009. Under OMB regulations, the Agency may continue to conduct or sponsor the collection of information while this submission is pending at OMB. 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 in title 40 of the CFR, after appearing in the **Federal Register** when approved, are listed in 40 CFR part 9, are displayed either by publication in the **Federal Register** or by other appropriate means, such as on the related collection instrument or form, if applicable. The display of OMB control numbers in certain EPA regulations is consolidated in 40 CFR part 9.

Abstract: Section 3005 of Subtitle C of RCRA requires treatment, storage or disposal facilities (TSDFs) to obtain a permit. To obtain the permit, the TSDFs must submit an application describing the facility's operation. There are two parts to the RCRA permit application—Part A and Part B. Part A defines the processes to be used for treatment, storage, and disposal of hazardous wastes; the design capacity of such processes; and the specific hazardous wastes to be handled at the facility. Part B requires detailed site specific information such as geologic, hydrologic, and engineering data. In the event that permit modifications are proposed by the applicant or EPA, modifications must conform to the requirements under Sections 3004 and 3005.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 229 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 which have subsequently changed; 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: Entities potentially affected by this action are business or other for-profit; as well as State, Local, or Tribal governments.

Estimated Number of Respondents: 145.

Frequency of Response: On occasion.

Estimated Total Annual Hour Burden: 33,260.

Estimated Total Annual Cost: $7,956,839, which includes $2,254,188 annualized labor costs and $5,702,651 annualized capital or O&M costs.

Changes in the Estimates: There is a slight increase of 783 hours in the total estimated burden currently identified in the OMB Inventory of Approved ICR Burdens due to revised estimates of the respondent universe.

Dated: November 19, 2009.

John Moses,

Director, Collection Strategies Division.

[FR Doc. E9–28258 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OECA–2009–0417; FRL–8985–1]

Agency Information Collection Activities; Submission to OMB for Review and Approval; Comment Request; NSPS for the Phosphate Fertilizer Industry, EPA ICR Number 1061.11, OMB Control Number 2060–0037

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that an Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval. This is a request to renew an existing approved collection. The ICR, which is abstracted below, describes the nature of the collection and the estimated burden and cost.

DATES: Additional comments may be submitted on or before December 28, 2009.

ADDRESSES: Submit your comments, referencing docket ID number EPA–HQ–OECA–2009–0417, to (1) EPA online using *http://www.regulations.gov* (our preferred method), or by e-mail to *docket.oeca@epa.gov,* or by mail to: EPA Docket Center (EPA/DC), Environmental Protection Agency, Enforcement and Compliance Docket and Information Center, mail code 28221T, 1200 Pennsylvania Avenue, NW., Washington, DC 20460, and (2) OMB at: Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Robert C. Marshall, Jr., Office of Compliance, Mail code: 2223A, Environmental Protection Agency, 1200 Pennsylvania Avenue, NW., Washington, DC 20460; telephone number: (202) 564–7021; fax number: (202) 564–0050; e-mail address: *marshall.robert@epa.gov.*

SUPPLEMENTARY INFORMATION: EPA has submitted the following ICR to OMB for review and approval according to the procedures prescribed in 5 CFR 1320.12. On July 8, 2009 (74 FR 32580), EPA sought comments on this ICR pursuant to 5 CFR 1320.8(d). EPA received no comments. Any additional comments on this ICR should be submitted to EPA and OMB within 30 days of this notice.

EPA has established a public docket for this ICR under docket ID number EPA–HQ–OECA–2009–0417, which is available for public viewing online at *http://www.regulations.gov,* in person viewing at the Enforcement and Compliance Docket in the EPA Docket Center (EPA/DC), EPA West, Room 3334, 1301 Constitution Avenue, NW., Washington, DC. The EPA Docket Center Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Reading Room is (202) 566–1744, and the telephone number for the Enforcement and Compliance Docket is (202) 566–1752.

Use EPA's electronic docket and comment system at *http://www.regulations.gov,* to submit or view public comments, access the index listing of the contents of the docket, and to access those documents in the docket that are available electronically. Once in the system, select ''docket search,'' then key in the docket ID number identified above. Please note that EPA's policy is that public comments, whether submitted electronically or in paper, will be made available for public viewing at *http://www.regulations.gov,* as EPA receives them and without change, unless the comment contains copyrighted material, Confidential Business Information (CBI), or other information whose public disclosure is restricted by statute. For further information about the electronic docket, go to *http://www.regulations.gov.*

Title: NSPS for the Phosphate Fertilizer Industry (Renewal).

ICR Numbers: EPA ICR Number 1061.11, OMB Control Number 2060–0037.

ICR Status: This ICR is scheduled to expire on December 31, 2009. Under OMB regulations, the Agency may continue to conduct or sponsor the collection of information while this submission is pending at OMB. 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 in title 40 of the CFR, after appearing in the **Federal Register** when approved, are listed in 40 CFR part 9, and displayed either by publication in the **Federal Register** or by other appropriate means, such as on the related collection instrument or form, if applicable. The display of OMB control numbers in certain EPA regulations is consolidated in 40 CFR part 9.

Abstract: 40 CFR part 60, subparts T, U, V, W, and X, applies to owners and operators of each phosphate fertilizer production and storage facility. The provisions of this subpart apply to wet-process phosphoric acid plants having a design capacity of more than 15 tons of equivalent phosphorous pentoxide (P_2O_5) feed per calendar day. The affected facility includes any combination of: reactors, filters, evaporators, and hot wells. Any facility that commences construction or modification after October 22, 1974 is subject to the requirements. Owners and operators must conduct an initial performance test, record amounts of feed material and storage, record pressure drop across control devices, and comply with a total fluoride emission standard. In addition to the monitoring, recordkeeping and reporting requirements listed in the General Provisions (40 CFR part 60), the phosphate fertilizer industry is required to meet the specific requirements at 40 CFR part 60, subparts T, U, V, W, and X to determine if compliance has been achieved.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 46 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 which have subsequently changed; 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: Phosphate fertilizer plants.

Estimated Number of Respondents: 13.

Frequency of Response: Initially, occasionally, and semiannually.

Estimated Total Annual Hour Burden: 1,194.

Estimated Total Annual Cost: $437,702, which includes $117,512 in labor costs, no annualized capital/startup costs and $320,190 in operation and maintenance (O&M) costs.

Changes in the Estimates: There is no change in the labor hours in this ICR compared to the previous ICR. This is due to two considerations. First, the

regulations have not changed over the past three years and are not anticipated to change over the next three years. Secondly, the growth rate for respondents is very low, negative, or non-existent. Therefore, the labor hours in the previous ICR reflect the current burden to the respondents and are reiterated in this ICR. There is a minor change to the cost figures because the previous ICR used a technical labor rate only. The updated labor categories and associated rates result in an increase to total labor cost. In addition, the previous ICR rounded to the nearest $1,000; this ICR presents cost figures which differ by less than $500 from the previous ICR due to using exact figures instead of rounding.

Dated: November 16, 2009.

John Moses,

Director, Collection Strategies Division.

[FR Doc. E9–28261 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2008–0917; FRL–8984–9]

Agency Information Collection Activities; Submission to OMB for Review and Approval; Comment Request; Standards for Pesticide Containers and Containment; EPA ICR No. 1632.03, OMB Control No. 2070–0133

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*), this document announces that an Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval. This is a request to renew an existing approved collection. The ICR, which is abstracted below, describes the nature of the information collection and its estimated burden and cost.

DATES: Additional comments may be submitted on or before December 28, 2009.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA–HQ–OPP–2008–0917, to (1) EPA online using *http://www.regulations.gov* (our preferred method), by mail—Office of Pesticide Programs (OPP), Regulatory Public Docket (7502P), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460, and (2) OMB by mail to: Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Cameo Smoot, Field and External Affairs Division, Office of Pesticide Programs, 7506P, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460; telephone number: 703–305–5454; fax number: 703–305–5884; e-mail address: *smoot.cameo@epa.gov.*

SUPPLEMENTARY INFORMATION: EPA has submitted the following ICR to OMB for review and approval according to the procedures prescribed in 5 CFR 1320.12. On February 25, 2009 (74 FR 8537), EPA sought comments on this ICR pursuant to 5 CFR 1320.8(d). EPA received no comments. Any additional comments on this ICR should be submitted to EPA and OMB within 30 days of this notice.

EPA has established a public docket for this ICR under Docket ID No. EPA–HQ–OPP–2008–0917, which is available for online viewing at *http://www.regulations.gov,* or in person viewing at the OPP Regulatory Public Docket in Rm. S–4400, One Potomac Yard (South Building), 2777 S. Crystal Drive, Arlington, VA. The hours of operation of this Docket Facility are from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The Docket telephone number is (703) 305–5805. Use EPA's electronic docket and comment system at *http://www.regulations.gov,* to submit or view public comments, access the index listing of the contents of the docket, and to access those documents in the docket that are available electronically. Once in the system, select ''docket search,'' then key in the docket ID number identified above. Please note that EPA's policy is that public comments, whether submitted electronically or in paper, will be made available for public viewing at *http://www.regulations.gov* as EPA receives them and without change, unless the comment contains copyrighted material, confidential business information (CBI), or other information whose public disclosure is restricted by statute. For further information about the electronic docket, go to *http://www.regulations.gov.*

Title: Standards for Pesticide Containers and Containment.

ICR numbers: EPA ICR No. 1632.03, OMB Control No. 2070–0133.

ICR Status: This ICR is scheduled to expire on November 30, 2009. Under OMB regulations, the Agency may continue to conduct or sponsor the collection of information while this submission is pending at OMB. 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 in title 40 of the CFR, after appearing in the **Federal Register** when approved, are listed in 40 CFR part 9, are displayed either by publication in the **Federal Register** or by other appropriate means, such as on the related collection instrument or form, if applicable. The display of OMB control numbers in certain EPA regulations is consolidated in 40 CFR part 9.

Abstract: This information collection request covers the information collection activities associated with the container design and residue removal requirements and containment structure requirements. With respect to the container design and residue removal requirements, the information collection activities are associated with the requirement that businesses subject to the container regulations (pesticide registrants) and repackaging regulations (pesticide registrants and refillers) maintain records of test data, cleaning procedures, certain data when a container is refilled, and other supporting information. These records are subject to both call-in by EPA and on-site inspection by EPA and its representatives. EPA has not established a regular schedule for the collection of these records, and there is no reporting. With respect to the containment structure requirements, the information collection activities are associated with the requirement that businesses subject to the containment structure regulations maintain records of the: (1) Monthly inspection and maintenance of each containment structure and all stationary bulk containers; (2) duration over which non-stationary bulk containers holding pesticide and not protected by a secondary containment unit remain at the same location; and (3) construction date of the containment structure. The businesses subject to the containment structure regulations include agrichemical retailers and refilling establishments, custom blenders and commercial applicators of agricultural pesticides. The records have to be maintained by the owners and operators of such businesses. There is no regular schedule for the collection of either of these records, nor does EPA anticipate a call-in of records at some future date. Instead, the records would be available to inspectors to ensure that businesses are in compliance with containment requirements. These inspections are

generally conducted by the states, who enforce FIFRA regulations through cooperative agreements with EPA.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 7.4 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 which have subsequently changed; 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: Entities potentially affected by this ICR include pesticide registrants and businesses who formulate pesticide products or pesticide formulation intermediates (NAICS code 325320), farm supply wholesalers (NAICS code 422910), swimming pool applicators (classified under NAICS codes 561790, 453998, and 235990), and agricultural (aerial and ground) commercial applicators (classified under NAICS code 115112).

Estimated Number of Respondents: 23,586. This includes 1,804 registrant facilities, 16,795 agricultural pesticide refillers, 322 swimming pool supply companies, and 4,665 facilities requiring secondary containment.

Frequency of Response: On occasion. There is no regular reporting involved. This ICR only involves recordkeeping requirements.

Estimated Total Annual Hour Burden: 174,550.5 hours. This includes 139,563 hours for container design and residue removal requirements and 34,987.5 hours for containment structure requirements.

Estimated Total Annual Cost: $6,124,953. This includes $4,902,723 for container design and residue removal requirements and $1,222,230 for containment structure requirements.

Changes in the Estimates: The renewal of this ICR will result in an overall increase of 122,493.5 hours in the total estimated respondent burden identified in the currently approved ICR. When the information collection associated with this ICR was approved in 2006, the burden hours were adjusted to reflect only the burden associated with initial rule familiarization and state requests to use their containment regulations in lieu of Federal regulations—a total of 52,057 hours. These were the only burdens that were imposed by the pesticide container and containment regulations during the course of that approval. EPA was instructed to revise the estimates, upon resubmission, to reflect the burden imposed in 2009 and beyond because of compliance with the requirements.

Dated: November 18, 2009.

John Moses,

Director, Collection Strategies Division.

[FR Doc. E9–28259 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[Regional Docket Nos. V–2008–2, FRL–8985–3]

Clean Air Act Operating Permit Program; Petition for Objection to State Operating Permit for BP Products North America, Inc., Whiting Business Unit

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of final order on petition to object to Clean Air Act (Act) operating permit.

SUMMARY: This document announces that the Administrator of EPA has responded to a petition submitted by the Environmental Law and Policy Center, Hoosier Environmental Council, Natural Resources Defense Council, Save the Dunes, Sierra Club, Susan Eleuterio, and Tom Tsourlis (petitioners) asking EPA to object to an operating permit issued by the Indiana Department of Environmental Management to the BP Products North America, Inc., Whiting Business Unit (Whiting). The Administrator granted the petition in part and denied it in part.

Pursuant to section 505(b)(2) of the Act, a petitioner may seek in the United States Court of Appeals for the appropriate circuit judicial review of those portions of a petition which EPA denied. Any petition for review shall be filed within 60 days from the date this notice appears in the **Federal Register**, pursuant to section 307 of the Act.

ADDRESSES: You may review copies of the final order, the petition, and other supporting information at the EPA Region 5 Office, 77 West Jackson Boulevard, Chicago, Illinois 60604. If you wish to examine these documents, you should make an appointment at least 24 hours before visiting the EPA office. Additionally, the final order for the Whiting petition is available electronically at: *http://www.epa.gov/region07/programs/artd/air/title5/petitiondb/petitiondb.htm.*

FOR FURTHER INFORMATION CONTACT: Pamela Blakley, Chief, Air Permits Section, Air Programs Branch, Air and Radiation Division, EPA, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, telephone (312) 886–4447.

SUPPLEMENTARY INFORMATION: The Act affords EPA a 45-day period to review, and object, as appropriate, to operating permits proposed by State permitting authorities. Section 505(b)(2) of the Act authorizes any person to petition the EPA Administrator within 60 days after the expiration of the EPA review period to object to a State operating permit if EPA has not done so. A petition must be based only on objections to the permit that were raised with reasonable specificity during the public comment period provided by the State, unless the petitioner demonstrates that it was impracticable to raise issues during the comment period, or the grounds for the issues arose after this period.

On August 19, 2008, EPA received a petition requesting that EPA object to the Title V operating permit for Whiting. The Petitioners allege that the permit is not in compliance with the requirements of the Act.

Specifically, the Petitioners allege that: (1) The permit application lacks emission information and calculations critical for determining applicable requirements and setting appropriate limits and conditions; (2) the minor source permit fails to comply with New Source Review requirements because the project is a major modification when all project emissions are properly included; (3) the permit does not include applicable Best Available Control Technology and Lowest Achievable Emission Rate limits for flares and other sources; (4) BP and IDEM failed to conduct the proper greenhouse gas Best Achievable Control Technology analysis; and (5) the permit omits compliance schedules that Title V requires to ensure compliance with all applicable requirements, as supported by the Notice of Violation issued by EPA to BP for its Whiting refinery.

On October 16, 2009, the Administrator issued an order granting the Whiting petition in part and denying it in part. The order explains the reasons behind EPA's conclusions.

Dated: November 9, 2009.

Bharat Mathur,

Acting Regional Administrator, Region 5.

[FR Doc. E9–28266 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–SFUND–2006–0361; FRL–8985–7]

Emergency Planning and Community Right-to-Know Act; Contractor Access to Trade Secrets and Address Change for Submitting Trade Secret Claims

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The EPA has authorized the following contractor to access trade secret information that has been, or will be, submitted to EPA under sections 303, 311 and 312 of the Emergency Planning and Community Right-to-Know Act (EPCRA): CGI Federal, Inc. and its subcontractor, Management Support Technology, Inc. (MSTI), (GSA Contract #GS–35F4797H TO#1518, expiring March 30, 2012). The EPA also announces a new address to which EPCRA trade secrets are to be sent.

DATES: This new address is effective on November 25, 2009.

ADDRESSES: EPCRA Trade Secrets submitted to EPA should be mailed to: CGI Federal, c/o CDX Reporting Center, P.O. 10162, Fairfax, VA 22038. Courier deliveries and express mail should be addressed to: CDX Reporting Center, c/o CGI Federal, 12601 Fair Lakes Circle, Fairfax, VA 22033.

FOR FURTHER INFORMATION CONTACT: Sicy Jacob at (202) 564–8019.

SUPPLEMENTARY INFORMATION: The EPA is issuing this notice to inform all submitters of trade secret claims submitted under sections 303, 311 and 312 of EPCRA that EPA may provide the above mentioned contractor and its subcontractor access to these materials on a need-to-know basis. This contractor will provide technical support to the Office of Emergency Management in the receipt, processing and storage of these trade secret claims submitted to EPA. In accordance with 40 CFR 350.23, EPA has determined that the contractor and its subcontractor require access to trade secret and confidential information submitted to EPA under 40 CFR part 350 in order to perform work satisfactorily under the above noted contract. The contractor's and subcontractor's personnel will be required to sign nondisclosure agreements prior to receiving access to trade secrets. All contractor access to trade secrets will take place at the contractor's facility. The contractor will have appropriate procedures and facilities in place to safeguard the trade secrets to which the contractor and its subcontractor have access. Clearance for access to trade secrets is scheduled to expire on March 30, 2012 or at contract termination.

EPCRA Trade Secrets submitted to EPA should be mailed to: CGI Federal, c/o CDX Reporting Center, P.O. 10162, Fairfax, VA 22038. Courier deliveries and express mail should be addressed to: CDX Reporting Center, c/o CGI Federal, 12601 Fair Lakes Circle, Fairfax, VA 22033.

Dated: November 16, 2009.

Deborah Y. Dietrich,

Director, Office of Emergency Management.

[FR Doc. E9–28288 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2009–0773; FRL–8800–5]

Clean Water Act and Federal Insecticide, Fungicide, and Rodenticide Act Common Effects Aquatic Life Assessment for Pesticides Using Available Data: Regional Stakeholder Meetings

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of Public Meetings.

SUMMARY: EPA will conduct six public meetings to solicit input on methods being evaluated by the Office of Pesticide Programs (OPP) and the Office of Water (OW), with the support of the Office of Research and Development (ORD) to characterize effects from pesticides on fish, other aquatic organisms, and aquatic plants in aquatic ecosystems. These public meetings will be held in Chicago, IL (Region 5), Edison, NJ (Region 2), Kansas City, KS (Region 7), Atlanta, GA (Region 4), San Francisco, CA (Region 9), and Seattle, WA (Region 10), starting in January 2010. At the public meetings, EPA will provide presentations that detail its initial thinking on how to ensure that pesticide effects are characterized consistently by both OPP and OW.

DATES: The public meetings will be held on the following dates: January 11, 2010; January 12, 2010; January 14, 2010; January 19, 2010; January 21, 2010; and January 22, 2010.

ADDRESSES: The meetings will be held at the following locations and times:

Date	Time	Location
January 11, 2010	1 p.m. to 5 p.m.	EPA Region 2 2890 Woodbridge Ave. Building 205 Main Conference Room Edison, NJ 08837
January 12, 2010	1 p.m. to 5 p.m.	EPA Region 4 Sam Nunn Atlanta Federal Center Augusta Conference Room 61 Forsyth St., SW Atlanta, GA 30303
January 14, 2010	9 a.m. to 1 p.m	EPA Region 5 Ralph Metcalfe Federal Building Valdas V. Adamkus Resource Center – 12th Floor Lake Michigan Room 77 W. Jackson Boulevard Chicago, IL 60604
January 19, 2010	9 a.m. to 1 p.m	EPA Region 7 901 North 5th St. Room 2240 A Kansas City, KS 66101
January 21, 2010	9 a.m. to 1 p.m	EPA Region 10 1200 Sixth Ave., Suite 900 Seattle, WA 98101
January 22, 2010	1 p.m. to 4 p.m.	EPA Region 9 Ronald V. Dellums Federal Building Edward R. Roybal Auditorium and Conference Center 1301 Clay St. Oakland, CA 94612

Additional information concerning these meetings will be available on December 1, 2009 at the following web site: *www.epa.gov/oppefed1/cwa_fifra_effects_methodology/index.html.*

To request accommodation of a disability, please contact the person listed under **FOR FURTHER INFORMATON CONTACT**, preferably at least 10 days prior to the meeting, to give EPA as much time as possible to process your request.

FOR FURTHER INFORMATION CONTACT: Jane Hopkins, Field and External Affairs Division (7506P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW, Washington, D.C. 20460; telephone number: (703) 305–7195; e-mail address: *hopkins.jane@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

This action is directed to the public in general, and may be of interest to a wide range of stakeholders, including environmental, water resources professionals, and agricultural advocates, the chemical industry, pesticide users, and members of the public interested in the sale, distribution, or use of pesticides. Since others also may be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Get Copies of this Document and Other Related Information?

EPA has established a docket for this action under docket ID number EPA–HQ–OPP–2009–0773. Publicly available docket materials are available either in the electronic docket at *http://www.regulations.gov*, or, if only available in hard copy, at the Office of Pesticide Programs (OPP) Regulatory Public Docket in Rm. S–4400, One Potomac Yard (South Bldg.), 2777 S. Crystal Dr., Arlington, VA. The hours of operation of this Docket Facility are from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The Docket Facility telephone number is (703) 305–5805.

II. Background

Section 304(a)(1) of the Clean Water Act (CWA) requires EPA to develop, publish, and from time to time, revise criteria for water quality accurately reflecting the latest scientific knowledge. Water quality criteria are scientifically derived numeric values that measure the level beyond which pollutants in ambient water will have deleterious effects on aquatic life or human health. Water quality criteria developed under Section 304(a) are based solely on data and scientific judgments on the relationship between pollutant concentrations and environmental and human health effects. Section 304(a) criteria do not reflect consideration of economic impacts or the technological feasibility of meeting the chemical concentrations in ambient water.

Section 304(a) criteria provide guidance to states and authorized tribes in adopting water quality standards that ultimately provide the basis for controlling discharges or releases of pollutants. The criteria also provide guidance to EPA when promulgating Federal regulations under Section 303(c) when such action is necessary. Under the CWA and its implementing regulations, states and authorized tribes adopt water quality criteria to measure attainment of designated uses (e.g., public water supply, recreational use, industrial use). EPA's recommended criteria do not impose legally binding requirements. States and authorized tribes have the discretion to adopt, where appropriate, other scientifically defensible water quality criteria that differ from EPA's recommended criteria.

FIFRA requires that all pesticides used in the United States be registered by EPA for use and, thus, ensures Federal control of distribution, sale, and use of pesticides. Registration assures that pesticides will be properly labeled and that, if used in accordance with labeled specifications, will not cause unreasonable adverse effects on human health and the environment. FIFRA ecological risk assessments quantitatively evaluate reduced survival of aquatic animals from direct acute exposures and survival, growth, and reproductive impairment for aquatic animals from direct chronic exposures. Assessments for aquatic plants focus on growth rates and biomass (reproduction) measurements. Risk management decisions for pesticide registration under FIFRA take into consideration benefits in addition to risks of pesticides used; however, benefits are not considered in characterizing ecological effects under FIFRA or in deriving ambient water quality criteria (AWQC) values under CWA.

For FIFRA ecological effects assessments, EPA peer reviews toxicity data provided by the registrant as required by regulation, as well as data from public sources obtained from EPA's ECOTOX database. Current testing requirements for aquatic organisms include toxicity studies containing information on survival, reproduction, and growth endpoints for freshwater and estuarine/marine animals and biomass and growth endpoints for aquatic plants. These test requirements are defined for each chemical class by use category in title 40 of the Code of Federal Regulations, part 158. Studies are performed on laboratory test organisms in the following broad taxonomic groupings: freshwater fish and invertebrates, estuarine/marine fish and invertebrates, and aquatic plants. For screening-level assessments, OPP's effects assessments are based on the lowest acute and chronic toxicity values from the most sensitive species tested in acceptable studies. More refined assessments may use the full species sensitivity distribution for a given taxa or other toxicity endpoints, as for the variability and uncertainty of the data (probabilistic approaches). The ''OPP Aquatic Benchmarks'' is a web site developed by OPP that contains the aquatic toxicity endpoints used in EPA pesticide risk assessments. (*http://www.epa.gov/oppefed1/ecorisk_ders/aquatic_life_benchmarks.htm*).

Although both OPP's and OW's approaches afford a high degree of protection for aquatic life, stakeholders have identified a need for consistent and timely Federal input that will allow EPA, states, tribes, and the public to gauge whether pesticides represent a concern for aquatic life, for example, based on water monitoring results. To address these concerns, the Agency has begun a process to explore how to build on the high quality science in both OW and OPP to develop additional tools and approaches to support a consistent and common set of effects characterization methods using best available information. A Scoping Document has been developed that describes this effort in more detail. A letter signed by the Office Directors of OPP and OW, and reinforced by the Scoping Document, has invited public participation in our collective efforts. Following through on this invitation, regional public meetings are being planned for January 2010 to solicit input on the Agency's initial thinking regarding methods, tools, and approaches that are being developed and evaluated by OPP and OW, with the support of ORD, to assure that pesticide ecological effects are characterized consistently. The areas for consideration under this effort include:

- Development and evaluation of predictive tools for use in development of community level benchmarks
- Development of aquatic life community level benchmarks with datasets that do not conform to the ''1985 Guidelines''
- Derivation of aquatic life screening values for aquatic plants

The tools and approaches developed by EPA will:

- Continue to be based upon sound science and utilize the available data,
- Be legally defensible under our statutory mandates,
- Be based upon methodologies that are as consistent and practical as possible,
- Be implementable at the Federal and State level.
- Be developed as quickly and efficiently as possible, and
- Reflect stakeholder input and comments.

During these meetings, EPA will also solicit input from Regional stakeholders regarding the following:

1. Additional sources of pesticide data and relevant reports.
2. The white paper topics.
3. The availability of data, tools, approaches, and data sets on aquatic toxicity that may be useful for this effort.
4. The types of values that are used by states and/or regions for protecting aquatic life in the absence of ambient water quality criteria.
5. Examples of situations in which differences between OW and OPP assessment approaches were an issue.

Following these meetings, the Agency plans to develop a set of white papers, describing potential new tools and analytical approaches that may be used by the Agency, state pesticide and water quality agencies, and other stakeholders.

For more information about water quality criteria and Water Quality Standards, refer to the following:

- Water Quality Standards Handbook (EPA 823–B94–005a);
- Advanced Notice of Proposed Rule Making (ANPRM), (63 FR 36742);
- Water Quality Criteria and Standards Plan – Priorities for the Future (EPA 822–R–98–003);
- Guidelines and Methodologies Used in the Preparation of Health Effects Assessment Chapters of the Consent Decree Water Criteria Documents (45 FR 79347);
- Methodology for Deriving Ambient Water Quality Criteria for the Protection of Human Health (2000), EPA–822–B–00–004);
- Guidelines for Deriving Numerical National Water Quality Criteria for the Protection of Aquatic Organisms and Their Uses (EPA 822/R–85–100);
- National Strategy for the Development of Regional Nutrient Criteria (EPA 822–R–98–002); and
- EPA Review and Approval of State and Tribal Water Quality Standards (65 FR 24641).

You can find these publications through EPA's National Service Center for Environmental Publications (NSCEP, previously NCEPI) or on the Office of Science and Technology's home page (*http://www.epa.gov/waterscience*).

For more information about the OPP Ecological Exposure Assessment Process under FIFRA, refer to the following: ''Overview of the Ecological Risk Assessment Process in the Office of Pesticide Programs,'' which describes how pesticide data are used in ecological risk assessments (*http://www.epa.gov/oppfead1/endanger/consultation/ecorisk-overview.pdf*). The data requirements for aquatic non-target plants and animals for pesticides are described in title 40 of the Code of Federal Regulations, revised July 1, 2008 (§ 158.660 Non-target Plant Protection Data Requirements). The required procedures for conducting the studies are described in OPPTS Harmonized Test Guidelines Series 850 ''Ecological Effects Test Guidelines – Public Drafts'' (*http://www.epa.gov/opptsfrs/publications/OPPTS_Harmonized/850_Ecological_Effects_Test_Guidelines/Drafts/*). Information on procedures used to evaluate these studies are described in: Standard Evaluation Protocols, the guidance document entitled ''the Rejection Rate Analysis: Ecological Effects'' (EPA 738–R–94–035), and in the OPP Overview Document. Public literature is accessed by OPP through EPA's ECOTOX database (*http://cfpub.epa.gov.ecotox/*). The ''OPP Aquatic Benchmarks,'' a web site developed by OPP, contains the aquatic toxicity endpoints used in pesticide assessments (*Http://www.epa.gov/oppefed1ecorisk_ders/aquatic_life_benchmarks.htm*).

III. How Can I Request to Participate in this Meeting?

This meeting is open to the public; registration is not required for attending or for participating in this meeting. Seats will be available on a first come, first served basis.

List of Subjects

Environmental protection, Ambient water quality criteria, Aquatic benchmarks, Aquatic community, Aquatic life, Ecological risk assessment, Pesticides and pest.

Dated: November 13, 2009.

Debra Edwards,

Director, Office of Pesticide Programs.

[FR Doc. E9–28059 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2009–0787; FRL–8798–6]

Difenzoquat; Notice of Receipt of Request to Voluntarily Cancel Pesticide Registrations

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In accordance with section 6(f)(1) of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), as amended, EPA is issuing a notice of receipt of a request by the registrant to voluntarily cancel their registrations of products containing the pesticide difenzoquat. The request would terminate difenzoquat use on barley and wheat. The request would terminate the last difenzoquat products registered for use in the United States. EPA intends to grant this request at the close of the comment period for this announcement unless the Agency receives substantive comments within the comment period that would merit its further review of the request, or unless the registrant withdraws their request within this period. Upon acceptance of this request, any sale, distribution, or use of products listed in this notice will be permitted only if such sale, distribution, or use is consistent with the terms as described in the final order.

DATES: Comments must be received on or before December 28, 2009.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPP–2009–0787, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the on-line instructions for submitting comments.
- *Mail*: Office of Pesticide Programs (OPP) Regulatory Public Docket (7502P), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001.
- *Delivery*: OPP Regulatory Public Docket (7502P), Environmental Protection Agency, Rm. S–4400, One Potomac Yard (South Bldg.), 2777 S. Crystal Dr., Arlington, VA. Deliveries are only accepted during the Docket Facility's normal hours of operation (8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays). Special arrangements should be made for deliveries of boxed information. The Docket Facility telephone number is (703) 305–5805.

Instructions: Direct your comments to docket ID number EPA–HQ–OPP–2009–0787. EPA's policy is that all comments received will be included in the docket without change and may be made available on-line at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through regulations.gov or e-mail. The regulations.gov website is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through regulations.gov, your e-mail address will be automatically captured and included as part of the comment that is

placed in the docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the docket are listed in the docket index available at *http://www.regulations.gov*. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either in the electronic docket at *http://www.regulations.gov*, or, if only available in hard copy, at the OPP Regulatory Public Docket in Rm. S–4400, One Potomac Yard (South Bldg.), 2777 S. Crystal Dr., Arlington, VA. The hours of operation of this Docket Facility are from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The Docket Facility telephone number is (703) 305–5805.

FOR FURTHER INFORMATION CONTACT: Eric Miederhoff, Pesticide Re-evaluation Division (7508P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (703) 347–8028; fax number: (703) 308–7070; e-mail address: *miederhoff.eric@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

This action is directed to the public in general, and may be of interest to a wide range of stakeholders including environmental, human health, and agricultural advocates; the chemical industry; pesticide users; and members of the public interested in the sale, distribution, or use of pesticides. Since others also may be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

B. What Should I Consider as I Prepare My Comments for EPA?

1. *Submitting CBI.* Do not submit this information to EPA through regulations.gov or e-mail. Clearly mark the part or all of the information that you claim to be CBI. For CBI information in a disk or CD-ROM that you mail to EPA, mark the outside of the disk or CD-ROM as CBI and then identify electronically within the disk or CD-ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

2. *Tips for preparing your comments.* When submitting comments, remember to:

i. Identify the document by docket ID number and other identifying information (subject heading, **Federal Register** date and page number).

ii. Follow directions. The Agency may ask you to respond to specific questions or organize comments by referencing a Code of Federal Regulations (CFR) part or section number.

iii. Explain why you agree or disagree; suggest alternatives and substitute language for your requested changes.

iv. Describe any assumptions and provide any technical information and/or data that you used.

v. If you estimate potential costs or burdens, explain how you arrived at your estimate in sufficient detail to allow for it to be reproduced.

vi. Provide specific examples to illustrate your concerns and suggest alternatives.

vii. Explain your views as clearly as possible, avoiding the use of profanity or personal threats.

viii. Make sure to submit your comments by the comment period deadline identified.

II. Background on the Receipt of Requests to Cancel and/or Amend Registrations to Delete Uses

This notice announces receipt by EPA of a request from registrant AMVAC Chemical Corporation to cancel all 3 product registrations for the herbicide difenzoquat. Difenzoquat is registered for use on only two crops, wheat and barley. In a letter dated November 2, 2009, AMVAC Chemical Corporation requested EPA to cancel the affected product registrations identified in Table 1 of this notice. If the registrant's request is granted, the last difenzoquat products registered in the United States will be canceled effective December 31, 2009.

III. What Action is the Agency Taking?

This notice announces receipt by EPA of a request from a registrant to cancel difenzoquat product registrations. The affected products and the registrants making the requests are identified in Table 1 of this unit.

Under section 6(f)(1)(A) of FIFRA, registrants may request, at any time, that their pesticide registrations be canceled or amended to terminate one or more pesticide uses. Section 6(f)(1)(B) of FIFRA requires that before acting on a request for voluntary cancellation, EPA must provide a 30–day public comment period on the request for voluntary cancellation or use termination. In addition, section 6(f)(1)(C) of FIFRA requires that EPA provide a 180–day comment period on a request for voluntary cancellation or termination of any minor agricultural use before granting the request, unless: The registrants request a waiver of the comment period, or; the Administrator determines that continued use of the pesticide would pose an unreasonable adverse effect on the environment.

The difenzoquat registrants have requested that EPA waive the 180–day comment period. EPA will provide a 30–day comment period on the proposed requests.

Unless a request is withdrawn by the registrant within 30 days of publication of this notice, or if the Agency determines that there are substantive comments that warrant further review of this request, an order will be issued canceling the affected registrations.

TABLE 1. — DIFENZOQUAT PRODUCT REGISTRATIONS WITH PENDING REQUESTS FOR CANCELLATION

Registration Number	Product Name	Company
5481–536	Avenge Technical Herbicide	AMVAC Chemical Corporation
5481–537	Avenge Wild Oat Herbicide	AMVAC Chemical Corporation
5481–538	Avenge SG Wild Oat Herbicide	AMVAC Chemical Corporation

Table 2, of this unit includes the name and address of record for the

registrant of the products listed in Table 1 of this unit.

TABLE 2. — REGISTRANT REQUESTING VOLUNTARY CANCELLATION AND/OR AMENDMENTS

EPA Company Number	Company Name and Address
5481	AMVAC Chemical Corporation, 4695 Macarthur Court, Suite 1250, Newport Beach, CA 92660–1706

IV. What is the Agency's Authority for Taking this Action?

Section 6(f)(1) of FIFRA provides that a registrant of a pesticide product may at any time request that any of its pesticide registrations be canceled or amended to terminate one or more uses. FIFRA further provides that, before acting on the request, EPA must publish a notice of receipt of any such request in the **Federal Register**. Thereafter, following the public comment period, the Administrator may approve such a request.

V. Procedures for Withdrawal of Request and Considerations for Reregistration of Difenzoquat

Registrants who choose to withdraw a request for cancellation must submit such withdrawal in writing to the person listed under **FOR FURTHER INFORMATION CONTACT**, postmarked before December 28, 2009. This written withdrawal of the request for cancellation will apply only to the applicable FIFRA section 6(f)(1) request listed in this notice. If the products have been subject to a previous cancellation action, the effective date of cancellation and all other provisions of any earlier cancellation action are controlling.

VI. Provisions for Disposition of Existing Stocks

Existing stocks are those stocks of registered pesticide products which are currently in the United States and which were packaged, labeled, and released for shipment prior to the effective date of the cancellation action.

In any order issued in response to these requests for cancellation of difenzoquat product registrations, EPA proposes to include the following provisions for the treatment of any existing stocks of the products identified or referenced in Table 1 in Unit III.

If the request for voluntary cancellation is granted as discussed in this unit, the Agency proposes to issue a cancellation order that will allow AMVAC to sell and distribute existing stocks of the products identified in Unit III. until December 31, 2010. All sale or distribution of existing stocks by AMVAC is prohibited after December 30, 2010, unless that sale or distribution is solely for the purpose of facilitating disposal or export of the product.

The Agency will allow persons other than the registrant to continue to sell and/or use existing stocks of canceled products until such stocks are exhausted, provided that such use is consistent with the terms of the previously approved labeling on, or that accompanied, the canceled product. The order will specifically prohibit any use of existing stocks that is not consistent with such previously approved labeling. The Agency will publish the cancellation order in the **Federal Register**.

List of Subjects

Environmental protection, Pesticides and pests.

Dated: November 12, 2009.

Peter Caulkins,

Acting Director, Pesticide Re-evaluation Division, Office of Pesticide Programs.

[FR Doc. E9–28057 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2006–0955; FRL–8800–2]

Rodenticides; Product Cancellation Order; Correction

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice; correction and clarification.

SUMMARY: EPA issued a rodenticides product Cancellation Order in the **Federal Register** of September 30, 2009. This document is being issued to correct clerical errors and to clarify the existing stocks provisions.

DATES: The correction is effective date of publication in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Rusty Wasem, Pesticide Re-evaluation Division (7508P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: 703-305-6979; e-mail address: *wasem.russell@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

The Agency included in the notice a list of those who may be potentially affected by this action. If you have questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Get Copies of this Document and Other Related Information?

EPA has established a docket for this action under docket identification (ID) number EPA–HQ–OPP–2006–0955. Publicly available docket materials are available either in the electronic docket at *http://www.regulations.gov*, or, if only available in hard copy, at the Office of Pesticide Programs (OPP) Regulatory Public Docket in Rm. S–4400, One Potomac Yard (South Bldg.), 2777 S. Crystal Dr., Arlington, VA. The hours of operation of this Docket Facility are from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The Docket Facility telephone number is (703) 305–5805.

II. What Does this Correction Do?

In the **Federal Register** of September 30, 2009 EPA issued a product cancellation order canceling certain rodenticide registrations voluntarily requested by the registrants and accepted by the Agency. Subsequent to the September 30, 2009 publication date, it was determined that some of the products which were listed in Table 1—Rodenticide Product Cancellations, had been cancelled previously. This notice corrects the September 30, 2009 notice and clarifies the provisions for disposition of existing stocks.

FR Doc.E9-23452 published in the **Federal Register** of September 30, 2009 (74 FR 50194) (FRL–8438–6) is corrected as follows:

1. The **DATES** caption on page 50194, is corrected to read:

DATES: The products listed in Table 1 are cancelled on June 4, 2011.

2. On page 50195, table 1 is corrected to read as follows:

TABLE 1.—RODENTICIDE PRODUCT CANCELLATIONS

EPA Registration Number	Product Name
Cholecalciferol (PC Code 202901)	
12455-57	Quintox Mouse Seed
Bromadiolone (PC Code 112001)	
12455-68	Contrac Mouse Bait Station
12455-104	Contract Mouse Control Kit
Bromethalin (PC Code 112802)	
47629-10	Bromethalin Manufacturing Concentrate
Diphacinone (PC Code 067701)	
3487-26	Eagles-14 Diphacinone Rat Bait
11885-12	Master Mix Blue Death-D Rat & Mouse Bait
11885-15	Master Mix Blue Death-D Rat & Mouse Hide-A-Pack
Warfarin (PC Code 086002)	
3487-19	Eagles-7 Rat Bait
62577-7	Echols Mouse & Rat Pellets
72500-7	Kaput Mouse Blocks

III. Products Previously Cancelled

The registrations listed in Table 2 below were inadvertently included in Table 1 of the notice published on September 30, 2009, for which this notice corrects. The products listed in Table 2 below were canceled previously for non-payment of maintenance fees and do not have an effective cancellation date of June 4, 2011. Please note that regardless of the existing stocks provision for products listed in Table 2 below, registrants of these products are not permitted to release these products into the channels of trade after June 4, 2011.

TABLE 2.—PRODUCTS PREVIOUSLY CANCELLED

EPA Registration Number	Product Name	Date of Cancellation
Cholecalciferol (PC Code 202901)		
3240-28	Rampage Mouse Seed	July 16, 2009
3240-42	Rampage Rat & Mouse Bait	July 16, 2009
Bromadiolone (PC Code 112001)		
12455-103	Contrac Bait Trays	September 15, 2009
Bromethalin (PC Code 112802)		
12455-100	Fastrac Mouse Seed Place Pac	September 15, 2009
Diphacinone (PC Code 067701)		
12455-67	Ditrac Mouse Bait Station	September 15, 2009
Diphacinone, sodium salt (PC Code 067705)		
3240-17	Motomco Water Soluble Diphacinone Rodenticide Concentrate Kills Rats And Mice	July 16, 2009
Warfarin (PC Code 086002)		
5887-51	Black Leaf Warf Pellets	July 16, 2009
5887-98	Black Leaf Warf Pellets Mouse Killer	July 16, 2009

TABLE 2.—PRODUCTS PREVIOUSLY CANCELLED—Continued

EPA Registration Number	Product Name	Date of Cancellation
12455-15	Warfarin Rat And Mouse Bait	September 15, 2009
Warfarin, sodium salt (PC Code 086003)		
12455-22	Liqua-Tox Liquid Concentrate	September 15, 2009
Zinc Phosphide (PC Code 088601)		
12455-59	ZP Rodent Bait Place Pac	September 15, 2009
12455-85	Mole And Gopher Bait	September 15, 2009

List of Subjects

Environmental protection, Pesticides and pests.

Dated: November 17, 2009.

Richard P. Keigwin, Jr.

Director, Pesticide Re-evaluation Division, Office of Pesticide Programs.

[FR Doc. E9–28168 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[FRL–8984–2]

Notice of a Project Waiver of Section 1605 (Buy American Requirement) of the American Recovery and Reinvestment Act of 2009 (ARRA) to the Gwinnett County, GA, Department of Water Resources

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The EPA is hereby granting a project waiver of the Buy American requirements of ARRA Section 1605 under the authority of Section 1605(b)(2) [manufactured goods are not produced in the United States in sufficient and reasonably available quantities and of a satisfactory quality] to the Gwinnett County, Georgia, Department of Water Resources (County) for the purchase of an Austrian manufactured Anaerobic digester gas fueled engine generator set specified as General Electric (GE) Jenbacher JMS 616, 2147 kilowatts for application in a combined heat and power system for use at the F. Wayne Hill Resources Center in the County. The product is manufactured by GE Jenbacher (Jenbach, Austria) and provided by General Electric Water & Process Technologies. The County stated that there was no apparent domestic manufactured biogas engine generator set with the specific fuel utilization/electric power output capacity and variable fuel blending capability required for the utility's combined heat and power needs. This is a project specific waiver and only applies to the use of the specified product for the ARRA funded project being proposed. Any other ARRA project that may wish to use the same product must apply for a separate waiver based on the specific project circumstances. The Acting Regional Administrator is making this determination based on the review and recommendation of the EPA Region 4, Water Protection Division, Grants and Infrastructure Branch. The County has provided sufficient documentation to support their request. The Assistant Administrator of the Office of Administration and Resources Management has concurred on this decision to make an exception to Section 1605 of ARRA. This action permits the purchase of an anaerobic digester gas fueled engine generator set manufactured by GE Jenbacher for the proposed project being implemented by Gwinnett County, Georgia.

DATES: *Effective Date:* October 7, 2009.

FOR FURTHER INFORMATION CONTACT: Carl Biemiller, Project Officer, (404) 562–9341, Grants and Infrastructure Branch, Water Protection Division, Region 4, US EPA, Atlanta Federal Center, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960.

SUPPLEMENTARY INFORMATION: In accordance with ARRA Section 1605(c) and pursuant to Section 1605(b)(2) of Public Law 111–5, Buy American requirements, the EPA hereby provides notice that it is granting a project waiver to the County for the acquisition of the GE Jenbacher Austrian manufactured biogas engine generator set. The manufacturer is GE Water & Process Technologies Company.

Section 1605 of the ARRA requires that none of the appropriated funds may be used for the construction, alteration, maintenance, or repair of a public building or public work unless all of the iron, steel, and manufactured good use in the project are produced in the United States, unless a waiver is provided to the recipient by the EPA. A waiver may be provided if EPA determines that (1) Applying these requirements would be inconsistent with the public interest; (2) iron, steel, and the relevant manufactured goods are not produced in the United States in sufficient and reasonably available quantities and of a satisfactory quality; or (3) iron, steel and the relevant manufactured goods produced in the United States will increase the cost of the overall project by more than 25 percent.

The County's Department of Water Resources proposes to construct the F. Wayne Hill Water Resources Center (WRC) Digester Gas to Energy Project. This project would permit a renewable energy source for use by the project and the nearby wastewater treatment plant (WWTP). The project intends to convert previously flared anaerobic digester gas to electricity and heat for plant operations. The County proposes to use a General Electric (GE) Jenbacher JMS 616, 2147 kilowatts gas engine to convert digester gas to electrical and thermal energy with the recapture of the heat from the engine-generator in a combined heat and power (CHP) design. Electrical energy generated by the CHP system will reduce the utility needs of the WRC by an estimated thirty (30) percent, partially replacing grid purchased electricity. Thermal energy from the CHP system will be beneficially utilized to maintain the optimum temperature in the anaerobic digestion process now performed by natural gas boilers. The County's specifications require that the design rating of the biogas engine generator be sized to utilize as much of the WRC's available biogas as possible. The application states that based on this requirement, the engine generator set to be supplied must be rated for a power output in excess of 2000 kw. Also, to maximize the utilization of the Center's available biogas, the engine generator

must be capable of utilizing a blended fuel mixture of petroleum derived gas and biogas in order to be capable of operating continuously between the specified range of methane gas production (varying between 400 SCFM and 700 SCFM). This variable blending fuel capacity feature is known as ''blend-on-the fly.''

The County's Department of Water Resources has requested a waiver from the Buy American provision for the purchase of a GE Jenbacher JMS 616, 2147 kilowatts gas engine set manufactured in Jenbach, Austria. The project specifications provided listed manufacturers for the project, and the prospective bidders consulted with multiple suppliers. All of the prospective bidders provided alternative pricing for a Caterpillar G3520C DM 5860, 1600kw/12.47V low BTU gas cogeneration system assembled in Mapelton, IL. Upon evaluation of the domestic manufacturer's product, the county determined that a single Caterpillar unit could not produce excess of 2000kw that could operate continuously over the specified range (as low as 400 SCFM and as high as 700 SCFM). The Caterpillar unit is rated at 1600kw and also has no blending capabilities.

The application also states that the Caterpillar unit is not able to run continuously due to its inability to ''blend-on-the-fly'' until the influent flow of a facility is in excess of approximately 50 million gallons per day (MGD). Above 50 MGD, the gas would have to be stored to burn at a later time. If the gas storage tanks are full, the gas would be burned through the flairs. Conversely, the GE Jenbacher gas engine generator can utilize the full range of gas production quantities by operating at reduced engine speeds with a variable speed drive or by operating at the full engine speed-supplementing the low BTU digester gas with natural gas provided by the gas utility to provide the greatest electrical output. This ''blend-on-the-fly'' technology beneficially utilizes the full amount of available gas, allowing for continuous operations through periods of variable digester gas production. Therefore, the GE Jenbacher gas engine can still be run during periods of low digester gas production to reduce utility fed electricity usage during peak consumption periods. Continuous operation of the engine-generator will also provide a contant heat source to meet the digester's process heating requirement, thereby eliminating the need for natural gas boilers. These boilers would still be required with the Caterpillar gas engine generator. Thus, the Caterpillar unit is neither as efficient nor is it otherwise of a satisfactory quality to meet the specifications of the project.

The functional requirement to maximize biogas use is clearly essential to the objective of substantially increasing the energy efficiency of the facility and turning the current environmental detriment of flaring methane, a particularly potent greenhouse gas, into an energy asset. By doing so, the project has also qualified for the ARRA Green Project Reserve, which is a high priority ARRA objective for SRF funded projects. Requiring a less efficient product would be inconsistent with the explicit and specific intent of Congress to achieve greater energy efficiency as stated in the SRF specific 20% Green Project Reserve requirements of Title VII of the ARRA. The County's submission clearly articulates entirely functional reasons for its technical specifications, and has provided sufficient documentation that the relevant manufactured goods are not produced in the United States in sufficient and reasonably available quantity and of a satisfactory quality to meet its technical requirements and specifications.

The April 28, 2009 EPA Headquarters Memorandum, ''Implementation of Buy American provisions of Public Law 111–5, the American Recovery and Reinvestment Act of 2009,'' defines ''satisfactory quality'' as ''the quality of steel, iron or manufactured goods specified in the project plans and designs.''

EPA's national contractor prepared a technical assessment report dated August 14, 2009 based on the submitted waiver request. The report determined that the waiver request submittal was complete, that adequate technical information was provided, and that there were no weaknesses in the justification provided. The report confirmed the waiver applicant's claim that there are no comparable domestic products that can meet both the power output of the engine generator and the dual fuel capability needed for the project.

Furthermore, the purpose of the ARRA is to stimulate economic recovery in part by funding current infrastructure construction, not to delay projects that are ready to proceed. Approval of the waiver would permit construction to promptly proceed with positive economic benefits to the County in the form of jobs and related services and materials which would aid the economic recovery.

The Region 4 Grants and Infrastructure Branch has reviewed this waiver request and has determined that the supporting documentation provided by the County is sufficient to meet the criteria listed under ARRA Section 1605(b), OMB's regulation at 2 CFR 176.100 and the aforementioned EPA Headquarters Memorandum of April 28, 2009. ARRA Section 1605(b) (2) permits a waiver if ''Iron, steel, and manufactured goods are not produced in the United States in sufficient and reasonably available quantities and of a satisfactory quality.'' Based on the information provided to EPA from the County, and to the best of our knowledge at the time of the review, there does not appear to be any biogas engine generator set currently manufactured in the United States available to meet the County's specifications and requirements. Therefore, this waiver request meets the applicable criteria and is justified.

The Administrator's March 31, 2009, delegation of authority memorandum provided acting Regional Administrators with the authority to issue exceptions to Section 1605 of ARRA within the geographic boundaries of their respective regions and with respect to requests by individual grant recipients. Having established both a proper basis to specify the particular good required for this project, and that this manufactured good was not available from a producer in the United States, the Gwinnett County, Georgia, Department of Water Resources is granted a waiver from the Buy American requirements of Section 1605(a) of Public Law 111–5 for the purchase of a anaerobic digester gas-fueled engine generator set specified as GE Jenbacher JMS 616, 2147 kilowatts for application in a combined heat and power system as specified in the County's request of July 22, 2009, with supplemental information. This supplementary information constitutes the detailed written justification required by Section 1605(c) for waivers ''based on a finding under subsection 9b.''

Authority: Public Law 111–5, section 1605.

Dated: October 7, 2009.

J. Scott Gordon,

Acting Regional Administrator, Region 4.

[FR Doc. E9–28293 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–8984–1]

Notice of a Project Waiver of Section 1605 (Buy American requirement) of the American Recovery and Reinvestment Act of 2009 (ARRA) to the Johnston County Department of Public Utilities (the County), North

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Acting Regional Administrator of EPA Region 4 is hereby granting a waiver of the Buy America requirements of ARRA Section 1605 under the authority of Section 1605(b)(2) (manufactured goods are not produced in the United States in sufficient and reasonably available quantities and of a satisfactory quality) to the County for the purchase of resin beads (MIEX® DOC Resin) supplied by Orica Ltd, in Victoria, Australia and manufactured in Australia. The applicant indicates that MIEX® DOC Resin is necessary to the MIEX® process, a treatment process evaluated in pilot studies at the County and selected for implementation. The MIEX® DOC Resin is only manufactured in Australia. It is patented and no alternative exists which can be used with the MIEX® process. The Acting Regional Administrator is making this determination based on the review and recommendations of the Grants and SRF Section. The County has provided sufficient documentation to support their request.

DATES: *Effective Date:* October 1, 2009.

FOR FURTHER INFORMATION CONTACT: Ed Springer, Chief, Grants and SRF Section, Water Protection Division (WPD), (404) 562–8410, U.S. EPA Region 4,61 Forsyth St. SW, Atlanta, GA 30303.

SUPPLEMENTARY INFORMATION: In accordance with ARRA Section 1605(c), the EPA hereby provides notice that it is granting a project waiver of the requirements of Section 1605(b)(2) of Public Law 111–5, Buy American requirements, to the County for the acquisition of resin beads (MIEX® DOC Resin) supplied by Orica Ltd, in Victoria, Australia and manufactured in Australia. The applicant indicates that MIEX® DOC Resin is necessary to the MIEX® process, a treatment process evaluated in pilot studies at the County and selected for use. The MIEX® DOC Resin is only manufactured in Australia. It is patented and no alternative exists which can be used with the MIEX® process. Section 1605 of the ARRA requires that none of the appropriated funds may be used for the construction, alteration, maintenance, or repair of a public building or public work unless all of the iron, steel, and manufactured goods used in the project is produced in the United States unless a waiver is provided to the recipient by EPA. A waiver may be provided if EPA determines that (1) applying these requirements would be inconsistent with public interest; (2) iron, steel, and the relevant manufactured goods are not produced in the United States in sufficient and reasonably available quantities and of a satisfactory quality; or (3) inclusion of iron, steel, and the relevant manufactured goods produced in the United States will increase the cost of the overall project by more than 25 percent.

In order to meet the new Long Term II Surface Water Treatment Rule and Stage 2 Disinfection By-Product Rule under the Safe Drinking Water Act, the County will be required to reduce the levels of dissolved organic carbon (DOC)—a disinfection byproduct precursor of regulatory concern—from its source water supply. In 2007, the County commissioned their engineer to conduct a treatability testing program to evaluate treatment technologies for removing DOC from the County's source water supply. The treatability testing program evaluated powdered activated carbon, granular activated carbon, and the MIEX® process/resin for DOC removal. The 2007 treatability study summarized a previous treatability testing program conducted for the County in 2000, which concluded that physical/chemical treatments (*i.e.,* conversion of chlorine disinfection to chloramines, alternative coagulants with enhanced clarification, dissolved air flotation and membrane treatment [using submerged low pressure membranes]) would be ineffective in meeting required treatment levels. The 2007 treatability testing program selected the MIEX® process/resin to meet the County's treatment requirements.

Further, the County's waiver request states that ''[t]he Public Water Supply Section, Division of Environmental Health, N.C. Department of Environment and Natural Resources has reviewed the report and subsequent design and approved the project.'' Approval of a public water system's compliance technology by the primary regulatory enforcement agency of a State is a crucial prerequisite to initiation of a drinking water infrastructure project to comply with a National Primary Drinking Water Standard. Given this approval and in light of the outcome of the treatability testing program, the County did not have a basis to use a practicable alternative compliance technology within the ARRA time requirements for SRF projects to be under contract or construction by February 17, 2010.

The County's submission clearly articulates entirely reasonable reasons for choosing the type of technology that it chose for this project and has provided sufficient documentation that the relevant manufactured goods are not produced in the United States in sufficient and reasonably available quantity and of a satisfactory quality to meet its technical specifications.

The April 28, 2009 EPA HQ Memorandum, Implementation of Buy American provisions of Public Law 111–5, the ''American Recovery and Reinvestment Act of 2009'', defines ''reasonably available quantity'' as the quantity of iron, steel, or relevant manufactured good is available or will be available at the time needed and place needed, and in the proper form or specification as specified in the project plans and design. The County has incorporated specific technical design features for the proposed project based on pilot studies which demonstrated MIEX® treatment is the best alternative.

The County has provided information to the EPA representing that there are currently no resin beads manufactured in the United States that have the exact same product specifications in place. The County has also provided certification from its supplier representing that there are no beads of comparable quality available from a domestic manufacturer to meet its exact specifications. Based on additional research by EPA's consulting contractor (Cadmus), and to the best of the Region's knowledge at this time, there do not appear to be other resin beads available to meet the County's specifications.

Furthermore, the purpose of the ARRA provisions was to stimulate economic recovery by funding current infrastructure construction, not to delay projects that are already shovel ready by requiring entities, like the County, to revise their design and potentially choose a more costly and less efficient project. The imposition of ARRA Buy American requirements on such projects eligible for DWSRF assistance would result in unreasonable delay and thus displace the ''shovel ready'' status for this project. To further delay construction is in direct conflict with the most fundamental economic purposes of ARRA: to create or retain jobs.

The Grants and SRF Section has reviewed this waiver request and has determined that the supporting documentation provided by the County is sufficient to meet the following criteria listed under Section 1605(b) and in the April 28, 2009, Implementation of Buy American provisions of Public Law 111–5, the ''American Recovery and Reinvestment Act of 2009'' Memorandum: Iron, steel, and the manufactured goods are not produced in the United States in sufficient and reasonably available quantities and of a satisfactory quality. The basis for this project waiver is the authorization provided in Section 1605(b)(2), due to the lack of production of this product in the United States in sufficient and reasonably available quantities and of a satisfactory quality in order to meet the County's design specifications. The March 31, 2009 Delegation of Authority Memorandum provided Regional Administrators with the authority to issue exceptions to Section 1605 of ARRA within the geographic boundaries of their respective regions and with respect to requests by individual grant recipients.

Having established both a proper basis to specify the particular good required for this project, and that this manufactured good was not available from a producer in the United States, the County is hereby granted a waiver from the Buy American requirements of Section 1605(a) of Public Law 111–5 for the purchase of resin beads (MIEX® DOC Resin) supplied by Orica Ltd, in Victoria, Australia and manufactured in Australia as specified in the County's request of June 26, 2009. This supplementary information constitutes the detailed written justification required by Section 1605(c) for waivers based on a finding under subsection (b).

Authority: Public Law 111–5, section 1605.

Dated: October 7, 2009.

J. Scott Gordan,

Acting Regional Administrator, Region 4.

[FR Doc. E9–28291 Filed 11–24–09; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL MARITIME COMMISSION

Notice of Agreement Filed

The Commission hereby gives notice of the filing of the following agreement under the Shipping Act of 1984. Interested parties may submit comments on the agreement to the Secretary, Federal Maritime Commission, Washington, DC 20573, within ten days of the date this notice appears in the **Federal Register**. A copy of the agreement is available through the Commission's Web site (*http://www.fmc.gov*) or by contacting the Office of Agreements at (202)–523–5793 or *tradeanalysis@fmc.gov.*

Agreement No.: 011775–002.

Title: NYK/WWL South America Space Charter Agreement.

Parties: Nippon Yusen Kaisha (''NYK'') and Wallenius Wilhelmsen Lines AS (''WWL'').

Filing Party: Wayne R. Rohde, Esq.; Sher & Blackwell LLP; 1850 M Street, NW.; Suite 900; Washington, DC 20036.

Synopsis: The amendment deletes the U.S. Pacific Coast, Alaska and Hawaii from the geographic scope of the agreement, and authorizes the parties to discuss and agree on the operation of two vessel loops.

Dated: November 20, 2009.

By Order of the Federal Maritime Commission.

Karen V. Gregory,

Secretary.

[FR Doc. E9–28262 Filed 11–24–09; 8:45 am]

BILLING CODE 6730–01–P

FEDERAL MARITIME COMMISSION

Ocean Transportation Intermediary License Applicants

Notice is hereby given that the following applicants have filed with the Federal Maritime Commission an application for license as a Non-Vessel-Operating Common Carrier and Ocean Freight Forwarder—Ocean Transportation Intermediary pursuant to section 19 of the Shipping Act of 1984 as amended (46 U.S.C. Chapter 409 and 46 CFR part 515).

Persons knowing of any reason why the following applicants should not receive a license are requested to contact the Office of Transportation Intermediaries, Federal Maritime Commission, Washington, DC 20573.

Non-Vessel-Operating Common Carrier Ocean Transportation Intermediary Applicants

Emarat Shipping Inc., 1106 S Technology Cir., Anaheim, CA 92805. *Officer:* Tareq K. Elbarq, President (Qualifying Individual).

New Pacific Alliance, Inc., 15117 S. Broadway Street, Gardena, CA 90248. *Officer:* Danny Kim, CEO (Qualifying Individual).

Daystar Global Solutions, Inc., 100 Wallace Ave., Ste. 207, Sarasota, FL 34237. *Officer:* Jennifer Chung, President (Qualifying Individual).

All Transport Worldwide, Corp., 2816 Timothy Ave., Redondo Beach, CA 90278. *Officer:* Andres J. Villablanca, CEO (Qualifying Individual).

Non-Vessel-Operating Common Carrier and Ocean Freight Forwarder Transportation Intermediary Applicants

Eagle Transportation, LLC, 63 Ninety Eight Place Blvd., Hattiesburg, MS 39402. *Officers:* Maria Hurtado, Account Executive (Qualifying Individual), Ronnie Sharpe, President.

U.S. Xpress, Inc. dba Xpress Network Solutions, 4080 Jenkins Road, Chattanooga, TN 37421. *Officer:* Christine M. Geror, Freight Forwarding Agent (Qualifying Individual).

Mariam International Ltd. Co. dba Liberty Logistics, 939 Poydras Street, Sugarland, TX 77498. *Officers:* Teresa L. Roberson, Vice President (Qualifying Individual), Suhail Sharief, President.

Ghanem Forwarding, LLC, 1 N Charles Street, Ste. 1200, Baltimore, MD 21201. *Officer:* Wael Ghanem, General Manager (Qualifying Individual).

Triton Overseas Transport, Inc., 3340 Greens Rd., Bldg. A, Ste. 410, Houston, TX 77032. *Officer:* William R. Onorato, President (Qualifying Individual).

Ocean Freight Forwarder—Ocean Transportation Intermediary Applicants

ITT Forwarding, Inc., 2537 S. Gessner, Suite 108, Houston, TX 77063. *Officers:* Edward Schmidt, Vice President (Qualifying Individual), Jon Hulsey, President.

Preferred Movers International, LLC, 49 Forbus Drive, Crossville, TN 38555. *Officers:* Johnny Simon, Vice President (Qualifying Individual), Robert G. Krumpols, President.

Dated: November 20, 2009.

Karen V. Gregory,

Secretary.

[FR Doc. E9–28263 Filed 11–24–09; 8:45 am]

BILLING CODE 6730–01–P

FEDERAL MARITIME COMMISSION

Ocean Transportation Intermediary License Revocations

The Federal Maritime Commission hereby gives notice that the following Ocean Transportation Intermediary licenses have been revoked pursuant to section 19 of the Shipping Act of 1984 (46 U.S.C. Chapter 409) and the regulations of the Commission pertaining to the licensing of Ocean Transportation Intermediaries, 46 CFR

Part 515, effective on the corresponding date shown below:

License Number: 018630N.
Name: American International Shipping Company.
Address: 7 Emily Road, Manalapan, NJ 07726.
Date Revoked: November 7, 2009.
Reason: Failed to maintain a valid bond.

License Number: 014160N.
Name: Cargo Logistics Inc.
Address: 186 Sherman Ave., P.O. Box 186, Glenridge, NJ 07028.
Date Revoked: October 21, 2009.
Reason: Failed to maintain a valid bond.

License Number: 004411N.
Name: Debbie D. Sukhai-Sheffield DBA S & S Enterprises.
Address: 4463 Niobe Circle, Rancho Cordova, CA 95742.
Date Revoked: October 30, 2009.
Reason: Failed to maintain a valid bond.

License Number: 020146N.
Name: Global Carrier Alliance Corp.
Address: 1880 Century Park East, Ste. 900, Los Angeles, CA 90067.
Date Revoked: October 28, 2009.
Reason: Failed to maintain a valid bond.

License Number: 018084F.
Name: Go-Trans (North America) Inc.
Address: 147–32 Farmers Blvd., 2nd Floor, Jamaica, NY 11434.
Date Revoked: August 22, 2009.
Reason: Failed to maintain a valid bond.

License Number: 019788N.
Name: Miriam Family Cargo, Inc.
Address: 18 NW 12th Ave., Miami, FL 33128.
Date Revoked: October 22, 2009.
Reason: Failed to maintain a valid bond.

Sandra L. Kusumoto,
Director, Bureau of Certification and Licensing.
[FR Doc. E9–28265 Filed 11–24–09; 8:45 am]
BILLING CODE 6730–01–P

FEDERAL MARITIME COMMISSION

Ocean Transportation Intermediary License; Reissuance

Notice is hereby given that the following Ocean Transportation Intermediary license has been reissued by the Federal Maritime Commission pursuant to section 19 of the Shipping Act of 1984 (46 U.S.C. Chapter 409) and the regulations of the Commission pertaining to the licensing of Ocean Transportation Intermediaries, 46 CFR Part 515.

License No.	Name/address	Date reissued
020295NF	Yavid Corporation, 10913 NW. 30th Street, #103, Doral, FL 33172.	September 17, 2009.

Sandra L. Kusumoto,
Director, Bureau of Certification and Licensing.
[FR Doc. E9–28264 Filed 11–24–09; 8:45 am]
BILLING CODE 6730–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Announcement of Meeting of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020

AGENCY: Department of Health and Human Services, Office of the Secretary, Office of Public Health and Science, Office of Disease Prevention and Health Promotion.

ACTION: Notice of meeting.

Authority: 42 U.S.C. 217a, Section 222 of the Public Health Service Act, as amended. The Committee is governed by the provision of Public Law 92–463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

SUMMARY: The U.S. Department of Health and Human Services (HHS) announces the next federal advisory committee meeting regarding the national health promotion and disease prevention objectives for 2020. This meeting will be open to the public and will be held online via WebEx software. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 will address efforts to develop the nation's health promotion and disease prevention objectives and strategies to improve the health status and reduce health risks for Americans by the year 2020. The Committee will provide to the Secretary of Health and Human Services advice and consultation for developing and implementing the next iteration of national health promotion and disease prevention goals and objectives and provide recommendations for initiatives to occur during the initial implementation phase of the goals and objectives. HHS will use the recommendations to inform the development of the national health promotion and disease prevention objectives for 2020 and the process for implementing the objectives. The intent is to develop and launch objectives designed to improve the health status and reduce health risks for Americans by the year 2020.

DATES: The Committee will meet on December 11, 2009 from 1:30 p.m. to 4:30 p.m. Eastern Standard Time (EST).

ADDRESSES: The meeting will be held online, via WebEx software. For detailed instructions about how to make sure that your windows computer and browser is set up for WebEx, please visit the ''Secretary's Advisory Committee'' Web page of the Healthy People Web site at: *http://www.healthypeople.gov/hp2020/advisory/default.asp.*

FOR FURTHER INFORMATION CONTACT: Emmeline Ochiai, Designated Federal Officer, Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Disease Prevention and Health Promotion, 1101 Wootton Parkway, Room LL–100, Rockville, MD 20852, (240) 453–8259 (telephone), (240) 453–8281 (fax). Additional information is available on the Internet at *http://www.healthypeople.gov.*

SUPPLEMENTARY INFORMATION:

Purpose of Meeting: Every 10 years, through the Healthy People initiative, HHS leverages scientific insights and lessons from the past decade, along with the new knowledge of current data, trends, and innovations to develop the next iteration of national health promotion and disease prevention objectives. Healthy People provides science-based, 10-year national objectives for promoting health and preventing disease. Since 1979, Healthy People has set and monitored national health objectives to meet a broad range of health needs, encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of our prevention and health promotion activities. Healthy People

2020 will reflect assessments of major risks to health and wellness, changing public health priorities, and emerging issues related to our nation's health preparedness and prevention.

Public Participation at Meeting: Members of the public are invited to listen to the online Committee meeting. There will be no opportunity for oral public comments during the online Committee meeting. Written comments, however, are welcome throughout the development process of the national health promotion and disease prevention objectives for 2020. They can be submitted through the Healthy People Web site at: *http://www.healthypeople.gov/hp2020/comments/* or they can be e-mailed to *HP2020@hhs.gov*.

To listen to the Committee meeting, individuals must pre-register to attend at the Healthy People Web site located at *http://www.healthypeople.gov.* Participation in the meeting is limited. Registrations will be accepted until maximum WebEx capacity is reached and must be completed by 9 a.m. EST on December 11, 2009. A waiting list will be maintained should registrations exceed WebEx capacity. Individuals on the waiting list will be contacted as additional space for the meeting becomes available.

Registration questions may be directed to Hilary Scherer at *HP2020@norc.org* (e-mail), (301) 634–9374 (phone) or (301) 634–9301 (fax).

Dated: November 18, 2009.

Penelope Slade-Sawyer,

RADM, USPHS, Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion).

[FR Doc. E9–28320 Filed 11–24–09; 8:45 am]

BILLING CODE 4150–32–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: ''Spreading Techniques to Radically Reduce Antibiotic Resistant Bacteria (Methicillin Resistant Staphylococcus aureus, or MRSA).'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 350 1–3520, AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by January 25, 2010.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by e-mail at *doris.lefkowitz@AHRQ.hhs.gov.*

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by e-mail at *doris.lefkowitz@AHRQ.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

Spreading Techniques To Radically Reduce Antibiotic Resistant Bacteria (Methicillin Resistant Staphylococcus aureus, or MRSA)

Healthcare Acquired Infections (HAIs) caused almost 100,000 deaths among the 2.1 million people who acquired infections while hospitalized in 2000, and HAI rates have risen relentlessly since then. Alarmingly, 70% of HATs are due to bacteria that are resistant to commonly used antibiotics, with Methicillin Resistant Staphylococcus aureus (MRSA) being the most rapidly growing, and among the most virulent, pathogens. Resistance is increasing rapidly in all types of hospitals (Huang 2007). Despite evidence that routinely applied, simple interventions do work, most hospitals have failed to make notable progress in reducing MRSA infections. Hospitals in some European countries and select U.S. hospitals, however, have succeeded with impressive results.

Sites that have already achieved dramatic decreases in their MRSA infection rates have done so by implementing precautions to prevent transmission, using system redesign approaches. Further, many hospitals have successfully instituted isolation procedures for patients suspected to be MRSA carriers. In doing so, these hospitals have followed the broadly disseminated guidelines for hand hygiene and contact isolation precautions. This study is a follow up to a recent study implemented in 6 hospital systems in the Indianapolis metropolitan area that used a ''MRSA intervention bundle'' composed of active surveillance screening, contact isolation precautions, and increased hand hygiene. Preliminary data from that initial study suggest a 60% decrease in MRSA rates in participating intensive care units (ICUs) (Doebbeling, B. Redesigning Hospital Care for Quality and Efficiency Applications of Positive Deviance and Lean in Reducing MRSA. Presentation at AHRQ Annual Meeting, Rockville, MD, Sept 2009).

This study is designed to further test this intervention bundle in non-ICU settings in hospitals currently using the intervention bundle in their ICUs, as well as in additional ICUs in newly recruited hospital systems. This project will utilize the same guidelines and precautions that were applied in the original study, and will add an innovative feature that will use electronic medical record systems to improve identifying, communicating and tracking MRSA infections among healthcare systems. More specifically, this study has five aims:

(1) Further test the ''MRSA intervention bundle'' from the original Indianapolis MRSA study, and test the intervention in additional units in the 4 original Indianapolis hospital systems and an additional 3 hospital systems beyond Indianapolis;

(2) Identify and monitor healthcare associated community onset (HACO) MRSA cases and controls who receive care in participating hospitals and affiliated settings, identify strategies to reduce HACO MRSA and demonstrate reduction of HACO MRSA;

(3) Assess the relative effectiveness of various antibiotics in abatement or eradication of MRSA carriage in hospital patients;

(4) Evaluate the effectiveness of the tested implementation strategies and innovations by applying information technology to enable consistent collection, sharing, analysis and reporting of data;

(5) Disseminate findings and promote outreach to target audiences and other stakeholders.

While many secondary data are available for this study, Aims 1 and 2 involve primary data collection. Use of the intervention bundle requires that opinion leaders and front line workers be equipped with techniques used in the reorganization of healthcare delivery to improve health outcomes (Singhal and Greiner, 2007; IHI, 2005). These techniques will assist in identifying goals, implementing the interventions to meet local needs and measuring and feeding back progress on key processes and outcomes to staff and others.

The study also incorporates an additional informatics surveillance system to allow participating hospitals to more efficiently communicate, share and track MRSA infections. This system will save infection control and clinicians' time—for example, by electronically identifying patients with a known history of drug-resistant infections when they first contact a new institution.

This study is being conducted by AHRQ through its contractor, Indiana University and the Regenstrief Institute, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(l) and (2).

Method of Collection

There will be 3 types of data collection to support the study Aims:

- Electronic medical record data on MRSA infections and rates will be collected from an existing and unique healthcare information exchange (Indiana Network for Patient Care or INPC) in the Indianapolis area, and the CDC's National Healthcare Safety Network (Aims 1–5).
- Data on hand washing, swabbing, and isolation rates will be collected by observation (Aims 1, 2, and 4).
- Four surveys will be conducted: A brief Social Network Analysis (SNA), a Cultural Survey, a Patient Healthcare Use survey, and an Implementation Assessment of key informants (Aims 1, 4, and 5).

The social network analysis questionnaire (SNA) (Wasserman *et al.*, 1994) will be administered to understand with whom hospital personnel work, how hospital networks mature over time and how information is shared. Additionally, cultural beliefs, attitudes, and knowledge will be captured by surveying staff on intervention units of participating hospitals using a cultural questionnaire. To compare changes in the network and cultural beliefs, both the SNA and the cultural questionnaire will be administered to staff at baseline and again one year later. These data will be collected from a sample of staff in the intervention units. Project team leaders will select relevant staff regularly working and providing patient care or direct patient services on the unit in a purposive sample. These staff will receive the paper-based questionnaires during staff meetings and will return them anonymously. A study ID will serve to determine which staff has responded and allow linkage of baseline and follow-up surveys.

The implementation assessment will be an interview obtained quarterly to key informants at each organization to assess the approaches to implementation of the program (*e.g.*, dose, intensity, leadership support, teamwork, etc). This assessment will be a short (10–12) item questionnaire.

Additionally, to better understand the healthcare associated community acquired aspect of MRSA transmission, 200 patients will be surveyed to gather risk factors and healthcare use statistics that we have found in preliminary studies are not otherwise available in electronic databases or medical records.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours associated with the hospital's time to participate in this research. Electronic medical record data will be collected weekly from 7 participating hospitals, however only two of these hospitals will use their staff to perform this data collection. Over the course of the project electronic medical record data will be extracted 52 times and each data extraction will take about 10 hours. Observational data will be collected weekly from all participating hospitals, however only 3 hospitals will use their staff to perform the observations. The project will require 52 observations per hospital and are estimated to take about 3 hours to perform.

Both the social network analysis questionnaire and the culture questionnaire will be administered twice, pretest and posttest, to about 75 personnel at each of the 7 hospitals. The social network analysis questionnaire will take about 15 minutes to complete while the culture questionnaire will take 30 minutes. The implementation assessment questionnaire will be administered quarterly to 3 key informants at each hospital and will take about one hour.

The patient healthcare use questionnaire will be completed by 200 patients sampled from the 7 participating hospitals. Each patient will respond once which will require about 15 minutes. The total annualized burden hours for all the associated data collections are estimated to be 2,430. Exhibit 2 shows the estimated annualized cost burden associated with the respondents' time to participate in this research. The total annual cost burden is estimated to be $76,118.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of hospitals	Numer of responses per hospital	Hours per response	Total burden hours
Electronic Medical Record Data Collection	2	52	10	1,040
Observational Data Collection	3	52	3	468
Social Network Analysis Questionnaire	7	150	15/60	263
Culture Questionnaire	7	150	30/60	525
Implementation Assessment Questionnaire	7	12	1	84
Patient Healthcare Use Questionnaire	200	1	15/60	50
Total	226	na	na	2,430

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of hospitals	Total burden hours	Average hourly wate rate*	Total cost burden
Electronic Medical Record Data Collection	2	1040	$30.03	$31,231
Observational Data Collection	3	468	$20.98	9,819
Social Network Analysis Questionnaire	7	263	$38.28	10,068

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN—Continued

Form name	Number of hospitals	Total burden hours	Average hourly wate rate*	Total cost burden
Culture Questionnaire	7	525	$38.28	$20,097
Implementation Assessment Questionnaire	7	84	$45.33	$3,808
Patient Healthcare Use Questionnaire	200	50	$21.90	$1,095
Total	226	2,430	na	$76,118

*Based upon the mean of the average wages for Nursing Care Providers ($30.03), Primary Care Physicians ($84.97), Allied Health Providers ($20.98), Administrators, Chief Executives ($76.23) and All Workers ($21.90); National Compensation Survey: Occupational wages in the United States May 2008, ''U.S. Department of Labor, Bureau of Labor Statistics.''

Estimated Annual Costs to the Federal Government

Exhibit 3 shows the total and annualized cost of this project to the Federal Government over a two-year period. The total cost of this project is $1.8 million dollars which includes $785,000 for project development, $70,000 for data collection activities, $235,000 for data analysis, $125,000 for publication of the results, $170,000 for project management and $415,000 for overhead costs.

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

Cost component	Total cost	Annualized cost
Project Development	$785,000	$262,000
Data Collection Activities	$70,000	$35,000
Data Processing and Analysis	$235,000	$78,000
Publication of Results	$125,000	$125,000
Project Management	$170,000	$57,000
Overhead	$415,000	$138,000
Total	$1,800,000	$900,000

Request for Comments

In accordance with the above-cited Paperwork Reduction Act legislation, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ healthcare research and healthcare information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: November 16, 2009.

Carolyn M. Clancy,

Director.

[FR Doc. E9–28211 Filed 11–24–09; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2008–D–0413]

Guidance for Industry on Residual Solvents in Drug Products Marketed in the United States; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a guidance for industry entitled ''Residual Solvents in Drug Products Marketed in the United States.'' On July 1, 2008, the United States Pharmacopeia (USP) published a new test requirement for the control of residual solvents, General Chapter <467> ''Residual Solvents,'' which replaced USP General Chapter <467> ''Organic Volatile Impurities.'' The change affects all compendial drug products marketed in the United States. This guidance reflects FDA's recommendations on how to comply with those USP changes.

DATES: Submit written or electronic comments on agency guidances at any time.

ADDRESSES: Submit written requests for single copies of the guidance to the Division of Drug Information, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, rm. 2201, Silver Spring, MD 20993–0002. Send one self-addressed adhesive label to assist that office in processing your requests. Submit written comments on the guidance to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to *http://www.regulations.gov* . See the **SUPPLEMENTARY INFORMATION** section for electronic access to the guidance document.

FOR FURTHER INFORMATION CONTACT: Chris Watts, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, rm. 4142 Silver Spring, MD 20993–0002, 301–796–1625.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a guidance for industry entitled ''Residual Solvents in Drug Products Marketed in the United States.'' On August 7, 2008 (73 FR 46020), FDA announced the availability of the draft version of this guidance. The public comment period closed on October 6, 2008. A number of comments were received, which the agency considered carefully as it finalized the guidance. In response to the comments, FDA made appropriate changes. The guidance provides information on how new drug application (NDA) and abbreviated new drug application (ANDA) applicants for noncompendial drug products should limit residual solvents as described in the International Conference on Harmonisation guidance for industry ''Q3C Impurities: Residual Solvents;'' how manufacturers of compendial drug products that are not marketed under an approved NDA or ANDA can comply with the new General Chapter <467> and the Federal Food, Drug, and Cosmetic Act; and how holders of NDAs or ANDAs for compendial drug products should report changes in chemistry, manufacturing, and controls specifications to FDA to comply with the USP General Chapter <467> ''Residual Solvents'' and § 314.70 (21 CFR 314.70).

This guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The guidance represents the agency's current thinking on USP General Chapter <467> ''Residual Solvents.'' It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. The Paperwork Reduction Act of 1995

This guidance refers to previously approved collections of information found in FDA regulations. These collections of information are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). Information submitted in the chemistry, manufacturing, and controls section of an application under 21 CFR 314.50(d)(1), as well as in amendments to pending applications under 21 CFR 314.60, is approved by OMB under Control Number 0910–0001. Information submitted in an annual report under § 314.70(d)(2)(i) and (d)(3) is approved by OMB under Control Number 0910–0001. Recordkeeping required under 21 CFR 211.165(e) and 211.194(a)(2) is approved by OMB under Control Number 0910–0139.

III. Comments

Interested persons may submit to the Division of Dockets Management (see **ADDRESSES**) written or electronic comments regarding this document. Submit a single copy of electronic comments or two paper copies of any mailed comments, except that individuals may submit one paper copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

IV. Electronic Access

Persons with access to the Internet may obtain the document at either *http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm* or *http://www.regulations.gov*.

Dated: November 19, 2009.

David Horowitz,

Assistant Commissioner for Policy.

[FR Doc. E9–28247 Filed 11–24–09; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Cancer Advisory Board, November 30, 2009, 6:30 p.m. to December 2, 2009, 12 p.m., National Institutes of Health, Building 31, 31 Center Drive, 10, Bethesda, MD, 20892 which was published in the **Federal Register** on November 4, 2009, 74FR57182.

This **Federal Register** Notice is being amended to reflect the change in the start and end times of the closed session on December 1, 2009 to 3:45 p.m. to 4:30 p.m.

Dated: November 19, 2009.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E9–28279 Filed 11–24–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Meeting

Pursuant to section 10(a) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of a meeting of the National Institutes of Health Peer Review Advisory Committee.

The meeting will be open to the public, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

Name of Committee: National Institutes of Health Peer Review Advisory Committee.

Date: February 1, 2010.

Time: 8 a.m. to 5 p.m.

Agenda: Provide technical and scientific advice and recommendations to the NIH Director, the Deputy Director for Extramural Research, and the Director of the Center for Scientific Review (CSR) on all procedures and policies related to the process of peer review by which the scientific and technical merit of NIH grant applications is assessed.

Place: Bethesda North Marriott Hotel & Conference Center, Montgomery County Conference Center Facility, 5701 Marinelli Road, North Bethesda, MD 20852.

Contact Person: Cheryl A. Kitt, PhD, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3030, MSC 7776, Bethesda, MD 20892, 301–435–1112, *kittc@csr.nih.gov*.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: November 17, 2009.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E9–28287 Filed 11–24–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Mental Health; Notice of Meeting

Pursuant to section 10(a) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of an Interagency Autism Coordinating Committee (IACC) meeting.

The purpose of the IACC meeting is to continue discussing recommendations for the annual update of the IACC Strategic Plan for Autism Spectrum Disorders Research. The IACC meeting will be conducted and available to the public via a telephone conference call and a webinar.

Name of Committee: Interagency Autism Coordinating Committee (IACC)

Type of meeting: Open meeting via conference call and webinar only; no in-person meeting.

Date: December 11, 2009.

Time: 9 a.m. to 1 p.m.* Eastern Time—* Approximate end time.

Meeting Registration: No registration is required to listen to the conference call or view the webinar.

Agenda: To continue discussion on recommendations for the annual update of the IACC Strategic Plan for Autism Spectrum Disorder Research.

Webinar: https://www2.gotomeeting.com/register/906979171.

Conference Call Access: Dial: 888–455–2920. Access code: 9984461.

Contact Person: Ms. Lina Perez, Office of Autism Research Coordination, Office of the Director, National Institute of Mental Health, NIH, 6001 Executive Boulevard, NSC, Room 8200, Bethesda, MD 20892–9669, Phone: (301) 443–6040, E-mail: *IACCPublicInquiries@mail.nih.gov*.

Any interested person may submit written comments to the IACC prior to the meeting by sending the statement to the Contact Person listed on this notice by 5 p.m. ET on December 8, 2009. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person. All written statements received by the deadline will be provided to the IACC for their consideration.

The meeting will be open to the public through a conference call phone number and a webinar conducted using a web presentation tool on the Internet. Individuals who participate using this service and who need special assistance, such as captioning of the conference call or other reasonable accommodations, should submit a request to the contact person listed above at least seven days prior to the meeting. If you experience any technical problems with the Web presentation tool or conference call, please e-mail *IACCTechSupport@acclaroresearch.com*.

Members of the public who participate using the conference call phone number will be able to listen to the meeting but will not be heard. This phone call may end prior to or later than 1 p.m., depending on the needs of the Committee.

To access the webinar on the Internet the following computer capabilities are required: (A) Internet Explorer 5.0 or later, Netscape Navigator 6.0 or later or Mozilla Firefox 1.0 or later; (B) Windows® 2000, XP Home, XP Pro, 2003 Server or Vista; (C) Stable 56k, cable modem, ISDN, DSL or better Internet connection; (D) Minimum of Pentium 400 with 256 MB of RAM (Recommended); (E) Java Virtual Machine enabled (Recommended)

This meeting is being published less than 15 days prior to the meeting due to the timing limitations for completing the updating of the Annual Strategic Plan for Autism Spectrum Disorder Research.

Information about the IACC is available on the Web site: *http://www.iacc.hhs.gov*.

Meeting schedule subject to change.

Dated: November 19, 2009.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E9–28284 Filed 11–24–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Arthritis and Musculoskeletal and Skin Diseases; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Arthritis and Musculoskeletal and Skin Diseases Special Emphasis Panel; Clinical Trial Grant Review.

Date: December 8, 2009.

Time: 2 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Eric H. Brown, PhD, Scientific Review Officer, National Institute of Arthritis, Musculoskeletal and Skin Diseases, National Institutes of Health, 6701 Democracy Blvd., Room 824, Msc 4872, Bethesda, MD 20892–4872, (301) 594–4955,*browneri@mail.nih.gov*.

Name of Committee: National Institute of Arthritis and Musculoskeletal and Skin Diseases Special Emphasis Panel; Providing Radiologic Outcomes for the Osteoarthritis Initiative.

Date: December 16, 2009.

Time: 10 a.m. to 11:30 a.m.

Agenda: To review and evaluate contract proposals.

Place: National Institutes of Health, One Democracy Plaza, 6701 Democracy Boulevard, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Charles N. Rafferty, PhD, Chief, Review Branch, National Institute of Arthritis, Musculoskeletal and Skin Diseases, National Institutes of Health, 6701 Democracy Boulevard, Suite 800, Bethesda, MD 20817, 301–534–4952, *raffertycn@mail.nih.gov*.

Name of Committee: National Institute of Arthritis and Musculoskeletal and Skin Diseases Special Emphasis Panel; Clinical Outcome Instrument Development.

Date: January 26, 2010.

Time: 8 a.m. to 1 p.m.

Agenda: To review and evaluate grant applications.

Place: Embassy Suites at the Chevy Chase Pavilion, 4300 Military Road, NW., Washington, DC 20015.

Contact Person: Michael L. Bloom, PhD., MBA, Scientific Review Officer, National Institute of Arthritis, Musculoskeletal and Skin Diseases, National Institutes of Health, 6701 Democracy Blvd.; Room 820, MSC 4872, Bethesda, MD 20892–4872, 301–594–4953, *Michael_Bloom@nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.846, Arthritis, Musculoskeletal and Skin Diseases Research; 93.701, ARRA Related Biomedical Research and Research Support Awards, National Institutes of Health, HHS)

Dated: November 19, 2009.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E9–28289 Filed 11–24–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and

the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Allergy and Infectious Diseases Special Emphasis Panel; Plasmodium Vivax and Malaria Research.

Date: December 16, 2009.

Time: 10:30 a.m. to 12:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6700B Rockledge Drive, Bethesda, MD 20817 (Telephone Conference Call).

Contact Person: Eleazar Cohen, Ph.D., Scientific Review Officer, Scientific Review Program, Division of Extramural Activities, National Institutes of Health, NIAID, 6700B Rockledge Drive, Room 3129, Bethesda, MD 20892, 301–435–3564, *ec17w@nih.gov.*

Name of Committee: National Institute of Allergy and Infectious Diseases Special Emphasis Panel; Innate Immunity.

Date: December 17, 2009.

Time: 12 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6700B Rockledge Drive, Bethesda, MD 20817 (Telephone Conference Call).

Contact Person: Priti Mehrotra, Ph.D., Chief, Immunology Review Branch, Scientific Review Program, DEA/NIAID/NIH/DHHS, 6700B Rockledge Drive, Room 3138, Bethesda, MD 20892–7616, 301–435–9369, *pm158b@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: November 19, 2009.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E9–28286 Filed 11–24–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Member Conflict: Molecular and Cellular Neuroscience.

Date: December 15, 2009.

Time: 2 p.m. to 4 p.m.

*Agenda:*To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892. (Telephone Conference Call).

Contact Person: Jonathan K. Ivins, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4040A, MSC 7806, Bethesda, MD 20892. (301) 594–1245. *ivinsj@csr.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: November 18, 2009.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E9–28276 Filed 11–24–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

Agency Information Collection Activities: Application To Establish a Centralized Examination Station

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: 30-Day notice and request for comments; Extension of an existing information collection: 1651–0061.

SUMMARY: U.S. Customs and Border Protection (CBP) of the Department of Homeland Security has submitted the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act: Application to Establish a Centralized Examination Station (CES). This is a proposed extension and revision of an information collection that was previously approved. CBP is proposing that this information collection be extended with no change to the burden hours. This document is published to obtain comments from the public and affected agencies. This proposed information collection was previously published in the **Federal Register** (74 FR 48280) on September 22, 2009, allowing for a 60-day comment period. This notice allows for an additional 30 days for public comments. This process is conducted in accordance with 5 CFR 1320.10.

DATES: Written comments should be received on or before December 28, 2009.

ADDRESSES: Interested persons are invited to submit written comments on this proposed information collection to the Office of Information and Regulatory Affairs, Office of Management and Budget. Comments should be addressed to the OMB Desk Officer for Customs and Border Protection, Department of Homeland Security, and sent via electronic mail to *oira_submission@omb.eop.gov* or faxed to (202) 395–5806.

SUPPLEMENTARY INFORMATION:

U.S. Customs and Border Protection (CBP) encourages the general public and affected Federal agencies to submit written comments and suggestions on proposed and/or continuing information collection requests pursuant to the Paperwork Reduction Act (Pub. L. 104–13). Your comments should address one of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency/component, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agencies/components 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 collections of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological techniques or other forms of information.

Title: Application to Establish Centralized Examination Station.

OMB Number: 1651–0061.

Form Number: None.

Abstract: If a port director decides his or her port needs a Centralized Examination Station (CES), the port director announces this need to the public and solicits applications to operate a CES. The information contained in the application will be used to determine the suitability of the applicant's facility, the fairness of his

fee structure, his knowledge of cargo handling operations and his knowledge of CBP procedures.

Current Actions: There are no changes to the information collection. This submission is being made to extend the expiration date.

Type of Review: Extension (without change).

Affected Public: Businesses.

Estimated Number of Respondents: 50.

Estimated Number of Annual Responses per Respondent: 1.

Estimated Time per Response: 2 hours.

Estimated Total Annual Burden Hours: 100.

If additional information is required contact: Tracey Denning, U.S. Customs and Border Protection, Office of Regulations and Rulings, 799 9th Street, NW., 7th Floor, Washington, DC 20229–1177, at 202–325–0265.

Dated: November 19, 2009.

Tracey Denning,

Agency Clearance Officer, U.S. Customs and Border Protection.

[FR Doc. E9–28290 Filed 11–24–09; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–1829–DR; Docket ID FEMA–2008–0018]

North Dakota; Amendment No. 7 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster for the State of North Dakota (FEMA–1829–DR), dated March 24, 2009, and related determinations.

DATES: *Effective Date:* November 6, 2009.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Disaster Assistance Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated November 6, 2009, the President amended the cost-sharing arrangements regarding Federal funds provided under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), in a letter to W. Craig Fugate, Administrator, Federal Emergency Management Agency, Department of Homeland Security, under Executive Order 12148, as follows:

I have determined that the damage in certain areas of the State of North Dakota resulting from severe storms and flooding during the period of March 13 to August 10, 2009, is of sufficient severity and magnitude that special cost sharing arrangements are warranted regarding Federal funds provided under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (''the Stafford Act'').

Therefore, I amend my declaration of March 24, 2009, to authorize Federal funds for all categories of Public Assistance at 90 percent of total eligible costs.

This adjustment to State and local cost sharing applies only to Public Assistance costs and direct Federal assistance eligible for such adjustments under the law. The Robert T. Stafford Disaster Relief and Emergency Assistance Act specifically prohibits a similar adjustment for funds provided for Other Needs Assistance (Section 408), and the Hazard Mitigation Grant Program (Section 404). These funds will continue to be reimbursed at 75 percent of total eligible costs.

(The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Dated: November 10, 2009.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. E9–28308 Filed 11–24–09; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–3306–EM; Docket ID FEMA–2008–0018]

Puerto Rico; Amendment No. 1 to Notice of an Emergency Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of an emergency declaration for the Commonwealth of Puerto Rico (FEMA–3306–EM), dated October 24, 2009, and related determinations.

DATES: *Effective Date:* October 26, 2009.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Disaster Assistance Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the incident period for this emergency is closed effective October 26, 2009.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. E9–28303 Filed 11–24–09; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

Federal Radiological Preparedness Coordinating Committee

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice of public meeting.

SUMMARY: The Federal Radiological Preparedness Coordinating Committee (FRPCC) is holding a public meeting on December 9, 2009 in Washington, DC.

DATES: The meeting will take place on December 9, 2009 from 9 a.m. to 11 a.m. Send written statements and requests to make oral statements to the contact person listed below by close of business November 30, 2009.

ADDRESSES: The meeting will be held in the large first floor conference room in the North building of the Technology World Building Conference Facility located at 800 K St. NW., Washington, DC 20024.

FOR FURTHER INFORMATION CONTACT: Timothy Greten, FRPCC Executive Secretary, DHS/FEMA, 1800 South Bell Street-CC847, Mail Stop 3025, Arlington, VA 20598–3025; telephone (202) 646–3907; fax (703) 305–0837; or e-mail *timothy.greten@dhs.gov*.

SUPPLEMENTARY INFORMATION: The role and functions of the Federal Radiological Preparedness Coordinating Committee (FRPCC) are described in 44 CFR 351.10(a) and 351.11(a). The FRPCC is holding a public meeting on December 9, 2009, from 9 a.m. to 11 a.m., in the large first floor conference room in the North building of the Technology World Building Conference Facility located at 800 K St. NW., Washington, DC 20024. Please note that the meeting may close early. This meeting is open to the public, subject to the availability of space. Public meeting participants must pre-register to be admitted to the meeting. To pre-register, please provide your name and telephone number by close of business on November 30, 2009, to the individual listed in the **FOR FURTHER INFORMATION CONTACT** section above.

The tentative agenda for the FRPCC meeting includes: (1) Introductions; (2) reports from FRPCC Subcommittees; (3) old business and new business; and (4) business from the floor. The FRPCC Chair shall conduct the meeting in a way that will facilitate the orderly conduct of business. Reasonable provisions will be made, if time permits, for oral statements from the public of not more than five minutes in length. Any member of the public who wishes to make an oral statement at the meeting should send a written request for time by close of business on November 30, 2009, to the individual listed in the **FOR FURTHER INFORMATION CONTACT** section above. Any member of the public who wishes to file a written statement with the FRPCC should provide the statement by close of business on November 30, 2009, to the individual listed in the **FOR FURTHER INFORMATION CONTACT** section above.

Information on Services for Individuals With Disabilities

For information on facilities or services for individuals with disabilities or to request special assistance at the meeting, please write or call the individual listed in the **FOR FURTHER INFORMATION CONTACT** section above as soon as possible.

Authority: 44 CFR 351.10(a) and 351.11(a).

Dated: November 4, 2009.

James R. Kish,

Director, Technological Hazards Division, Chair, Federal Radiological Preparedness Coordinating Committee, National Preparedness Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–28307 Filed 11–24–09; 8:45 am]

BILLING CODE 9110–21–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Customs and Border Protection

[CBP Dec. 09–43]

Updated List of the Ports-of-Entry Designated for Departure of Nonimmigrant Aliens Who Are Subject to Special Registration

AGENCY: U.S. Customs and Border Protection, Department of Homeland Security.

ACTION: Notice.

SUMMARY: This notice announces that U.S. Customs and Border Protection is adding two new ports of entry to the list of ports through which nonimmigrant aliens subject to special registration requirements may depart from the United States. The new ports-of-entry include Oakland International Airport, California and Saipan, the Commonwealth of the Northern Mariana Islands. Special registration is required of nonimmigrant aliens whose presence in the United States requires closer monitoring.

DATES: *Effective Date:* Nonimmigrant aliens subject to special registration requirements may depart from the Oakland International Airport, California, effective November 25, 2009, and Saipan, the Commonwealth of the Northern Mariana Islands, effective November 28, 2009.

FOR FURTHER INFORMATION CONTACT: Kenneth Sava, U.S. Customs and Border Protection, Office of Field Operations, at (202) 344–2589.

SUPPLEMENTARY INFORMATION:

Nonimmigrant Aliens Subject to Special Registration Requirements

Certain nonimmigrant aliens, who apply for admission to the United States, are subject to special registration requirements. Upon arrival in the United States, they shall provide information required by the Department of Homeland Security (DHS), such as information relating to their visa status, and they shall be fingerprinted and photographed. Other special registration requirements include appearing at in-person verification or re-registration interviews at the discretion of DHS; providing notice to DHS of any change of address, residence, employment, or educational institution; and reporting departure from the United States to close their registration.

Pursuant to 8 CFR 264.1(f)(2)(i), the Secretary of Homeland Security, in consultation with the Secretary of State, may designate, by publishing a notice in the **Federal Register**, nonimmigrant aliens from certain foreign countries as subject to the special registration requirements. Nonimmigrant aliens, who meet certain pre-existing criteria indicating that such aliens' presence in the United States warrants monitoring due to the national security interests or law enforcement interests of the United States, are also subject to the special registration requirements. *See* 8 CFR 264.1(f)(2)(iii). By regulation, the special registration requirements also apply to any nonimmigrant aliens whom a consular or inspecting officer has reason to believe are nationals or citizens of one of the designated countries. *See* 8 CFR 264.1(f)(2)(ii).

Upon departure from the United States, nonimmigrant aliens subject to the special registration requirements must report to an inspecting officer at and depart from an approved port-of-entry (POE) as set forth by publication in the **Federal Register.**[1] *See* 8 CFR 264.1(f)(8). To date, there have been four **Federal Register** publications designating approved POEs for departure. On September 30, 2002, the former INS published a notice in the **Federal Register** at 67 FR 61352 which sets forth an affirmative list of 68 POEs that could be used for departure by specially registered nonimmigrant aliens. On February 19, 2003, the former INS published a notice in the **Federal Register** at 68 FR 8047, corrected at 68 FR 8967 (Feb. 26, 2003), adding 31 POEs, expanding the listing of POEs approved for departure to 99. Finally, on August 8, 2006, CBP published a notice in the **Federal Register** at 71 FR 45061 updating the listing of POEs by removing one POE from the listing and adding 17 further POEs for a total of 115 POEs that could be used for departure by specially registered nonimmigrant aliens.

[1] An alien who has been specially registered and has not yet departed the United States may seek relief from the departure control requirement for that admission by applying to the U.S. Customs and Border Protection (CBP) field office director for the port from which the alien intends to depart. The alien must establish that exigent or unusual circumstances exist and that the alien warrants a favorable exercise of discretion. *See* 8 CFR 264.1(f)(7)(i).

This notice expands the August 8, 2006 listing by adding two POEs.

Additional Ports-of-Entry Designated for Final Registration and Departure by Nonimmigrant Aliens Subject to Special Registration

Effective November 25, 2009, Oakland International Airport, California, is designated as a POE authorized to provide final registration and departure by nonimmigrant aliens subject to special registration.

Effective November 28, 2009, Saipan, the Commonwealth of the Northern Mariana Islands, is designated as a POE authorized to provide final registration and departure by nonimmigrant aliens subject to special registration.

Ports-of-Entry Which Are Not Authorized for the Departure of Nonimmigrant Aliens Subject to Special Registration

Due to the limited availability of resources, specifically departure staff and facilities, CBP must limit the POEs authorized for departure registration to effectively capture departure data. Nonimmigrant aliens who are subject to special registration may not depart the United States from any POE, or from any other location, other than those listed below.

Ports-of-Entry Designated for Final Registration and Departure by Nonimmigrant Aliens Subject to Special Registration: Updated List

The below updated list of POEs includes all POEs designated for final registration and departure by nonimmigrant aliens subject to special registration, including the two POEs added by this notice. Nonimmigrant aliens subject to special registration may be examined by CBP and may depart from the following POEs:

Amistad Dam POE, Texas;
Alcan POE, Alaska;
Anchorage International Airport, Alaska;
Atlanta Hartsfield International Airport, Georgia;
Baltimore Washington International Airport, Maryland;
Boeing Field, Seattle, Washington;
Bridge of the Americas POE, Texas;
Brownsville/Matamoros POE, Texas;
Buffalo Peace Bridge POE, New York;
Cape Vincent POE, New York;
Calexico POE, California;
Calais POE, Maine;
Cape Canaveral Seaport, Florida;
Chicago Midway Airport, Illinois;
Chicago O'Hare International Airport, Illinois;
Champlain POE, New York;
Charlotte International Airport, North Carolina;
Chateaugay POE, New York;
Cincinnati/Northern Kentucky International Airport, Ohio;
Cleveland International Airport, Ohio;
Columbus POE, New Mexico;
Cyril E. King Airport, United States Virgin Islands;
Dallas/Fort Worth International Airport, Texas;
Del Rio International Bridge POE, Texas;
Denver International Airport, Colorado;
Derby Line POE, Vermont;
Detroit International (Ambassador) Bridge POE, Michigan;
Detroit Canada Tunnel, Michigan;
Detroit Metro Airport, Michigan;
Douglas POE, Arizona;
Dunseith POE, North Dakota;
Eagle Pass POE, Texas;
Eastport POE, Idaho;
Fort Covington POE, New York;
Fort Duncan Bridge POE, Texas;
Frontier POE, Washington;
Galveston POE, Texas;
Grand Portage POE, Minnesota;
Guam International Airport;
Heart Island POE, New York;
Hidalgo POE, Texas;
Highgate Springs POE, Vermont;
Honolulu International Airport, Hawaii;
Honolulu Seaport, Hawaii;
Houlton POE, Maine;
Houston George Bush Intercontinental Airport, Texas;
Houston Seaport, Texas;
International Falls POE, Minnesota;
Jacksonville Seaport, Florida;
John F. Kennedy International Airport, New York;
Ketchikan Seaport, Alaska;
Kona International Airport and Seaport, Hawaii;
Gateway to the Americas Bridge POE, Laredo, Texas;
Las Vegas (McCarran) International Airport, Nevada;
Lewiston Bridge POE, New York;
Logan International Airport, Massachusetts;
Long Beach Seaport, California;
Los Angeles International Airport, California;
Lukeville, Arizona;
Madawaska POE, Maine;
Mayaguez Seaport, Puerto Rico;
Melbourne International Airport, Florida;
Memphis International Airport;
Miami International Airport, Florida;
Miami Marine Unit, Florida;
Minneapolis/St. Paul International Airport, Minnesota;
Mooers POE, New York;
New Orleans International Airport and Seaport;
Niagara Falls, Rainbow Bridge, New York;
Newark International Airport, New Jersey;
Nogales POE, Arizona;
Oakland International Airport, California;
Ogdensburg POE, New York;
Orlando, Florida;
Oroville POE, Washington;
Otay Mesa POE, California;
Pacific Highway POE, Washington;
Pembina POE, North Dakota;
Philadelphia International Airport, Pennsylvania;
Phoenix (Sky Harbor) International Airport, Arizona;
Piegan POE, Montana;
Pittsburgh International Airport, Pennsylvania;
Point Roberts POE, Washington;
Ponce Seaport, Puerto Rico;
Port Everglades Seaport, Florida;
Port Arthur POE, Texas;
Port Huron POE, Michigan;
Portal POE, North Dakota;
Portland International Airport, Oregon;
Progreso Bridge POE, Texas;
Raymond POE, Montana;
Rochester International Airport, Minnesota;
Rochester-Ferry Terminal, New York;
Roosville POE, Montana;
Rouses Point POE, New York;
Saipan, the Commonwealth of the Northern Mariana Islands (on or after November 28, 2009);
San Antonio International Airport, Texas;
San Diego (Lindbergh Field) International Airport, California;
San Diego Seaport, California;
San Francisco International Airport, California;
San Juan International Airport and Seaport, Puerto Rico;
Sanford International Airport, Florida;
Sault Ste. Marie POE, Michigan;
Savannah International Airport, Georgia;
Seaway International Bridge/Massena POE, New York;
Seattle Tacoma International Airport, Washington;
Southwest Florida International Airport, Florida;
St. Petersburg/Clearwater International Airport, Florida;
St. Louis International Airport (Lambert Field), Missouri;
St. Thomas Seaport, U.S. Virgin Islands;
Sumas POE, Washington;
Sweetgrass POE, Montana;
Tampa International Airport and Seaport, Florida;
Thousand Islands POE, New York;
Trout River POE, New York;
Washington Dulles International Airport, Virginia; and
Ysleta POE, Texas.

Notice of Where To Report for Final Registration and Departure

The regulations governing the manner in which aliens are registered in the

United States are contained in 8 CFR 264.1. Upon registration, whether registered at a POE upon admission to the United States or subsequent to admission, each nonimmigrant alien subject to special registration will be issued an information packet that will list each POE authorized for departure and other instructions on how to comply with 8 CFR 264.1. This packet will also contain specific information regarding hours of operation, directions and contact numbers.

This updated list will also be available on the following Web site: *http://www.cbp.gov/linkhandler/cgov/travel/id_visa/nseers/nseers_ports.ctt/nseers_ports.doc.* CBP will announce any changes to the list of POEs by notice in the **Federal Register** and will make the list available on the above Web site.

Dated: November 23, 2009.

Jayson P. Ahern,

Acting Commissioner, U.S. Customs and Border Protection.

[FR Doc. E9–28418 Filed 11–23–09; 4:15 pm]

BILLING CODE 9111–14–P

DEPARTMENT OF THE INTERIOR

National Park Service

Final White-tailed Deer Management Plan, Environmental Impact Statement, Valley Forge National Historical Park, PA

AGENCY: National Park Service, Department of the Interior.

ACTION: Notice of Availability of the Record of Decision for the Final White-tailed Deer Management Plan and Environmental Impact Statement for Valley Forge National Historical Park.

SUMMARY: Pursuant to Section 102(2)(C) of the National Environmental Policy Act of 1969, as amended, the National Park Service (NPS) announces the availability of the Record of Decision for the Final White-tailed Deer Management Plan/Environmental Impact Statement (Final plan/EIS) for Valley Forge National Historical Park, Pennsylvania. The Regional Director, Northeast Region, has approved the Record of Decision for the Final plan/EIS, selecting Alternative D, Combined Lethal and Nonlethal Actions, which was described as the NPS preferred alternative in the Final plan/EIS, released to the public for the required 30-day no-action period beginning August 28, 2009 and ending September 28, 2009. The Record of Decision includes a statement of the decision made, synopses of other alternatives considered, the basis for the decision, a description of the environmentally preferred alternative, a finding on impairment of park resources and values, a description of consistency with Section 101(b) of the National Environmental Policy Act, a listing of measures to minimize environmental harm, and an overview of public involvement in the decision-making process. As soon as practicable, the National Park Service will begin to implement the selected alternative.

Copies of the Record of Decision may be downloaded from the NPS Planning, Environment and Public Comment (PEPC) Web site (*http://parkplanning.nps.gov/vafo*) or a hardcopy may be obtained from the contact listed below.

FOR FURTHER INFORMATION CONTACT: Kristina M. Heister, Natural Resource Manager, Valley Forge National Historical Park, 1400 North Outer Line Drive, King of Prussia, PA 19406, (610) 783–0252, or online at *http://parkplanning.nps.gov/vafo.*

SUPPLEMENTARY INFORMATION: Development of the Environmental Impact Statement for the White-tailed Deer Management Plan for Valley Forge National Historical Park was initiated in 2006, pursuant to the 2006 House Appropriations Report (HR 109–465): ''The public has been patient as the NPS has worked through its process in regard to management of the over-abundance of white-tailed deer at the park. Within existing funds, NPS is directed to begin the environmental impact statement for deer management. The Committee expects that the plan will be funded fully so that it can be completed in fiscal year 2008. The Committee further expects that implementation of the selected action will begin immediately upon signing of the Record of Decision.''

The purpose of the plan/EIS is to develop a white-tailed deer management strategy that supports long-term protection, preservation, and restoration of native vegetation and other natural and cultural resources while maintaining a deer population at Valley Forge NHP. Forest regeneration has been selected as the primary measure of plan success. Although other factors may affect forest regeneration, such as the forest canopy, nonnative invasive species, pests/disease, fire, and forest fragmentation, this plan focuses on the role and impact of white-tailed deer in the ecological environment, which has been documented through research and long-term monitoring at Valley Forge NHP. The secondary purpose of the plan/EIS is to provide appropriate response to chronic wasting disease (CWD), a fatal, neurological disease identified in free-ranging and captive mule deer, white-tailed deer, elk, and moose. CWD is not currently known to be present in the park or the Commonwealth of Pennsylvania; however, changes in the proximity of CWD to the park boundary and other risk factors have resulted in an elevated risk of CWD occurrence within the park; therefore, integration of CWD response into white-tailed deer management represents an effort on the part of the NPS to be proactive and fully prepared given the high level of risk of the park for exposure to and amplification of CWD.

The following objectives related to deer management at Valley Forge NHP were developed for the plan.

Vegetation

- Protect arid promote restoration of the natural abundance, distribution, structure, and composition of native plant communities by reducing deer browsing.
- Reduce deer browsing pressure enough to promote tree and shrub regeneration that results in a diverse forest structure dominated by native species.
- Promote a mix of native herbaceous plant species and reduce the competitive advantage of invasive, nonnative plant species.

Wildlife and Wildlife Habitat

- Maintain a white-tailed deer population within the park that allows for protection and restoration of native plant communities.
- Protect and preserve other native wildlife species by promoting the restoration of native plant communities.
- Reduce the probability of occurrence, promote early detection, and reduce the probability of spread of chronic wasting disease.

Threatened, Endangered, and Special Status Species

- Protect and promote restoration of special status plant and animal species and their habitat.

Cultural Resources

- Protect the integrity of the cultural landscape, including the patterns of open versus wooded land, commemorative plantings, and vegetative screenings.
- Protect archeological resources by promoting the growth and maintenance of native vegetative cover and reducing trampling and soil erosion.

The NPS has selected Alternative D (Combined Lethal and Nonlethal Actions), which was described as the NPS preferred alternative in the Final

plan/ETS. The selected alternative continues current deer management actions, including vegetation and deer population monitoring, small fenced areas, roadkill removal, public education, coordination with the PGC, and CWD monitoring and response. In addition, the selected alternative includes two lethal actions (sharpshooting and capture and euthanasia in certain circumstances where sharpshooting is not appropriate) that will be used in combination to reduce deer population size and a non-lethal action (reproductive control) to maintain the deer population at the desired density. These actions will be conducted by qualified Federal employees or contractors. The selected alternative establishes a range of 31 to 35 deer per square mile as the initial deer density goal. This deer density is consistent with the density range reported in the scientific literature as necessary for adequate tree regeneration and reflects the documented deer density at the park in 1983, when habitat was considered in good condition. Up to four years will be required to reach this goal given the limited accessibility of some areas and increased difficulty in locating deer as the population size decreases.

Forest regeneration has been selected as the primary measure of plan success; therefore, tree seedlings will be monitored to determine at what point the browsing impacts will warrant implementation of the management actions contained in the selected alternative. Because the goal is to manage for successful forest regeneration within the park and not for deer density, the selected alternative incorporates an adaptive management strategy to better manage based on the uncertainty concerning the impacts the change in deer population densities will have on vegetation recovery. The results of deer removal would be documented annually through monitoring of forest regeneration so that the number of deer to be removed could be adjusted based on the response of the vegetation to a lower deer density. If monitoring indicated that vegetation was not regenerating, management actions would be adjusted.

By using an adaptive management approach, park managers will be able to change the timing or intensity of management treatments to better meet the goals of the plan as new information is obtained.

The selected alternative includes measures to respond to detection of CWD. Should chronic wasting disease (CWD) be confirmed within five miles of the park boundary or the park falls within a State established CWD-containment zone then active lethal surveillance will be implemented (lethal removal of deer for the purposes of assessing disease presence, prevalence, and distribution). Portions of the plan related to CWD were prepared in cooperation with the Pennsylvania Game Commission.

In addition to the selected alternative, two other action alternatives and the no action alternative were presented and analyzed in the Draft and Final Environmental Impact Statements.

Alternative A (no action) would continue the existing deer management activities of monitoring deer population size and vegetation, small scale fencing of selected vegetation, removal of deer killed on roadways, public education, coordination with the Pennsylvania Game Commission, and continuation of limited CWD surveillance; no new deer management actions would be implemented.

Alternative B, Combined Nonlethal Actions, would combine several non-lethal actions, including large-scale rotational fencing of 10% to 15% of the park's forested area and reproductive control of does to gradually reduce deer population in the park. Chronic wasting disease surveillance would include live testing (via tonsillar biopsy) and removal of CWD-positive individuals.

Alternative C, Combined Lethal Actions, would use qualified Federal employees or contractors to directly reduce the deer population in the park through sharpshooting and through capture and euthanasia, where appropriate. CWD response would include rapid reduction of the deer population to the target deer density and the potential for a one-time reduction action to not less than 10 deer per square mile through sharpshooting and through capture and euthanasia. These actions would be taken for the purposes of assessing disease presence, prevalence, and distribution. These actions may also minimize the likelihood of CWD becoming established, minimize the likelihood of amplification and spread if the disease is introduced, and promote elimination of CWD, if possible.

To identify the selected alternative, the planning team ranked each alternative based on: (1) The ability to meet the individual plan objectives; and (2) the potential impacts on the environment. The rankings were added up to determine which alternative best met the objectives. Alternatives C and D were closely ranked in their ability to meet all of the objectives. The NPS also considered the safety of implementing each alternative in identifying the selected alternative. Under Alternative D, the time that shooting would occur in the park would be less than under Alternative C. Because Alternative D maintains the efficiency of Alternative C in meeting the plan objectives and further improves safety by reducing the time that sharpshooting activities would occur in the park, Alternative D was selected for implementation.

The foreseeable environmental consequences of the selected alternative were fully assessed and documented in the Final plan/EIS. All practicable means to avoid and minimize environmental harm that could result from implementation of the selected alternative have been identified and incorporated into the selected alternative. After review of the potential environmental effects, the alternative selected for implementation will not impair park resources or values and will not violate the NPS Organic Act.

This decision is the result of a public planning process that began in 2006. At different points in the development of the plan/EIS, the NPS provided information and updates via newsletters, news releases, public meetings, the park Web site, and briefings. A Notice of Intent to prepare an ETS was published in the **Federal Register** on September 7, 2006, initiating a 90-day public scoping period between September 7, 2006 and December 8, 2006. Two public scoping meetings were held to facilitate the public involvement process early in the planning stage and to obtain community feedback on the initial concepts for deer management at Valley Forge NHP. The results of public scoping were documented in a Public Comment Analysis Report which was provided for public review on the park Web site (*http://www.nps.gov/vafo*) and on PEPC (*http://parkplanning.nps.gov/vafo*).

A Notice of Availability of the Draft White-tailed Deer Management Plan/EIS (Draft plan/EIS) for Valley Forge NHP was published in the **Federal Register** on December 19, 2008. The Draft plan/EIS was available for a 60-day public and agency review from December 19, 2008 through February 17, 2009. Copies of the document were distributed to individuals, agencies, organizations, and local libraries. Two public meetings were held in January, 2009. Comments received on the Draft plan/EIS related to general lethal reduction, objectives in taking action, and the preferred combined lethal and nonlethal alternative. The majority of these comments were nonsubstantive. Comments in support of Alternative D: Combined Lethal and Nonlethal Actions were the second most common

comment. Comments received on the Draft plan/EIS resulted in minor factual changes to the text, and an update of Appendix E: Review of White-tailed Deer Reproductive Control, with current literature, expert review and comments, and more detailed explanation of criteria for an acceptable chemical reproductive control agent. Associated sections of the Final plan/EIS were updated to reflect changes to Appendix E. A summary of public comments and NPS responses is contained in Appendix F of the Final plan/EIS. A Notice of Availability of the Final plan/EIS was published in the **Federal Register** on August 28, 2009. The 30-day no-action period ended on September 28, 2009.

The official primarily responsible for implementing the updated General Management Plan is the Superintendent of Valley Forge National Historical Park.

Dennis R. Reidenbach,

Regional Director, Northeast Region, National Park Service.

[FR Doc. E9–28060 Filed 11–24–09; 8:45 am]

BILLING CODE M

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Kalispel Tribe of Indians Tobacco and Liquor Code

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: This notice publishes an amendment to the Kalispel Tribe of Indians' Tobacco and Liquor Code published in the **Federal Register** August 1, 1979 (44 FR 45258). The amendment regulates and controls the possession and consumption of liquor within the Tribal lands. The Tribal lands are located in Indian country and this amended Code allows for possession of alcoholic beverages within their boundaries. This Ordinance will increase the ability of the Tribal government to control liquor sales, possession and consumption by the community and its members.

DATES: *Effective Date:* This amended Code is effective on December 28, 2009.

FOR FURTHER INFORMATION CONTACT: Betty Scissons, Tribal Government Services Officer, Northwest Regional Office, 911 NE. 11th Ave., 8th Floor, Portland, OR 97232, Telephone: (503) 231–6723, Fax (503) 231–2189; or Elizabeth Colliflower, Office of Indian Services, 1849 C Street NW., Mail Stop 4513–MIB, Washington, DC 20240, Telephone: (202) 513–7640.

SUPPLEMENTARY INFORMATION: Pursuant to the Act of August 15, 1953, Public Law 83–277, 67 Stat. 586, 18 U.S.C. 1161, as interpreted by the Supreme Court in *Rice* v. *Rehner,* 463 U.S. 713 (1983), the Secretary of the Interior shall certify and publish in the **Federal Register** notice of adopted or amended liquor ordinances or codes for the purpose of regulating liquor transactions in Indian country. The Kalispel Tribe of Indians amended its Tribal Tobacco and Liquor Code by Resolution No. 2008–45 on July 22, 2008. The purpose of this Code is to govern the sale and possession of alcohol within Tribal lands of the Tribe. This notice is published in accordance with the authority delegated by the Secretary of the Interior to the Assistant Secretary—Indian Affairs. I certify that the amended Tobacco and Liquor Code for the Kalispel Tribe of Indians was duly adopted by the Kalispel Tribe's Business Committee on July 22, 2008.

Dated: November 17, 2009.

Larry Echo Hawk,

Assistant Secretary—Indian Affairs.

The amended Kalispell Tribe of Indian's Tobacco and Liquor Code reads as follows:

Chapter 10

Kalispel Tobacco and Liquor Code

§ 10–1 Title and Purpose.

10–1.01 Title.

This chapter shall be known as the Kalispel Tobacco and Liquor Code.

10–1.02 Purpose

This Code is enacted to:

1. Regulate the distribution and sale of tobacco products on the Kalispel Reservation in conformity with the compact between the Kalispel Tribe and the State of Washington.

2. Regulate the distribution and sale of liquor and beer products on the Kalispel Reservation in conformity with 18 U.S.C. 1161 and any Tribal-State liquor compact.

3. Regulate tobacco, liquor and beer products in order to protect and promote the general health, safety and welfare of members of the Kalispel Tribe.

4. Generate revenue to fund needed Tribal programs and services.

§ 10–2 Definitions.

10–2.01 Definitions

Unless otherwise required by the context, the following words and phrases shall have the designated meanings:

1. ''Alcohol'' is that substance known as ethyl alcohol, hydrated oxide of ethyl, or spirit of wine, which is produced by the fermentation or distillation of grain, starch, molasses, or sugar, or other substance including all dilutions and mixtures of this substance.

2. ''Beer'' means any malt beverage, flavored malt beverage, or malt liquor as these terms are defined in this chapter.

3. ''Cigarette'' shall mean any roll for smoking made wholly or in part of tobacco being flavored, adulterated, or mixed with any other ingredients, where such wrapper is wholly or in the greater part made of paper of any material except where such is wholly or in the greater part made of natural leaf tobacco in its natural state.

4. ''Commercial Sale'' shall mean the transfer, exchange or barter, in any or by any means whatsoever for a consideration, by any person, association, partnership, or corporation, of cigarettes, tobacco products and/or liquor and beer products.

5. ''Council'' shall mean the Kalispel Tribal Business Committee as constituted by Article III of the Constitution and By-laws of the Kalispel Indian Tribe, Washington.

6. ''Distributor'' shall mean a person who buys liquor in any variety from a brewery, distillery, vineyard, foreign source outside of the United States, and includes any representatives of such a source such as a brewer or brewer agent.

7. ''Liquor'' includes the four varieties of liquor herein defined (alcohol, spirits, wine and beer), and all fermented, spirituous, vinous, or malt liquor, or combinations thereof, and mixed liquor, a part of which is fermented, spirituous, vinous or malt liquor, or otherwise intoxicating; and every liquid or solid or semisolid or other substance, patented or not, containing alcohol, spirits, wine or beer, and all drinks or drinkable liquids and all preparations or mixtures capable of human consumption, and any liquid, semisolid, solid, or other substance, which contains more than one percent of alcohol by weight shall be conclusively deemed to be intoxicating. Liquor does not include confections or food products that contain one percent or less of alcohol by weight.

8. ''Liquor Outlet'' shall mean a Tribally licensed retail sales business selling liquor or beer on the Kalispel Indian Reservation.

9. ''Malt Beverage'' or ''malt liquor'' means any beverage such as beer, ale, lager, stout, porter, flavored malt beverages such as wine coolers, or Guinness obtained by the alcoholic fermentation of an infusion or decoction of pure hops, or the pure extract of hops and pure barley malt or other

wholesome grain or cereal in pure water containing not more than eight percent of alcohol by weight, and not less than one-half of one percent of alcohol by volume. Any such beverage containing more than eight percent of alcohol by weight shall be referred to as *strong beer.*

10. ''Member'' shall mean any person whose name appears on the official roll of the Kalispel Indian Tribe.

11. ''Operator'' shall mean an enrolled member of the Kalispel Tribe, enrolled member of another Federally recognized Tribe, a Tribal leasee or Tribally-licensed business entity licensed by the Kalispel Tribe of Indians to operate a tobacco and/or liquor and beer outlet.

12. ''Reservation'' shall mean the Kalispel Indian Reservation as set apart by Executive Order of March 23,1914, and all other lands, wherever located, owned by the Kalispel Tribe of Indians, including lands held in fee, or any interest in lands held by the Tribe, whether or not such lands or interests are held in trust for the Tribe by the United States, and any lands, wherever located, held in trust by the United States for a member or members of the Kalispel Tribe of Indians unless located on another Federally recognized Indian Tribe's Reservation and having already been determined by the Federal Government to be in ''reservation'' status as to a Tribe other than the Kalispel Tribe of Indians. All waterways, roadways, rights of way, public lands, lakes and streams located on the above described lands held by the Tribe or its members are considered Reservation lands, subject to applicable Federal and Tribal laws and regulations.

13. ''Spirits'' shall mean any beverage which contains alcohol obtained by distillation and intended for consumption.

14. ''Tobacco Outlet'' shall mean a Tribally licensed retail sales business selling tobacco products on the Kalispel Indian Reservation.

15. ''Tobacco Products'' shall mean cigars, cheroots, stogies, granulated, plug cut, crim cut, ready rubbed, and other smoking tobacco, snuff, cavendish, snuff flour, plug and twist tobacco, fine cut and other chewing tobaccos shorts and other kinds and forms of tobacco, prepared in such a manner as to be suitable for chewing or smoking in a pipe or otherwise, or both for smoking and chewing. Tobacco products shall not include cigarettes.

16. ''Tribe'' shall mean the Kalispel Indian Community of the Kalispel Indian Reservation, Washington.

17. ''Wholesale Price'' shall mean the established price for which cigarettes, tobacco products and/or liquor and beer products are sold to the Kalispel Indian Tribe or any licensed operator by the manufacturer or distributor, exclusive of any discount or other reduction.

18. ''Wine'' shall mean any alcoholic beverage obtained by fermentation of fruits or other agricultural products containing sugar and containing not more than twenty-four percent alcohol by volume and not less than one-half of one percent of alcohol by volume. For purposes of this chapter, ''wine coolers'' shall not be defined as wine but rather as a ''malt beverage''.

§ 10–3 Kalispel Tobacco, Liquor and Beer Control Commission.

10–3.01 Creation and Authority

The Kalispel Business Committee shall be the Kalispel Tobacco, Liquor and Beer Control Commission. The Commission is empowered to:

1. Administer this Code by exercising general control, management, and supervision of all tobacco and/or liquor and beer sales, places of sale and sales outlets as well as exercising all powers necessary to accomplish the purposes of this Code;

2. Adopt and enforce rules and regulations in furtherance of the purposes of this Code and in the performance of its administrative functions.

10–3.02 Records Confidential

All records of the Kalispel Tobacco, Liquor and Beer Commission showing purchase of liquor by any individual or group shall be confidential and shall not be inspected except by members or employees of the Kalispel Tobacco, Liquor and Beer Commission or its authorized representative.

§ 10–4 Generally Applicable Regulations

10–4.01 Conformity with State and Federal Laws.

Operators of tobacco and/or liquor and beer outlets shall comply with applicable Tribal/State compact requirements and State of Washington liquor standards to the extent required by 18 U.S.C. 1161. However, total jurisdiction over the sale of liquor and beer products is reserved to and exercised by the Kalispel Tobacco, Liquor and Beer Commission within the boundaries of the Kalispel Indian Reservation.

10–4.02 Sales to Persons Apparently Intoxicated

Any person who sells, gives or otherwise provides liquor, wine or beer to a person apparently under the influence of liquor shall be in violation of this Chapter.

10–4.03 Identification for Sale Required—Proof of Minimum Age

Where there may be question of a person's right to purchase cigarettes, tobacco products or alcoholic beverages by reason of his or her age, such person shall be required to present any one of the following officially issued cards of identification which shows correct age and bears his or her signature and photograph:

1. Driver's license of any State or Identification Card issued by any State Department of Motor Vehicles;

2. United States Active Duty Military Identification;

3. Passport;

4. Tribal Identification Card approved by the Washington State Liquor Control Board;

5. Kalispel Tribal Identification or Enrollment card.

10–4.04 Expired Identification Not Valid

An officially issued identification card described in Section 10–4.02 must be current to be valid identification. An officially issued identification card that is expired is not valid identification for the purpose of purchasing cigarettes, tobacco products or alcoholic beverages.

10–4.05 Sales to Minors Prohibited

It shall be unlawful to:

1. Provide, give, sell or otherwise supply liquor, beer or other alcoholic beverages to any person under twenty-one (21) years of age, either for his or her own use or for the use of his or her parents or for the use of any other person.

2. Provide, give, sell or otherwise supply cigarettes or tobacco products to any person under eighteen (18) years of age, either for his or her own use or for the use of his or her parents or for the use of any other person.

10–4.06 Employment of Minors

No person under the age of twenty-one (21) years shall be employed in any service in connection with the sale, handling or dispensing of liquor, either on a paid or voluntary basis, except as otherwise provided herein.

1. Northern Quest Casino employees must be twenty-one (21) years of age to be employed in a position involving the sale or dispensing of liquor. Northern Quest Casino employees under twenty-one (21) years of age shall not sell or dispense liquor. Individuals under twenty-one (21) years of age may be employed as:

(a) Servers not working on the gaming floor who handle beer, wine and liquor

provided they have successfully completed Mandatory Alcohol Server Training (MAST) and there is direct supervision by an adult twenty-one (21) years of age or older; or

(b) As cashiers, greeters, cooks or custodians, or as a gaming employee as defined in Kalispel Tribal Code § 11–11.02(B), where they are not selling or handling beer, wine or liquor.

2. Non-gaming facility employees eighteen (18) years or older may sell and handle beer or wine not to be consumed on the premises provided that they have successfully completed Mandatory Alcohol Server Training (MAST) and there is direct supervision by an adult twenty-one (21) years of age or older.

10–4.07 Consumption of Liquor Upon Licensed Premises Prohibited

No Tribal operator shall permit any person to open or consume liquor on his or her premises or any premises adjacent thereto and in his or her control. This prohibition shall not apply to lawful sales and consumption of alcohol at the Kalispel Tribe's Northern Quest Casino located on the Reservation lands in Airway Heights, Washington or upon approval of the Commission of additional licensed liquor outlets on Reservation lands acquired in the future.

10–4.08 Conduct on Licensed Premises

1. No Tribal operator shall be disorderly, boisterous or intoxicated on the licensed premises or on any public premises adjacent thereto which are under his or her control, nor shall he or she permit any disorderly boisterous or intoxicated person to be thereon.

2. No operator or employee shall consume liquor of any kind while working on the licensed premises.

3. No Tribal operator shall encourage, sanction or knowingly permit any activity that would be in violation of Chapter 9 of the Kalispel Tribe Law and Order Code.

§ 10–5 Tribal Taxation of Tobacco and Liquor

10–5.01 Tribal Cigarette Tax

The Kalispel Tribe will levy a tax on the retail sale of each pack of cigarettes, the amount of which is established by the cigarette tax compact between the Kalispel Tribe and the State of Washington.

10–5.02 Tribal Tobacco Product Tax

Other tobacco products, excluding cigarettes, shall be taxed at a rate determined to be fair and equitable by the Commission, but the Commission may establish tax rates dependent solely on the given class of merchandise.

10–5.03 Exemption From Cigarette and Tobacco Tax

An operator may, upon approval of the Commission and in a non-discriminatory manner, exempt enrolled members of the Kalispel Tribe and enrolled members of another Federally recognized Indian Tribe, band, or Alaskan Native, or a member of the Canadian First Nations, from imposition of the Tribe's cigarette and tobacco product taxes, provided, however, the individual present a valid Tribal identification card upon purchase of the cigarettes or tobacco products.

10–5.04 Tribal Alcoholic Beverage Tax

All alcoholic beverages, including packaged liquor, wine and beer, and those products dispensed for consumption at a licensed liquor outlet, shall be taxed at a rate determined to be fair and equitable by the Commission, but the Commission may establish tax rates dependent solely on the given class of merchandise.

10–5.05 Added to Retail Price

The excise taxes levied hereunder shall be added to the retail selling price of cigarettes, tobacco products, and alcoholic beverages sold to the ultimate consumer.

10–5.06 Use and Allocation of Revenue

The excise taxes levied hereunder shall be placed in the General Fund of the Kalispel Tribe. The revenue may be allocated at the discretion of the Tribal Council to Tribal projects and expenses for essential government services.

§ 10–6 Application for Tobacco Outlet License or Liquor and Beer Outlet License

10–6.01 Eligibility for Application

Any enrolled member of the Kalispel Indian Tribe, an enrolled member of another Federally recognized Tribe, a Tribal leasee or a Tribally-licensed business entity may apply to the Commission for a tobacco outlet license and/or a liquor and beer outlet license.

10–6.02 Processing of Application

The Tribal secretary-treasurer shall receive and process applications, and be the official representative of the Tribe and Commission in matters relating to tobacco and/or liquor and beer outlets excise tax collections and related matters. The Commission or its authorized representative shall obtain additional information as deemed appropriate. If the Commission or its authorized representative is satisfied that the applicant is a suitable and reputable person, the Commission or its authorized representative may issue a license for the sale of tobacco products and/or liquor and beer products.

10–6.03 Application Fee

Each application shall be accompanied by an application charge or fee of fifty dollars ($50.00). An application for both a tobacco outlet license and a liquor and beer outlet license shall be considered to be two applications with an application charge of fifty dollars ($50.00) each.

10–6.04 Issuance of License

Upon approval of an application, the Commission shall issue the applicant a tobacco outlet license and/or a liquor and beer outlet license whichever the case may be, for one year which shall entitle the operator to establish and maintain one outlet for the type being permitted on the Kalispel Indian Reservation. This license shall be nontransferable. It shall be renewable annually at the discretion of the Commission by filing a new application form and payment of the application fee as provided in this Section.

10–6.05 Display of License

Any entity issued a license shall frame under glass and display the license on the premises.

10–6.06 Revocation of Operator's License

Failure of an operator to abide by the provisions of this chapter and any additional regulations or requirements imposed by the Commission will constitute grounds for revocation of the operator's license as well as enforcement of the penalties provided in Section 10.10.

§ 10–7 Non-Tribal Owned Outlets

10–7.01 Applicability

This Section applies to tobacco and liquor outlets that are owned and operated by an individual who is an enrolled member of the Kalispel Indian Tribe, an enrolled member of another Federally recognized Tribe, a Tribal leasee or a Tribally-licensed business entity. This section shall not apply to gaming facilities or outlets operated by the Kalispel Tribe as business enterprises of the Tribe.

10–7.02 Nature of Outlet

Each tobacco and/or liquor and beer outlet, licensed hereunder, shall be managed by an operator pursuant to a license granted by the Commission, hereunder, and shall conform to the regulations and prohibitions outlined by this Chapter.

10–7.03 Right of Commission To Screen Suppliers

The operator of any licensed outlet shall keep the Commission informed in writing of the identity of suppliers and wholesalers who supply or are expected to supply tobacco or liquor stocks to the outlet. The Commission may at its discretion and for any reasonable cause limit or prohibit the purchase of said stock from a supplier or wholesaler.

10–7.04 Freedom of Information From Suppliers

Operators shall in their purchase of stock and in their business relationships with suppliers cooperate with and assure a free flow of information and data to the Commission from suppliers relating to all sales to and business arrangements between the suppliers and operators. The Commission may, in its discretion, require the receipt from the suppliers of all invoices, bills of lading, billings or other documentary record of sales to the operator.

10–7.05 Operator's Premises Open to Commission Inspection

The premises of all Tribal Operators, including vehicles used in connection with liquor sales, shall be open at all times to inspection by the Kalispel Liquor Commission.

10–7.06 Operator's Records

The originals or copies of all sales slips, invoices and other memoranda covering all purchases of liquor by operators shall be kept on file in the retail premises of the operator purchasing the same for at least five (5) years after each purchase, and shall be filed separately and kept apart from all other records, and as nearly as possible shall be filed in consecutive order and each month's records kept separate so to render the same readily available for inspection and checking. All canceled checks, bank statements and books of accounting covering or involving the purchase of liquor, and all memoranda, if any, showing payment of money for liquor other than by check, shall be likewise preserved for availability for inspection and checking.

10–7.07 Other Business by Operator

An operator may conduct another business simultaneously with managing a tobacco or liquor and beer outlet for the Tribe. The other business may be conducted on the same premises, but the operator shall be required to maintain separate books of account for the other business.

10–7.08 Audit

All of the books and other business records of the outlet shall be available for inspection and audit by the Commission or its authorized representative for any reasonable time.

10–7.09 Tribal Liability and Credit

An operator is forbidden to represent or give the impression to any supplier or other person with whom he or she does business that he is an official representative of the Tribe or Commission authorized to pledge Tribal credit or financial responsibility for any of the expenses of his or her business operation. The operator shall hold the Kalispel Indian Tribe harmless from all claims and liability of whatever nature. The Commission shall revoke the operator's outlet license if the outlet is not operated in a businesslike manner or if it does not remain financially solvent or does not pay its operating expenses and bills before they become delinquent.

10–7.10 Bond for Excise Tax

The excise tax together with reports on forms to be supplied by the Tribe shall be remitted to the Tribal office monthly unless otherwise specified in writing by the Commission. The operator shall furnish a satisfactory bond to the Tribe in an amount to be specified by the Commission guaranteeing his or her payment of excise tax.

10–7.11 Insurance

The operator shall maintain at his or her expense adequate insurance covering liability, fire, theft, vandalism and other insurable risks. The Commission or the Business Committee may establish as a condition of any licenses, higher limits and any additional coverage it deems advisable. All insurance policies shall name the Tribe as an insured.

10–7.12 Liability for Bills

The Tribe shall have no legal responsibility for any unpaid bills owed by a non-Tribally owned tobacco or liquor and beer outlet to a wholesale supplier or to any other person. The operator shall make arrangements with his or her wholesalers to send copies of all of his or her purchase invoices to the Tribal office.

10–7.13 Assent to Tribal Court Jurisdiction

Operation of a Tribally-licensed tobacco or liquor outlet by a business entity creates a consensual relationship between the Tribe and the operator and the operator consents to Tribal court jurisdiction.

§ 10–8 Tribal Enterprises

10–8.01 Applicability

This Section applies to Kalispel Tribal business enterprises, including tobacco and liquor outlets and gaming facilities. This Section is not applicable to outlets described in Section 10–7.01.

10–8.02 Subrogation of Chapter 17 Provisions

Each tobacco and/or liquor and beer outlet, owned, managed and operated as a Kalispel Tribal Business Enterprise shall conform to the regulations and prohibitions outlined by this Chapter, to the extent that they are not in conflict with Chapter 17 of the Kalispel Tribe Law and Order Code. In case of conflict, the provisions of this Chapter shall be subrogated for the applicable provisions in Chapter 17.

10–8.03 Other Business

A tobacco and/or liquor and beer outlet, owned, managed and operated as a Kalispel Tribal Business Enterprise may conduct another business simultaneously with the outlet. The other business may be conducted on the same premises, but separate books of account for the other business shall be maintained.

10–8.04 Insurance

A tobacco and/or liquor and beer outlet, owned, managed and operated as a Kalispel Tribal Business Enterprise shall be covered by adequate insurance covering liability, fire, theft, vandalism and other insurable risks. The Commission or the Business Committee may establish higher limits and any additional coverage it deems advisable. All insurance policies shall name the Tribe as an insured.

10–8.05 Liability For Bills

The Tribe shall have legal responsibility for any unpaid bills owed by a tobacco or liquor and beer outlet owned, managed and operated as a Kalispel Tribal Business Enterprise to a wholesale supplier or to any other person. This liability is expressly limited by Section 17–8 of the Kalispel Tribe Law and Order Code.

§ 10–9 Tribal Court Jurisdiction

10–9.01 Jurisdiction

The Kalispel Tribal Court shall have jurisdiction over all matters described in this Code. This jurisdiction shall extend over Indians and Non-Indians to the full extent allowed by Federal, State and Tribal Law.

§ 10–10 Violations and Penalties

1–10.01 Violation and Penalties

Any tobacco or liquor outlet operator violating this chapter shall be guilty of an offense and subject to fine that the Tribal Court determines to be appropriate and/or the Tribal Court may also order that the license to sell tobacco or liquor be revoked or suspended.

1–10.02 Integration of Chapter 9

With the exception of Section 10–4.07, which permits purchase and consumption of alcoholic beverages at Northern Quest casino and other Tribally licensed liquor outlets, nothing in this chapter shall be deemed to override the criminal offenses described in Chapter 9 of the Kalispel Tribe Law and Order Code. The criminal offenses described therein shall have full force and effect concurrently with any violation of this Chapter.

10–10.03 Integration of Chapter 13

If an action or omission is deemed to violate both this Chapter and Chapter 9, the Tribal prosecutor shall prosecute the offense or violation under whichever provision provides for the harsher sentence, either under this Chapter or Chapter 13 of the Kalispel Tribe Law and Order Code.

10–10.04 Non-Indian Violators

Non-Indian individuals found to be in violation of this Chapter, Chapter 9 or an applicable statute under the Revised Code of Washington shall be subject to legal action that is in conformity with current Washington law.

§ 10–11 Sovereign Immunity

10–11.01 Consent To Sue Tribe Not Granted

This Chapter does not grant jurisdiction or authority to bring suit against the Kalispel Indian Tribe. Nothing in this Chapter shall be deemed a waiver of the sovereign immunity from suit of the Tribe or its agents, entities, instrumentalities, or officials, which immunity is hereby held to extend to the Tribe and its officers and employees acting for the Tribe within the scope of their Tribal authority.

§ 10–12 Separability

10–12.01 Separability

If any provision of this chapter, its application to any person or circumstance is held invalid, the remainder of the chapter or the application of the provision to other persons or circumstances is not affected.

[FR Doc. E9–28230 Filed 11–24–09; 8:45 am]
BILLING CODE 4310–4J–P

DEPARTMENT OF THE INTERIOR

National Park Service

National Register of Historic Places; Notification of Pending Nominations and Related Actions

Nominations for the following properties being considered for listing or related actions in the National Register were received by the National Park Service before November 6, 2009. Pursuant to § 60.13 of 36 CFR Part 60 written comments concerning the significance of these properties under the National Register criteria for evaluation may be forwarded by United States Postal Service, to the National Register of Historic Places, National Park Service, 1849 C St., NW., 2280, Washington, DC 20240; by all other carriers, National Register of Historic Places, National Park Service, 1201 Eye St., NW., 8th floor, Washington, DC 20005; or by fax, 202–371–6447. Written or faxed comments should be submitted by December 10, 2009.

J. Paul Loether,

Chief, National Register of Historic Places/National Historic Landmarks Program.

CALIFORNIA

Mendocino County

Navarro, Navarro Beach Rd., Albion, 09001089

IOWA

Polk County

Mattes, Minnie Y. and Frank P., House, (Architectural Legacy of Proudfoot & Bird in Iowa MPS) 1305 34th St., Des Moines, 09001090

KANSAS

Bourbon County

Fort Scott Downtown Historic District, Oak to 3rd St., Scott Ave. to National Ave., Fort Scott, 09001091

Doniphan County

Wathena Fruit Growers' Association Building, 104 3rd St., Wathena, 09001092

MARYLAND

Anne Arundel County

Quarter Place, 216 Marlboro Rd., Lothian, 09001094

Scott, Lula G., Community Center (Rosenwald Schools of Anne Arundel County, Maryland MPS), 6243 Shady Side Rd., Shady Side, 09001093

MASSACHUSETTS

Middlesex County

Crafts Street City Stable (Newton MRA), 90 Crafts St., Newton, 09001095

Plymouth County

Marshfield Hills HD, Bow, Highland, Main, Old Main, Pleasant and Prospect Sts., Glen, Marshfield, 09001096

MINNESOTA

Blue Earth County

Mapleton Public Library, 104 1st. Ave. NE., Mapleton, 09001097

MISSOURI

Jackson County

Switzer School Buildings, generally bounded by Madison Ave. and Summit St., 18th to 20th Sts., Kansas City, 09001098

St. Louis Independent city

Marine Villa Neighborhood Historic District (South St. Louis Historic Working and Middle Class Streetcar Suburbs MPS), Roughly bounded by S. Broadway, Chippewa, Cahokia, Kosciusko & Winnebago, St. Louis, 09001099

NEW JERSEY

Monmouth County

Carlton, Theatre, The, 99 Monmouth St., Red Bank Borough, 09001100

Salem County

Boudinot—Southard Farmstead, 135 N. Maple Ave., Bernards Township, 09001101

Somerset County

Six Mile Run Reformed Church, 3037 NJ 27, Franklin, 09001102

NORTH CAROLINA

Catawba County

Claremont High School Historic District (Boundary Increase), (Hickory MRA) 505–753 N. Center St., 102–126 and 401 2nd Ave NE, 406–602 3rd Ave. NE, 12–118 5th Ave. NW, 212–258 5th Ave., Hickory, 09001103

Currituck County

Jarvisburg Colored Schools, 7301 NC 158, Jarvisburg, 09001104

Durham County

Hope Valley Historic District, (Durham MRA) Avon Rd., Chelsea Circle, Cornwall Rd., Devon Rd. Exeter Way, Littlewoods Ln., Norwich Way, Stratford Rd., Durham, 09001105

Wake County

Meadowbrook Country Club, 8025 Country Club Dr., Garner, 09001106

SOUTH CAROLINA

Richland County

Spigner, A. Fletcher, House, 2028 Wheat St., Columbia, 09001107

UTAH

San Juan County

Neck and Cabin Springs Grazing Area, Grand View Point Rd., Moab, 09001108

WYOMING

Albany County

University Neighborhood Historic District, Roughly bounded by 6th St., 15th St., University Ave. and Custer St., Laramie, 09001109

Big Horn County

Carey Block, 602 Greybull Ave., Greybull, 09001110

[FR Doc. E9–28232 Filed 11–24–09; 8:45 am]

BILLING CODE P

DEPARTMENT OF THE INTERIOR

National Park Service

National Register of Historic Places; Weekly Listing of Historic Properties

Pursuant to (36 CFR 60.13(b,c)) and (36 CFR 63.5), this notice, through publication of the information included herein, is to apprise the public as well as governmental agencies, associations and all other organizations and individuals interested in historic preservation, of the properties added to, or determined eligible for listing in, the National Register of Historic Places from September 14, to September18, 2009.

For further information, please contact Edson Beall via: United States Postal Service mail, at the National Register of Historic Places, 2280, National Park Service, 1849 C St., NW., Washington, DC 20240; in person (by appointment), 1201 Eye St., NW., 8th floor, Washington DC 20005; by fax, 202–371–2229; by phone, 202–354–2255; or by e-mail, *Edson_Beall@nps.gov.*

Dated: November 17, 2009.

J. Paul Loether,

Chief, National Register of Historic Places/National Historic Landmarks Program.

KEY: State, County, Property Name, Address/Boundary, City, Vicinity, Reference Number, Action, Date, Multiple Name

ALABAMA

Monroe County

Monroeville Downtown Historic District, Parts of N. and S. Alabama Aves., E. and W. Claiborne St., N. and S. Monut Pleasant Aves., Pineville Rd., Monroeville, 09000606, LISTED, 9/16/09

ARKANSAS

Poinsett County

Harrisburg Commercial Historic District, Roughly bounded by Jackson, Water, South & Gould Sts., Harrisburg, 09000736, LISTED, 9/18/09

Marked Tree Commercial Historic District, Elm St. between Liberty & Frisco Sts.; Frisco St. between Elm and Nathan Sts., Marked Tree, 09000735, LISTED, 9/18/09

Pope County

Atkins Commercial Historic District, Roughly bounded by Main, Church, & 1st Sts., Ave., 2., Atkins, 09000739, LISTED, 9/18/09

IOWA

Black Hawk County

Fowler Company Building, The, 226–228 E. 4th St., Waterloo, 09000712, LISTED, 9/16/09

Dubuque County

Schrup, John and Marie (Palen) Farmstead Historic District, 10086 Lake Eleanor Rd., Dubuque vicinity, 09000713, LISTED, 9/16/09

Poweshiek County

Kent Union Chapel and Cemetery, 3386 V18 Rd., Brooklyn vicinity, 09000715, LISTED, 9/16/09

MASSACHUSETTS

Berkshire County

Tyringham Cemetery, Church Rd., Tyringham, 09000716, LISTED, 9/16/09

Suffolk County

Fairview Cemetery, 45 Fairview Ave., Boston, 09000717, LISTED, 9/16/09

MISSISSIPPI

Coahoma County

Clarksdale Historic District, Roughly bounded by the Sunflower R., 10th St., DeSoto Ave. & Clark St., Clarksdale, 09000763, LISTED, 9/14/09

MISSOURI

Adair County,

Travelers Hotel, 301 W. Washington St., Kirksville, 09000718, LISTED, 9/16/09

St. Louis County

Meramec River U.S. Bridge—J421, Historic U.S. Rt. 66 spanning the Meramec River, Eureka vicinity, 09000888, LISTED, 9/16/09 (Route 66 in Missouri MPS)

St. Louis Independent City

Grand—Bates Suburb Historic District, Roughly bounded by Bates St., Grand Blvd., I–55, Alaska Ave., Fillmore & Iron Sts., St. Louis, 09000719, LISTED, 9/16/09

NEW YORK

Montgomery County

Kilts Farmstead, Address Restricted, Stone Arabia vicinity, 09000721, LISTED, 9/18/09

New York County

Trinity Lutheran Church of Manhattan, 164 W. 100th St., New York, 09000722, LISTED, 9/16/09

Saratoga County

Bullard Block, 90–98 Broad St., Schuylerville vicinity, 09000723, LISTED, 9/16/09

NORTH CAROLINA

Robeson County

Surles, W.R. Memorial Library, 105 W. Main St., Proctorville, 09000725, LISTED, 9/16/09

VIRGINIA

Danville Independent City

Hylton Hall, 700 Lanier Ave., Danville (Independent City), 09000726, LISTED, 9/14/09

Goochland County

Oak Grove, 664 Manakin Rd., Manikan-Sabot, 09000727, LISTED, 9/16/09

Highland County

Crab Run Lane Truss Bridge, VA 645 over Crab Run, McDowell, 09000728, LISTED, 9/16/09

Hopewell Independent City

Hopewell High School Complex, 1201 City Point Rd., Hopewell (Independent City), 09000729, LISTED, 9/16/09

Richmond Independent City

Ninth Street Office Building, 202 N. 9th St., Richmond (Independent City), 09000730, LISTED, 9/16/09

Richmond Independent City

West Franklin Street Historic District (Boundary Increase), 900 blk. West Grace St., 4000 blk. N. Harrison St., 300 blk. Shafer St., Richmond (Independent City), 09000731, LISTED, 9/16/09

WASHINGTON

Thurston County

Millersylvania State Park, 12245 Tilley Rd., Olympia, 09000732, LISTED, 9/16/09

WEST VIRGINIA

Jefferson County

South Charles Town Historic District, S. George, S. Mildred, S. Samuel, & S. Church Sts., Charles Town, 09000733, LISTED, 9/16/09

[FR Doc. E9–28231 Filed 11–24–09; 8:45 am]

BILLING CODE P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–686]

Certain Bulk Welding Wire Containers and Components Thereof and Welding Wire; Notice of Commission Determination Not To Review an Initial Determination Granting Complainant's Motion To Amend the Complaint and Notice of Investigation

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: Notice is hereby given that the U.S. International Trade

Commission has determined not to review an initial determination (''ID'') (Order No. 9) of the presiding administrative law judge (''ALJ'') granting complainant's motion to amend the complaint and notice of investigation.

FOR FURTHER INFORMATION CONTACT: Panyin A. Hughes, Esq., Office of the General Counsel, U.S. International Trade Commission, 500 E Street, SW., Washington, DC 20436, telephone (202) 205–3042. Copies of non-confidential documents filed in connection with this investigation are or will be available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 500 E Street, SW., Washington, DC 20436, telephone (202) 205–2000. General information concerning the Commission may also be obtained by accessing its Internet server at *http://www.usitc.gov.* The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.* Hearing-impaired persons are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on (202) 205–1810.

SUPPLEMENTARY INFORMATION: The Commission instituted this investigation on September 8, 2009, based on a complaint filed by The Lincoln Electric Company of Cleveland, Ohio and Lincoln Global, Inc. of City of Industry, California (collectively, ''Lincoln''). 74 FR 46223 (Sept. 8, 2009). The complaint alleged violations of section 337 of the Tariff Act of 1930 (19 U.S.C. 1337) in the importation into the United States, the sale for importation, or the sale within the United States after importation of certain bulk welding wire containers and components thereof and welding wire by reason of infringement of certain claims of United States Patent Nos. 6,260,781; 6,648,141; 6,708,864; 6,913,145; 7,309,038; 7,398,881; and 7,410,111. *Id.* The complaint named five respondents: Atlantic China Welding Consumables, Inc., of Sichuan, China; ESAB AB, of Göteborg, Sweden (''ESAB AB''); Hyundai Welding Co., Ltd., of Seoul, Korea; Kiswel Co., Ltd. of Seoul, Korea; and Sidergas SpA, of Ambrogio (Verona) Italy. *Id.* at 46224.

On October 28, 2009, Lincoln filed an unopposed motion to amend the complaint and notice of investigation to remove ESAB AB from the investigation and add The ESAB Group, Inc. of Florence, South Carolina (''The ESAB Group''). Lincoln stated that ESAB AB has represented that it is not involved in the manufacture, importation into the United States, sale for importation, or sale with the United States after importation of bulk wire containers, components thereof and welding wire. Lincoln further stated that the entity responsible for the activities that form the basis of Lincoln's claim against ESAB AB is The ESAB Group, and that neither ESAB AB nor The ESAB Group oppose the motion.

On October 30, 2009, the ALJ issued Order No. 9 granting Lincoln's motion. None of the parties petitioned for review of Order No 9. The Commission has determined not to review the ID.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in section 210.42(h) of the Commission's Rules of Practice and Procedure (19 CFR 210.42(h)).

Issued: November 19, 2009.

By order of the Commission.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. E9–28222 Filed 11–24–09; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Notice of Lodging of a Consent Decree Under the Clean Water Act

Notice is hereby given that on November 13, 2009, a proposed Consent Decree in *United States* v. *City of Akron, Ohio and State of Ohio,* Civil Action No. 05:09–cv–0272 was lodged with the United States District Court for the Northern District of Ohio.

In this action the United States, and the State of Ohio in a cross-claim, sought civil penalties and injunctive relief for violations of the Clean Water Act, 33 U.S.C. 1251 *et seq.,* in connection with the City of Akron's (''Akron's'') operation of its municipal wastewater treatment facility and sewer system. The United States' First Amended Complaint and the State's cross-claim allege, among other things, that Akron violated the Clean Water Act and its National Pollution Discharge Elimination System (''NPDES'') Permit by discharging pollutants from Combined Sewer Overflow (''CSO'') points to navigable waters and waters of the State during dry weather, and during wet weather in a manner that violates the general effluent limitations of the NPDES Permit; diverting wastewater from secondary treatment at the treatment plant, known as the Water Pollution Control Station (''WPCS''); failing to monitor or report the results of its monitoring; and releasing untreated sewage from its sewer system into buildings and onto public and private property.

Under the proposed Decree, Akron will develop and implement a comprehensive plan to eliminate or reduce (i) combined sewer overflows in its sewer system and (ii) bypasses around secondary treatment at the WPCS. Within eight years, Akron will expand secondary treatment capacity at the WPCS to at least 130 million gallons of wastewater per day and will construct separate sewer lines for five combined sewer outfall points. Akron will also implement capacity, maintenance and emergency response programs to improve sewer system performance and to eliminate or reduce releases from the sewer collection system, including basement backups, releases into buildings, and onto property. The proposed Decree requires Akron to pay a total civil penalty of $500,000. Also, as a State Supplemental Environmental Project to improve water quality in the Cuyahoga River, Akron will pay $900,000 towards the removal of the Brecksville (or Route 82) Dam.

The Department of Justice will receive for a period of sixty (60) days from the date of this publication comments relating to the proposed Consent Decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and either e-mailed to *pubcomment-ees.enrd@usdoj.gov* or mailed to P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *City of Akron, Ohio and State of Ohio,* D.J. Ref. 90–5–1–1–3144/2.

The proposed Consent Decree may be examined at the Office of the United States Attorney, Northern District of Ohio, 208 Federal Building, Two South Main Street, Akron, OH 44308–1855 (contact Assistant United States Attorney James Bickett (330/761–0523), and at U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, IL 60604–3590 (contact Associate Regional Counsel Susan Perdomo (312/886–0557)). During the public comment period the proposed Consent Decree may also be examined on the following Department of Justice Web site, *http://www.usdoj.gov/enrd/Consent_Decrees.html.* A copy of the proposed consent decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611 or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*), fax no.

(202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy from the Consent Decree Library, please enclose a check in the amount of $29.50 (25 cents per page reproduction cost) payable to the U.S. Treasury or, if by e-mail or fax, forward a check in that amount to the Consent Decree Library at the stated address.

Maureen M. Katz,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. E9–28221 Filed 11–24–09; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

Federal Bureau of Investigation

[OMB Number 1110–NEW]

Agency Information Collection Activities: New Collection, Comments Requested

ACTION: 60-day emergency notice of information collection under review: New collection; Cargo Theft Incident Report.

The Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and clearance in accordance with emergency review procedures of the Paperwork Reduction Act of 1995. OMB approval has been requested by February 27, 2010. The proposed information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted until January 25, 2010 This process is conducted in accordance with 5 CFR 1320.10.

All comments and suggestions, or questions regarding additional information, to include obtaining a copy of the proposed information collection instrument with instructions, should be directed to Gregory E. Scarbro, Unit Chief, Federal Bureau of Investigation, Criminal Justice Information Services Division (CJIS), Module E–3, 1000 Custer Hollow Road, Clarksburg, West Virginia 26306, or facsimile to (304) 625–3566.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Comments should address one or more of the following four points:

(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, 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 of other forms of information technology, *e.g.,* permitting electronic submission of responses.

Overview of This Information Collection

(1) *Type of information collection:* New collection.

(2) *The title of the form/collection:* Cargo Theft Incident Report.

(3) *The agency form number, if any, and the applicable component of the department sponsoring the collection: Form Number:* None;

Sponsor: Criminal Justice Information Services Division, Federal Bureau of Investigation, Department of Justice.

(4) *Affected public who will be asked or required to respond, as well as a brief abstract: Primary:* City, county, state, federal, and tribal law enforcement agencies.

Brief Abstract: This collection is needed to collect information on cargo theft incidents committed throughout the United States.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* There are approximately 17,799 law enforcement agency respondents that submit monthly for a total of 213,588 responses with an estimated response time of 5 minutes per response.

(6) *An estimate of the total public burden (in hours) associated with this collection:* There are approximately 17,799 hours, annual burden, associated with this information collection.

If additional information is required contact: Ms. Lynn Bryant, Department Clearance Officer, Policy and Planning Staff, Justice Management Division, United States Department of Justice, Patrick Henry Building, Suite 1600, 601 D Street, NW., Washington, DC 20530.

Dated: November 19, 2009.

Lynn Bryant,

Department Clearance Officer, PRA, United States Department of Justice.

[FR Doc. E9–28223 Filed 11–24–09; 8:45 am]

BILLING CODE 4410–02–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review: Comment Request

November 19, 2009.

The Department of Labor (DOL) hereby announces the submission of the following public information collection requests (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of each ICR, with applicable supporting documentation; including, among other things, a description of the likely respondents, proposed frequency of response, and estimated total burden may be obtained from the RegInfo.gov Web site at *http://www.reginfo.gov/public/do/PRAMain* or by contacting Darrin King on 202–693–4129 (this is not a toll-free number)/e-mail: *DOL_PRA_PUBLIC@dol.gov.*

Interested parties are encouraged to send comments to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Department of Labor—Occupational Safety and Health Administration (OSHA), Office of Management and Budget, Room 10235, Washington, DC 20503, Telephone: 202–395–7316/Fax: 202–395–5806 (these are not toll-free numbers), E-mail: *OIRA_submission@omb.eop.gov* within 30 days from the date of this publication in the **Federal Register.** In order to ensure the appropriate consideration, comments should reference the OMB Control Number (see below).

The OMB is particularly interested in comments which:

- 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;
- 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;
- Enhance the quality, utility, and clarity of the information to be collected; and

• 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.

Agency: Occupational Safety and Health Administration.

Type of Review: Extension without change of a previously approved collection.

Title of Collection: Benzene (29 CFR 1910.1028).

OMB Control Number: 1218–0129.

Affected Public: Business or other for-profits.

Estimated Number of Respondents: 13,498.

Estimated Total Annual Burden Hours: 126,184.

Estimated Total Annual Costs Burden (excludes hourly wage costs): $8,189,789.

Description: The Department's regulations at 29 CFR 1910.1028 requires employers to train workers about the hazards of benzene, to monitor worker exposure, to provide medical surveillance, and maintain accurate records of worker exposure to benzene. These records are used by employers, workers, physicians and the Government to ensure that workers are not harmed by exposure to benzene in the workplace. For additional information, see the related 60-day preclearance notice published in the **Federal Register** at Vol. 74 FR 39978 on August 10, 2009. PRA documentation prepared in association with the preclearance notice is available on *http://www.regulations.gov* under docket number OSHA–2009–00021.

Agency: Occupational Safety and Health Administration.

Type of Review: Extension without change of a previously approved collection.

Title of Collection: Personal Protective Equipment (PPE) for Shipyard Employment (29 CFR part 1915, subpart 1).

OMB Control Number: 1218–0215.

Affected Public: Business or other for-profits.

Estimated Number of Respondents: 639.

Estimated Total Annual Burden Hours: 2,827.

Estimated Total Annual Costs Burden (excludes hourly wage costs): $0.

Description: The Department's regulations at 29 CFR part 1915, subpart I requires employers to provide and ensure that each affected employee uses the appropriate personal protective equipment (PPE) for the eyes, face, head, extremities, torso, and respiratory system, including protective clothing, protective shields, protective barriers, life-saving equipment, personal fall arrest systems, and positioning device systems that meets the applicable provisions of this subpart, whenever workers are exposed to hazards that require the use of PPE. For additional information, see the related 60-day preclearance notice published in the **Federal Register** at Vol. 74 FR 45883 on September 4, 2009. PRA documentation prepared in association with the preclearance notice is available on *http://www.regulations.gov* under docket number OSHA–2009–0017.

Darrin A. King,

Departmental Clearance Officer.

[FR Doc. E9–28220 Filed 11–24–09; 8:45 am]

BILLING CODE 4510–26–P

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

[Docket No. OSHA–2009–0030]

Announcement of a Meeting of the Advisory Committee on Construction Safety and Health (ACCSH) and ACCSH Work Group Meetings

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Announcement of a meeting of the Advisory Committee on Construction Safety and Health (ACCSH) and ACCSH Work Group meetings.

SUMMARY: ACCSH will meet December 10 and 11, 2009, in Washington, DC. In conjunction with ACCSH's meeting, its Work Groups will meet December 8 and 9, 2009.

DATES: *ACCSH:* ACCSH will meet from 8:30 a.m. to 4:30 p.m., Thursday, December 10, 2009, and from 8:30 a.m. to Noon, Friday, December 11, 2009.

ACCSH Work Groups: ACCSH Work Groups will meet Tuesday, December 8, and Wednesday, December 9, 2009. (For Work Group meeting times, see the Work Group Schedule information in the **SUPPLEMENTARY INFORMATION** section of this notice.)

Submission of comments, requests to speak, speaker presentations, and requests for special accommodation: Comments, requests to address the ACCSH meeting, written or electronic speaker presentations, and requests for special accommodation for the ACCSH and ACCSH Work Group meetings must be submitted (postmarked, sent, transmitted) by December 2, 2009.

ADDRESSES:

ACCSH and ACCSH Work Group Meetings: ACCSH and ACCSH Work Group meetings will be held in Rooms N–3437 A–C, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210.

Submission of comments, requests to speak, and speaker presentations: Interested persons may submit comments, requests to address the ACCSH meeting, and speaker presentations using one of the following methods:

Electronically: You may submit materials, including attachments, electronically at *http://www.regulations.gov,* which is the Federal eRulemaking Portal. Follow the on-line instructions for submissions or comments.

Facsimile (FAX): If your submission, including attachments, does not exceed 10 pages, you may fax it to the OSHA Docket Office at (202) 693–1648.

Mail, hand delivery, express mail, messenger, or courier service: Submit three copies of your submissions to the OSHA Docket Office, Room N–2625, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210; telephone (202) 693–2350 (TTY (877) 889–5627). Deliveries (hand deliveries, express mail, messenger, and courier service) are accepted during the Department of Labor's and OSHA Docket Office's normal business hours, 8:15 a.m.–4:45 p.m., e.t., weekdays, except holidays.

Requests for special accommodations: Submit requests for special accommodations to Ms. Veneta Chatmon, OSHA, Office of Communications, Room N–3647, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210; telephone (202) 693–1999; e-mail *chatmon.veneta@dol.gov.*

Instructions: All submissions, requests to speak, speaker presentations, and requests for special accommodations must include the Agency name (Occupational Safety and Health Administration) and the docket number for this meeting (Docket No. OSHA–2009–0030). Because of security-related procedures, submissions by regular mail may experience significant delays. For information about security procedures for submitting materials by hand delivery, express mail, messenger, or courier service, contact the OSHA Docket Office.

Comments, speaker presentations and requests to speak, including personal information, are placed in the public

docket without change and may be available online. Therefore, OSHA cautions against submitting certain personal information such as social security numbers and birthdates. For further information on submitting comments, requests to speak, speaker presentations, and requests for public accommodation, see the Public Participation information in the **SUPPLEMENTARY INFORMATION** section.

To read or download documents in the public docket for this ACCSH meeting, go to Docket No. OSHA–2009–0030 at *http://www.regulations.gov.* All documents in the public docket are listed in the *http://www.regulations.gov* index; however, some documents (e.g., copyrighted material) are not available to read on line or download from that webpage. All documents, including copyrighted material, are available for inspection and copying at the OSHA Docket Office. Please contact the OSHA Docket Office for assistance making submissions to or obtaining materials from the public docket.

FOR FURTHER INFORMATION CONTACT:

For press inquiries: Ms. Jennifer Ashley, OSHA, Office of Communications, Room N–3647, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210; telephone (202) 693–1999.

For general information about ACCSH and ACCSH meetings: Mr. Michael Buchet, OSHA, Directorate of Construction, Room N–3468, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210; telephone (202) 693–2020; e-mail *buchet.michael@dol.gov.*

SUPPLEMENTARY INFORMATION:

ACCSH Meeting

ACCSH will meet Thursday, December 10, 2009 and Friday, December 11, 2009, in Washington, DC. The meeting is open to the public.

ACCSH is authorized to advise the Secretary of Labor and Assistant Secretary of Labor for Occupational Safety and Health in the formulation of standards affecting the construction industry and on policy matters arising in the administration of the safety and health provisions of the Contract Work Hours and Safety Standards Act (Construction Safety Act) (40 U.S.C. 3701, 3704) and the Occupational Safety and Health Act of 1970 (29 U.S.C. 651 *et seq.*). (See also 29 CFR 1911.10 and 1912.3).

The agenda topics for this meeting include:

- *Welcome/Remarks from the Office of the Assistant Secretary;*
- *Remarks from the Directorate of Construction;*
- *OSHA 10–Hour Outreach Training and Hispanic Summit Discussion—Office of the Assistant Secretary;*
- *Analysis of FY 2007 Construction Health Enforcement Data—Center for Construction Research and Training (CPWR);*
- *Stimulus Impact on Transportation and Utility Construction—Associated General Contractors;*
- *Stimulus Impact on Alternate Energy, Transmission and Distribution, Including Smart Grid Concerns—National Electrical Contractors Association;*
- *Committee Consideration of and Recommendations to the Assistant Secretary Concerning the following:*
- Proposed Rule on the Standards Improvement Project III (SIP III);
- Revisions to OSHA's Occupational Injury and Illness Recording and Reporting (Recordkeeping) regulation; and
- Proposed Rule on Occupational Exposure to Crystalline Silica;
- *Work Group Reports, Work Group and Committee Administration; and*
- *Public Comment Period.*

ACCSH meetings are transcribed and detailed minutes of the meetings are prepared. The transcript and minutes are placed in the public docket for the meeting. The docket also includes ACCSH Work Group reports, speaker presentations, comments, and other materials and requests submitted to the Committee.

ACCSH Work Group Meetings

In conjunction with the ACCSH meeting, the following ACCSH Work Groups will meet on Tuesday, *December 8, 2009 in Rooms N–3437 A/B or C:*

- Regulatory Compliance (Focused Inspection) 8 to 9:40 a.m.—Room C;
- Silica 9:50 to 11:30 a.m.—Room A/B;
- Residential Fall Protection 12:30 to 2:10 p.m.—Room A/B;
- Trenching 2:20 to 4 p.m.—Room C; and
- Multilingual 4:10 to 5:50 p.m.—Room C.

The following additional ACCSH Work Groups will meet on Wednesday,

December 9, 2009 in Rooms N–3437 A/B or C:

- Powered Fastening Tools (Nail guns) 8:30 to 10:10 a.m.—Room A/B;
- ROPS (Roll Over Protective Structures) 10:20 to Noon—Room A/B;
- Diversity—Women in Construction 1:00 to 2:40 p.m.—Room C; and
- Education and Training (OTI) 2:50 to 4:30 p.m.—Room A/B.

For additional information on ACCSH Work Group meetings or participating in them, please contact Mr. Buchet at the address above or look on the ACCSH page on OSHA's Web page at *http://www.osha.gov.*

Public Participation

ACCSH Meetings and ACCSH Work Group Meetings: ACCSH and ACCSH Work Group meetings are open to the public. Individuals needing special accommodations for ACCSH or ACCSH Work Group meeting access please contact Ms. Chatmon (see **ADDRESSES** section).

Submission of written comments, requests to address ACCSH, speaker presentations, and requests for special accommodations: Interested persons may submit comments, requests to address ACCSH, presentations, and requests for special accommodations (1) Electronically, (2) by FAX, or (3) by hard copy (mail, hand delivery, express mail, messenger, and courier). All submissions must include the docket number for this ACCSH meeting (Docket No. OSHA–2009–0030). Individuals who want to address ACCSH at the meeting must submit their requests and written or electronic presentations (e.g. PowerPoints) by December 2, 2009. The request must state the amount of time desired to speak, the interest the presenter represents (e.g., businesses, organizations, affiliations, etc.), if any, and a brief outline of the presentation. PowerPoint presentations must be compatible with PowerPoint 2003.

Alternately at the ACCSH meeting, individuals may also request to address ACCSH by signing the public comment request sheet and listing the interests they represent, if any, and the topic(s) to be addressed. In addition, they must provide 20 hard copies of any materials, written or electronic, that they plan to present to ACCSH.

Requests to address the Committee may be granted at the ACCSH Chair's discretion and as time and circumstances permit.

Comments, requests to address ACCSH, and speaker presentations are included without change in the meeting record and may be made available online at *http://www.regulations.gov.* Therefore, OSHA cautions interested parties about submitting certain personal information such as birth dates and social security numbers.

Access to the record of ACCSH meetings, including Work Group reports: To read or download the record of this ACCSH meeting including transcript, minutes, Work Group reports and other submissions go to Docket No. OSHA–2009–0030 at *http://www.regulations.gov.* The meeting record and all submissions for this meeting will be listed in the *http://*

www.regulations.gov index; however, some documents (e.g., copyrighted materials) are not publicly available through the Web page. The record and all submissions, including materials not available through *http://www.regulations.gov* will be available for inspection and copying in the OSHA Docket Office (see **ADDRESSES**).

Authority and signature: Mr. Jordan Barab, Acting Assistant Secretary of Labor for Occupational Safety and Health, directed the preparation of this notice under the authority granted by section 7 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 656), section 107 of the Contract Work Hours and Safety Standards Act (Construction Safety Act) (40 U.S.C. 3701 *et seq.*), the Federal Advisory Committee Act (5 U.S.C. App), 29 CFR Parts 1911 and 1912, 41 CFR Part 102, and Secretary of Labor's Order No. 5–2007 (72 FR 31160).

Signed at Washington, DC this 19th day of November 2009.

Jordan Barab,

Acting Assistant Secretary of Labor for Occupational Safety and Health.

[FR Doc. E9–28135 Filed 11–24–09; 8:45 am]

BILLING CODE 4510–26–P

LEGAL SERVICES CORPORATION

Sunshine Act Meeting Notice; Board of Directors and Four Board Committees

DATE AND TIME: The Legal Services Corporation Board of Directors and four of the Board's Committees will meet on November 30, 2009 in the order set forth in the following schedule. The first meeting will commence at 11 a.m., Eastern Time. Each meeting thereafter will commence promptly upon adjournment of the immediately preceding meeting, with the Audit Committee and the Finance Committee meeting jointly.

LOCATION: Legal Services Corporation, 3333 K Street, NW., Washington, DC 20007, 3rd Floor Conference Center.

PUBLIC OBSERVATION: For all meetings and portions thereof open to public observation, members of the public who are unable to attend but wish to listen to the proceedings may do so by following the telephone call-in directions given below. You are asked to keep your telephone muted to eliminate background noises. From time to time the presiding Chairman may solicit comments from the public.

CALL-IN DIRECTIONS FOR OPEN SESSIONS:

- Call toll-free number: 1–866–451–4981;
- When prompted, enter the following numeric pass code: 3899506694;
- When connected to the call, please mute your telephone immediately.

MEETING SCHEDULE:

	Time
1. Joint Meeting of the *Audit Committee* and *Finance Committee.*	11 a.m.
2. *Governance & Performance Review Committee.*	
3. *Search Committee for an Interim LSC President.*	
4. *Board of Directors.*	

Status of Meetings

Open, except as noted below:

- *Joint Meeting of the Audit & Finance Committees*—A portion of the meeting may be closed to the public pursuant to a vote of the Board of Directors so the committees may consider and perhaps act on recommendations related to how the Corporation may proceed with self-correction of an independent contractor issue and what related actions to take on proposed resolutions concerning LSC's 403(b) Thrift Plan and related provisions of the Employee Handbook. The Committees will also hear a briefing by the Corporation's independent auditors regarding the status of LSC's fiscal year 2009 financial audit and their preliminary findings.[1] A *verbatim* written transcript will be made of the closed session of the meeting. However, the transcript of any portions of the closed session falling within the relevant provisions of the Government in the Sunshine Act, 5 U.S.C. 552b(c)(2) and (9)(B), and the corresponding provisions of the Legal Services Corporation's implementing regulation, 45 CFR 1622.5(a) and (g), will not be available for public inspection. A copy of the General Counsel's Certification that, in his opinion, the closing is authorized by law will be available upon request.
- *Search Committee for LSC Interim President*—A portion of the meeting may be closed to the public pursuant to a vote of the Board of Directors so the committee may consider and perhaps act on a recommendation to make to the full Board as to an Interim President for LSC. A *verbatim* written transcript will be made of the closed session of the Committee meeting. However, the transcript of any portions of the closed session falling within the relevant provisions of the Government in the Sunshine Act, 5 U.S.C. 552b(c)(6), and the corresponding provisions of the Legal Services Corporation's implementing regulation, 45 CFR 1622.5(e), will not be available for public inspection. A copy of the General Counsel's Certification that in his opinion the closing is authorized by law will be available upon request.
- *Board of Directors*—A portion of the meeting of the Board of Directors may be closed to the public pursuant to a vote of the Board of Directors to consider and perhaps act on: recommendations on selection of labor counsel to advise and represent the Corporation on union matters; recommendations related to how the Corporation may proceed with self-correction of an independent contractor issue and what related actions to take on the proposed resolutions concerning LSC's 403(b) Thrift Plan and related provisions of the Employee Handbook; and a recommendation on selection of an Interim President for LSC.

A *verbatim* written transcript will be made of the closed session of the Board meeting. However, the transcript of any portions of the closed session falling within the relevant provisions of the Government in the Sunshine Act, 5 U.S.C. 552b(c)(2), (6) and (9)(B), and the corresponding provisions of the Legal Services Corporation's implementing regulation, 45 CFR 1622.5(a), (e) and (g), will not be available for public inspection. A copy of the General Counsel's Certification that, in his opinion, the closing is authorized by law will be available upon request.

MATTERS TO BE CONSIDERED:

Joint Meeting of Audit Committee & Finance Committee

Agenda

Open Session

1. Approval of agenda.

Closed Session

2. Briefing by the auditing firm performing the annual independent audit of LSC on the status of the fiscal year 2009 audit and any preliminary findings.

3. Consider and act on recommendations to make to the Board related to how the Corporation should proceed with self-correction of an independent contractor issue and what related actions to take on proposed resolutions revising LSC's 403(b) Thrift Plan with regard to the minimum hours

[1] Any portion of the closed session consisting solely of briefings does not fall within the Sunshine Act definition of the term ''meeting'' and, therefore, the requirements of the Sunshine Act do not apply to such portion of the closed session. 5 U.S.C. 552b (a)(2) and (b). See also 45 CFR 1622.2 and 1622.3.

requirements for participation and related conforming amendments to the LSC Employee Handbook.

Open Session

4. Consider and act on recommendations to make to the Board related to what actions to take on proposed resolutions revising LSC's 403(b) Thrift Plan with regard to the minimum hours requirements for participation, related conforming amendments to the LSC Employee Handbook, and amendments to the LSC Employee Handbook regarding merger of LSC's TDA and 403(b) thrift plans.

5. Consider and act on recommendation to make to the Board regarding proposed use of the LSC President's discretionary fund.

6. Consider and act on other business.

7. Public comment.

8. Consider and act on motion to adjourn meeting.

Governance and Performance Review Committee

Agenda

Open Session

1. Approval of agenda.

2. Consider and act on performance review of the Inspector General.

3. Consider and act on other business.

4. Public comment.

5. Consider and act on motion to adjourn meeting.

Search Committee for Interim LSC President

Agenda

Open Session

1. Approval of agenda.

Closed Session

2. Consider and act on a recommendation to make to Board as to an interim President for LSC.

Open Session

3. Consider and act on other business.

4. Public Comment.

5. Consider and act on motion to adjourn meeting.

Board of Directors

Agenda

Open Session

1. Approval of agenda.

2. Consider and act on whether to authorize an executive session of the *Board* to address items listed below under Closed Session.

Closed Session

3. Consider and act on recommendations regarding selection of labor counsel to advise and represent the Corporation on union matters.

4. Consider and act on recommendation as to selection of an interim President for LSC.

5. Consider and act on recommendations related to how the Corporation may proceed with self-correction of an independent contractor issue and related proposed resolutions revising LSC's 403(b) Thrift Plan with regard to the minimum hours requirements for participation and related conforming amendments to the LSC Employee Handbook.

6. Consider and act on the annual performance evaluation of the Inspector General.

Open Session

7. Consider and act on recommendations related to what actions to take on proposed resolutions revising LSC's 403(b) Thrift Plan with regard to the minimum hours requirements for participation, related conforming amendments to the LSC Employee Handbook, and amendments to the LSC Employee Handbook regarding merger of LSC's TDA and 403(b) thrift plans.

8. Public comment.

9. Consider and act on other business.

10. Consider and act on motion to adjourn meeting.

Contact Person for Information: Katherine Ward, Executive Assistant to the Vice President & General Counsel, at (202) 295–1500. Questions may be sent by electronic mail to *FR_NOTICE_QUESTIONS@lsc.gov.*

Special Needs: Upon request, meeting notices will be made available in alternate formats to accommodate visual and hearing impairments. Individuals who have a disability and need an accommodation to attend the meeting may notify Katherine Ward, at (202) 295–1500 or *FR_NOTICE_QUESTIONS@lsc.gov.*

Dated: November 20, 2009.

Victor M. Fortuno,

Vice President & General Counsel.

[FR Doc. E9–28333 Filed 11–23–09; 11:15 am]

BILLING CODE 7050–01–P

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

Records Schedules; Availability and Request for Comments

AGENCY: National Archives and Records Administration (NARA).

ACTION: Notice of availability of proposed records schedules; request for comments.

SUMMARY: The National Archives and Records Administration (NARA) publishes notice at least once monthly of certain Federal agency requests for records disposition authority (records schedules). Once approved by NARA, records schedules provide mandatory instructions on what happens to records when no longer needed for current Government business. They authorize the preservation of records of continuing value in the National Archives of the United States and the destruction, after a specified period, of records lacking administrative, legal, research, or other value. Notice is published for records schedules in which agencies propose to destroy records not previously authorized for disposal or reduce the retention period of records already authorized for disposal. NARA invites public comments on such records schedules, as required by 44 U.S.C. 3303a(a).

DATES: Requests for copies must be received in writing on or before December 28, 2009. Once the appraisal of the records is completed, NARA will send a copy of the schedule. NARA staff usually prepare appraisal memorandums that contain additional information concerning the records covered by a proposed schedule. These, too, may be requested and will be provided once the appraisal is completed. Requesters will be given 30 days to submit comments.

ADDRESSES: You may request a copy of any records schedule identified in this notice by contacting the Life Cycle Management Division (NWML) using one of the following means:

Mail: NARA (NWML), 8601 Adelphi Road, College Park, MD 20740–6001.

E-mail: request.schedule@nara.gov.

Fax: 301–837–3698.

Requesters must cite the control number, which appears in parentheses after the name of the agency which submitted the schedule, and must provide a mailing address. Those who desire appraisal reports should so indicate in their request.

FOR FURTHER INFORMATION CONTACT: Laurence Brewer, Director, Life Cycle Management Division (NWML), National Archives and Records Administration, 8601 Adelphi Road, College Park, MD 20740–6001. *Telephone:* 301–837–1539. *E-mail: records.mgt@nara.gov.*

SUPPLEMENTARY INFORMATION: Each year Federal agencies create billions of records on paper, film, magnetic tape, and other media. To control this accumulation, agency records managers prepare schedules proposing retention periods for records and submit these

schedules for NARA's approval, using the Standard Form (SF) 115, Request for Records Disposition Authority. These schedules provide for the timely transfer into the National Archives of historically valuable records and authorize the disposal of all other records after the agency no longer needs them to conduct its business. Some schedules are comprehensive and cover all the records of an agency or one of its major subdivisions. Most schedules, however, cover records of only one office or program or a few series of records. Many of these update previously approved schedules, and some include records proposed as permanent.

The schedules listed in this notice are media neutral unless specified otherwise. An item in a schedule is media neutral when the disposition instructions may be applied to records regardless of the medium in which the records are created and maintained. Items included in schedules submitted to NARA on or after December 17, 2007, are media neutral unless the item is limited to a specific medium. (*See* 36 CFR 1225.12(e).)

No Federal records are authorized for destruction without the approval of the Archivist of the United States. This approval is granted only after a thorough consideration of their administrative use by the agency of origin, the rights of the Government and of private persons directly affected by the Government's activities, and whether or not they have historical or other value.

Besides identifying the Federal agencies and any subdivisions requesting disposition authority, this public notice lists the organizational unit(s) accumulating the records or indicates agency-wide applicability in the case of schedules that cover records that may be accumulated throughout an agency. This notice provides the control number assigned to each schedule, the total number of schedule items, and the number of temporary items (the records proposed for destruction). It also includes a brief description of the temporary records. The records schedule itself contains a full description of the records at the file unit level as well as their disposition. If NARA staff has prepared an appraisal memorandum for the schedule, it too includes information about the records. Further information about the disposition process is available on request.

Schedules Pending:

1. Department of Agriculture, Grain Inspection, Packers and Stockyards Administration (N1–545–10–1, 1 item, 1 temporary item). Master files for an electronic information system used to manage the national grain inspection and weighing program.

2. Department of Health and Human Services, Food and Drug Administration (N1–88–09–11, 3 items, 3 temporary items). Files and reports relating to fees charged for services to industry and annual fees relating to products currently on the market. Also included are master files used for tracking the receipt and payment of user fees.

3. Department of Homeland Security, Immigration and Customs Enforcement (N1–567–09–5, 1 item, 1 temporary item). Master files for an electronic information system that contains information concerning aliens who are allowed to live outside of a detention facility while undergoing the deportation process.

4. Department of Homeland Security, Immigration and Customs Enforcement (N1–567–09–6, 3 items, 3 temporary items). Master files and outputs for an electronic information system that maintains information concerning suspected immigration status violators.

5. Department of the Interior, Southwestern Pennsylvania Heritage Preservation Commission (N1–48–09–14, 13 items, 6 temporary items). Records relating to operational functions of the Commission, including such records as project files, grants management records, and general correspondence. Proposed for permanent retention are substantive files, such as policy records, publications, Executive Committee records, and photographs.

6. Department of Justice, Executive Office for U.S. Attorneys (N1–60–09–30, 4 items, 4 temporary items). Records relating to the accreditation of continuing legal education courses sponsored by the Office of Legal Education. Included are such records as certifications, credit instruction packets, and individual state accreditation files.

7. Department of Justice, National Drug Intelligence Center (N1–523–09–3, 1 item, 1 temporary item). Master files of an electronic information system that tracks intelligence projects. Included is such information as project number and title, name of analyst assigned to the project, and dates of initiation and completion.

8. Department of Justice, U.S. Trustee Program (N1–60–09–53, 3 items, 3 temporary items). Master files of an electronic information system used to track the application and approval process for agencies and vendors being considered as credit and debt counseling providers.

9. Department of State, Bureau of East Asian and Pacific Affairs (N1–59–09–10, 6 items, 2 temporary items). Records relating to trips, as well as country files consisting of extra copies of telegrams. Proposed for permanent retention are calendars and appointment books of the Assistant Secretary, subject files, policy files, and files relating to interagency meetings. The proposed disposition instructions are limited to paper records for permanent items.

10. Department of State, Bureau of Human Resources (N1–59–09–46, 1 item, 1 temporary item). Records relating to career development workshops, such as instructors' materials and handouts.

11. Department of State, Bureau of Public Affairs (N1–59–09–23, 1 item, 1 temporary item). Master files of an electronic information system that contains data concerning the media environment in specific countries.

12. Department of State, Foreign Service Institute (N1–59–09–47, 1 item, 1 temporary item). Records relating to students at the School of Applied Information Technology. Records relate to such matters as courses taken, attendance, class rosters, funding for travel, and evaluations.

13. Department of State, Office of the Chief of Protocol (N1–59–09–45, 1 item, 1 temporary item). Master files of an electronic information system containing information on guests and participants at events.

14. Department of the Treasury, Internal Revenue Service (N1–58–09–38, 3 items, 3 temporary items). Master files, outputs, and system documentation associated with an electronic information system used to collect and centralize data from other agency systems for more efficient analysis.

15. Department of the Treasury, Internal Revenue Service (N1–58–09–39, 2 items, 2 temporary items). Master files and system documentation associated with an electronic information system used to provide states with taxpayer information.

16. Department of the Treasury, Internal Revenue Service (N1–58–09–46, 2 items, 2 temporary items). Master files and system documentation associated with an electronic information system used to track employee workload regarding taxpayer information requests at customer services sites.

17. Department of the Treasury, Internal Revenue Service (N1–58–09–47, 3 items, 3 temporary items). Master files, outputs, and system documentation associated with an electronic information system which

stores scanned payment images in order to expedite access to taxpayer remittance information.

18. Department of the Treasury, Internal Revenue Service (N1–58–09–58, 4 items, 4 temporary items). Master files, inputs, outputs, and system documentation associated with an electronic information system used in connection with notifying taxpayers of potential backup withholding due to unmet tax obligations.

19. Department of the Treasury, Internal Revenue Service (N1–58–09–111, 4 items, 4 temporary items). Master files, inputs, and system documentation associated with an electronic information system used to issue calling cards to employees who must place long distance telephone calls while traveling on business.

20. Department of the Treasury, Internal Revenue Service (N1–58–09–112, 2 items, 2 temporary items). Master files and system documentation associated with an electronic information system used to store information concerning solutions and remedies to technical problems and issues.

21. Agency for International Development, Management Bureau (N1–286–09–5, 1 item, 1 temporary item). Master files associated with an electronic information system used in connection with agency procurement activities.

22. Environmental Protection Agency, Agency-wide (N1–412–08–16, 1 item, 1 temporary item). Duplicative comments received from stakeholders that have been summarized. Summaries were previously approved for permanent retention.

23. Environmental Protection Agency, Agency-wide (N1–412–10–1, 2 items, 2 temporary items). Electronic and paper input documents associated with an electronic information system that contains information on toxic chemical releases and other waste management activities. Records were previously approved for disposal. The related electronic information system was previously scheduled as permanent.

24. Federal Energy Regulatory Commission, Agency-wide (N1–138–09–5, 1 item, 1 temporary item). Docketed case files relating to electric utilities. Paper copies of these files were previously approved for disposal.

25. Nuclear Regulatory Commission, Office of Nuclear Security and Incident Response (N1–431–08–11, 3 items, 2 temporary items). Master files and system operations records for an electronic information system used to capture data on conditions at nuclear power plants during an emergency event. Proposed for permanent retention are reports documenting events.

Dated: November 20, 2009.

Michael J. Kurtz,

Assistant Archivist for Records Services—Washington, DC.

[FR Doc. E9–28406 Filed 11–24–09; 8:45 am]

BILLING CODE 7515–01–P

NUCLEAR REGULATORY COMMISSION

Advisory Committee on Reactor Safeguards; Meeting of the ACRS Subcommittee on Regulatory Policies and Practices; Amendment to December 1, 2009, ACRS meeting Federal Register Notice

The **Federal Register** Notice for the ACRS Subcommittee Meeting on Regulatory Policies and Practices scheduled to be held on December 1, 2009, is being amended to notify the following:

The time of the meeting is being changed from 2:30 p.m.–4:30 p.m., to 8:30 a.m.–12 p.m. In addition to the review of the Draft Final Revision 1 to Regulatory Guide 1.151 (DG–1178), the Subcommittee will also review the Draft Final Revision 1 to Regulatory Guide 1.141 (DG–1213), ''Containment Isolation Provisions for Fluid Systems.''

The notice of this meeting was previously published in the **Federal Register** on Tuesday, November 10, 2009, [74 FR 58064]. All other items remain the same as previously published.

Further information regarding this meeting can be obtained by contacting Zena Abdullahi, Designated Federal Official (*Telephone:* 301–415–8716, *E-mail: Zena.Abdullahi@nrc.gov*), between 8:45 a.m. and 5:30 p.m. (ET).

Dated: November 18, 2009.

Antonio F. Dias,

Chief, Reactor Safety Branch B, Advisory Committee on Reactor Safeguards.

[FR Doc. E9–28244 Filed 11–24–09; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Advisory Committee on Reactor Safeguards (ACRS); Meeting of the Subcommittee on Digital Instrumentation and Control Systems; Notice of Meeting

The ACRS Subcommittee on Digital Instrumentation and Control Systems (DI&C) will hold a meeting on December 17, 2009, Room T2–B1, 11545 Rockville Pike, Rockville, Maryland.

The agenda for the subject meeting shall be as follows:

Thursday, December 17, 2009, 8:30 a.m.–12 p.m.

The Subcommittee will hear presentations by and hold discussions with representatives of the NRC staff and the industry regarding review of Draft Final Regulatory Guide 1.62, ''Manual Initiation of Protective Actions.'' The Subcommittee will gather information, analyze relevant issues and facts, and formulate proposed positions and actions, as appropriate, for deliberation by the full Committee.

Members of the public desiring to provide oral statements and/or written comments should notify the Designated Federal Official (DFO), Ms. Christina Antonescu (Telephone: 301–415–6792, E-mail: *Christina.Antonescu@nrc.gov*) five days prior to the meeting, if possible, so that appropriate arrangements can be made. Thirty-five hard copies of each presentation or handout should be provided to the DFO thirty minutes before the meeting. In addition, one electronic copy of each presentation should be e-mailed to the DFO one day before the meeting. If an electronic copy cannot be provided within this timeframe, presenters should provide the DFO with a CD containing each presentation at least 30 minutes before the meeting. Electronic recordings will be permitted only during those portions of the meeting that are open to the public. Detailed procedures for the conduct of and participation in ACRS meetings were published in the **Federal Register** on October 14, 2009, (74 FR 52829–52830).

Detailed meeting agendas and meeting transcripts are available on the NRC Web site at *http://www.nrc.gov/reading-rm/doc-collections/acrs.* Information regarding topics to be discussed, changes to the agenda, whether the meeting has been canceled or rescheduled, and the time allotted to present oral statements can be obtained from the Web site cited above or by contacting the identified DFO. Moreover, in view of the possibility that the schedule for ACRS meetings may be adjusted by the Chairman as necessary to facilitate the conduct of the meeting, persons planning to attend should check with these references if such rescheduling would result in major inconvenience.

Dated: November 19, 2009.

Antonio F. Dias,

Chief, Reactor Safety Branch B, Advisory Committee on Reactor Safeguards.

[FR Doc. E9–28245 Filed 11–24–09; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Advisory Committee on Reactor Safeguards (ACRS); Meeting of the ACRS Subcommittee on Radiation Protection and Nuclear Materials; Notice of Meeting

The ACRS Subcommittee on Radiation Protection and Nuclear Materials will hold a meeting on December 16, 2009, Room T2–B3, 11545 Rockville Pike, Rockville, Maryland.

The meeting will be open to public attendance.

The agenda for the subject meeting shall be as follows:

Wednesday, December 16, 2009—8:30 a.m.–4 p.m.

The Subcommittee will review (1) The NRC staff efforts to revise and update the radiation protection standards in 10 CFR Parts 20 and 50; (2) the status of NRC rulemaking efforts for unique waste streams including depleted uranium; and (3) the proposed Revision 2 to Regulatory Guide 4.11, ''Terrestrial Environmental Studies for Nuclear Power Plants.'' The Subcommittee will hear presentations by and hold discussions with NRC staff and other interested persons regarding these matters. The Subcommittee will gather information, analyze relevant issues and facts, and formulate proposed positions and actions, as appropriate, for deliberation by the full Committee.

Members of the public desiring to provide oral statements and/or written comments should notify the Designated Federal Official (DFO), Mr. Neil Coleman, (Telephone: 301–415–7656, E-mail: *Neil.Coleman@nrc.gov*) five days prior to the meeting, if possible, so that appropriate arrangements can be made. Thirty-five hard copies of each presentation or handout should be provided to the DFO thirty minutes before the meeting. In addition, one electronic copy of each presentation should be emailed to the DFO one day before the meeting. If an electronic copy cannot be provided within this timeframe, presenters should provide the DFO with a CD containing each presentation at least 30 minutes before the meeting. Electronic recordings will be permitted. Detailed procedures for the conduct of and participation in ACRS meetings were published in the **Federal Register** on October 14, 2009, (74 FR 52829–52830).

Detailed meeting agendas and meeting transcripts are available on the NRC Web site at: *http://www.nrc.gov/reading-rm/doc-collections/acrs.* Information regarding topics to be discussed, changes to the agenda, whether the meeting has been canceled or rescheduled, and the time allotted to present oral statements can be obtained from the website cited above or by contacting the identified DFO. Moreover, in view of the possibility that the schedule for ACRS meetings may be adjusted by the Chairman as necessary to facilitate the conduct of the meeting, persons planning to attend should check with these references if such rescheduling would result in major inconvenience.

Dated: November 18, 2009.

Antonio F. Dias,

Chief, Reactor Safety Branch B, Advisory Committee on Reactor Safeguards.

[FR Doc. E9–28242 Filed 11–24–09; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2009–0511]

Proposed Generic Communications; Inservice Inspection and Testing Requirements of Dynamic Restraints (SNUBBERS)

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of opportunity for public comment.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC or Commission) is proposing to issue this draft regulatory issue summary (RIS) to remind licensees of the requirements for the inservice inspection (ISI) and testing of dynamic restraints (snubbers) under 10 CFR 50.55a(g) and 10 CFR 50.55a(b)(3)(v). This RIS requires no action or written response on the part of an addressee.

DATES: Comment period expires January 11, 2010. Comments submitted after this date will be considered if it is practical to do so, but assurance of consideration cannot be given except for comments received on or before this date.

ADDRESSES: You may submit comments by any one of the following methods. Please include Docket ID NRC–2009–0511 in the subject line of your comments. Comments submitted in writing or in electronic form will be posted on the NRC Web site and on the Federal rulemaking Web site Regulations.gov. Because your comments will not be edited to remove any identifying or contact information, the NRC cautions you against including any information in your submission that you do not want to be publicly disclosed.

The NRC requests that any party soliciting or aggregating comments received from other persons for submission to the NRC inform those persons that the NRC will not edit their comments to remove any identifying or contact information, and therefore, they should not include any information in their comments that they do not want publicly disclosed.

Federal Rulemaking Web site: Go to *http://www.regulations.gov* and search for documents filed under Docket ID NRC–2009–0511. Address questions about NRC dockets to Carol Gallagher 301–492–3668; e-mail *Carol.Gallagher@nrc.gov.*

Mail comments to: Michael T. Lesar, Chief, Rulemaking and Directives Branch (RDB), Division of Administrative Services, Office of Administration, Mail Stop: TWB–05–B01M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, or by fax to RDB at (301) 492–3446.

You can access publicly available documents related to this notice using the following methods:

NRC's Public Document Room (PDR): The public may examine and have copied for a fee publicly available documents at the NRC's PDR, Public File Area O1 F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland.

NRC's Agencywide Documents Access and Management System (ADAMS): Publicly available documents created or received at the NRC are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/adams.html.* From this page, the public can gain entry into ADAMS, which provides text and image files of NRC's public documents. If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the NRC's PDR reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to *pdr.resource@nrc.gov.*

Federal Rulemaking Web site: Public comments and supporting materials related to this notice can be found at *http://www.regulations.gov* by searching on Docket ID: NRC–2009–0511.

FOR FURTHER INFORMATION CONTACT: Gurjendra S. Bedi, NRR/DCI/CPTB, at 301–415–1393 or by e-mail at *Gurjendra.Bedi@nrc.gov*

SUPPLEMENTARY INFORMATION:

NRC Regulatory Issue Summary 2009–XX; Inservice Inspection and Testing Requirements of Dynamic Restraints (SNUBBERS)

Addressees

All holders of operating licenses for nuclear power reactors under the provisions of Title 10 of the Code of Federal Regulations (10 CFR) part 50, ''Domestic Licensing of Production and Utilization Facilities,'' except those who have permanently ceased operations and have certified that fuel has been permanently removed from the reactor vessel.

All holders of, and applicants for, nuclear power plant construction permits, early site permits, and limited work authorizations for nuclear power reactors under the provisions of 10 CFR part 50.

Intent

The U.S. Nuclear Regulatory Commission (NRC or Commission) is issuing this regulatory issue summary (RIS) to remind licensees of the requirements for the inservice inspection (ISI) and testing of dynamic restraints (snubbers) under 10 CFR 50.55a(g) and 10 CFR 50.55a(b)(3)(v). This RIS requires no action or written response on the part of an addressee.

Background

The regulations at 10 CFR 50.55a(b) detail the Codes and standards that have been approved for inclusion in 10 CFR part 50, including the effective edition and addenda of the American Society of Mechanical Engineer (ASME) Boiler and Pressure Vessel (BPV) Code and the ASME Code for Operation and Maintenance of Nuclear Power Plants (OM Code).

The regulations at 10 CFR 50.55a(g) establish the ISI requirements that licensees must use when performing ISI of components (including supports). 10 CFR 50.55a(g)(4) states, ''Throughout the service life of a boiling or pressurized water-cooled nuclear power facility, components (including supports) which are classified as ASME Code Class 1, Class 2, and Class 3 must meet the requirements, except design and access provisions and preservice examination requirements, set forth in Section XI of editions of the ASME BPV Code and addenda.'' ASME Section XI provides the rules for ISI of nuclear power plant components.

The regulation at 10 CFR 50.55a(g)(4)(ii) requires the use of the latest edition and addenda of the Code that has been incorporated by reference 12 months prior to the beginning of each 120-month inspection interval. This Code is considered the ''Code of Record'' for the inspection interval.

The regulation at 10 CFR 50.55a(g)(4)(iv) states that ISI of components (including supports) may meet the requirements set forth in subsequent editions to the ''Code of Record'' and addenda that are incorporated by reference in 10 CFR 50.55a(b), subject to limitations and modifications listed in 10 CFR 50.55a(b) and subject to Commission approval.

The regulations at 10 CFR 50.55a(g) require ISI of components (including supports) without specifically mentioning ''snubbers.'' Consequently, confusion resulted and some licensees mistakenly believed that ISI and testing of snubbers is not a regulatory requirement. The NRC clarified, in the final rule dated September 22, 1999, [(Volume 64 of the **Federal Register**, pages 51370, 51388–89 (64 FR 51370, 51388–89)], that testing of snubbers is a regulatory requirement and has been for many years.

The regulations at 10 CFR 50.55a(g)(4) require that ASME Code Class 1, 2, and 3 components (including supports) meet the ISI requirements of ASME Code Section XI. Article IWF–5000, ''Inservice Inspection Requirements for Snubbers,'' of ASME Code Section XI provides requirements for the examination and testing of snubbers in nuclear power plants. Therefore, inservice examination and testing of snubbers are required by 10 CFR 50.55a because it incorporates by reference ASME Section XI requirements, including Article IWF–5000. Article IWF–5000 has required the ISI and testing of snubbers since the first issuance of Subsection IWF in the Winter 1978 Addenda of ASME Section XI, which was incorporated in 10 CFR 50.55a in January 1982. Before ASME Section XI incorporated snubber examination and testing requirements, licensees used snubber examination and testing requirements as defined in their plants' TS.

Improved Standard TS for various boiling and pressurized water-cooled nuclear power plants (NUREG–1430 thru 1434, Revision 3, published in June 2004) allow relocating inservice examination and testing requirements of snubbers from the TS to a plant's Technical Requirements Manual (TRM). However, relocating snubber ISI and testing requirements from the TS to TRM does not eliminate the need to comply with the 10 CFR 50.55a requirements.

For plants using their TS to govern ISI and testing of snubbers, 10 CFR 50.55a (g)(5)(ii) requires that if a revised ISI program for a facility conflicts with the TS, the licensee shall apply to the Commission for amendment of the TS to conform the TS to the revised program. Therefore, when performing 120-month ISI program updates in accordance with 10 CFR 50.55a (g)(4), licensees must submit any required amendments to ensure their TS remain consistent with the new code of record or NRC-approved alternative used in lieu of the Code requirements. The TS governing the snubber ISI and test program do not eliminate the 10 CFR50.55a requirements to update the program at 120-month intervals or to request and receive NRC authorization for alternatives to the Code requirements when appropriate.

The 2004 edition of ASME Section XI and the ASME OM Code are incorporated in 10 CFR 50.55a (Industry Codes and Standards; Amended Requirements, 73 FR 52730; September 10, 2008). Article IWF–5000 of the ASME BPV Code, Section XI, 2004 Edition, requires preservice and inservice examinations and testing of snubbers at nuclear power plants as part of the licensee's ISI program in accordance with ASME/American National Standards Institute Standard for Operation and Maintenance of Nuclear Power Plants, Part 4 (OM–4), 1987 Edition with OMa-1988 Addenda.

The regulation at 10 CFR 50.55a(b)(3)(v) allows the optional use of Subsection ISTD, ''Preservice and Inservice Examination and Testing of Dynamic Restraint (Snubbers) in Light-Water Reactor Nuclear Power Plants,'' of the ASME OM Code-1995 Edition through the latest edition and addenda incorporated by reference in 10 CFR 50.55a(b)(3) in lieu of ASME Section XI, Articles IWF–5200(a) and (b) and IWF–5300(a) and (b) by making appropriate changes to TS or licensee-controlled documents. The regulation at 10 CFR 50.55a(b)(3)(v) also states, ''Preservice and inservice examination must be performed using the VT–3 visual examination method described in IWA–2213.''

Licensees shall perform the ISI and testing of snubbers in accordance with ASME Section XI or the OM Code and the applicable addenda as required by 10 CFR 50.55a(g) or 10 CFR 50.55a(b)(3)(v), except where the NRC has granted specific written relief, pursuant to 10 CFR 50.55a(g)(6)(i), or authorized alternatives pursuant to 10 CFR 50.55a(3). The regulation at 10 CFR 50.55a(a)(3) states that licensees may use alternatives to the requirements of 10 CFR 50.55a(g) when authorized by the NRC if (1) the proposed alternatives would provide an acceptable level of quality and safety, or (2) compliance

with the specified requirements would result in hardship or unusual difficulty without a compensating increase in the level of quality and safety.

Licensees have the option to control the ASME Code-required examination and testing of snubbers through their plant's TS or other licensee-controlled documents (*i.e.,* TRM *etc.*). However, when these documents represent an alternative to the code requirements incorporated by reference in 10 CFR 50.55a, they must be authorized by the NRC, pursuant to 10 CFR 50.55a(a)(3), on a case by case basis. As stated in 10 CFR 50.55a(a)(3), the use of an alternative in lieu of the Code requirements is subject to Commission approval. Additionally, plant TS may require updating in accordance with 10 CFR 50.55a(g)(5)(ii) if needed to conform them to the program that is in effect for the 120-month ISI interval.

Discussion

The staff has identified several instances in which nuclear power plant licensees have used a TRM, or other licensee-controlled documents and procedures which do not meet requirements of the ''Code of Record'' for the ISI and testing of snubbers without requesting approval to use these alternatives from the Commission. The staff is issuing this RIS to remind licensees that they must submit a request and receive NRC approval to use an alternative to control the examination and testing of snubbers through their plants licensee-controlled documents (*i.e.*, TRM *etc.*), when they represent a departure from and are used in lieu of the ASME Section XI or OM Code requirements.

The regulation at 10 CFR 50.55a requires ISI of components (including supports) in accordance with ASME Section XI or OM Code requirements. The use of a TRM, or any other licensee-controlled documents that represent a departure from the Code requirements for snubber ISI and testing requires NRC approval. The use of alternatives in lieu of the Code requirements is addressed in 10 CFR 50.55a(a)(3). When requesting authorization to use an alternative, licensees must demonstrate the proposed alternative would provide an acceptable level of quality and safety, or they must demonstrate why compliance with the Code requirement would result in hardship or unusual difficulty without a compensating increase in the level of quality and safety.

In addition, for licensees using plant TS to control snubber examination and testing, the requirement to perform 10-year program updates in accordance with 10 CFR 50.55a(g)(4) still exists. If the TS represent an alternative to the requirements of the code edition and addenda specified in 10 CFR 50.55a(b) that is to be used for the ISI interval, licensees are required to request authorization from the NRC to use the alternative in accordance with 10 CFR 50.55a(a)(3). The regulation at 10 CFR 50.55a(g)(5)(ii) also requires that a licensee apply for an amendment to conform the TS to the revised program in cases where there is a conflict between the revised program and the TS.

Some licensees mistakenly concluded that the ISI and testing of snubbers is not a 10 CFR 50.55a regulatory requirement, because 10 CFR 50.55a requires ISI of components (including supports) without specifically mentioning snubbers and since snubber examination and testing was historically covered by a plant's TS. The resulting confusion led some licensees to believe that they do not need to request NRC approval to use an alternative (i.e., TS, TRM, or other licensee-controlled documents) in lieu of the Code requirements. The Commission has clarified, however, that snubber inspection and testing is a regulatory requirement.

Typically, if licensees use TS, TRM, or any other licensee-controlled documents which represent a departure from the ASME Code requirements for the ISI and testing of snubbers, they would submit an alternative for NRC approval as required by 10 CFR 50.55a(a)(3). The authorized alternative becomes a regulatory requirement that may be used in lieu of ASME Section XI or OM Code requirements for performing the ISI and testing of snubbers. The NRC staff must review and approve changes to these requirements for authorization under 10 CFR 50.55a(a)(3) or as an exemption under 10 CFR 50.12, ''Specific Exemptions.'' Alternatives requested and authorized pursuant to 10 CFR 50.55a(a)(3) are only valid for that particular 10-year ISI interval, unless specifically authorized for a different period in the associated NRC safety evaluation. In a subsequent 10-year ISI interval, licensees must resubmit an alternative for NRC staff review and approval if they choose not to adopt the ASME Code edition and addenda specified in the regulations for snubber examination and testing. In addition, for program changes that create a conflict with the plant TS, the licensee shall apply for an amendment to conform the TS to the program in accordance with 10 CFR 50.55a(g)(5)(ii).

Backfit Discussion

This RIS reminds stakeholders of existing regulatory requirements within 10 CFR 50.55a(b) and 10 CFR 50.55a(g) for the ISI and testing of dynamic restraints (snubbers). This RIS does not represent a new or different staff position about the implementation of 10 CFR 50.55a. This RIS reminds addressees of the need to request NRC approval for the use of TS, TRM, or other licensee-controlled documents in lieu of the ASME Code requirements as required by 10 CFR 50.55a(a)(3). It requires no action or written response beyond what is required in 10 CFR 50.55a. Any action that addressees take to implement procedural or inspection changes in accordance with the information in this RIS ensures compliance with current regulations; and therefore, is not a backfit under 10 CFR 50.109, ''Backfitting'' and specifically the exception provided for in 10 CFR 50.109(a)(4)(i). Consequently, the NRC staff did not perform a backfit analysis.

Federal Register Notification

To be done after the public comments periods.

Congressional Review Act

This RIS is not a rule as designated by the Congressional Review Act (5 U.S.C. 801–886) and; therefore, is not subject to the Act.

Paperwork Reduction Act Statement

This RIS does not contain any information collections and; therefore, is not subject to the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.)*

Contact

Please direct any questions about this matter to Gurjendra S. Bedi, NRR/DCI/CPTB, at 301–415–1393 or by e-mail at *Gurjendra.Bedi@nrc.gov*

End of Draft Regulatory Issue Summary

Documents may be examined, and/or copied for a fee, at the NRC's Public Document Room at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland. Publicly available records will be accessible electronically from the Agencywide Documents Access and Management System (ADAMS) Public Electronic Reading Room on the Internet at the NRC Web site, *http://www.nrc.gov/NRC/ADAMS/index.html.* If you do not have access to ADAMS or if you have problems in accessing the documents in ADAMS, contact the NRC Public Document Room (PDR) reference staff at 1–800–397–4209

or 301–415–4737 or by e-mail to *pdr@nrc.gov.*

Dated at Rockville, Maryland, this 19th day of November 2009.

For The Nuclear Regulatory Commission.

Martin C. Murphy,

Chief, Generic Communications Branch, Division of Policy and Rulemaking, Office of Nuclear Reactor Regulation.

[FR Doc. E9–28241 Filed 11–24–09; 8:45 am]

BILLING CODE 7590–01–P

POSTAL REGULATORY COMMISSION

[Docket No. A2010–1; Order No. 342]

Post Office Closing

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: This document informs the public that an appeal of the closing of the Cranberry, PA post office has been filed. It identifies preliminary steps and provides a procedural schedule. Publication of this document will allow the Postal Service, petitioner, and others to take appropriate action.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov.* Commenters who cannot submit their views electronically should contact the person identified in **FOR FURTHER INFORMATION CONTACT** by telephone for advice on alternatives to electronic filing.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 or *stephen.sharfman@prc.gov.*

SUPPLEMENTARY INFORMATION: Notice is hereby given that pursuant to 39 U.S.C. 404(d), the Commission has received an appeal of the closing of the Cranberry Post Office, Cranberry, PA 16319. The appeal was received by the Commission on October 6, 2009. The appeal was not filed as a Participant Statement on PRC Form 61; however, the petitioners have the option of filing supplemental information or facts. The Commission hereby institutes a proceeding under 39 U.S.C. 404(d)(5) and designates the case as Docket No. A2010–1 to consider the petitioner's appeal.

Categories of issues apparently raised. The categories of issues that appear to be raised include: Effect on the community (39 U.S.C. 404(d)(2)(A)(i)).

After the Postal Service files the administrative record and the Commission reviews it, the Commission may find that there are additional legal issues. Or, the Commission may find that the Postal Service's determination disposes of one or more of those issues. The deadline for the Postal Service to file the administrative record with the Commission is December 1, 2009. 39 CFR 3001.113.

Availability; Web site posting. The Commission has posted the appeal and supporting material on its Web site at *http://www.prc.gov.* Additional filings in this case and participants' submissions also will be posted on the Web site, if provided in electronic format or amenable to conversion, and not subject to a valid protective order or Privacy Act concerns. Information on how to use the Commission's Web site is available online or by contacting the Commission's Web master via telephone at 202–789–6873 or via electronic mail at *PRC-WEBMASTER@prc.gov.*

The appeal and all related documents are also available for public inspection in the Commission's docket section. Docket section hours are 8 a.m. to 4:30 p.m., Monday through Friday, except on Federal government holidays. Docket section personnel may be contacted via electronic mail at *prc-dockets@prc.gov* or via telephone at 202–789–6846.

Filing of documents. All filing of documents in this case shall be made using the Internet (Filing Online) pursuant to Commission rules 9(a) and 10(a) at the Commission's Web site *http://www.prc.gov,* unless a waiver is obtained. 39 CFR 3001.9(a) and 10(a). Instructions for obtaining an account to file documents online may be found on the Commission's Web site, *http://www.prc.gov,* or by contacting the Commission's docket section at *prc-dockets@prc.gov* or via telephone at 202–789–6846.

Intervention. Those, other than the petitioners and respondent, wishing to be heard in this matter are directed to file a notice of intervention on or before December 7, 2009 in accordance with 39 CFR 3001.111. The notice of intervention shall be filed using the Internet (Filing Online) at the Commission's Web site (*http://www.prc.gov*), unless a waiver is obtained for hardcopy filing. 39 CFR 3001.9(a) and 10(a).

Public Representative. Patricia Gallagher is designated as the Public Representative to represent the interests of the general public.

Further procedures. By statute, the Commission is required to issue its decision within 120 days from the date this appeal was filed. 39 U.S.C. 404(d)(5). A standard procedural schedule has been developed to accommodate this statutory deadline. The procedural schedule contemplated by 39 CFR 3001.110 *et seq.* has been adjusted for administrative convenience and will provide the petitioners and Postal Service with ample time to file documents. In the interest of expedition, in light of the 120-day decision schedule, the Commission may request the Postal Service or other participants to submit memoranda of law on any appropriate issue. As required by the Commission rules, if any motions are filed, responses are due 7 days after any such motion is filed. 39 CFR 3001.21. If necessary, the Commission also may ask petitioners or the Postal Service for more information.

It is ordered:

1. The Postal Service shall file the administrative record in this appeal, or otherwise file a responsive pleading to the appeal, by December 1, 2009.

2. The procedural schedule listed below is hereby adopted.

3. Pursuant to 39 U.S.C. 505, Patricia Gallagher is designated officer of the Commission (Public Representative) to represent the interests of the general public.

4. The Secretary shall arrange for publication of this notice and order in the **Federal Register**.

By the Commission.

Judith M. Grady,

Acting Secretary.

PROCEDURAL SCHEDULE

October 6, 2009	Filing of Appeal.
December 1, 2009	Deadline for Postal Service to file administrative record in this appeal or responsive pleading.
December 7, 2009	Deadline for supplemental information or facts in support of petition (*see* 39 CFR 3001.115(a) and (b)).
December 7, 2009	Deadline for filing petitions to intervene (*see* 39 CFR 3001.111(b)).
December 29, 2009	Deadline for answering brief in support of Postal Service (*see* 39 CFR 3001.115(c)).
January 13, 2010	Deadline for reply briefs in response to answering briefs (*see* 39 CFR 3001.115(d)).

PROCEDURAL SCHEDULE—Continued

January 15, 2010	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).
February 3, 2010	Expiration of the Commission's 120-day decisional schedule (*see* 39 U.S.C. 404(d)(5)).

[FR Doc. E9–28243 Filed 11–24–09; 8:45 am]
BILLING CODE 7710–FW–P

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Investor Education and Advocacy, Washington, DC 20549–0213.

Extension:

Rule 23c–3 and Form N–23c–3; SEC File No. 270–373; OMB Control No. 3235–0422.

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 350 *et seq.*), the Securities and Exchange Commission (the ''Commission'') has submitted to the Office of Management and Budget a request for extension of the previously approved collection of information discussed below.

Rule 23c–3 (17 CFR 270.23c–3) under the Investment Company Act of 1940 (15 U.S.C. 80a–1 *et seq.*) is entitled: ''Repurchase of Securities of Closed-End Companies.'' The rule permits certain closed-end investment companies (''closed-end funds'' or ''funds'') to offer to repurchase from shareholders a limited number of shares at net asset value. The rule includes several reporting and recordkeeping requirements. The fund must send shareholders a notification that contains specified information each time the fund makes a repurchase offer (on a quarterly, semi-annual, or annual basis, or for certain funds, on a discretionary basis not more often than every two years). The fund also must file copies of the shareholder notification with the Commission (electronically through the Commission's Electronic Data Gathering, Analysis, and Retrieval System (''EDGAR'')) attached to Form N–23c–3 (17 CFR 274.221), a filing that provides limited information about the fund and the type of offer the fund is making.[1] The fund must describe in its annual report to shareholders the fund's policy concerning repurchase offers and the results of any repurchase offers made during the reporting period. The fund's board of directors must adopt written procedures designed to ensure that the fund's investment portfolio is sufficiently liquid to meet its repurchase obligations and other obligations under the rule. The board periodically must review the composition of the fund's portfolio and change the liquidity procedures as necessary. The fund also must file copies of advertisements and other sales literature with the Commission as if it were an open-end investment company subject to section 24 of the Investment Company Act (15 U.S.C. 80a–24) and the rules that implement section 24.[2]

The requirement that the fund send a notification to shareholders of each offer is intended to ensure that a fund provides material information to shareholders about the terms of each offer, which may differ from previous offers on such matters as the maximum amount of shares to be repurchased (the maximum repurchase amount may range from 5% to 25% of outstanding shares). The requirement that copies be sent to the Commission is intended to enable the Commission to monitor the fund's compliance with the notification requirement. The requirement that the shareholder notification be attached to Form N–23c–3 is intended to ensure that the fund provides basic information necessary for the Commission to process the notification and to monitor the fund's use of repurchase offers. The requirement that the fund describe its current policy on repurchase offers and the results of recent offers in the annual shareholder report is intended to provide shareholders current information about the fund's repurchase policies and its recent experience. The requirement that the board approve and review written procedures designed to maintain portfolio liquidity is intended to ensure that the fund has enough cash or liquid securities to meet its repurchase obligations, and that written procedures are available for review by shareholders and examination by the Commission. The requirement that the fund file advertisements and sales literature as if it were an open-end investment company is intended to facilitate the review of these materials by the Commission or FINRA to prevent incomplete, inaccurate, or misleading disclosure about the special characteristics of a closed-end fund that makes periodic repurchase offers.

Compliance with the collection of information requirements of the rule and form is mandatory only for those funds that rely on the rule in order to repurchase shares of the fund. The information provided to the Commission on Form N–23c–3 will not be kept confidential. 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 control number.

The Commission staff estimates that 31 funds make use of rule 23c–3 annually, including one fund that is relying upon rule 23c–3 for the first time. The Commission staff estimates that on average a fund spends 89 hours annually in complying with the requirements of the rule and Form N–23c–3, with funds relying upon rule 23c–3 for the first time incurring an additional one-time burden of 28 hours. The Commission therefore estimates the total annual burden of the rule's and form's paperwork requirements to be 2787 hours.

Written comments are invited on: (a) Whether the collections of information are necessary for the proper performance of the functions of the Commission, including whether the information has practical utility; (b) the accuracy of the Commission's estimate of the burdens of the collections of information; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burdens of the collections of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and

[1] Form N–23c–3 requires the fund to state its registration number, its full name and address, the date of the accompanying shareholder notification, and the type of offer being made (periodic, discretionary, or both).

[2] Rule 24b–3 under the Investment Company Act (17 CFR 270.24b–3), however, would generally exempt the fund from that requirement when the materials are filed instead with the Financial Industry Regulatory Authority (''FINRA''). These materials are virtually always submitted to FINRA, instead of the Commission, under FINRA procedures which apply to the underwriter of every fund.

suggestions submitted in writing within 60 days of this publication.

Please direct your written comments to Charles Boucher, Director/CIO, Securities and Exchange Commission, C/O Shirley Martinson, 6432 General Green Way, Alexandria, VA 22312; or send an e-mail to: *PRA_Mailbox@sec.gov.*

Dated: November 17, 2009.

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E9–28228 Filed 11–24–09; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Investor Education and Advocacy, Washington, DC 20549–0213.

Extension:

Form N–3; SEC File No. 270–281; OMB Control No. 3235–0316.

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (the ''Commission'') is soliciting comments on the collection of information summarized below. The Commission plans to submit this existing collection of information to the Office of Management and Budget for extension and approval.

The title for the collection of information is ''Form N–3 (17 CFR 239.17a and 274.11b) under the Securities Act of 1933 (15 U.S.C. 77) and under the Investment Company Act of 1940 (15 U.S.C. 80a), Registration Statement of Separate Accounts Organized as Management Investment Companies.'' Form N–3 is the form used by separate accounts offering variable annuity contracts which are organized as management investment companies to register under the Investment Company Act of 1940 (''Investment Company Act'') and/or to register their securities under the Securities Act of 1933 (''Securities Act''). Form N–3 is also the form used to file a registration statement under the Securities Act (and any amendments thereto) for variable annuity contracts funded by separate accounts which would be required to be registered under the Investment Company Act as management investment companies except for the exclusion provided by Section 3(c)(11) of the Investment Company Act (15 U.S.C. 80a–3(c)(11)). Section 5 of the Securities Act (15 U.S.C. 77e) requires the filing of a registration statement prior to the offer of securities to the public and that the statement be effective before any securities are sold, and Section 8 of the Investment Company Act (15 U.S.C. 80a–8) requires a separate account to register as an investment company.

Form N–3 also permits separate accounts offering variable annuity contracts which are organized as investment companies to provide investors with a prospectus and a statement of additional information covering essential information about the separate account when it makes an initial or additional offering of its securities. Section 5(b) of the Securities Act requires that investors be provided with a prospectus containing the information required in a registration statement prior to the sale or at the time of confirmation or delivery of the securities. The form also may be used by the Commission in its regulatory review, inspection, and policy-making roles.

The Commission estimates that there is one initial registration statement and 30 post-effective amendments to initial registration statements filed on Form N–3 annually and that the average number of portfolios referenced in each initial filing and post-effective amendment is 2. The Commission further estimates that the hour burden for preparing and filing a post-effective amendment on Form N–3 is 154.7 hours per portfolio. The total annual hour burden for preparing and filing post-effective amendments is 9,282 hours (30 post-effective amendments × 2 portfolios × 154.7 hours per portfolio). The estimated annual hour burden for preparing and filing initial registration statements is 1,845.4 hours (1 initial registration statement × 2 portfolios × 922.7 hours per portfolio). The total annual hour burden for Form N–3, therefore, is estimated to be 11,127.4 hours (9,282 hours + 1,845.4 hours).

The information collection requirements imposed by Form N–3 are mandatory. Responses to the collection of information will not be kept confidential. 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 control number.

Written comments are invited on: (a) 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; (b) the accuracy of the agency's estimate of the burden of the collection of information; (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 respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

Please direct your written comments to Charles Boucher, Director/CIO, Securities and Exchange Commission, C/O Shirley Martinson, 6432 General Green Way, Alexandria, VA 22312; or send an e-mail to: *PRA_Mailbox@sec.gov.*

Dated: November 18, 2009.

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E9–28225 Filed 11–24–09; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Investor Education and Advocacy, Washington, DC 20549–0213.

Extension:

Rule 17j–1; SEC File No. 270–239; OMB Control No. 3235–0224.

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 350l–3520), the Securities and Exchange Commission (the ''Commission'') is soliciting comments on the collection of information summarized below. The Commission plans to submit this existing collection of information to the Office of Management and Budget for extension and approval.

Conflicts of interest between investment company personnel (such as portfolio managers) and their funds can arise when these persons buy and sell securities for their own accounts (''personal investment activities''). These conflicts arise because fund personnel have the opportunity to profit from information about fund transactions, often to the detriment of fund investors. Beginning in the early 1960s, Congress and the Securities and Exchange Commission (''Commission'') sought to devise a regulatory scheme to effectively address these potential conflicts. These efforts culminated in the addition of section 17(j) to the Investment Company Act of 1940 (the

''Investment Company Act'') (15 U.S.C. 80a–17(j)) in 1970 and the adoption by the Commission of rule 17j–1 (17 CFR 270.17j–1) in 1980.[1] The Commission proposed amendments to rule 17j–1 in 1995 in response to recommendations made in the first detailed study of fund policies concerning personal investment activities by the Commission's Division of Investment Management since rule 17j–1 was adopted. Amendments to rule 17j–1, which were adopted in 1999, enhanced fund oversight of personal investment activities and the board's role in carrying out that oversight.[2] Additional amendments to rule 17j–1 were made in 2004, conforming rule 17j–1 to rule 204A–1 under the Investment Advisers Act of 1940 (15 U.S.C. 80b), avoiding duplicative reporting, and modifying certain definitions and time restrictions.[3]

Section 17(j) makes it unlawful for persons affiliated with a registered investment company (''fund'') or with the fund's investment adviser or principal underwriter (each a ''17j–1 organization''), in connection with the purchase or sale of securities held or to be acquired by the investment company, to engage in any fraudulent, deceptive, or manipulative act or practice in contravention of the Commission's rules and regulations. Section 17(j) also authorizes the Commission to promulgate rules requiring 17j–1 organizations to adopt codes of ethics.

In order to implement section 17(j), rule 17j–1 imposes certain requirements on 17j–1 organizations and ''Access Persons'' [4] of those organizations. The rule prohibits fraudulent, deceptive or manipulative acts by persons affiliated with a 17j–1 organization in connection with their personal securities transactions in securities held or to be acquired by the fund. The rule requires each 17j–1 organization, unless it is a money market fund or a fund that does not invest in Covered Securities,[5] to: (i) Adopt a written codes of ethics, (ii) submit the code and any material changes to the code, along with a certification that it has adopted procedures reasonably necessary to prevent Access Persons from violating the code of ethics, to the fund board for approval, (iii) use reasonable diligence and institute procedures reasonably necessary to prevent violations of the code, (iv) submit a written report to the fund describing any issues arising under the code and procedures and certifying that the 17j–1 entity has adopted procedures reasonably necessary to prevent Access Persons from violating the code, (v) identify Access Persons and notify them of their reporting obligations, and (vi) maintain and make available to the Commission for review certain records related to the code of ethics and transaction reporting by Access Persons.

The rule requires each Access Person of a fund (other than a money market fund or a fund that does not invest in Covered Securities) and of an investment adviser or principal underwriter of the fund, who is not subject to an exception,[6] to file: (i) Within 10 days of becoming an Access Person, a dated initial holdings report that sets forth certain information with respect to the access person's securities and accounts; (ii) dated quarterly transaction reports within 30 days of the end of each calendar quarter providing certain information with respect to any securities transactions during the quarter and any account established by the Access Person in which any securities were held during the quarter; and (iii) dated annual holding reports providing information with respect to each Covered Security the Access Person beneficially owns and accounts in which securities are held for his or her benefit. In addition, rule 17j–1 requires investment personnel of a fund or its investment adviser, before acquiring beneficial ownership in securities through an initial public offering (IPO) or in a private placement, to obtain approval from the fund or the fund's investment adviser.

The requirements that the management of a rule 17j–1 organization provide the fund's board with new and amended codes of ethics and an annual issues and certification report are intended to enhance board oversight of personal investment policies applicable to the fund and the personal investment activities of Access Persons. The requirements that Access Persons provide initial holdings reports, quarterly transaction reports, and annual holdings reports and request approval for purchases of securities through IPOs and private placements are intended to help fund compliance personnel and the Commission's examinations staff monitor potential conflicts of interest and detect potentially abusive activities. The requirement that each rule 17j–1 organization maintain certain records is intended to assist the organization and the Commission's examinations staff in determining if there have been violations of rule 17j–1.

We estimate that annually there are approximately 75,757 respondents under rule 17j–1, of which 5,757 are rule 17j–1 organizations and 70,000 are Access Persons. In the aggregate, these respondents make approximately 105,125 responses annually. We estimate that the total annual burden of complying with the information collection requirements in rule 17j–1 is approximately 292,740 hours. This hour burden represents time spent by Access Persons that must file initial and annual holdings reports and quarterly transaction reports, investment personnel that must obtain approval before acquiring beneficial ownership in any securities through an IPO or private

[1] Prevention of Certain Unlawful Activities with Respect to Registered Investment Companies, Investment Company Act Release No. 11421 (Oct. 31, 1980) (45 FR 73915 (Nov. 7, 1980)).

[2] Personal Investment Activities of Investment Company Personnel, Investment Company Act Release No. 23958 (Aug. 20, 1999) (64 FR 46821–01 (Aug. 27, 1999)).

[3] Investment Adviser Codes of Ethics, Investment Advisers Act Release No. 2256 (Jul. 2, 2004) (66 FR 41696 (Jul. 9, 2004)).

[4] Rule 17j–1(a)(1) defines an ''access person'' as ''Any advisory person of a Fund or of a Fund's investment adviser. If an investment adviser's primary business is advising Funds or other advisory clients, all of the investment adviser's directors, officers, and general partners are presumed to be Access Persons of any Fund advised by the investment adviser. All of a Fund's directors, officers, and general partners are presumed to be Access Persons of the Fund.'' The definition of Access Person also includes ''Any director, officer or general partner of a principal underwriter who, in the ordinary course of business, makes, participates in or obtains information regarding, the purchase or sale of Covered Securities by the Fund for which the principal underwriter acts, or whose functions or duties in the ordinary course of business relate to the making of any recommendation to the Fund regarding the purchase or sale of Covered Securities.'' Rule 17j–1(a)(1).

[5] A ''Covered Security'' is any security that falls within the definition in section 2(a)(36) of the Act, except for direct obligations of the U.S. Government, bankers' acceptances, bank certificates of deposit, commercial paper and high quality short-term debt instruments, including repurchase agreements, and shares issued by open-end funds. Rule 17j–1(a)(4).

[6] Rule 17j–1(d)(2) contains the following exceptions: (i) An Access Person need not file a report for transactions effected for, and securities held in, any account over which the Access Person does not have control; (ii) an independent director of the fund, who would otherwise not need to report and who does not have information with respect to the fund's transactions in a particular security, does not have to file an initial holdings report or a quarterly transaction report; (iii) an Access Person of a principal underwriter of the fund does not have to file reports if the principal underwriter is not affiliated with the fund (unless the fund is a unit investment trust) or any investment adviser of the fund and the principal underwriter of the fund does not have any officer, director, or general partner who serves in one of those capacities for the fund or any investment adviser of the fund; (iv) an Access Person to an investment adviser need not make quarterly reports if the report would duplicate information provided under the reporting provisions of the Investment Adviser's Act; and (v) an Access Person need not make quarterly transaction reports if the information provided in the report would duplicate information received by the 17j–1 organization in the form of broker trade confirmations or account statements or information otherwise in the records of the 17j–1 organization.

placement, and the responsibilities of Rule 17j–1 organizations arising from information collection requirements under rule 17j–1. These include notifying Access Persons of their reporting obligations, preparing an annual rule 17j–1 report and certification for the board, documenting their approval or rejection of IPO and private placement requests, maintaining annual rule 17j–1 records, maintaining electronic reporting and recordkeeping systems, amending their codes of ethics as necessary, and, for new fund complexes, adopting a code of ethics.

We estimate that there is an annual cost burden of approximately $5,000 per fund complex, for a total of $3,275,000, associated with complying with the information collection requirements in rule 17j–1. This represents the costs of purchasing and maintaining computers and software to assist funds in carrying out rule 17j–1 recordkeeping.

These burden hour and cost estimates are based upon the Commission staff's experience and discussions with the fund industry. The estimates of average burden hours and costs are made solely for the purposes of the Paperwork Reduction Act. These estimates are not derived from a comprehensive or even a representative survey or study of the costs of Commission rules.

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 control number.

Written comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the Commission, including whether the information will have practical utility; (b) the accuracy of the Commission's estimate of the burden of the collections of information; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burdens of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

Please direct your written comments to Charles Boucher, Director/CIO, Securities and Exchange Commission, C/O Shirley Martinson, 6432 General Green Way, Alexandria, VA 22312; or send an e-mail to: *PRA_Mailbox @sec.gov*.

November 19, 2009.

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E9–28226 Filed 11–24–09; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Rule 17Ad–16; SEC File No. 270–363; OMB Control No. 3235–0413]

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Investor Education and Advocacy, Washington, DC 20549–0213.

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (''Commission'') is soliciting comments on the existing collection of information provided for in Rule 17Ad–13 (17 CFR 240.17Ad–13) under the Securities Exchange Act of 1934 (15 U.S.C. 78a *et seq.*) (''Exchange Act''). The Commission plans to submit this existing collection of information to the Office of Management and Budget for extension and approval.

Rule 17Ad–16 requires a registered transfer agent to provide written notice to the appropriate qualified registered securities depository when assuming or terminating transfer agent services on behalf of an issuer or when changing its name or address. In addition, transfer agents that provide such notice shall maintain such notice for a period of at least two years in an easily accessible place. This rule addresses the problem of certificate transfer delays caused by transfer requests that are directed to the wrong transfer agent or the wrong address.

We estimate that the transfer agent industry submits 3,000 Rule 17Ad–16 notices to appropriate qualified registered securities depositories. The staff estimates that the average amount of time necessary to create and submit each notice is approximately 15 minutes per notice. Accordingly, the estimated total industry burden is 750 hours per year (15 minutes multiplied by 3,000 notices filed annually).

Because the information needed by transfer agents to properly notify the appropriate registered securities depository is readily available to them and the report is simple and straightforward, the cost is relatively minimal. The average cost to prepare and send a notice is approximately $7.50 (15 minutes at $30 per hour). This yields an industry-wide cost estimate of $22,500 (3,000 notices multiplied by $7.50 per notice).

Written comments are invited on: (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 Commission's estimates of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

Comments should be directed to Charles Boucher, Director/Chief Information Officer, Securities and Exchange Commission, c/o Shirley Martinson, 6432 General Green Way, Alexandria, VA 22312 or send an e-mail to: *PRA_Mailbox@sec.gov.*

Dated: November 18, 2009.

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E9–28227 Filed 11–24–09; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–61032; File No. PCAOB–2009–01]

Public Company Accounting Oversight Board; Notice of Filing of Proposed Amendment to Board Rules Relating to Inspections

November 19, 2009.

Pursuant to Section 107(b) of the Sarbanes-Oxley Act of 2002 (the ''Act''), notice is hereby given that on July 2, 2009, the Public Company Accounting Oversight Board (the ''Board'' or ''PCAOB'') filed with the Securities and Exchange Commission (the ''SEC'' or ''Commission'') the proposed rule changes described in Items I, II, and III below, which items have been prepared by the Board. The Commission is publishing this notice to solicit comments on the proposed rule from interested persons.

I. Board's Statement of the Terms of Substance of the Proposed Rule

On June 25, 2009, the Board adopted an amendment to its rule relating to the

frequency of inspections. The proposed amendment adds a new paragraph (g) to existing Rule 4003. The text of the proposed amendment is set out below. Language added by the amendment is in italics.

Rule 4003. Frequency of Inspections

* * * * *

(g) With respect to any foreign registered public accounting firm concerning which the preceding provisions of this Rule, other than paragraphs (a) and (f), would set a 2009 deadline for the first Board inspection and that is headquartered in a country in which no foreign registered public accounting firm that the Board inspected before 2009 is headquartered, such deadline is extended to 2012, provided, however, that from among the group of all such firms, the Board shall conduct some first inspections in each of the years from 2009 to 2012, scheduled according to such criteria as the Board shall publicly announce.

II. Board's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule

In its filing with the Commission, the Board included statements concerning the purpose of, and basis for, the proposed rule. The text of these statements may be examined at the places specified in Item IV below. The Board has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Board's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule

(a) Purpose

The Sarbanes-Oxley Act of 2002 directs the Board to conduct a continuing program of inspections to assess registered public accounting firms' compliance with certain requirements.[1] The Act prescribes inspection frequency requirements but also authorizes the Board to adjust the frequency requirements by rule if the Board finds that an adjustment is consistent with the purposes of the Act, the public interest, and the protection of investors.[2] Inspection frequency requirements adopted by the Board are set out in PCAOB Rule 4003, ''Frequency of Inspections.''

The Board began a regular cycle of inspections of U.S. firms in 2004 and has conducted 982 such inspections, including repeat inspections of several firms. Inspections of non-U.S. firms began in 2005, and the Board has inspected 140 non-U.S. firms. Those firms are located in 26 jurisdictions.[3] There are, however, currently 68 non-U.S. firms that, by virtue of when they first issued audit reports after registering with the PCAOB, the Board is required to inspect for the first time by the end of 2009.[4] For the reasons described below, the Board has adopted Rule 4003(g), which would affect the timing of a subset of those 68 inspections. Specifically, Rule 4003(g) will give the Board the ability to postpone, for up to three years, first inspections that the Board is currently required to conduct before the end of 2009 in jurisdictions where the Board conducted no inspections before 2009. The amendment does not affect inspection frequency requirements concerning any other first inspections, or concerning any second or later inspections, of firms that issue audit reports for issuers.[5]

The PCAOB has recognized since the outset of its inspection program that inspections of non-U.S. firms pose special issues.[6] In its oversight of non-U.S. firms, the Board seeks, to the extent reasonably possible, to coordinate and cooperate with local authorities. Since 2003, when the PCAOB began operations, a number of jurisdictions have also developed their own auditor oversight authorities with inspection responsibilities or enhanced existing oversight systems.[7] The Board believes that it is in the interests of the public and investors for the Board to develop efficient and effective cooperative arrangements with its non-U.S. counterparts.[8] In jurisdictions that have their own inspection programs, this may include conducting joint inspections of firms that are subject to both regulators' authority.

Indeed, the Board has a specific framework for working cooperatively with its non-U.S. counterparts to conduct joint inspections and, to the extent deemed appropriate by the Board in any particular case, relying on inspection work performed by that counterpart.[9] PCAOB Rule 4011 permits non-U.S. firms that are subject to Board inspection to formally request that the Board, in conducting its inspection, rely on a non-U.S. inspection to the extent deemed appropriate by the Board. If a Rule 4011 request is made, Rule 4012 provides that the Board will, at an appropriate time before each inspection of the firm, determine the degree, if any, to which the Board may rely on the non-U.S. inspection. Rule 4012 describes aspects of the non-U.S. system that the Board will evaluate in making that determination. Even where the Board does not work with a local regulator to conduct joint inspections, the Board communicates with its counterpart or other local authorities (such as securities regulators or other government agencies and ministries) regarding its inspections to be conducted in the jurisdiction.

In some jurisdictions, the PCAOB's ability to conduct inspections, either by itself or jointly with a local regulator, is complicated by the concerns of local authorities about potential legal obstacles and sovereignty issues. The Board seeks to work with the home-country authorities to try to resolve these and any other concerns.[10]

The effort involved in attempting to resolve potential conflicts of law, or to evaluate a non-U.S. system in response to a Rule 4011 request, can be

[1] *See* Section 104(a) of the Act.

[2] *See* Section 104(b) of the Act.

[3] The Board has inspected non-U.S. firms located in Argentina, Australia, Bermuda, Brazil, Canada, Chile, Colombia, Greece, Hong Kong, India, Indonesia, Ireland, Israel, Japan, Kazakhstan, Mexico, New Zealand, Norway, Panama, Peru, the Russian Federation, Singapore, South Africa, South Korea, Chinese-Taipei, and the United Kingdom.

[4] This discussion does not include, or apply to, 21 non-U.S. firms whose first inspection deadline has been moved from 2008 to 2009 under Rule 4003(f).

[5] Existing Rule 4003 effectively sets deadlines for the Board's inspections not only of firms that issue audit reports, but also of firms that play a substantial role in the preparation or furnishing of an audit report (as defined in PCAOB Rule 1001(p)(ii)). The Board has previously submitted for Commission approval amendments to Rules 4003(b) and 4003(d) that would eliminate from the Rule any frequency requirement or deadline for the Board to inspect a firm that plays a substantial role but does not issue an audit report. Unless and until the Commission approves such a rule change, however, the extension in proposed rule 4003(g) would (if approved by the Commission) apply to required 2009 PCAOB inspections of non-U.S. firms (in jurisdictions encompassed by the rule's terms) that have played a substantial role as well as to required 2009 inspections of non-U.S. firms that have issued audit reports.

[6] *See* Briefing Paper, Oversight of Non-U.S. Public Accounting Firms (October 28, 2003) (hereinafter ''Oversight of Non-U.S. Firms''); Final Rules Relating to the Oversight of Non-U.S. Public Accounting Firms, PCAOB Release No. 2004–005 (June 9, 2004).

[7] In 2006, for instance, the European Union enacted a directive requiring the creation of an effective system of public oversight for statutory auditors and audit firms within each Member State. See The Directive 2006/43/EC of the European Parliament and the Council (May 17, 2006) (the ''Eighth Directive''). In addition, among others, Canada created the Canadian Public Accountability Board, and in Australia, the responsibilities of the Australian Securities and Investments Commission were expanded to include auditor oversight. In Asia, Japan established the Certified Public Accountants and Auditing Oversight Board, South Korea delegated responsibility for auditor oversight to its Financial Supervisory Service, and Singapore established the Accounting and Corporate Regulatory Authority.

[8] *See* Oversight of Non-U.S. Firms at 2–3.

[9] *See* PCAOB Rules 4011 and 4012; *see also* Oversight of Non-U.S. Firms at 2–3.

[10] *See* Oversight of Non-U.S. Firms at 3.

substantial. The effort typically involves negotiating the principles of an arrangement for cooperation consistent with the inspection obligations that the Act imposes on the Board. It also involves the Board gaining a detailed understanding of the other jurisdiction's auditor oversight system in order for the Board to determine the degree of reliance it is willing to place on inspection work performed under that system in a particular inspection year.

Additional effort is involved in coordinating the scheduling of specific inspections. Where possible, the Board seeks to conduct inspections jointly with local authorities both to take advantage of potential efficiencies and to avoid imposing unnecessary regulatory burdens on firms. Like the PCAOB, several of these other authorities proceed according to inspection frequency requirements. While some of the Board's counterparts are established and have inspection programs, many have only recently begun inspections or are still building up their inspections resources. As a result, synchronizing the inspections schedules of these authorities and the PCAOB's requirements is sometimes difficult.

Notwithstanding these challenges, the Board has so far conducted 140 non-U.S. inspections. Moreover, 61 of those inspections, in six jurisdictions, have been conducted jointly with other auditor oversight authorities, while inspections in 20 jurisdictions have been conducted solely by the PCAOB.[11]

As noted above, under existing Rule 4003, there are 68 non-U.S. firms that, by virtue of when they first issued audit reports after registering with the PCAOB, the Board is required to inspect for the first time by the end of 2009. Those firms are located in 36 jurisdictions, including several jurisdictions in which the Board has already conducted first inspections of other firms. Of those firms, 49 are located in 24 jurisdictions where the Board has not conducted any inspections to date. Most of those 24 jurisdictions have or soon will have a local auditor oversight authority with which the Board would seek to work toward cooperative arrangements before conducting inspections. Because of the steps involved in concluding such arrangements and to evaluate the local system, the Board has concerns about proceeding as if that work can be completed for all of the jurisdictions in which the PCAOB has not previously conducted inspections in time to conduct the required inspections by the end of 2009.

Accordingly, the Board is adopting a new paragraph (g) to Rule 4003 to allow the Board to postpone, for up to three years, the first inspection of any non-U.S. firm that the Board is currently required to conduct by the end of 2009 and that is in a jurisdiction where the Board has not conducted an inspection before 2009.

In determining the schedule for completion of the inspections subject to new paragraph (g), the Board will implement its proposal to sequence these 49 inspections such that certain minimum thresholds will be satisfied in each of the years from 2009 to 2012. The minimum thresholds relate to U.S. market capitalization of firms' issuer audit clients. The Board will begin by ranking the 49 firms according to the total U.S. market capitalization of a firm's foreign private issuer audit clients.[12] Working from the top of the list (highest U.S. market capitalization total) down, the 49 firms will be distributed over 2009 to 2012 such that, at a minimum, the following criteria are satisfied:

- By the end of 2009, the Board will inspect firms whose combined issuer audit clients' U.S. market capitalization constitutes at least 35 percent of the aggregate U.S. market capitalization of the audit clients of all 49 firms;
- By the end of 2010, the Board will inspect firms whose combined issuer audit clients' U.S. market capitalization constitutes at least 90 percent of that aggregate;
- By the end of 2011, the Board will inspect firms whose combined issuer audit clients' U.S. market capitalization constitutes at least 99.9 percent of that aggregate; and
- The Board will inspect the remaining firms in 2012.[13]

In addition to meeting those market capitalization thresholds, the Board also will satisfy certain criteria concerning the number of those 49 firms that will be inspected in each year. Specifically, the Board will conduct at least four of the 49 inspections in 2009, at least 11 more in 2010, and at least 14 more in 2011.[14]

It is important to note that the distribution described above will not operate to prevent an inspection from occurring earlier than called for by the schedule. Any inspection may be moved to an earlier year for a variety of reasons, such as the presence of risk factors (including risk factors relating to referred work[15] that the firm performs on audits for which it is not the principal auditor), synchronization of schedules with a local regulator for purposes of a joint inspection, or simply the opportunity and the availability of resources to do an inspection earlier (including availability of inspectors with specialized industry knowledge and relevant language skills). In addition, the Board will at least annually review updated market capitalization data and consider whether there have been any changes that warrant moving a particular inspection forward to an earlier year.

Conversely, the Board does not intend to make changes that would move an inspection of one of these 49 firms to a later year than in the initial distribution except as the result of a development relating to the market capitalization of the firm's issuer clients. Specifically, if a firm's issuer audit client market capitalization drops significantly and the firm performs no significant amount of referred work on audits, its inspection might be delayed to a later year. In any event, the Board will not, for any reason, move one of these 49 inspections to a later year than in the initial distribution without publicly describing the change and the reason for it.

In the Board's view, this adjustment to the inspection frequency requirement is consistent with the purposes of the Act, the public interest, and the protection of investors. The Board believes that its approach to implementing Rules 4011 and 4012, developing cooperative arrangements, and conducting joint inspections with foreign regulators is enhancing the Board's efforts to carry out its inspection responsibilities. There is long-term value in accepting a limited delay in inspections to continue working toward

[11] Joint inspections have been conducted in Australia, Canada, South Korea, Norway, Singapore and the United Kingdom.

[12] For purposes of the ranking described here, the Board will use the average monthly market capitalization on which each issuer's share of the Board's 2008 accounting support fee was based. Thus, the market capitalization figure used for the ranking does not include the value of any referred work performed by the firm.

[13] Under existing provisions of Rule 4003 that are not affected by this amendment, 2012 would also be the deadline for the Board to conduct the second inspection of those of the 49 firms whose first inspection occurs in 2009.

[14] The issuer audit client U.S. market capitalization currently associated with a significant number of the 49 firms is relatively low, and even zero in a number of cases where firms appear to have stopped issuing audit reports for issuers. As a result, approximately 92% of the relevant issuer market capitalization is associated with 15 of the 49 firms.

[15] Because the PCAOB is still in the process of gathering information about each firm's referred work, the 2009 inspections will not use referred work as a risk factor for purposes of scheduling.

cooperative arrangements where it appears reasonably possible to reach them. The Board also believes that the additional time to conduct certain inspections will have the added benefit of giving the Board more time to continue to enhance its inspection program, particularly in the areas of risk assessment and pre-inspection planning, and the Board intends to do so.

The Board recognizes that some non-U.S. firms may be reluctant to comply with PCAOB inspection demands because of a concern that doing so might violate local law or the sovereignty of their home country. The Board believes that the purposes of the Act, the public interest, and the protection of investors are better served, up to a point, by delaying some of the first inspections to work toward a cooperative resolution than by precipitating legal disputes involving conflicts between U.S. and non-U.S. law that could arise if the Board sought to enforce compliance with its preferred schedule without regard for the concerns of non-U.S. authorities.

The Board does not intend, however, to make any further adjustments to the inspection frequency requirements applicable to firms whose first inspection was due no later than 2009. While the Board will continue to work toward cooperation and coordination with authorities in the relevant jurisdictions, the Board will make inspection demands on the firms early enough in the year in which they are scheduled for inspection according to the above described sequencing to allow the Board to conduct the inspections during that year.[16]

(b) Statutory Basis

The statutory basis for the proposed rule is Title I of the Act.

B. Board's Statement on Burden on Competition

The Board does not believe that the proposed rule will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The proposed rule imposes no burden beyond the burdens clearly imposed and contemplated by the Act.

C. Board's Statement on Comments on the Proposed Rule Received From Members, Participants or Others

The Board released the proposed rule amendment for public comment in Release No. 2008–007 (December 4, 2008). A copy of Release No. 2008–007 and the comment letters received in response to the PCAOB's request for comment are available on the PCAOB's Web site at *http://www.pcaobus.org/Rules/Docket_027.* The Board received twenty-four written comment letters. The Board has carefully considered the comment letters, as discussed below.

Several commenters suggested that the Board exercise its authority under Section 106 of the Act to exempt firms that cannot cooperate with PCAOB inspections due to legal conflicts or sovereignty-based opposition from their local governments. The Board believes that it is not in the interests of investors or the public to exempt non-U.S. firms from the Act's inspection requirement given that the Board has previously determined not to exempt non-U.S. firms from the Act's registration requirements and given that an inspection is the Board's primary tool of oversight.[17]

The Board also received several comment letters addressing the length of the proposed extension for certain firms with 2009 deadlines. Some comment letters expressed concern about the inspection delay of up to three years but ultimately expressed qualified support for the Board's decision. These comments urged the Board to permit no further delays and to proceed as described above by sequencing the inspection of firms subject to the extension based on certain thresholds relating to the U.S. market capitalization of firms' issuer audit clients. Some comments also suggested that the Board should utilize the additional time provided by the proposed extension to enhance its international inspections program, particularly in the areas of risk assessment and pre-inspection planning.

Other comment letters supported the Board's decision to extend the inspection deadlines, but some qualified their support by noting that three years may not be enough time to overcome the legal conflicts and sovereignty concerns in all relevant jurisdictions. Several comments expressed support for the Board's plan to sequence the deferred inspections in time based on the U.S. market capitalization of the firms' clients, but some also noted that this plan did not adequately take into account the varying degree of legal conflicts present in the different jurisdictions and might have the effect of requiring early on during the three year period the inspection of firms in jurisdictions with legal obstacles that cannot be overcome quickly.

As explained above, the Board believes that an extension of up to three years for the relevant firms is the appropriate course. Distributing the affected firms across three years strikes the proper balance between avoiding unnecessary delays in the inspection of registered firms and allowing reasonable time for the Board to continue its efforts to reach cooperative arrangements with the relevant home-country regulators. The Board believes that any longer or further extension would not be in the interests of investors or the public.

III. Date of Effectiveness of the Proposed Rule and Timing for Commission Action

Within 60 days of the date of publication of this notice in the **Federal Register** or within such longer period as (i) 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 Board 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, including whether the proposed rule changes are consistent with the requirements of Title I of the Act. Comments may be submitted by any of the following methods:

[16] Apart from the proposed rule amendment, the Board has implemented certain practices to provide additional transparency with regard to the Board's international inspections program. These practices include (1) making a public announcement, near the beginning of each year until 2012, identifying all non-U.S. jurisdictions in which there are firms that the Board will inspect that year, (2) maintaining a public list of all registered firms that have not yet had their first Board inspection even though more than four years have passed since the end of the calendar year in which they first issued an audit report while registered with the Board, and (3) making biannual public announcements of the Board's progress toward meeting the thresholds described above with respect to the number of firms to be inspected and the aggregate market capitalization of firm clients. The Board also maintains on its Web site a list of all jurisdictions in which there are registered firms that the Board has inspected. Additional details concerning these practices are provided in PCAOB Release No. 2009–003, available on the Board's Web site at *http://www.pcaobus.org/Rules/Docket_027.*

[17] When it first became operational, the Board considered whether to exempt non-U.S. firms from registration with the Board. The Board determined that exempting non-U.S. firms would not protect the interests of investors or further the public interest given that registration is the predicate to all of the Board's other oversight programs. See Registration System for Public Accounting Firms, PCAOB Release No. 2003–007 (May 6, 2003) at 13.

Electronic Comments

• Use the Commission's Internet comment form (*http://www.sec.gov/rules/pcaob.shtml*); or

• Send an e-mail to *rule-comments@sec.gov*. Please include File Number PCAOB–2009–01 on the subject line.

Paper Comments

Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number PCAOB–2009–01. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/pcaob/shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule changes that are filed with the Commission, and all written communications relating to the proposed rule changes 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, 100 F Street, NE., Washington, DC 20549 on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the PCAOB. All comments received will be posted without change; we do not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number PCAOB–2009–01 and should be submitted on or before December 16, 2009.

By the Commission.

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–28239 Filed 11–24–09; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–61025; File No. SR–NYSEArca–2009–102]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by NYSE Arca, Inc. Amending Rule 7.25

November 18, 2009.

Pursuant to Section 19(b)(1)[1] of the Securities Exchange Act of 1934 (the ''Act'')[2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on November 6, 2009, NYSE Arca, Inc. (''NYSE Arca'' or the ''Exchange'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change 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.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend Rule 7.25 to remove the requirement that for each security in which a Market Maker is registered as a Lead Market Maker, the Lead Market Maker also register as an Odd Lot Dealer in that security. The text of the proposed rule change is available at the Exchange, the Commission's Public Reference Room, and *http://www.nyse.com*.

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 self-regulatory organization 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 those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Rule 7.25 to remove the requirement that for each security in which a Market Maker is registered as a Lead Market Maker (''LMM''), the LMM also register as an Odd Lot Dealer (''OLD'') in that security (the ''LMM–OLD requirement''). Going forward, LMMs may choose to register as an OLD, but will not be required to do so.

The LMM–OLD requirement was originally established in order to ensure that a mechanism existed whereby the Exchange could facilitate odd lot executions for its primary listings that could not otherwise be routed away to another market center for execution.[4] This historical concern no longer exists. All orders in primary listings, whether odd lot or round lot, are eligible for routing to away market centers. Any eligible unexecuted balance of odd lot orders, like round lot orders, shall be routed to away market centers for execution pursuant to NYSE Arca Equities Rule 7.37(d). Also, for purposes of ranking and execution, round lot, mixed lot and odd lot orders are treated in the same manner on the NYSE Arca Marketplace.[5] As a result, it is no longer necessary to require LMMs to register as OLDs. Instead, as with all market makers, LMMs may choose to register as an OLD, but will not be required to do so.

In addition, until recently, the Exchange paid a $0.02 per share credit to market makers that executed against an odd lot order. This rebate represented a higher than standard rebate, and acted as an incentive for market makers to register as OLDs. However, the Exchange notes that as of August 3, 2009, the Exchange eliminated all distinct odd lot pricing and now makes no distinction with respect to the rates applied to odd lot and round lot executions.[6]

The Exchange is not otherwise altering any other rights or obligations of LMMs.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with and furthers the objectives of Section 6(b)(5) of the Act,[7] in that it is designed to promote just and equitable principles of

[1] 15 U.S.C.78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] *See* Securities Exchange Act Release No. 52827 (November 23, 2005), 70 FR 72139 (December 1, 2005) (order approving SR–PCX–2005–56).

[5] If there is an Odd Lot Dealer registered in the security, the order shall be matched in the Odd Lot Tracking Order Process pursuant to Rule 7.37(c). If there is no Odd Lot Dealer registered in that security, the odd lot will be routed away pursuant to NYSE Arca Equities Rule 7.37(d).

[6] *See* Securities Exchange Act Release No. 60495 (August 13, 2009), 74 FR 41957 (August 19, 2009) (notice of filing and immediate effectiveness of SR–NYSEArca–2009–72).

[7] 15 U.S.C. 78f(b)(5).

trade, remove impediments to and perfect the mechanisms of a free and open market and a national market system and, in general, to protect investors and the public interest. The Exchange is simply eliminating the requirement that LMMs register as an OLD in the security in which they are also registered as an LMM. The Exchange is not otherwise altering the rights and obligations of LMMs.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative prior to 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act [8] and Rule 19b–4(f)(6) thereunder.[9]

A proposed rule change filed under Rule 19b–4(f)(6) of the Act [10] normally does not become operative prior to 30 days after the date of the filing. However, Rule 19b–4(f)(6) [11] permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest.

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–NYSEArca–2009–102 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEArca–2009–102. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). 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, 100 F Street, NE., Washington, DC 20549–1090 on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing will also be available for inspection and copying at NYSE Arca's principal office and on its Internet Web site at *http://www.nyse.com*. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEArca–2009–102 and should be submitted on or before December 16, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E9–28197 Filed 11–24–09; 8:45 am]

BILLING CODE 8011–01–P

[8] 15 U.S.C. 78s(b)(3)(A).

[9] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[10] 17 CFR 240.19b–4(f)(6).

[11] *Id.*

[12] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–61026; File No. SR–FINRA–2009–076]

Self-Regulatory Organizations; Financial Industry Regulatory Authority, Inc.; Notice of Filing of Proposed Rule Change To Amend the FINRA Rule 9550 Series (Expedited Proceedings)

November 18, 2009.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on November 5, 2009, Financial Industry Regulatory Authority, Inc. (''FINRA'') 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 FINRA. On November 17, 2009, FINRA filed Amendment No. 1. [3] 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

FINRA is proposing to (1) Modify various time requirements regarding expedited proceedings, (2) add an expedited proceeding for failure to pay restitution, and (3) harmonize a remedy in an expedited procedure with a remedy in the FINRA By-Laws.

The text of the proposed rule change is available on FINRA's Web site at: *http://www.finra.org,* at the principal office of FINRA and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Amendment No. 1 to SR–FINRA–2009–076 supersedes and replaces in its entirety the proposed rule change as filed on November 5, 2009. FINRA filed Amendment No. 1 so that the text of Proposed FINRA Rule 9559 as set forth in this rule filing could reflect amendments adopted pursuant to proposed rule change SR–FINRA–2008–067. *See* Securities Exchange Act Release No. 60933 (November 4, 2009), 74 FR 58334 (November 12, 2009) (Order Approving File No. SR–FINRA–2008–067).

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, FINRA 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. FINRA 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

In March 2004, the SEC approved a rule change that created the NASD Rule 9550 Series to consolidate, clarify, and streamline most procedural rules that had an expedited proceeding component.[4] Having used the procedures for five years and having conducted a recent analysis of their effectiveness, FINRA is proposing a few modifications that will strengthen investor protection and improve administrative efficiency. The proposed changes are discussed separately below.

Shortening Time Periods

The Rule 9550 Series provides a procedural mechanism for FINRA to address certain types of misconduct more quickly than would be possible using the ordinary disciplinary process. At the same time, the Rule 9550 Series provides firms and associated persons with numerous procedural protections, including the ability to request a hearing that often results in a stay of the action. FINRA proposes shortening the time within which a hearing must be held from the current 60 days after a hearing request to 30 days after the request in relation to the following FINRA rules:

- Rule 9551 (Failure To Comply With Public Communication Standards);
- Rule 9552 (Failure To Provide Information or Keep Information Current);
- Rule 9553 (Failure To Pay FINRA Dues, Fees and Other Charges);
- Rule 9554 (Failure To Comply With an Arbitration Award or Related Settlement); and
- Rule 9555 (Failure to Meet the Eligibility or Qualification Standards or Prerequisites for Access to Services).

The proposed change[5] strengthens investor protection while maintaining procedural safeguards for respondents, makes the timing of the hearings more consistent with other hearings in the rule series, and reflects FINRA's experience over the past five years in resolving these matters. The change would increase investor protection by limiting the period during which a wrongdoer could continue doing business while the matter is pending. Moreover, the issues involved in these cases usually are straightforward (*e.g.,* whether the respondent paid an arbitration award or FINRA fee or provided required information) and do not require lengthy preparation time. The change also would bring these hearing provisions more in line with the other expedited actions in the Rule 9550 Series, which require hearings to be held within 14 days or five business days of the respondent's request for a hearing depending on the type of conduct at issue. Finally, five years' experience has established that hearings can be held much more quickly than the current scheme contemplates.

In addition to modifying the timing of hearings, FINRA proposes amending Rule 9552 to shorten the period before a suspension automatically turns into an expulsion or bar. Rule 9552 allows FINRA to suspend a member or associated person for failure to provide any information requested or required to be filed pursuant to the FINRA By-Laws or rules, such as FOCUS reports or annual audits. Under the rule, FINRA may provide written notice to such member or person specifying the nature of the failure and stating that failure to take corrective action within 21 days after service of the notice will result in suspension. The rule also provides that a member or person suspended under the rule who fails to request termination of the suspension within six months is automatically expelled or barred. FINRA proposes shortening that timeframe from six months to three months. Three months provides sufficient time for respondents to seek to lift the suspension while moving the process forward at a more efficient and reasonable pace.

Adding an Expedited Procedure for Failure To Pay Restitution

FINRA proposes amending Rule 9554, which contains expedited procedures for failure to pay FINRA arbitration awards, to also permit FINRA to take expedited action for failure to comply with a FINRA order of restitution or a FINRA settlement providing for restitution. Restitution is an equitable remedy used to restore victims to their position before the wrongful conduct occurred and to compensate them for unjust losses or injury suffered as the result of another's wrongdoing.[6] The SEC and FINRA have long stressed the importance of imposing restitution where an ''identifiable person … has suffered a quantifiable loss as a result of a respondent's misconduct.''[7]

Although FINRA can take expedited action against a member firm or associated person for failure to pay fines, dues, and fees to FINRA and for failure to pay an arbitration award to a third party, FINRA currently does not have explicit authority to take expedited action against firms or associated persons who fail to pay restitution to a third party (usually investors who have been harmed). FINRA's only recourse is to initiate an ordinary disciplinary action, which can take several months to conclude. FINRA believes that firms and associated persons should not be permitted to continue doing business for prolonged periods when they have failed to pay restitution to third parties. The proposal would close this loophole.

Harmonizing Remedies

FINRA proposes harmonizing the remedy for an individual's failure to pay an arbitration award in Rule 9554 with the remedy for the same misconduct in the FINRA By-Laws. At present, Rule 9554 states that FINRA may suspend or cancel the membership of a firm and may suspend or bar an individual for failure to pay an arbitration award. Article VI, Section 3(b) of the FINRA By-Laws, however, limits the remedy regarding an individual's failure to pay an arbitration award to a suspension. To make the rule consistent with the By-Laws, the proposed change would limit the remedy against individuals in such

[4] *See* Securities Exchange Act Release No. 49380 (March 9, 2004), 69 FR 12386 (March 16, 2004) (Order Approving File No. SR–NASD–2003–110)); *Notice to Members* 04–36 (May 2004). Expedited proceedings in this context refer to fast-tracked matters that take place outside the ordinary FINRA disciplinary process. In September 2008, the SEC approved the adoption of the NASD Rule 9550 Series as the FINRA Rule 9550 Series. *See* Securities Exchange Act Release No. 58643 (September 25, 2008), 73 FR 57174 (October 1, 2008) (Order Approving File Nos. SR–FINRA–2008–021; SR–FINRA–2008–022; SR–FINRA–2008–026; SR–FINRA–2008–028 and SR–FINRA–2008–029); Regulatory Notice 08–57 (October 2008).

[5] FINRA would implement the proposed change by amending Rule 9559, which contains the hearing provisions for the Rule 9550 Series. FINRA also would make conforming changes to Rule 9559 regarding the pre-hearing exchange of documents between the parties to the expedited proceeding.

[6] *See David Joseph Dambro,* 51 S.E.C. 513, 518 (1993).

[7] FINRA Sanction Guidelines, at 4; *see also Dambro,* 51 S.E.C. at 518 (emphasizing importance of getting money back to investors who were harmed by broker's misconduct).

cases to suspension and would eliminate any reference to barring individuals.

FINRA will announce the effective date of the proposed rule change in a *Regulatory Notice* to be published no later than 60 days following Commission approval. The effective date will be 30 days following publication of the *Regulatory Notice* announcing Commission approval.

2. Statutory Basis

The proposed rule change is consistent with the provisions of Section 15A(b)(6) of the Act,[8] which requires, among other things, that FINRA's rules must be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest. The proposal also is consistent with Section 15A(b)(7) of the Act,[9] which provides that FINRA members and associated persons must be appropriately disciplined for violations of any provisions of the Act or FINRA rules. The proposed rule change is consistent with these purposes because it promotes a fair and efficient disciplinary process and provides a mechanism to take expedited action when a member or associated person fails to pay restitution.

B. Self-Regulatory Organization's Statement on Burden on Competition

FINRA does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

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, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–FINRA–2009–076 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–FINRA–2009–076. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). 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, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of FINRA. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make publicly available. All submissions should refer to File Number SR–FINRA–2009–076 and should be submitted on or before December 16, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[10]

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E9–28224 Filed 11–24–09; 8:45 am]

BILLING CODE 8011–01–P

[8] 15 U.S.C. 78*o*–3(b)(6).

[9] 15 U.S.C. 78*o*–3(b)(7).

[10] 17 CFR 200.30–3(a)(12).

DEPARTMENT OF STATE

[Public Notice 6807]

Notice of Meeting of the Advisory Committee on International Law

A meeting of the Advisory Committee on International Law will take place on Friday, December 11, 2009, from 9:15 a.m. to approximately 5:30 p.m., at the George Washington University Law School (Michael K. Young Faculty Conference Center, 5th Floor), 2000 H St., NW., Washington, DC. The meeting will be chaired by the Legal Adviser of the Department of State, Harold H. Koh, and will be open to the public up to the capacity of the meeting room. It is anticipated that the agenda of the meeting will cover a range of current international legal topics, including treaty scope and enforcement issues, the relationship between human rights treaties and humanitarian law; issues relating to the International Criminal Court; options for compliance with the International Court of Justice's decision in the *Case Concerning Avena and Other Mexican Nationals* (*Mexico* v. *United States of America*); and the law of non-international armed conflict. Members of the public will have an opportunity to participate in the discussion.

Members of the public who wish to attend the session should, by Monday, December 7, 2009, notify the Office of the Legal Adviser (telephone: 202–776–8323) of their name, professional affiliation, address, and telephone number. A valid photo ID is required for admittance. A member of the public who needs reasonable accommodation should make his or her request by December 4, 2009; requests made after that time will be considered but might not be possible to accommodate.

Dated: November 19, 2009.

David DeBartolo,

Office of Claims and Investment Disputes, Office of the Legal Adviser, Executive Director, Advisory Committee on International Law, Department of State.

[FR Doc. E9–28274 Filed 11–24–09; 8:45 am]

BILLING CODE 4710–08–P

DEPARTMENT OF STATE

[Public Notice 6810]

Defense Trade Advisory Group Meeting Agenda

Summary: As announced in the **Federal Register** (Volume 74, Number 218, Pages 58675–58676) the Defense Trade Advisory Group (DTAG) will meet in open session from 1 p.m. until 5 p.m. on Friday, December 4, 2009. The meeting agenda will be as follows: 1 until 1:15 Opening Remarks; 1:15–2:45 Export Control Reform; 2:45–3:00 Break; 3–3:45 Draft revision to ITAR Section 126.4; 3:45–4:45 Draft revision to ITAR Section 129; 4:45–5 Concluding Remarks. The draft revisions to ITAR Sections 126.4 and 129 that will be discussed at the meeting will be posted on the PM/DDTC Web site (*http://www.pmddtc.state.gov*) prior to the meeting in order to provide attendees with the opportunity to review before the meeting. Please refer to the **Federal Register** Notice referenced above for particulars regarding location of meeting and attendance.

Dated: 18 November 2009.

Robert S. Kovac,

Designated Federal Officer, Defense Trade Advisory Group, Department of State.

[FR Doc. E9–28273 Filed 11–24–09; 8:45 am]

BILLING CODE 4710–25–P

DEPARTMENT OF STATE

[Public Notice 6820]

Bureau of Political-Military Affairs: Directorate of Defense Trade Controls; Notifications to the Congress of Proposed Commercial Export Licenses

SUMMARY: Notice is hereby given that the Department of State has forwarded the attached Notifications of Proposed Export Licenses to the Congress on the dates indicated on the attachments pursuant to sections 36(c) and 36(d) and in compliance with section 36(f) of the Arms Export Control Act (22 U.S.C. 2776).

DATES: *Effective Date:* As shown on each of the 16 letters.

FOR FURTHER INFORMATION CONTACT: Mr. Robert S. Kovac, Managing Director, Directorate of Defense Trade Controls, Bureau of Political-Military Affairs, Department of State (202) 663–2861.

SUPPLEMENTARY INFORMATION: Section 36(f) of the Arms Export Control Act mandates that notifications to the Congress pursuant to sections 36(c) and 36(d) must be published in the **Federal Register** when they are transmitted to Congress or as soon thereafter as practicable.

October 13, 2009 (Transmittal 091–09)
Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed technical assistance agreement to include the export of technical data, defense services, and defense articles in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the transfer of technical data, defense services, and hardware to support the Proton launch of the SkyTerra 2 Commercial Communication Satellite from the Baikonur Cosmodrome in Kazakhstan.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,
Assistant Secretary Legislative Affairs.

October 22, 2009 (Transmittal 099–09)
Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed technical assistance agreement to include the export of defense articles, technical data and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the transfer of defense articles, to include technical data, and defense services to support the Proton launch of the Telstar 14R Commercial Communication Satellite from the Baikonur Cosmodrome in Kazakhstan.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,
Assistant Secretary Legislative Affairs.

November 12, 2009 (Transmittal 104–09)
Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(d) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services for the manufacture of Modified 20mm x 102mm PELE Ammunition for end use by the U.S. Air Force in the F–15 and F–16 Aircraft.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,
Assistant Secretary Legislative Affairs.

October 13, 2009 (Transmittal 109–09)
Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed amendment to a manufacturing license agreement for the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services to support the manufacture of X200–Series transmissions in the Republic of Korea for an authorized sales territory.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,
Assistant Secretary Legislative Affairs.

October 13, 2009 (Transmittal 110–09)
Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) and Section 36(d) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services for the manufacture of the 737 Airborne Early Warning & Control (AEW&C) System, Peace Eagle, for end-use by the Turkish Air Force.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,

Assistant Secretary Legislative Affairs.

October 15, 2009 (Transmittal 112–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed amendment to a technical assistance agreement for the export of defense articles, including technical data, and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data and defense services for the integration of surfaced launched AMRAAM electronics kits for the National Advanced Surface to Air Missile System FIN Program in Finland.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,

Assistant Secretary Legislative Affairs.

October 13, 2009 (Transmittal 113–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed technical assistance agreement to include the export of technical data, defense services, and defense articles in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the transfer of technical data, defense services, and hardware to support the Proton launch of the QuetzSat-1 Commercial Communication Satellite from the Baikonur Cosmodrome in Kazakhstan.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,

Assistant Secretary Legislative Affairs.

October 13, 2009 (Transmittal 118–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed amendment to a manufacturing license agreement for the export of defense articles, to include technical data, and defense services in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the transfer of defense articles, to include technical data, and defense services to support the manufacture of the AN/ASA–70 Tactical Data Display Group for the Japanese Government's P–3C Anti-Submarine Warfare program.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,

Assistant Secretary Legislative Affairs.

October 13, 2009 (Transmittal 121–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed permanent export license for the export of defense articles, to include technical data, related to firearms in the amount of $1,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, to include technical data, related to sale of Lewis Machine & Tool Co. (LMT) .308 caliber (7.62mm) Semi Automatic Rifles for use by the United Kingdom Ministry of Defence.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,

Assistant Secretary Legislative Affairs.

November 12, 2009 (Transmittal 123–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed amendment to a manufacturing license agreement for the export of defense articles, to include technical data, and defense services.

The transaction contained in the attached certification involves the export of defense articles, to include technical data, and defense services for the Laser Target Designator/Range Finders and Gated Laser illuminators for Night Television for the AC–130U Gunship for end-use by the U.S. Air Force.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,

Assistant Secretary Legislative Affairs.

November 12, 2009 (Transmittal 124–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(d) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services for the manufacture in Japan of the GAU–19 Gun.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights, and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,

Assistant Secretary Legislative Affairs.

November 12, 2009 (Transmittal 125–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed amendment to a manufacturing assistance agreement for the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, to include technical data, and defense services to Japan for the overhaul and manufacture of SIIS–3XT4/T4 ejection seats for the XT4/T4 trainer aircraft for use in Japan.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,
Assistant Secretary Legislative Affairs.

November 12, 2009 (Transmittal 127–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) and Section 36(d) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad in the amount of $50,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, including technical data, and defense services for the modification of CH–47SD Chinook Helicopters to the CH–47F configuration for the Singapore Ministry of Defence.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,
Assistant Secretary Legislative Affairs.

October 22, 2009 (Transmittal 129–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed amendment to a manufacturing license agreement for the export of defense articles, to include technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, to include technical data, and defense services for the manufacture of control section units and associated electronics modules in the United Kingdom for the AIM–120 Medium Range Air-to-Air Missile for end-use by the United States of America.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,
Assistant Secretary Legislative Affairs.

November 12, 2009 (Transmittal 132–09)

Hon. Nancy Pelosi, Speaker of the House of Representatives.

Dear Madam Speaker: Pursuant to Section 36(c) of the Arms Export Control Act, I am transmitting, herewith, certification of a proposed amendment to a manufacturing license agreement for the export of defense articles, including technical data, and defense services in the amount of $100,000,000 or more.

The transaction contained in the attached certification involves the export of defense articles, to include technical data, and defense services to Australia for the manufacture and service of F/A–18 Trailing Edge Flaps, Trailing Edge Flap Shrouds, Ailerons, and Aileron Shrouds and their associated minor components and parts.

The United States Government is prepared to license the export of these items having taken into account political, military, economic, human rights and arms control considerations.

More detailed information is contained in the formal certification which, though unclassified, contains business information submitted to the Department of State by the applicant, publication of which could cause competitive harm to the United States firm concerned.

Sincerely,

Richard R. Verma,
Assistant Secretary Legislative Affairs.

Dated: 18 November 2009.

Robert S. Kovac,

Managing Director, Directorate of Defense Trade Controls, Department of State.

[FR Doc. E9–28270 Filed 11–24–09; 8:45 am]

BILLING CODE 4710–25–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Notice of Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits Filed Under Subpart B (Formerly Subpart Q) During the Week Ending November 7, 2009

The following Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits were filed under Subpart B (formerly Subpart Q) of the Department of Transportation's Procedural Regulations (*See* 14 CFR 301.201 *et seq.*). The due date for Answers, Conforming Applications, or Motions to Modify Scope are set forth below for each application. Following the Answer period DOT may process the application by expedited procedures. Such procedures may consist of the adoption of a show-cause order, a tentative order, or in appropriate cases a final order without further proceedings.

Docket Number: DOT–OST–2009–0287.

Date Filed: November 2, 2009.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: November 23, 2009.

Description: Application of Brussels Airlines NV/SA (''Brussels Airlines'') requesting an amended exemption authority and the issuance of a foreign air carrier permit to conduct scheduled and charter services, including; (i) Foreign scheduled and charter air transportation of persons, property and mail from any point or points behind any Member State(s) of the European Union, via any point or points in any Member State(s) and via intermediate points to any point or points in the United States and beyond; (ii) foreign scheduled and charter air transportation of persons, property and mail between any point or points in the United States and any point or points in any member of the European Common Aviation Area; (iii) foreign scheduled and charter cargo air transportation between any point or points in the United States and any other point or points; (iv) other charters; and (v) transportation authorized by any additional route rights made available to European Community carriers in the future. Brussels Airlines further requests a corresponding exemption to the extent necessary to enable it to provide the service described above pending issuance of a foreign air carrier permit and such additional or other relief as the Department may deem necessary or appropriate.

Docket Number: DOT–OST–2005–20491.

Date Filed: November 5, 2009.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: November 27, 2009.

Description: Application of NetJets—Transportes Aereos, S.A. (''NTA'') requesting a renewal and amended exemption and a foreign air carrier permit authorizing NTA to engage in charter foreign air transportation of persons, property and mail to and from points in the United States to the full extent permitted by its homeland operating authority and the EU–U.S. open-skies agreement.

Renee V. Wright,

Program Manager, Docket Operations, Federal Register Liaison.

[FR Doc. E9–28249 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–9X–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Aviation Proceedings, Agreements Filed the Week Ending November 7, 2009

The following Agreements were filed with the Department of Transportation under the Sections 412 and 414 of the Federal Aviation Act, as amended (49 U.S.C. 1382 and 1384) and procedures governing proceedings to enforce these provisions. Answers may be filed within 21 days after the filing of the application.

Docket Number: DOT–OST–2009–0279.

Date Filed: November 2, 2009.

Parties: Members of the International Air Transport Association.

Subject: TC23/123 Africa-Japan, Korea, Resolutions and Specified Fares Tables (Memo 0420), Intended effective date: 1 April 2010.

Docket Number: DOT–OST–2009–0280.

Date Filed: November 2, 2009.

Parties: Members of the International Air Transport Association.

Subject: TC23/123 Africa-South East Asia Resolutions and Specified Fares Tables (Memo 0423), Intended effective date: 1 April 2010.

Docket Number: DOT–OST–2009–0281.

Date Filed: November 2, 2009.

Parties: Members of the International Air Transport Association,

Subject: TC23/123 Africa-South Asian Subcontinent, Resolutions and Specified Fares Tables (Memo 0424), Intended effective date: 1 April 2010.

Docket Number: DOT–OST–2009–0282.

Date Filed: November 2, 2009.

Parties: Members of the International Air Transport Association.

Subject: TC23/123 Africa-TC3 (except South West Pacific), Areawide Resolutions (Memo 0425), Intended effective date: 1 April 2010.

Docket Number: DOT–OST–2009–0283.

Date Filed: November 2, 2009.

Parties: Members of the International Air Transport Association.

Subject: TC23/123 Middle East-South East Asia, Resolutions and Specified Fares Tables (Memo 0423), Intended effective date: 1 April 2010.

Docket Number: DOT–OST–2009–0284.

Date Filed: November 2, 2009.

Parties: Members of the International Air Transport Association.

Subject: TC23/123 Middle East-Japan, Korea Resolutions and Specified Fares Tables (Memo 0425), Intended effective date: 1 April 2010.

Docket Number: DOT–OST–2009–0285.

Date Filed: November 2, 2009.

Parties: Members of the International Air Transport Association.

Subject: TC23/123 Middle East-South Asian Subcontinent, Resolutions and Specified Fares Tables, (Memo 0426), Intended effective date: 1 April 2010.

Docket Number: DOT–OST–2009–0286.

Date Filed: November 2, 2009.

Parties: Members of the International Air Transport Association.

Subject: TC23/123 Middle East-TC3 (except South West Pacific), Areawide Resolutions (Memo 0427), Intended effective date: 1 April 2010.

Renee V. Wright,

Program Manager, Docket Operations, Federal Register Liaison.

[FR Doc. E9–28250 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–9X–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[USCG–2007–28532]

Port Dolphin Energy LLC, Port Dolphin Liquefied Natural Gas Deepwater Port License Application

AGENCY: Maritime Administration, DOT.

ACTION: Notice of Availability of Record of Decision.

SUMMARY: The Maritime Administration announces the availability of the Record of Decision for the Port Dolphin Energy LLC (Port Dolphin Energy) Deepwater Port License Application. On October 26, 2009, the Acting Maritime Administrator, David T. Matsuda, issued the Record of Decision ''approving with conditions'' Port Dolphin Energy's application to own, construct, and operate a liquefied natural gas (LNG) deepwater port 28 miles southwest of Tampa Bay, Florida. Issuance of this Record of Decision completes the application review and license approval process, mandated by the Deepwater Port Act of 1974, as amended (the Act).

ADDRESSES: Copies of the Record of Decision for the Port Dolphin Energy LNG Deepwater Port License Application are available on request from the Docket Management Facility, M–30, U.S. Department of Transportation, West Building, Ground Floor, Rm. W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, or via the Internet at *http://www.regulations.gov* (Document ID: USCG–2007–28532–0240).

FOR FURTHER INFORMATION CONTACT: Yvette Fields, Director, Office of Deepwater Ports and Offshore Activities, Maritime Administration, telephone: 202–366–0926, e-mail: *Yvette.Fields@dot.gov* or Patrick Marchman, Maritime Administration, telephone: 202–366–7206, e-mail: *Patrick.Marchman@dot.gov.* The full text of the Record of Decision (Document ID: USCG–2007–28532–0240) is available as a part of the public docket for the complete Port Dolphin Energy Deepwater Port License Application (Docket Number USCG–2007–28532), maintained by the U.S. Department of Transportation Docket Management Facility. If you have questions regarding the docket, please contact Renee V. Wright, Program Manager, Docket Operations, telephone: 202–493–0402.

SUPPLEMENTARY INFORMATION:

Application Review Process

On March 29, 2007, Port Dolphin Energy LLC, a limited liability company organized and existing under the laws of the State of Delaware and an ultimate subsidiary of Leif Hoegh & Company Limited, submitted to the Maritime Administration and the U.S. Coast Guard (USCG), an application for approval of a license to own, construct, operate, and ultimately decommission a deepwater port, known as Port Dolphin, approximately 28 miles southwest of Tampa Bay, Florida, for the purpose of importing Liquefied Natural Gas (LNG) into the United States. On June 15, 2007, Port Dolphin Energy's application was deemed complete by the Maritime Administration and the USCG. On June 25, 2007, the Maritime Administration and USCG published a notice in the **Federal Register** [72 FR 34741–34742] to announce the availability of the application for public inspection and request public comments on the proposed project and its potential impacts on the environment.

Pursuant to the statutory requirements of the Act, the Maritime Administration and the USCG conducted an environmental review of the Port Dolphin project and prepared an environmental impact statement in accordance with procedures stipulated under the National Environmental Policy Act (NEPA). The Federal environmental review process was conducted in close coordination with cooperating Federal and Florida State agencies, integrating the environmental values and concerns expressed by local communities. Additional information

regarding the application and environmental review process for the Port Dolphin project can be found on the public docket at *http://www.regulations.gov* (Document ID: USCG–2007–28532).

Decision Process

Provisions of the Act require the Maritime Administrator to render his decision on a deepwater port license application within 90 days from the date of the final public hearing. The final public hearing for the Port Dolphin project was held on July 28, 2009. In rendering a decision, the Maritime Administrator must either: (1) Approve the application as it is proposed, (2) approve the application ''subject to certain conditions'', or (3) deny the application. This Record of Decision, approves the Port Dolphin Energy Deepwater Port License Application, ''subject to certain conditions,'' which have been designed to ensure that Port Dolphin Energy utilizes the best available technology in the operation of its port, exercises care to preserve and enhance the environment, and protect Florida's coastal communities and natural resources. Further, the Record of Decision describes the framework by which the Maritime Administrator must base his decision as defined by the nine approval criteria prescribed by the Act. These nine approval criteria ensure: (1) Financial responsibility; (2) compliance with all applicable laws, regulations and license conditions; (3) national interest; (4) international navigation, safety, and use of the high seas; (5) protection and enhancement of the environment; (6) advice of the Administrator of the Environmental Protection Agency; (7) consultation with the Secretaries of State, Defense, and Army, (8) approval of the Governor of the adjacent coastal State, in this case the Governor of Florida, and (9) consistency with the Coastal Zone Management Act.

The Port Dolphin Record of Decision provides an overview of the Federal environmental review process and describes the comprehensive consultation and technical review of the application conducted by the Maritime Administration and USCG, in consultation with the National Oceanic Atmospheric Administration (NOAA), the Environmental Protection Agency, the State of Florida, and other cooperating Federal and State agencies. During the decision-making process, the Acting Maritime Administrator gave careful consideration to the specific concerns expressed by members of the local Florida coastal communities, such as Longboat Key and Manatee County, regarding the potential impacts on local sand resources. Reasonable efforts were made by the Federal Government, the State of Florida, local communities, and Port Dolphin Energy to bring this matter to a satisfactory resolution. Conditions recommended by cooperating Federal and State agencies, including the specific conditions of approval required by the Governor of Florida, as outlined in his decision letter of September 11, 2009 and in a subsequent Memorandum of Agreement established between the State of Florida and Port Dolphin Energy, have been incorporated into this Record of Decision as conditions of approval. These conditions, which allow for removal of sand prior to the pipeline installation and sharing of costs, will become enforceable and binding under the official deepwater port License upon issuance. The Maritime Administration projects that the official Port Dolphin Energy Deepwater Port License will be issued in early 2010. The full text of the Record of Decision can be viewed at *http://www.regulations.gov* (Document ID: USCG–2007–28532–0240).

Dated: November 16, 2009.

By order of the Maritime Administrator.

Christine Gurland,

Secretary, Maritime Administration.

[FR Doc. E9–28326 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–81–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Opportunity for Public Comment on Surplus Property Release at Kinston Regional Jetport, Kinston, NC

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice.

SUMMARY: Under the provisions of Title 49, U.S.C. 47153(d), notice is being given that the FAA is considering a request from the North Carolina Global TransPark Authority to waive the requirement that a 9.683 acre parcel of surplus property, located at the Kinston Regional Jetport, be used for aeronautical purposes.

DATES: Comments must be received on or before December 28, 2009.

ADDRESSES: Comments on this notice may be mailed or delivered in triplicate to the FAA at the following address: Atlanta Airports District Office, 1701 Columbia Ave., Campus Building, Suite 2–260, College Park, GA 30337.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Ms. Darlene A. Waddell, Executive Director at the following address: 2780 Jetport Road, Suite A, Kinston, NC 28504.

FOR FURTHER INFORMATION CONTACT: Rusty Nealis, Program Manager, Atlanta Airports District Office, 1701 Columbia Ave., Campus Bldg., Suite 2–260, College Park, GA 30337, (404) 305–7142. The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA is reviewing a request by the North Carolina Global TransPark Authority to release 9.683 acres of surplus property at the Kinston Regional Jetport. The surplus property will be developed for industrial and commercial use.

Any person may inspect the request in person at the FAA office listed above under **FOR FURTHER INFORMATION CONTACT.**

In addition, any person may, upon request, inspect the request, notice and other documents germane to the request in person at 2780 Jetport Road, Suite A, Kinston, NC 28504.

Issued in Atlanta, Georgia on November 16, 2009.

Scott L. Seritt,

Manager, Atlanta Airports District Office, Southern Region.

[FR Doc. E9–28208 Filed 11–24–09; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Opportunity for Public Comment on Surplus Property Release at Kinston Regional Jetport, Kinston, NC

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice.

SUMMARY: Under the provisions of Title 49, U.S.C. Section 47153(d), notice is being given that the FAA is considering a request from the North Carolina Global TransPark Authority to waive the requirement that a 35.19 acre parcel of surplus property, located at the Kinston Regional Jetport, be used for aeronautical purposes.

DATES: Comments must be received on or before December 28, 2009.

ADDRESSES: Comments on this notice may be mailed or delivered in triplicate to the FAA at the following address: Atlanta Airports District Office, 1701 Columbia Ave., Campus Building, Suite 2–260, College Park, GA 30337.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Ms. Darlene A.

Waddell, Executive Director at the following address: 2780 Jetport Road, Suite A, Kinston, NC 28504.

FOR FURTHER INFORMATION CONTACT: Rusty Nealis, Program Manager, Atlanta Airports District Office, 1701 Columbia Ave., Campus Bldg., Suite 2–260, College Park, GA 30337, (404) 305–7142. The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA is reviewing a request by the North Carolina Global TransPark Authority to release 35.19 acres of surplus property at the Kinston Regional Jetport. The surplus property will be used to construct a facility for Spirit AeroSystems.

Any person may inspect the request in person at the FAA office listed above under **FOR FURTHER INFORMATION CONTACT**.

In addition, any person may, upon request, inspect the request, notice and other documents germane to the request in person at 2780 Jetport Road, Suite A, Kinston, NC 28504.

Issued in Atlanta, Georgia on November 16, 2009.

Scott L. Seritt,

Manager, Atlanta Airports District Office, Southern Region.

[FR Doc. E9–28207 Filed 11–24–09; 8:45 am]

BILLING CODE M

DEPARTMENT OF THE TREASURY

Fiscal Service

Notice of Rate for Use in Federal Debt Collection and Discount and Rebate Evaluation

AGENCY: Financial Management Service, Fiscal Service, Treasury.

ACTION: Notice of rate for use in Federal debt collection and discount and rebate evaluation.

SUMMARY: Pursuant to Section 11 of the Debt Collection Act of 1982, as amended (31 U.S.C. 3717), the Secretary of the Treasury is responsible for computing and publishing the percentage rate to be used in assessing interest charges for outstanding debts owed to the Government. Treasury's Cash Management Requirements (TFM Volume I, Part 6, Chapter 8000) prescribe use of this rate by agencies as a comparison point in evaluating the cost effectiveness of a cash discount. In addition, 5 CFR 1315.8 of the Prompt Payment rule on ''Rebates'' requires that this rate be used in determining when agencies should pay purchase card invoices when the card issuer offers a rebate. Notice is hereby given that the applicable rate is 1.00 percent for calendar year 2010.

DATES: The rate will be in effect for the period beginning on January 1, 2010, and ending on December 31, 2010.

FOR FURTHER INFORMATION CONTACT: Inquiries should be directed to the Agency Enterprise Solutions Division, Financial Management Service, Department of the Treasury, 401 14th Street, SW., Washington, DC 20227 (Telephone: 202–874–6720).

SUPPLEMENTARY INFORMATION: The rate reflects the current value of funds to the Treasury for use in connection with Federal Cash Management systems and is based on investment rates set for purposes of Public Law 95–147, 91 Stat. 1227. Computed each year by averaging Treasury Tax and Loan (TT&L) investment rates for the 12-month period ending every September 30, rounded to the nearest whole percentage, for applicability effective each January 1, the rate is subject to quarterly revisions if the annual average, on a moving basis, changes by 2 percentage points. The rate in effect for the calendar year 2010 reflects the average investment rates for the 12-month period that ended September 30, 2009.

Dated: November 17, 2009.

Sheryl R. Morrow,

Assistant Commissioner, Federal Finance.

[FR Doc. E9–28206 Filed 11–24–09; 8:45 am]

BILLING CODE M

Federal Register

Wednesday,
November 25, 2009

Book 2 of 2 Books
Pages 61737–62206

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414 et al.

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Final Rule; Medicare Program; Solicitation of Independent Accrediting Organizations To Participate in the Advanced Diagnostic Imaging Supplier Accreditation Program; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, 415, 485, and 498

[CMS–1413–FC]

RINs 0938–AP40

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period implements changes to the physician fee schedule and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. It also implements or discusses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008. (See the Table of Contents for a listing of the specific issues addressed in this rule.)

This final rule with comment period also finalizes the calendar year (CY) 2009 interim relative value units (RVUs) and issues interim RVUs for new and revised codes for CY 2010. In addition, in accordance with the statute, it announces that the update to the physician fee schedule conversion factor is −21.2 percent for CY 2010, the preliminary estimate for the sustainable growth rate for CY 2010 is −8.8 percent, and the conversion factor (CF) for CY 2010 is $28.4061.

DATES: *Effective Dates:* With the exception of the provisions of § 414.68 and § 414.210(e)(5), this final rule is effective on January 1, 2010. The provisions of § 414.68 are effective on October 30, 2009, and the provisions of § 414.210(e)(5) are effective on July 1, 2010.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 29, 2009.

ADDRESSES: In commenting, please refer to file code CMS–1413–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the ''More Search Options'' tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1413–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1413–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

FOR FURTHER INFORMATION CONTACT: Rick Ensor, (410) 786–5617, for issues related to practice expense methodology.

Craig Dobyski, (410) 786–4584, for issues related to geographic practice cost indices and malpractice RVUs.

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

Regina Walker-Wren, (410) 786–9160, for issues related to the phasing out of the outpatient mental health treatment limitation.

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

Lisa Grabert, (410) 786–6827, for issues related to the Physician Resource Use Feedback Program.

Colleen Bruce, (410) 786–5529, for issues related to value-based purchasing.

Sandra Bastinelli, (410) 786–3630, for issues related to the implementation of accreditation standards.

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

Sarah McClain, (410) 786–2994, for issues related to the coverage of cardiac rehabilitation services.

Dorothy Shannon, (410) 786–3396, for issues related to payment for cardiac and pulmonary rehabilitation services.

Roya Lotfi, (410) 786–4072, for issues related to the coverage of pulmonary rehabilitation.

Jamie Hermansen, (410) 786–2064, for issues related to kidney disease patient education programs.

Terri Harris, (410) 786–6830, for issues related to payment for kidney disease patient education.

Brijet Burton, (410) 786–7364, for issues related to the compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen.

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

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

Edmund Kasaitis, (410) 786–0477, or Bonny Dahm, (410) 786–4006, for issues related to the Competitive Acquisition Program (CAP) for Part B drugs.

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

Monique Howard, (410) 786–3869, for issues related to CORF conditions of coverage.

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

Anne Tayloe Hauswald, (410) 786–4546, for clinical laboratory issues.

Troy Barsky, (410) 786–8873, or Roy Albert, (410) 786–1872, for issues related to physician self-referral.

Christopher Molling, (410) 786–6399, or Anita Greenberg, (410) 786–4601, for issues related to the repeal of transfer of title for oxygen equipment.

Michelle Peterman, (410) 786–2591, or Iffat Fatima, (410) 786–6709 for issues related to the grandfathering provisions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Acquisition Program.

Ralph Goldberg, (410) 786–4870, or Heidi Edmunds, (410) 786–1781, for issues related to the damages process caused by the termination of contracts awarded in 2008 under the DMEPOS Competitive Bidding program.

Diane Milstead, (410) 786–3355, or Gaysha Brooks, (410) 786–9649, for all other issues.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues: interim relative value units (RVUs) for selected codes identified in Addendum C; the physician self-referral designated health services (DHS) codes listed in Tables 31 and 32; services for consideration for the Five-Year Review of work RVUs for services as discussed in section II.P., and information concerning services provided under arrangement as discussed in section II.N.2.

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

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

Table of Contents

To assist readers in referencing sections contained in this preamble, we are providing a table of contents. Some of the issues discussed in this preamble affect the payment policies, but do not require changes to the regulations in the *Code of Federal Regulations* (CFR). Information on the regulation's impact appears throughout the preamble, and therefore, is not discussed exclusively in section XIII. of this final rule with comment period.

I. Background
A. Development of the Relative Value System
1. Work RVUs
2. Practice Expense Relative Value Units (PE RVUs)
3. Resource-Based Malpractice (MP) RVUs
4. Refinements to the RVUs
5. Adjustments to RVUs Are Budget Neutral
B. Components of the Fee Schedule Payment Amounts
C. Most Recent Changes to the Fee Schedule
II. Provisions of the Final Regulation and Analysis of the Public Comments
A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)
1. Practice Expense Methodology
a. Data Sources for Calculating Practice Expense
b. Allocation of PE to Services
c. Facility and Non-Facility Costs
d. Services With Technical Components (TCs) and Professional Components (PCs)
e. Transition Period
f. PE RVU Methodology
2. PE Revisions for CY 2010
a. SMS and Supplemental Survey Background
b. Physician Practice Information Survey (PPIS)
c. Equipment Utilization Rate
d. Miscellaneous PE Issues
e. AMA RUC PE Recommendations for Direct PE Inputs
f. Practice Expense for Intranasal Vaccine Administration Codes (CPT Codes 90467, 90468, 90473, and 90474)
B. Geographic Practice Cost Indices (GPCIs): Locality Discussion
1. Update—Expiration of 1.0 Work GPCI Floor
2. Payment Localities
C. Malpractice Relative Value Units (RVUs)
1. Background
2. Methodology for the Revision of Resource-Based Malpractice RVUs
D. Medicare Telehealth Services
1. Requests for Adding Services to the List of Medicare Telehealth Services
2. Submitted Requests for Addition to the List of Telehealth Services
a. Health and Behavior Assessment and Intervention (HBAI)
b. Nursing Facility Services
c. Critical Care Services
d. Other Requests
e. Summary: Result of Evaluation of 2010 Requests
3. Other Issues
E. Specific Coding Issues Related to the Physician Fee Schedule
1. Canalith Repositioning
2. Payment for an Initial Preventive Physical Examination (IPPE)
3. Audiology Codes: Policy Clarification of Existing CPT Codes
4. Consultation Services
F. Potentially Misvalued Codes Under the Physician Fee Schedule
1. Valuing Services Under the Physician Fee Schedule
2. High Cost Supplies
3. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Nonsurgical Services
4. AMA RUC Review of Potentially Misvalued Services
a. Site of Service
b. ''23-Hour'' Stay
c. AMA RUC Review of Potentially Misvalued Codes for CY 2010
5. PE Issues—Arthoscopy
6. Establishing Appropriate Relative Values for Physician Fee Schedule Services
G. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services
2. Section 131(b): Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)
3. Section 131(c): Physician Resource Use Measurement and Reporting Program
4. Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners
5. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescibing Incentive Program
6. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services
7. Section 139: Improvements for Medicare Anesthesia Teaching Programs
8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Cardiac Rehabilitation Services
9. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Pulmonary Rehabilitation Services
10. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment
11. Section 152(b): Coverage of Kidney Disease Patient Education Services
12. Section 153: Renal Dialysis Provisions
13. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen
H. Part B Drug Payment
1. Average Sales Price (ASP) Issues
2. Competitive Acquisition Program (CAP) Issues
I. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities
J. Discussion of Chiropractic Services Demonstration
1. Background
2. Analysis of Demonstration
3. Payment Adjustment
K. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

L. Ambulance Fee Schedule: Technical Correction to the Rural Adjustment Factor Regulations (§ 414.610)
M. Clinical Laboratory Fee Schedule: Signature on Requisition
N. Physician Self-Referral
1. General Background
2. Physician Stand in the Shoes
3. Services Provided ''Under Arrangements'' (Services Performed by an Entity Other Than the Entity That Submits the Claim): Solicitation of Comments
O. Durable Medical Equipment-Related Issues
1. Damages to Suppliers Awarded a Contract Under the Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (Medicare DMEPOS Competitive Bidding Program) Caused by the Delay of the Program
2. Notification to Beneficiaries for Suppliers Regarding Grandfathering
P. Five-Year Refinement of Relative Value Units
Q. Other Issues—Therapy Caps
III. Refinement of Relative Value Units for Calendar Year 2010 and Response to Public Comments on Interim Relative Value Units for 2009
A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units
B. Process for Establishing Work Relative Value Units for the Physician Fee Schedule
C. Work Relative Value Unit Refinements of Interim Relative Value Units
D. Interim 2009 Codes
E. Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2010 (Includes Table Titled ''AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes'')
F. Discussion of Codes and AMA RUC Recommendations
G. Additional Coding Issues
H. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2010
IV. Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS Codes
A. General
B. Annual Update to the Code List
V. Physician Fee Schedule Update for CY 2010
A. Physician Fee Schedule Update
B. The Percentage Change in the Medicare Economic Index (MEI)
C. The Update Adjustment Factor (UAF)
VI. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate (SGR)
A. Medicare Sustainable Growth Rate
B. Physicians' Services
C. Preliminary Estimate of the SGR for 2010
D. Revised Sustainable Growth Rate for 2009
E. Final Sustainable Growth Rate for 2008
F. Calculation of 2010, 2009, and 2008 Sustainable Growth Rates
VII. Anesthesia and Physician Fee Schedule Conversion Factors for CY 2010
A. Physician Fee Schedule Conversion Factor
B. Anesthesia Conversion Factor
VIII. Telehealth Originating Site Facility Fee Payment Amount Update
IX. Provisions of the Final Rule
X. Waiver of Proposed Rulemaking and Delay in Effective Date
XI. Collection of Information Requirements
XII. Response to Comments
XIII. Regulatory Impact Analysis
Regulation Text
Addendum A—Explanation and Use of Addendum B
Addendum B—Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2010
Addendum C—Codes With Interim RVUs
Addendum D—2010 Geographic Adjustment Factors (GAFs)
Addendum E—2010 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality
Addendum F—CY 2010 ESRD Wage Index for Non-Urban Areas Based on CBSA Labor Market Areas
Addendum G—CY 2010 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas
Addendum H—CPT/HCPCS Imaging Codes Defined by Section 5102(b) of the DRA
Addendum I—List of CPT/HCPCS Codes Used To Define Certain Designated Health Services Under Section 1877 of the Social Security Act

Acronyms

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

AA Anesthesiologist assistant
AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
AANA American Association of Nurse Anesthetists
ABMS American Board of Medical Specialties
ABN Advanced Beneficiary Notice
ACC American College of Cardiology
ACGME Accreditation Council on Graduate Medical Education
ACLS Advanced cardiac life support
ACR American College of Radiology
AED Automated external defibrillator
AFROC Association of Freestanding Radiation Oncology Centers
AHA American Heart Association
AHFS–DI American Hospital Formulary Service—Drug Information
AHRQ [HHS'] Agency for Healthcare Research and Quality
AMA American Medical Association
AMA–DE American Medical Association Drug Evaluations
AMP Average manufacturer price
AO Accreditation organization
AOA American Osteopathic Association
APA American Psychological Association
APTA American Physical Therapy Association
ARRA American Recovery and Reinvestment Act (Pub. L. 111–5)
ASC Ambulatory surgical center
ASP Average sales price
ASRT American Society of Radiologic Technologists
ASTRO American Society for Therapeutic Radiology and Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106–554)
BLS Basic Life support
BN Budget neutrality
BPM Benefit Policy Manual
CABG Coronary artery bypass graft
CAD Coronary artery disease
CAH Critical access hospital
CAHEA Committee on Allied Health Education and Accreditation
CAP Competitive acquisition program
CBIC Competitive Bidding Implementation Contractor
CBP Competitive Bidding Program
CBSA Core-Based Statistical Area
CF Conversion factor
CfC Conditions for Coverage
CFR Code of Federal Regulations
CKD Chronic kidney disease
CLFS Clinical laboratory fee schedule
CMA California Medical Association
CMHC Community mental health center
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CoP Condition of participation
COPD Chronic obstructive pulmonary disease
CORF Comprehensive Outpatient Rehabilitation Facility
COS Cost of service
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPI–U Consumer price index for urban customers
CPR Cardiopulmonary resuscitation
CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
CR Cardiac rehabilitation
CRNA Certified registered nurse anesthetist
CRP Canalith repositioning
CRT Certified respiratory therapist
CSW Clinical social worker
CY Calendar year
DEA Drug Enforcement Agency
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DOQ Doctor's Office Quality
DOS Date of service
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171)

DSMT Diabetes self-management training
E/M Evaluation and management
EDI Electronic data interchange
EEG Electroencephalogram
EHR Electronic health record
EKG Electrocardiogram
EMG Electromyogram
EMTALA Emergency Medical Treatment and Active Labor Act
EOG Electro-oculogram
EPO Erythopoeitin
ESRD End-stage renal disease
FAX Facsimile
FDA Food and Drug Administration (HHS)
FFS Fee-for-service
FR **Federal Register**
GAF Geographic adjustment factor
GAO General Accounting Office
GEM Generating Medicare [Physician Quality Performance Measurement Results]
GFR Glomerular filtration rate
GPO Group purchasing organization
GPCI Geographic practice cost index
HAC Hospital-acquired conditions
HBAI Health and behavior assessment and intervention
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HCRIS Healthcare Cost Report Information System
HDRT High dose radiation therapy
HH PPS Home Health Prospective Payment System
HHA Home health agency
HHRG Home health resource group
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HIT Health information technology
HITECH Health Information Technology for Economic and Clinical Health Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act)
HITSP Healthcare Information Technology Standards Panel
HIV Human immunodeficiency virus
HOPD Hospital outpatient department
HPSA Health Professional Shortage Area
HRSA Health Resources Services Administration (HHS)
IACS Individuals Access to CMS Systems
ICD International Classification of Diseases
ICF Intermediate care facilities
ICR Intensive cardiac rehabilitation
ICR Information collection requirement
IDTF Independent diagnostic testing facility
IFC Interim final rule with comment period
IMRT Intensity-Modulated Radiation Therapy
IPPE Initial preventive physical examination
IPPS Inpatient prospective payment system
IRS Internal Revenue Service
ISO Insurance services office
IVD Ischemic Vascular Disease
IVIG Intravenous immune globulin
IWPUT Intra-service work per unit of time
JRCERT Joint Review Committee on Education in Radiologic Technology
KDE Kidney disease education
LCD Local coverage determination
MA Medicare Advantage
MA–PD Medicare Advantage—Prescription Drug Plans
MAV Measure Applicability Validation
MCMP Medicare Care Management Performance
MDRD Modification of Diet in Renal Disease
MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC))
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MIEA–TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109–432)
MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275)
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173)
MNT Medical nutrition therapy
MOC Maintenance of certification
MP Malpractice
MPPR Multiple procedure payment reduction
MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539)
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MSA Metropolitan statistical area
NBRC National Board for Respiratory Care
NCD National Coverage Determination
NCQDIS National Coalition of Quality Diagnostic Imaging Services
NDC National drug code
NF Nursing facility
NISTA National Institute of Standards and Technology Act
NP Nurse practitioner
NPI National Provider Identifier
NPP Nonphysician practitioner
NQF National Quality Forum
NRC Nuclear Regulatory Commission
OACT [CMS'] Office of the Actuary
OBRA Omnibus Budget Reconciliation Act
ODF Open door forum
OGPE Oxygen generating portable equipment
OIG Office of Inspector General
OMB Office of Management and Budget
ONC [HHS'] Office of the National Coordinator for Health IT
OPPS Outpatient prospective payment system
OSCAR Online Survey and Certification and Reporting
PA Physician assistant
PAT Performance assessment tool
PC Professional component
PCI Percutaneous coronary intervention
PDP Prescription drug plan
PE Practice expense
PE/HR Practice expense per hour
PEAC Practice Expense Advisory Committee
PERC Practice Expense Review Committee
PFS Physician Fee Schedule
PGP [Medicare] Physician Group Practice
PHI Protected health information
PHP Partial hospitalization program
PIM [Medicare] Program Integrity Manual
PLI Professional liability insurance
POA Present on admission
POC Plan of care
PPI Producer price index
PPIS Physician Practice Information Survey
PPS Prospective payment system
PPTA Plasma Protein Therapeutics Association
PQRI Physician Quality Reporting Initiative
PR Pulmonary rehabilitation
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PT Physical therapy
PTCA Percutaneous transluminal coronary angioplasty
PVBP Physician and Other Health Professional Value-Based Purchasing Workgroup
RA Radiology assistant
RBMA Radiology Business Management Association
RFA Regulatory Flexibility Act
RHC Rural health clinic
RIA Regulatory impact analysis
RN Registered nurse
RNAC Reasonable net acquisition cost
RPA Radiology practitioner assistant
RRT Registered respiratory therapist
RUC [AMA's Specialty Society] Relative (Value) Update Committee
RVU Relative value unit
SBA Small Business Administration
SGR Sustainable growth rate
SLP Speech-language pathology
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
SOR System of record
SRS Stereotactic radiosurgery
STARS Services Tracking and Reporting System
TC Technical Component
TIN Tax identification number
TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109–432)
TTO Transtracheal oxygen
UPMC University of Pittsburgh Medical Center
USDE United States Department of Education
USP–DI United States Pharmacopoeia—Drug Information
VBP Value-based purchasing
WAMP Widely available market price

I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' The Act requires that payments under the physician fee schedule (PFS) are based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Before the establishment of the resource-based relative value system, Medicare payment for physicians'

services was based on reasonable charges.

A. Development of the Relative Value System

1. Work RVUs

The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101–239), and OBRA 1990, (Pub. L. 101–508). The final rule, published on November 25, 1991 (56 FR 59502), set forth the fee schedule for payment for physicians' services beginning January 1, 1992. Initially, only the physician work RVUs were resource-based, and the PE and malpractice RVUs were based on average allowable charges.

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (DHHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide, with appropriate adjustment of the conversion factor (CF), in a manner to assure that fee schedule amounts for anesthesia services are consistent with those for other services of comparable value. We established a separate CF for anesthesia services, and we continue to utilize time units as a factor in determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

We establish physician work RVUs for new and revised codes based on our review of recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

2. Practice Expense Relative Value Units (PE RVUs)

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising PEs.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs.

We established the resource-based PE RVUs for each physicians' service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.

This resource-based system was based on two significant sources of actual PE data: the Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses (RNs)) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. We have since refined and revised these inputs based on recommendations from the RUC. The AMA's SMS data provided aggregate specialty-specific information on hours worked and PEs.

Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) directed the Secretary of Health and Human Services (the Secretary) to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the **Federal Register** (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In the Calendar Year (CY) 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology.

3. Resource-Based Malpractice (MP) RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act requiring us to implement resource-based malpractice (MP) RVUs for services furnished on or after 2000. The resource-based MP RVUs were implemented in the PFS final rule published November 2, 1999 (64 FR 59380). The MP RVUs were based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every 5 years. The first Five-Year Review of the physician work RVUs was published on November 22, 1996 (61 FR 59489) and was effective in 1997. The second Five-Year Review was published in the CY 2002 PFS final rule with comment period (66 FR 55246) and was effective in 2002. The third Five-Year Review of physician work RVUs was published in the CY 2007 PFS final rule with comment period (71 FR 69624) and was effective on January 1, 2007. (**Note:** Additional codes relating to the third Five-Year Review of physician work RVUs were addressed in the CY 2008 PFS final rule with comment period (72 FR 66360).)

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes). As part of the CY 2007 PFS final rule with comment period (71 FR 69624), we implemented a new

methodology for determining resource-based PE RVUs and are transitioning it over a 4-year period.

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first Five-Year Review of the MP RVUs (69 FR 66263).

5. Adjustments to RVUs Are Budget Neutral

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than $20 million from what they would have been if the adjustments were not made. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if revisions to the RVUs cause expenditures to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million.

As explained in the CY 2009 PFS final rule with comment period (73FR 69730), as required by section 133(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), the separate budget neutrality (BN) adjustor resulting from the third Five-Year Review of physician work RVUs is being applied to the CF beginning with CY 2009 rather than the work RVUs.

B. Components of the Fee Schedule Payment Amounts

To calculate the payment for every physicians' service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PE, and malpractice expense in an area compared to the national average costs for each component.

RVUs are converted to dollar amounts through the application of a CF, which is calculated by CMS' Office of the Actuary (OACT).

The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU malpractice × GPCI malpractice)] × CF.

C. Most Recent Changes to the Fee Schedule

The CY 2009 PFS final rule with comment period (73 FR 69726) implemented changes to the PFS and other Medicare Part B payment policies. It also finalized the CY 2008 interim RVUs and implemented interim RVUs for new and revised codes for CY 2009 to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. The CY 2009 PFS final rule with comment period also addressed other policies, as well as certain provisions of the MIPPA.

As required by the statute, and based on section 131 of the MIPPA, the CY 2009 PFS final rule with comment period also announced the following for CY 2009: the PFS update of 1.1 percent, the initial estimate for the sustainable growth rate of 7.4 percent, and the conversion factor (CF) of $36.0666.

II. Provisions of the Final Regulation

In response to the CY 2010 PFS proposed rule (74 FR 33520) we received approximately 16,500 timely public comments. These included comments from concerned citizens, individual physicians, health care workers, professional associations and societies, manufacturers and Congressmen. The majority of the comments addressed proposals related to the MIPPA provisions concerning teaching anesthesiology and cardiac and pulmonary rehabilitation, the physician practice information survey (PPIS), and the impact of the proposed rule on specific specialties. To the extent that comments were outside the scope of the proposed rule, they are not addressed in this final rule with comment period.

A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

Practice expense (PE) is the portion of the resources used in furnishing the service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages but excluding malpractice expenses, as specified in section 1848(c)(1)(B) of the Act.

Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required CMS to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. Until that time, PE RVUs were based on historical allowed charges. This legislation stated that the revised PE methodology must consider the staff, equipment, and supplies used in the provision of a variety of medical and surgical services in various settings beginning in 1998. The Secretary has interpreted this to mean that Medicare payments for each service would be based on the relative PE resources typically involved with furnishing the service.

The initial implementation of resource-based PE RVUs was delayed from January 1, 1998, until January 1, 1999, by section 4505(a) of the BBA. In addition, section 4505(b) of the BBA required that the new payment methodology be phased in over 4 years, effective for services furnished in CY 1999, and fully effective in CY 2002. The first step toward implementation of the statute was to adjust the PE values for certain services for CY 1998. Section 4505(d) of the BBA required that, in developing the resource-based PE RVUs, the Secretary must—

- Use, to the maximum extent possible, generally-accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures and actual data on equipment utilization.
- Develop a refinement method to be used during the transition.
- Consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual physician PE.

In CY 1999, we began the 4-year transition to resource-based PE RVUs utilizing a ''top-down'' methodology whereby we allocated aggregate specialty-specific practice costs to individual procedures. The specialty-specific PEs were derived from the American Medical Association's (AMA's) Socioeconomic Monitoring Survey (SMS). In addition, under section 212 of the BBRA, we established a process extending through March 2005 to supplement the SMS data with data submitted by a specialty. The aggregate PEs for a given specialty were then allocated to the services furnished by that specialty on the basis of the direct input data (that is, the staff time, equipment, and supplies) and work RVUs assigned to each CPT code.

For CY 2007, we implemented a new methodology for calculating PE RVUs. Under this new methodology, we use the same data sources for calculating PE, but instead of using the ''top-down'' approach to calculate the direct PE RVUs, under which the aggregate direct and indirect costs for each specialty are allocated to each individual service, we now utilize a ''bottom-up'' approach to calculate the direct costs. Under the ''bottom up'' approach, we determine the direct PE by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide each service. The costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are based on our review of recommendations received from the AMA's Relative Value Update Committee (RUC). For a more detailed

explanation of the PE methodology, see the Five-Year Review of Work Relative Value Units Under the PFS and Proposed Changes to the Practice Expense Methodology proposed notice (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

Note: In section II.A.1 of this final rule with comment period rule, we discuss the current methodology used for calculating PE. In section II.A.2. of this final rule with comment period, which contains PE proposals for CY 2010, we summarize and respond to comments on our proposal to use data from the AMA Physician Practice Information Survey (PPIS) in place of the AMA's SMS survey data and supplemental survey data that is currently used in the PE methodology, as well as our proposal concerning equipment utilization assumptions.

1. Practice Expense Methodology

a. Data Sources for Calculating Practice Expense

The AMA's SMS survey data and supplemental survey data from the specialties of cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, gastroenterology, radiology, independent diagnostic testing facilities (IDTFs), radiation oncology, and urology are currently used to develop the PE per hour (PE/HR) for each specialty. For those specialties for which we do not have PE/HR, the appropriate PE/HR is obtained from a crosswalk to a similar specialty.

The AMA developed the SMS survey in 1981 and discontinued it in 1999. Beginning in 2002, we incorporated the 1999 SMS survey data into our calculation of the PE RVUs, using a 5-year average of SMS survey data. (See the CY 2002 PFS final rule with comment period (66 FR 55246).) The SMS PE survey data are adjusted to a common year, 2005. The SMS data provide the following six categories of PE costs:

- Clinical payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician clinical personnel.
- Administrative payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician personnel involved in administrative, secretarial, or clerical activities.
- Office expenses, which include expenses for rent, mortgage interest, depreciation on medical buildings, utilities, and telephones.
- Medical material and supply expenses, which include expenses for drugs, x-ray films, and disposable medical products.
- Medical equipment expenses, which include depreciation, leases, and rent of medical equipment used in the diagnosis or treatment of patients.
- All other expenses, which include expenses for legal services, accounting, office management, professional association memberships, and any professional expenses not previously mentioned in this section.

In accordance with section 212 of the BBRA, we established a process to supplement the SMS data for a specialty with data collected by entities and organizations other than the AMA (that is, those entities and organizations representing the specialty itself). (See the Criteria for Submitting Supplemental Practice Expense Survey Data interim final rule with comment period (65 FR 25664).) Originally, the deadline to submit supplementary survey data was through August 1, 2001. In the CY 2002 PFS final rule (66 FR 55246), the deadline was extended through August 1, 2003. To ensure maximum opportunity for specialties to submit supplementary survey data, we extended the deadline to submit surveys until March 1, 2005 in the Revisions to Payment Policies Under the Physician Fee Schedule for CY 2004 final rule with comment period (68 FR 63196) (hereinafter referred to as CY 2004 PFS final rule with comment period).

The direct cost data for individual services were originally developed by the Clinical Practice Expert Panels (CPEP). The CPEP data include the supplies, equipment, and staff times specific to each procedure. The CPEPs consisted of panels of physicians, practice administrators, and nonphysicians (for example, RNs) who were nominated by physician specialty societies and other groups. There were 15 CPEPs consisting of 180 members from more than 61 specialties and subspecialties. Approximately 50 percent of the panelists were physicians.

The CPEPs identified specific inputs involved in each physician's service provided in an office or facility setting. The inputs identified were the quantity and type of nonphysician labor, medical supplies, and medical equipment. The CPEP data has been regularly updated by various RUC committees on PE.

b. Allocation of PE to Services

Currently, the aggregate level specialty-specific PEs are derived from the AMA's SMS survey and supplementary survey data. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used. To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(i) *Direct costs.* The direct costs are determined by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide the service. The costs of these resources are calculated from the refined direct PE inputs in our PE database. These direct inputs are then scaled to the current aggregate pool of direct PE RVUs. The aggregate pool of direct PE RVUs can be derived using the following formula: (PE RVUs × physician CF) × (average direct percentage from survey PE/HR data)).

(ii) *Indirect costs.* Currently, the SMS and supplementary survey data are the sources for the specialty-specific aggregate indirect costs used in our PE calculations. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used. We then allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the physician work RVUs. For calculation of the 2010 PE RVUs, we use the 2008 procedure-specific utilization data crosswalked to 2010 services. To arrive at the indirect PE costs—

- We apply a specialty-specific indirect percentage factor to the direct expenses to recognize the varying proportion that indirect costs represent of total costs by specialty. For a given service, the specific indirect percentage factor to apply to the direct costs for the purpose of the indirect allocation is calculated as the weighted average of the ratio of the indirect to direct costs (based on the survey data) for the specialties that furnish the service. For example, if a service is furnished by a single specialty with indirect PEs that were 75 percent of total PEs, the indirect percentage factor to apply to the direct costs for the purposes of the indirect allocation would be (0.75/0.25) = 3.0. The indirect percentage factor is then applied to the service level adjusted indirect PE allocators.
- We currently use the specialty-specific PE/HR from the SMS survey data, as well as the supplemental surveys for cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, radiology, gastroenterology, IDTFs, radiation oncology, and urology. (**Note:** For radiation oncology, the data represent the combined survey data from the

American Society for Therapeutic Radiology and Oncology (ASTRO) and the Association of Freestanding Radiation Oncology Centers (AFROC)). As discussed in the CY 2008 PFS final rule with comment period (72 FR 66233), the PE/HR survey data for radiology is weighted by practice size. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used. We incorporate this PE/HR into the calculation of indirect costs using an index which reflects the relationship between each specialty's indirect scaling factor and the overall indirect scaling factor for the entire PFS. For example, if a specialty had an indirect practice cost index of 2.00, this specialty would have an indirect scaling factor that was twice the overall average indirect scaling factor. If a specialty had an indirect practice cost index of 0.50, this specialty would have an indirect scaling factor that was half the overall average indirect scaling factor.

- When the clinical labor portion of the direct PE RVU is greater than the physician work RVU for a particular service, the indirect costs are allocated based upon the direct costs and the clinical labor costs. For example, if a service has no physician work and 1.10 direct PE RVUs, and the clinical labor portion of the direct PE RVUs is 0.65 RVUs, we would use the 1.10 direct PE RVUs and the 0.65 clinical labor portions of the direct PE RVUs to allocate the indirect PE for that service.

c. Facility and Non-Facility Costs

Procedures that can be furnished in a physician's office, as well as in a hospital or facility setting have two PE RVUs: facility and non-facility. The non-facility setting includes physicians' offices, patients' homes, freestanding imaging centers, and independent pathology labs. Facility settings include hospitals, ambulatory surgical centers (ASCs), and skilled nursing facilities (SNFs). The methodology for calculating PE RVUs is the same for both facility and non-facility RVUs, but is applied independently to yield two separate PE RVUs. Because the PEs for services provided in a facility setting are generally included in the payment to the facility (rather than the payment to the physician under the PFS), the PE RVUs are generally lower for services provided in the facility setting.

d. Services With Technical Components (TCs) and Professional Components (PCs)

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

e. Transition Period

As discussed in the CY 2007 PFS final rule with comment period (71 FR 69674), the change to the PE methodology was implemented over a 4-year period. In CY 2010, the transition period for the change to the PE methodology is complete and PE RVUs will be calculated based entirely on the current methodology.

f. PE RVU Methodology

The following is a description of the PE RVU methodology. While there are some changes to the data sources, the methodology remains the same.

(i) Setup File

First, we create a setup file for the PE methodology. The setup file contains the direct cost inputs, the utilization for each procedure code at the specialty and facility/non-facility place of service level, and the specialty-specific survey PE per physician hour data.

(ii) Calculate the Direct Cost PE RVUs

Sum the costs of each direct input.

Step 1: Sum the direct costs of the inputs for each service. The direct costs consist of the costs of the direct inputs for clinical labor, medical supplies, and medical equipment. The clinical labor cost is the sum of the cost of all the staff types associated with the service; it is the product of the time for each staff type and the wage rate for that staff type. The medical supplies cost is the sum of the supplies associated with the service; it is the product of the quantity of each supply and the cost of the supply. The medical equipment cost is the sum of the cost of the equipment associated with the service; it is the product of the number of minutes each piece of equipment is used in the service and the equipment cost per minute. The equipment cost per minute is calculated as described at the end of this section.

Apply a BN adjustment to the direct inputs.

Step 2: Calculate the current aggregate pool of direct PE costs. To do this, multiply the current aggregate pool of total direct and indirect PE costs (that is, the current aggregate PE RVUs multiplied by the CF) by the average direct PE percentage from the SMS and supplementary specialty survey data. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used.

Step 3: Calculate the aggregate pool of direct costs. To do this, for all PFS services, sum the product of the direct costs for each service from Step 1 and the utilization data for that service.

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

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the Medicare PFS CF.

(iii) Create the Indirect PE RVUs

Create indirect allocators.

Step 6: Based on the SMS and supplementary specialty survey data, calculate direct and indirect PE percentages for each physician specialty. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used.

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, we are calculating the direct and indirect percentages across the global components, PCs, and TCs. That is, the direct and indirect percentages for a given service (for example, echocardiogram) do not vary by the PC, TC and global component.

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

For most services the indirect allocator is:

*indirect percentage * (direct PE RVU/direct percentage) + work RVU.*

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the

indirect allocator is: *indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU + work RVU.*

• If the clinical labor PE RVU exceeds the work RVU (and the service is not a global service), then the indirect allocator is: *indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU.*

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

For presentation purposes in the examples in the Table 1, the formulas were divided into two parts for each service. The first part does not vary by service and is *the indirect percentage * (direct PE RVU/direct percentage).* The second part is either the work RVU, clinical PE RVU, or both depending on whether the service is a global service and whether the clinical PE RVU exceeds the work RVU (as described earlier in this step.)

Apply a BN adjustment to the indirect allocators.

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the physician specialty survey data. This is similar to the Step 2 calculation for the direct PE RVUs.

Step 10: Calculate an aggregate pool of indirect PE RVUs for all PFS services by adding the product of the indirect PE allocators for a service from Step 8 and the utilization data for that service. This is similar to the Step 3 calculation for the direct PE RVUs.

Step 11: Using the results of Step 9 and Step 10, calculate an indirect PE adjustment so that the aggregate indirect allocation does not exceed the available aggregate indirect PE RVUs and apply it to indirect allocators calculated in Step 8. This is similar to the Step 4 calculation for the direct PE RVUs.

Calculate the Indirect Practice Cost Index.

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

Step 13: Using the specialty-specific indirect PE/HR data, calculate specialty-specific aggregate pools of indirect PE for all PFS services for that specialty by adding the product of the indirect PE/HR for the specialty, the physician time for the service, and the specialty's utilization for the service.

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

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

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

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

(iv) Calculate the Final PE RVUs.

Step 18: Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17.

Step 19: Calculate and apply the final PE BN adjustment by comparing the results of Step 18 to the current pool of PE RVUs. This final BN adjustment is required primarily because certain specialties are excluded from the PE RVU calculation for ratesetting purposes, but all specialties are included for purposes of calculating the final BN adjustment. (See ''Specialties excluded from ratesetting calculation'' below in this section.)

(v) Setup File Information

• *Specialties excluded from ratesetting calculation:* For the purposes of calculating the PE RVUs, we exclude certain specialties such as midlevel practitioners paid at a percentage of the PFS, audiology, and low volume specialties from the calculation. These specialties *are* included for the purposes of calculating the BN adjustment.

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

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

• *Identify professional and technical services not identified under the usual TC and 26 modifiers:* Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVU. For example, the professional service code 93010 is associated with the global code 93000.

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

• *Work RVUs:* The setup file contains the work RVUs from this proposed rule.

(vi) Equipment cost per minute

The equipment cost per minute is calculated as:

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

Where:

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

usage = equipment utilization assumption; 0.9 for certain expensive diagnostic equipment (see section II.A.2. of this final rule with comment period rule) and 0.5 for others.

price = price of the particular piece of equipment.

interest rate = 0.11.

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

maintenance = factor for maintenance; 0.05.

Note: To illustrate the PE calculation, in Table 1 we have used the conversion factor (CF) of $28.3769 which is the CF effective January 1, 2010 as published in this final rule with comment period.

BILLING CODE 4120–01–P

TABLE 1: Calculation of PE RVUs under Methodology for Selected Codes

		Step	Source	Formula	99213 Office visit, est Non-facility	33533 CABG, arterial, single Facility	71020 Chest x-ray Non-facility	71020TC Chest x-ray Non-facility	7102026 Chest x-ray Non-facility	93000 ECG, complete Non-facility	93005 ECG, tracing Non-facility	93010 ECG, report Non-facility
1	Labor cost (Lab)	Step 1	AMA		13.32	77.52	5.74	5.74	0.00	6.12	6.12	0.00
2	Supply cost (Sup)	Step 1	AMA		2.98	7.34	3.39	3.39	0.00	1.19	1.19	0.00
3	Equipment cost (Eqp)	Step 1	AMA		0.19	0.65	8.17	8.17	0.00	0.12	0.12	0.00
4	Direct cost (Dir)	Step 1		=(1)+(2)+(3)	16.50	85.51	17.31	17.31	0.00	7.43	7.43	0.00
5	Direct adjustment (Dir Adj)	Steps 2-4	See footnote*		0.508	0.508	0.508	0.508	0.508	0.508	0.508	0.508
6	Adjusted labor	Steps 2-4	=Lab*Dir Adj	=(1)*(5)	6.76	39.35	2.91	2.91	0.00	3.11	3.11	0.00
7	Adjusted supplies	Steps 2-4	=Sup*Dir Adj	=(2)*(5)	1.51	3.73	1.72	1.72	0.00	0.61	0.61	0.00
8	Adjusted equipment	Steps 2-4	=Eqp*Dir Adj	=(3)*(5)	0.10	0.33	4.15	4.15	0.00	0.06	0.06	0.00
9	Adjusted direct	Steps 2-4		=(6)+(7)+(8)	8.38	43.41	8.79	8.79	0.00	3.77	3.77	0.00
10	Conversion Factor (CF)	Step 5	MFS		28.4061	28.4061	28.4061	28.4061	28.4061	28.4061	28.4061	28.4061
11	Adj. labor cost converted	Step 5	=(Lab*Dir Adj)/CF	=(6)/(10)	0.24	1.39	0.10	0.10	0.00	0.11	0.11	0.00
12	Adj. supply cost converted	Step 5	=(Sup*Dir Adj)/CF	=(7)/(10)	0.05	0.13	0.06	0.06	0.00	0.02	0.02	0.00
13	Adj. equip cost converted	Step 5	=(Eqp*Dir Adj)/CF	=(8)/(10)	0.00	0.01	0.15	0.15	0.00	0.00	0.00	0.00
14	Adj. direct cost converted	Step 5		=(11)+(12)+(13)	0.29	1.53	0.31	0.31	0.00	0.13	0.13	0.00
15	Wrk RVU	Setup File	MFS		0.97	33.75	0.22	0.00	0.22	0.17	0.00	0.17
16	Dir_pct	Steps 6, 7	Surveys		25.6 %	18%	28.5%	28.5%	28.5%	28.9%	28.9%	28.9%
17	Ind_pct	Steps 6, 7	Surveys		74.4%	82%	71.5%	71.5%	71.5%	71.1%	71.1%	71.1%
18	Ind. Alloc. formula (1st part)	Step 8	See Step 8		((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)
19	Ind. Alloc. (1st part)	Step 8		See (18)	0.86	6.95	0.78	0.78	0.00	0.33	0.33	0.00

		Step	Source	Formula	99213 Office visit, est Non-facility	33533 CABG, arterial, single Facility	71020 Chest x-ray Non-facility	71020TC Chest x-ray Non-facility	7102026 Chest x-ray Non-facility	93000 ECG, complete Non-facility	93005 ECG, tracing Non-facility	93010 ECG, report Non-facility
20	Ind. Alloc. formulas (2nd part)	Step 8	See Step 8		(15)	(15)	(15)+(11)	(11)	(15)	(15)+(11)	(11)	(15)
21	Ind. Alloc. (2nd part)	Step 8		See (20)	0.97	33.75	0.32	0.10	0.22	0.28	0.11	0.17
22	Indirect Allocator (1st+2nd)	Step 8		=(19)+(21)	1.83	40.70	1.10	0.88	0.22	0.61	0.44	0.17
23	Indirect Adjustment (Ind Adj)	Steps 9-11	See footnote**		0.367	0.367	0.367	0.367	0.367	0.367	0.367	0.367
24	Adjusted Indirect Allocator	Steps 9-11	=Ind Alloc * Ind Adj		0.67	14.93	0.40	0.32	0.08	0.22	0.16	0.06
25	Ind.Practice Cost Index (PCI)	Steps 12-16	See Steps 12-16		1.094	0.892	0.859	0.859	0.859	0.928	0.928	0.928
26	Adjusted Indirect	Step 17	= Adj. Ind Alloc*PCI	=(24)*(25)	0.73	13.32	0.35	0.28	0.07	0.21	0.15	0.06
(27)	PE RVU	Steps 18-19	=(Adj Dir+Adj Ind) *budn	=((14)+(26)) *budn	1.03	14.85	0.66	0.59	0.07	0.34	0.28	0.06

Note: PE RVU in Table 1, row 27, may not match Addendum B due to rounding.

* The direct adj = [current pe rvus * CF * avg dir pct] / [sum direct inputs] = [Step 2] / [Step 3]

** The indirect adj = [current pe rvus * avg ind pct] / [sum of ind allocators] = [Step 9] / [Step 10]

BILLING CODE 4120-01-C

2. PE Revisions for CY 2010

a. SMS and Supplemental Survey Background

Currently, we use PE/HR obtained from the SMS surveys from 1995 through 1999. For several specialties that collected additional PE/HR data through a more recent supplemental survey, we accepted and incorporated these data in developing current PE/HR values.

While the SMS survey was not specifically designed for the purpose of establishing PE RVUs, we found these data to be the best available at the time. The SMS was a multi-specialty survey effort conducted using a consistent survey instrument and method across specialties. The survey sample was randomly drawn from the AMA Physician Masterfile to ensure national representativeness. The AMA discontinued the SMS survey in 1999.

As required by the BBRA, we also established a process by which specialty groups could submit supplemental PE data. In the May 3, 2000 interim final rule entitled, Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data, (65 FR 25664), we established criteria for acceptance of supplemental data. The criteria were modified in the CY 2001 and CY 2003 PFS final rules with comment period (65 FR 65380 and 67 FR 79971, respectively). We currently use supplemental survey data for the following specialties: cardiology; dermatology; gastroenterology; radiology; cardiothoracic surgery; vascular surgery; physical and occupational therapy; independent laboratories; allergy/immunology; independent diagnostic testing facilities (IDTFs); radiation oncology; medical oncology; and urology.

Because the SMS data and the supplemental survey data are from different time periods, we have historically inflated them by the MEI to help put them on as comparable a time basis as we can when calculating the PE RVUs. This MEI proxy has been necessary in the past due to the lack of contemporaneous, consistently collected, and comprehensive multispecialty survey data.

b. Physician Practice Information Survey (PPIS)

The AMA has conducted a new survey, the PPIS, which was expanded (relative to the SMS) to include nonphysician practitioners (NPPs) paid under the PFS. The PPIS, administered in CY 2007 and CY 2008, was designed to update the specialty-specific PE/HR data used to develop PE RVUs.

The AMA and our contractor, The Lewin Group (Lewin), analyzed the PPIS data and calculated the PE/HR for physician and nonphysician specialties, respectively. The AMA's summary worksheets and Lewin's final report are available on the CMS Web site at *http://www.cms.gov/PhysicianFeeSched/.* (See AMA PPIS Worksheets 1–3 and Lewin Group Final Report PPIS.) We also included a table in the proposed rule showing the current indirect PE/HR based on SMS and supplemental surveys, the PPIS indirect PE/HR, and the indirect cost percentages of total costs (74 FR 33530 through 33531).

The PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs using a consistent survey instrument and methods highly consistent with those used for the SMS and the supplemental surveys. The PPIS has gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. We believe the PPIS is the most comprehensive source of PE survey information available to date.

As noted, the BBRA required us to establish criteria for accepting supplemental survey data. Since the supplemental surveys were specific to individual specialties and not part of a comprehensive multispecialty survey, we had required that certain precision levels be met in order to ensure that the supplemental data was sufficiently valid, and acceptable for use in the development of the PE RVUs. Because the PPIS is a contemporaneous, consistently collected, and comprehensive multispecialty survey, we do not believe similar precision requirements are necessary and we did not propose to establish them for the use of the PPIS data.

For physician specialties, the PPIS responses were adjusted for non-response bias. Non-response bias is the bias that results when the characteristics of survey respondents differ in meaningful ways, such as in the mix of practice sizes, from the general population. The non-response adjustment was developed based on a comparison of practice size and other characteristic information between the PPIS survey respondents and data from the AMA Masterfile (for physician specialties) or information from specialty societies (for non-physician specialties). For six specialties (chiropractors, clinical social workers, nuclear medicine, osteopathic manipulative therapy, physical therapy, and registered dietitians) such an adjustment was not possible due to a lack of available characteristic data. The AMA and Lewin have indicated that the non-response weighting has only a small impact on PE/HR values.

Under our current policy, various specialties without SMS or supplemental survey data have been crosswalked to other similar specialties to obtain a proxy PE/HR. For specialties that were part of the PPIS for which we currently use a crosswalked PE/HR, we proposed instead to use the PPIS-based PE/HR. We also proposed to continue current crosswalks for specialties that did not participate in PPIS.

Supplemental survey data on independent labs, from the College of American Pathologists, was implemented for payments in CY 2005. Supplemental survey data from the National Coalition of Quality Diagnostic Imaging Services (NCQDIS), representing IDTFs, was blended with supplementary survey data from the American College of Radiology (ACR) and implemented for payments in CY 2007. Neither IDTFs, nor Independent Labs, participated in the PPIS. Therefore, we proposed to continue using the current PE/HR that was developed using their supplemental survey data.

We did not propose to use the PPIS data for reproductive endocrinology, sleep medicine, and spine surgery since these specialties are not separately recognized by Medicare and we do not know how to blend this data with Medicare recognized specialty data. We sought comment on this issue.

We did not propose changes to the manner in which the PE/HR data are used in the current PE RVU methodology. We proposed to update the PE/HR data itself based on the new survey. We proposed to utilize the PE/HR developed using PPIS data for all Medicare recognized specialties that participated in the survey for payments effective January 1, 2010. The impact of using the new PPIS-based PE/HR is discussed in the Regulatory Impact Analysis in section XIII. of this final rule with comment period.

The following is a summary of the public comments received on the PPIS survey and our responses.

Comment: MedPAC was generally supportive of the use of the PPIS survey data, stating:

> Ensuring the accuracy of PE payments is important given that close to half of all payments under the physician fee schedule are associated with practice expense. The Commission has repeatedly raised concerns that the specialty-specific cost data that CMS uses to derive PE RVUs are not current for most specialties, which might lead to payments becoming inaccurate over time.

Compared with the multiple data sources that CMS currently relies on for practice cost information, the PPIS is a step forward because: (1) It reflects current practice patterns and costs; (2) it measures costs of nearly all physician and nonphysician specialties; and (3) it uses a standard protocol for all specialty groups that was designed to derive PE RVUs. However, CMS should provide more information about the PPIS's response rate and representativeness. We are also concerned that CMS has not laid out options for ensuring the accuracy of PE RVUs in the long term. As a future step, CMS should consider alternatives for collecting specialty-specific cost data or options to decrease the reliance on such data.

Response: We agree with MedPAC that the PPIS is a step forward compared to the data sources currently used in the development of the PE RVUs.

With respect to additional information on the PPIS survey, the AMA has continued to respond to requests from the individual specialty societies for additional data analysis as they have done since the PPIS results were first released. We have also performed further analyses in response to comments received on the proposed rule. The results of these analyses are available on our Web site (described later in this section) and have not changed our conclusion that the PPIS is the most comprehensive, multi-specialty, contemporaneous, consistently collected PE data source available.

We also agree with MedPAC that it is appropriate to consider the future of the PE RVUs moving forward. We did not propose any changes to the methodology in conjunction with the use of the PPIS data. However, we seek comments from other stakeholders on the issues raised by MedPAC for the future. In particular, we seek comments regarding MedPAC's suggestion that we consider alternatives for collecting specialty-specific cost data or options to decrease the reliance on such data. For example, MedPAC stated that ''CMS should consider if Medicare or provider groups should sponsor future data collection efforts, if participation should be voluntary (such as surveys) or mandatory (such as cost reports), and whether a nationally representative sample of practitioners would be sufficient for either a survey or cost reports.'' MedPAC also stated that one option for decreasing the reliance on specialty-specific cost data would be the elimination of specialty-specific cost pools from the method used to derive indirect PE RVUs. We would address any changes through future rulemaking.

Comment: In addition to MedPAC, numerous specialty groups and individual physicians and practitioners supported utilizing the PPIS data. The commenters included family practice, general practice, geriatrics, pediatrics, internal medicine, obstetrics and gynecology, general surgery, infectious disease, emergency medicine, psychiatry, anesthesiology, colorectal surgery, dermatology, endocrinology, gastroenterology, neurology, neurosurgery, ophthalmology, optometry, orthopedic surgery, osteopathic physicians, otolaryngology, pathology, physical medicine and rehabilitation, physical and occupational therapy, plastic surgery, podiatry, pulmonary disease, spine surgery, thoracic surgery, transplant surgery, and vascular surgery.

Those in favor of using the PPIS data made one or more of the following points:

- PPIS was a nationally representative survey providing the most up-to-date and comprehensive data available from 51 specialties. It was a highly scientific and controlled undertaking, using a survey instrument that the AMA took great care to design, test, and implement.
- Seventy organizations contributed to the costs of the survey and agreed to take responsibility for communicating and publicizing the effort in order to enhance response rates. All groups had ample time to review and provide input and received monthly updates on response rates for their group.
- PPIS followed the exacting criteria that CMS has established for gathering this type of data and for producing results that are acceptable for submission. The AMA worked with CMS's contractor to ensure that all data met these criteria and were analyzed consistently across the various physicians and practitioner specialties. Any data that did not meet the criteria such as response outliers were excluded.
- The vast majority of the data currently used are completely outdated. MedPAC and GAO have been calling on CMS to update PE payments. The annual update of such data is inadequate to capture the true changes in practice costs that physicians have experienced over the years.
- Supplemental survey data from a limited number of specialties have caused significant distortions and misallocations of PE payments, and provided an unfair advantage to some specialties. Many organizations were unable to submit supplemental survey data due to the high cost of gathering the data.
- Concurrently and uniformly collected data will correct payment imbalances caused by the supplemental surveys. Due to BN, this leads to a shift in payment to some specialties at the expense of others. The new data will reduce the payment gap between primary care and other specialties.
- Blending PPIS data with existing data would preserve distortions and continue utilization of data that are more than 10 years old for some groups.

Response: We appreciate the support of this broad-based and diverse mix of primary care, surgical, and other nonsurgical specialties for our proposal. We agree with the commenters that the PPIS is the most comprehensive, multi-specialty, contemporaneous, consistently collected PE data source available.

Comment: There were also many specialty groups and individual physicians and practitioners strongly opposed to the use of the PPIS data. The commenters included representatives of the specialties of cardiology, radiation oncology, medical oncology, interventional radiology, hematology, nuclear medicine, urology, rheumatology, and dieticians. Those opposed to using the PPIS data made one or more of the following points:

- Some commenters stated that data were not collected in a contemporaneous, consistent, and comprehensive way;
- Some commenters stated that the PPIS should be subject to the same level of analysis as the supplemental surveys to assess accuracy and precision. The commenters also indicated that the survey did not meet the target goal for useable responses. The commenters stated that the low response rates, for some specialties, means that the data are not representative of the specialties' PEs. The commenters also stated that specialty societies should be given the names of the survey respondents, especially those that failed to fully complete the survey, so they could be contacted;
- Some commenters stated that there was not adequate transparency in the PPIS survey process and that there was insufficient information provided about the survey methodology and process;
- Some commenters stated that CMS should withdraw the proposal and take the time necessary to adequately examine the data submitted by AMA, consider changes to the PE methodology, and solicit public input on the validity of the data and the most appropriate way to integrate this data into the PFS; and
- Some commenters stated that if PPIS data is used, it should be blended with supplemental survey data and/or phased in over a number of years.

Response: The PPIS uses a consistent survey instrument and methodology across all specialty and health care professional groups. The sample was drawn from the AMA's Physician Masterfile, which is a listing of all member and non-member physicians in the United States. The survey was conducted in conjunction with national medical specialty societies and other health care professionals, representing 51 specialties and health professions in order to maximize the overall response rate. Respondents could submit information through multiple modalities, including telephone, fax, and Web-based reporting.

The survey was conducted by external contractors. In 2007 the PPIS project was contracted to the Gallup Organization. In late 2007 the AMA transitioned the survey effort to dmrkynetec, formally Doane Marketing Research, to complete the project. Dmrkynetec conducted the majority of the specialty level surveys that were previously implemented by CMS. Dmrkynetec used the same survey instruments as did the Gallup Organization in order that survey data collected by Gallup could be appropriately merged in the dmrkynetec data collection.

The survey methodology was highly consistent with the prior SMS methodology because only small deviations were allowed to accommodate practice style differences across the various groups surveyed. The PPIS was conducted in accordance with known conventions governing PE collection activities. One hundred completed surveys for each specialty was set as a goal for the PPIS, but was not a minimum requirement. More than 7,000 surveys were collected for 51 physicians, non MD/DO specialties, and health professions. For the majority of specialties, at least 100 surveys were collected.

The AMA provided specialty groups with information on the survey throughout the survey process. Monthly progress reports were issued on response rates. Due to confidentiality agreements with the AMA and participating specialty groups, raw survey data was not distributed to CMS or the specialty groups. However, this does not mean that analysis was not performed on the PPIS data.

In conjunction with publication of the proposed rule, we posted information on our Web site on physician response rates, precision and PE/HR. In addition, we posted Lewin's report entitled, ''Physician Practice Information Survey (PPIS) Data Submitted for 2010: Non-MD/DO and Health Professionals Practice Information'' (June 19, 2009). This report includes information on the PPIS survey process as well as the methodology for determining the PE/HR.

As noted earlier in our response to the MedPAC comment, the AMA has continued to respond to requests from the individual specialty societies for additional data analysis, as they have done since the PPIS results were first released. In response to comments received on the proposed rule, we have also performed additional analyses of summary data supplied by the AMA, the supplemental survey, and cardiology, urology, and radiology groups. This additional analysis indicates that while the PE/HR for these specialties differs between the data sources reviewed for certain practice sizes, these differences do not validate the commenters' conclusion that the PPIS data is invalid. We continue to believe that the PPIS is the most appropriate data source available for the development of resource-based PE RVUs. To view this analysis, please see our Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/*. (At this Web site, Go to ''PFS Federal Regulation Notices'' tab, and then chose ''CMS–1413–P.'' Lewin's original report is listed under the CY 2010 PFS proposed rule page. The additional AMA information and analysis of the PPIS is available at *http://www.ama-assn.org/go/ppisurvey*.

We disagree with some commenters that the same precision requirements that applied to the individual specialty supplemental surveys should apply to the broad multispecialty contemporaneous PPIS. Each individual specialty supplemental survey was being used alongside the multispecialty contemporaneous SMS survey data for all the other specialties. This is not the case for the PPIS data. We proposed to use the PPIS data in its entirety for all Medicare recognized specialties, with the exception of two supplier specialties that did not participate in the PPIS. Precision requirements were appropriate, and required by the BBRA, in the context of the selective acceptance of individual supplemental surveys, but are not necessary in the context of the much broader adoption of the PPIS data.

We also disagree that we should blend the supplemental survey data with the PPIS data. One of the advantages of the PPIS data is precisely that it is contemporaneous and collected in a consistent, broad multi-specialty manner. Blending this data with the supplemental survey data weakens the advantage of using the PPIS data, as was pointed out by commenters who favored its use.

However, we do recognize that some specialties experience significant payment reductions with the use of the PPIS data. Given the magnitude of these payment reductions for some specialties, we agree with commenters who suggested a transition to the new PE RVUs developed using the PPIS data. Historically, we have provided for 4-year transitions when we have significantly altered the PE methodology. While we did not propose any changes to the methodology in the proposed rule, we are persuaded by commenters that the use of the new PPIS data has a sufficiently significant impact to warrant the use of such a transition. In light of the comments received and our past practice, we are finalizing a 4-year transition (75/25, 50/50, 25/75, 0/100) from the current PE RVUs to the PE RVUs developed using the new PPIS data.

Comment: Some commenters that supported the use of the PPIS data and some who opposed its use claimed that Medicare pays only 51 percent of direct costs. Commenters maintained that the PE methodology results in the underpayment of procedures with high direct costs, and will shift procedures from the office to the higher cost hospital setting.

Response: The purpose of the resource-based PE methodology is to develop RVUs within the overall PFS BN requirements. We are unaware of any independent analysis that indicates that Medicare pays 51 percent of direct costs as a result of these BN requirements. In the PE methodology, there is a scaling factor applied in the development of the direct PE portion of the PE RVUs and there is a scaling factor applied in the development of the indirect PE portion. We believe that commenters may be misinterpreting the scaling factor applied in the development of the direct cost portion of the PE RVUs.

The PPIS data indicated a significant decrease in the percentage of PEs that are attributable to direct PEs and a corresponding increase in the percentage that are attributable to indirect PEs. The incorporation of the PPIS data, therefore, results in a decrease in the scaling factor applied in the development of the direct cost portion of the PE methodology from its current value of 0.63 to its new value of 0.51 and a corresponding increase in the scaling factor applied in development of the indirect cost portion. As stated earlier, the PPIS is the most comprehensive, multi-specialty, contemporaneous, consistently

collected source of PE data. The PPIS data indicates that direct costs are a smaller proportion of total PE costs for almost every single specialty surveyed (see Table 2). We are incorporating this result into our methodology and disagree with commenters that this empirically based decrease in the scaling factor for the direct cost portion of the PE RVU using the PPIS survey data is inappropriate.

Comment: The American Society of Clinical Oncology (ASCO) noted that section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) (MMA) added section 1848(c)(2)(H) of the Act, which requires us to use their supplemental survey submitted in 2003 for oncology drug administration services.

Response: We have reviewed the MMA provision and agree that, as amended, section 1848(c)(2)(H)(i) of the Act requires that we continue to use the supplemental survey data for oncology. We have revised the PE/HR for medical oncology, hematology, and hematology/oncology to reflect the continued use of these supplemental survey data.

Comment: Several commenters indicated that PPIS data for reproductive endocrinology, sleep medicine, and spine surgery should not be used because they are not separately recognized specialties by Medicare and it is difficult to blend this data with data from specialties that are recognized. Other commenters disagreed and recommended weights we could use to blend the PPIS data with the data from the recognized specialties for certain services.

Some commenters encouraged us to make these Medicare-recognized specialties because they perform work that is separate and apart from their parent specialty, require additional training, and have separate liability issues. Other commenters opposed the recognition of separate specialties for these groups, indicating that they are not markedly different from their parent specialties.

Response: We did not specifically solicit comments on whether reproductive endocrinology, sleep medicine, and spine surgery should be separately recognized Medicare specialties, nor did we make such a proposal. Specialties seeking such recognition must make a formal request using our existing process. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. L. 100–04, Chapter 26, Section 10.8, Requirements for Specialty Codes.)

We did consider the comments on blending in the PPIS data for the above physician groups as suggested by some commenters. However, we are more persuaded by the commenters who indicated that determining the correct blend would be difficult. We are reluctant to assign utilization weights to the mix of specialties that perform these services in the absence of actual claims data. We suggest that the commenters who wish us to use the PPIS data for these groups apply for a specialty code using our normal process. If approved, the claims data associated with the new specialty code could be used to incorporate the PPIS survey data for that specialty.

Comment: A group of commenters indicated that they were precluded from participating in the PPIS. Some commenters representing portable x-ray suppliers indicated that an inability to participate in the PPIS resulted in an inappropriately low crosswalk for their specialty to radiology.

Response: We did not exclude any specialty from participating in PPIS. Individual specialties made the decision whether to participate. However, we agree with the commenters representing portable x-ray suppliers that radiology may not be the most appropriate crosswalk for their specialty given the relatively low amount of physician time in the services performed by the specialty. In light of these comments, we are changing the PE/HR crosswalk for portable x-ray suppliers to IDTF, a specialty similar with respect to the physician time issue.

Comment: As noted earlier, commenters representing freestanding radiation oncology centers are opposed to the use of the PPIS data. However, if CMS were to use the PPIS data, these commenters requested that CMS adjust the PE/HR used for freestanding radiation oncology centers by eliminating the weighting of the data and by eliminating 21 survey responses whose physician hour information was missing from the data and imputed. The commenters also requested that we update the weights used to blend the hospital-based and freestanding radiation oncology center survey data based on more recent claims data.

Response: We agree with the commenters that it would be more consistent with the methodology used for other specialties to remove the 21 survey responses whose physician hour information was missing from the data and imputed. We also agree it is more appropriate to update the weights used to blend the hospital-based and freestanding radiation oncology center survey data based on more recent claims data. However, we disagree that it is appropriate to eliminate the weighting of the survey data, especially with the 21 observations with imputed physician practice hours removed from the survey sample respondent mix. Consistent with the weighting methodology for other physician specialties, we applied the AMA Masterfile weights to the data. More details on our analysis of this comment can be found on our Web site.

Comment: Some commenters indicated that since, by statute, registered dieticians are paid 85 percent of what a physician would be paid for providing medical nutrition therapy services, the PPIS survey data for registered dieticians should not be used in calculation of PE RVUs; and that we should, therefore, base the RVUs for these services only on the physician specialties that provide the service.

Response: We agree with commenters that, under the current PE methodology, the PPIS survey data for registered dieticians should not be used in the calculation of PE RVUs since they are paid 85 percent of what a physician would be paid for providing the service. To include them in the PE calculation would influence the rate setting to include what the services would be paid if performed by registered dieticians and not strictly on what the payment rate would be if provided by physicians. We will crosswalk the specialty of registered dietician to the ''all physician'' PE/HR rate.

In summary, based on the decisions described above, Table 2 shows the indirect PE/HR for the specialties that have PPIS survey data that we are adopting to calculate the PE RVUs. Also shown for these specialties is the previous indirect PE/HR used to calculate the PE RVUs. Note that for oncology, clinical laboratories, and IDTFs we are continuing to use the supplemental survey data as described above. Consistent with our past practice, the previous indirect PE/HRs for these specialties have been updated to CY 2006 using the MEI to put them on a comparable basis with the PPIS survey data.

TABLE 2—INDIRECT PE/HR FOR THE SPECIALTIES THAT HAVE PPIS SURVEY DATA

Specialty	Previous indirect PE/HR	Final rule indirect PE/HR	Previous indirect %	Final rule indirect %
All Physicians	$59.04	86.36	67	74
Allergy and Immunology	153.29	162.68	62	67
Anesthesiology	19.76	29.36	56	82
Audiology	59.04	72.17	67	85
Cardiology	131.02	88.04	56	65
Cardiothoracic Surgery	61.75	67.83	68	83
Chiropractor	49.60	65.33	69	86
Clinical Laboratory (Billing Independently)	66.46	68.32	37	37
Clinical Psychology	29.07	20.07	90	93
Clinical Social Work	29.07	17.80	90	97
Colon & Rectal Surgery	53.93	90.84	77	80
Dermatology	158.49	184.62	70	70
Emergency Medicine	36.85	38.36	88	94
Endocrinology	49.60	84.39	69	73
Family Medicine	52.79	90.15	62	76
Gastroenterology	101.30	96.78	70	75
General Practice	52.79	78.59	62	69
General Surgery	53.93	82.73	77	82
Geriatrics	49.60	54.14	69	74
Hand Surgery	98.56	148.78	72	77
Independent Diagnostic Testing Facilities	466.16	501.45	50	51
Internal Medicine	49.60	84.02	69	76
Interventional Pain Medicine	59.04	156.79	67	70
Interventional Radiology	118.48	82.56	58	81
Medical Oncology	141.84	145.81	59	59
Nephrology	49.60	66.00	69	80
Neurology	66.05	110.39	74	87
Neurosurgery	89.64	115.76	86	87
Nuclear Medicine	118.48	39.80	58	77
Obstetrics/Gynecology	69.74	99.32	67	67
Ophthalmology	103.28	170.07	65	70
Optometry	59.04	88.02	67	77
Oral Surgery (Dentist only)	96.01	173.19	71	65
Orthopaedic Surgery	98.56	131.40	72	81
Osteopathic Manipulative Therapy	59.04	53.93	67	93
Otolaryngology	96.01	141.54	71	75
Pain Medicine	59.04	122.42	67	70
Pathology	59.80	74.98	70	74
Pediatrics	51.52	76.27	62	69
Physical Medicine and Rehabilitation	84.92	110.13	71	84
Physical Therapy	35.17	57.26	65	84
Plastic Surgery	99.32	134.81	67	74
Podiatry	59.04	74.76	67	82
Psychiatry	29.07	30.10	90	94
Pulmonary Disease	44.63	55.26	76	74
Radiation Oncology (Hospital Based & Freestanding)	114.00	165.10	50	57
Radiology	118.48	95.60	58	71
Rheumatology	84.92	98.08	71	67
Urology	119.57	97.01	69	73
Vascular Surgery	60.10	83.98	63	73

c. Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, we currently perform these calculations with an equipment usage assumption of 50 percent. In the CY 2008 PFS proposed rule (72 FR 38132), we noted that if the assumed equipment usage percentage is set too high, the result would be an insufficient allowance at the service level for the practice costs associated with equipment. If the assumed equipment usage percentage is set too low, the result would be an excessive allowance for the practice costs of equipment at the service level. We acknowledged that the current 50 percent usage assumption does not capture the actual usage rates for all equipment, but stated that we did not believe that we had strong empirical evidence to justify any alternative approaches.

In the CY 2008 PFS final rule with comment period, we summarized comments received on this issue. Commenters' recommendations about making adjustments to the 50 percent utilization rate assumption varied. Some commenters recommended that we do nothing until stronger empirical evidence is available. Other commenters recommended a decrease in the utilization assumption while others recommended an increase in the utilization assumption. We agreed with the commenters that the equipment utilization rate should continue to be examined for accuracy. We indicated that we would continue to monitor the appropriateness of the equipment utilization assumption, and evaluate whether changes should be proposed in light of the data available.

In the CY 2010 PFS proposed rule (74 FR 33532), we acknowledged that since the publication of the CY 2008 PFS final rule with comment period, MedPAC addressed this issue in its March 2009 Report to Congress (see *http://www.medpac.gov/documents/Mar09_EntireReport.pdf).* In part of its discussion, MedPAC stated:

> In 2006, the Commission sponsored a survey by NORC of imaging providers in six markets, which found that MRI and CT machines are used much more than the 25 hours per week that CMS assumes (Table 2B–6). According to data from this survey, MRI scanners are used 52 hours per week, on average (median of 46 hours), and CT machines are operated 42 hours per week, on average (median of 40 hours) (NORC 2006). Although the survey results are not nationally representative, they are representative of imaging providers in the six markets included in the survey. We also analyzed data from a 2007 survey of CT providers by IMV, a market research firm (IMV Medical Information Division 2008). IMV data are widely used in the industry and have also appeared in published studies (Baker et al. 2008, Baker and Atlas 2004). Using IMV's data on 803 nonhospital CT providers (imaging centers, clinics, and physician offices), we calculated that the average provider uses its CT scanner 50 hours per week, which is twice the number CMS assumes. The IMV survey also found that nonhospital providers increased the average number of procedures per CT machine by 31 percent from 2003 to 2007, which indicates that providers either used their machines more hours per day or performed more scans per hour (IMV Medical Information Division 2008) (p. 108).

In the proposed rule, we stated that the studies cited by MedPAC indicated that the current equipment usage rate assumption is significantly understated, especially with respect to the types of high cost equipment that were the subject of the studies. The current 50 percent utilization rate translates into about 25 hours per week out of a 50-hour work week. The median value of 46 hours for Magnetic Resonance Imaging equipment from the first study cited by MedPAC is equivalent to a utilization rate of 92 percent on a 50-hour week. For Computed Tomography scanners, averaging the value from the first study of 40 hours per week and the value from the second study of 50 hours per week yields 45 hours and is equivalent to a 90 percent utilization rate on a 50-hour work week. Therefore, in the CY 2010 PFS proposed rule, we proposed to increase the equipment usage rate to 90 percent for all services containing equipment that cost in excess of $1 million dollars. We stated that the studies cited by MedPAC suggested that physicians and suppliers would not typically make huge capital investments in equipment that would only be utilized 50 percent of the time. We stated that we would continue to explore data sources regarding the utilization rates of equipment priced at less than $1 million dollars, but we did not propose a change in the usage rate for this less expensive equipment.

The following is a summary of the public comments received and our responses.

Comment: We received comments supporting our proposal to apply a 90 percent equipment utilization rate to expensive equipment priced at more than $1 million and comments opposing our proposal. MedPAC stated:

> ''The Commission supports CMS's proposal as it applies to diagnostic imaging machines that cost more than $1 million, and we encourage CMS to explore increasing the equipment use factor for diagnostic imaging machines that cost less than $1 million. MedPAC did not contemplate applying the policy to radiation therapy machines.''

Commenters supporting our proposal cited the MedPAC studies and the rationale we provided in the proposed rule.

Commenters opposing our proposal stated that the Balanced Budget Act of 1997 (BBA) directed CMS to ''utilize, to the maximum extent practicable, generally accepted cost accounting principles which: (1) Recognize all staff, equipment, supplies and expense, not just those which can be tied to specific procedures; and (2) use actual data on equipment utilization and other key assumptions.'' The commenters stated that the equipment usage proposal violates this provision of the BBA since we lacked sufficient empirical justification for the change. The commenters indicated that the National Opinion Research Center survey data, which was one data source used by MedPAC, was not nationally representative, and was never intended to determine equipment usage rates.

Some commenters referenced information submitted by the Radiology Benefit Management Association (RBMA) based on a survey of its members. The commenters stated that the information supported maintaining a 50 percent utilization usage rate assumption for diagnostic imaging equipment. The commenters also stated that the information indicated differences in utilization rates between rural and urban areas and that our proposal would create access issues, especially in rural areas.

In MedPAC's comment letter, it agreed with CMS that ''decreasing PE RVUs for expensive diagnostic imaging services should not affect access to care in rural areas.''

The AMA submitted summary equipment utilization data from the PPIS survey on MRI, CT, angiography, IMRT, and gamma camera. It stated that although there was a relatively small sample size, the survey responses suggest that equipment utilization varies depending on the type of equipment involved. The AMA requested that we allow specialty societies to provide data supporting lower utilization rates, if appropriate. It stated that this would allow for varying equipment utilization rate assumptions depending on the type of equipment being used, rather than a single utilization assumption.

Some commenters indicated that even if the available data did indicate a higher utilization rate for certain types of diagnostic equipment, we should not apply the change to all types of expensive diagnostic equipment. For example, we should not apply the usage rate to new imaging technology.

Some commenters requested that we not change the equipment usage rate assumption to 90 percent for any equipment until additional data sources can be identified. The commenters suggested that the equipment usage rate policy should not be limited to increasing usage rate assumptions but should also include potentially decreasing equipment usage rate assumptions when appropriate.

If we were to implement a higher utilization rate, some commenters suggested that the change be phased in over a number of years.

Response: We appreciate all of the comments received on this issue. At the time that we published the proposed rule, we had the data on MRI and CT from the MedPAC analysis. We indicated that the MedPAC studies suggested that physicians and suppliers would not typically make significant capital investments in equipment that would only be utilized 50 percent of the time. Commenters opposed to our proposal have questioned both the validity of the MedPAC analysis for CT and MRI and extrapolation of this data to all expensive equipment, particularly therapeutic equipment. While we are persuaded by PPIS data on angiography, IMRT, and Gamma Camera that the extrapolation of the MRI and CT data to all expensive equipment may be inappropriate, we disagree with commenters who indicated that we do not have an empirical basis for applying a 90 percent usage rate to MRIs and CTs.

As described earlier, the MedPAC analysis was performed on two data sources for different types of equipment. The first data source was the survey done by NORC for MRIs and CTs. The second data source was the IMV data for

CT scans. With respect to MRIs and CTs, we have now also received summary information from the RBMA and summary PPIS survey data from the AMA. The PPIS survey data results for MRIs (n=97) and CTs (n=86) are consistent with the findings from the MedPAC studies on MRIs and CTs. However, the data from the RBMA (17 members submitted a total of 46 center surveys) indicates a lower utilization rate for CT and MRI.

As we have described in section II.A.2.b. of this final rule with comment, the PPIS is the best available data source currently available on PEs. Given the corroboration of the MedPAC analysis by the PPIS data, we are confident that we are using the best data currently available on the utilization of MRIs and CTs (90 percent), consistent with the BBA requirement that we use actual data on equipment utilization.

We are open to receiving more comprehensive data than the responses of 16 RBMA members on this issue from the RBMA or other members of the public. We will evaluate any data submitted for consideration in future rulemaking.

We continue to agree with the MedPAC analysis and comment indicating that decreasing the PE payments for expensive diagnostic imaging services should not affect access to care in rural areas.

We also agree with commenters that it would be appropriate to transition the new PE RVUs developed using the higher 90 percent utilization rate for MRIs and CTs. As discussed elsewhere in this final rule, we are providing for a 4-year transition (25/75, 50/50, 75/25, 100/0) to the new PE RVUs.

As indicated above, we are not finalizing our proposal to increase the utilization rate assumption for expensive equipment other than MRIs and CTs, including therapeutic equipment. We are finalizing our proposal to increase the utilization rate to 90 percent for expensive diagnostic equipment priced at more than $1 million.

d. Miscellaneous PE Issues

As we have discussed in the past rulemaking (see the CY 2007 and CY 2008 PFS final rules with comment period (71 FR 69647 and 72 FR 66236, respectively), we continue to have concerns about the issue of PE RVUs for services which are utilized 24 hours a day/7 days a week, such as certain monitoring systems. For example, the PE equipment methodology was not developed with this type of 24/7 equipment in mind. As stated in the CY 2010 PFS proposed rule (74 FR 33532), we are continuing to analyze the issue of PEs for services, which are utilized 24 hours a day/7 days a week to identify any modifications to our methodology that would address the specific ''constant use'' issues associated with these services. Services that are currently contractor priced in CY 2009 would remain contractor priced in CY 2010. We also indicated that any proposed changes will be communicated through future rulemaking.

Comments: We received three comments regarding the proposal to continue to contractor price these services. All three commenters supported the establishment of a national price for cardiac outpatient telemetry. The commenters also indicated that they believe they were the only ones that should be billing these codes.

Response: We will finalize our proposal to continue to contractor price these services in 2010 so that we may conduct further analysis. Any proposed changes will be communicated through future rulemaking.

As discussed in the proposed rule, (74 FR 33532) we received comments regarding the PE direct cost inputs (for example, supply costs and the useful life of the renewable sources) related to the high dose radiation therapy (HDRT) and placement CPT codes (CPT codes 77785, *Remote afterloading high dose rate radionuclide brachytherapy; 1 channel,* 77786, *Remote afterloading high dose rate radionuclide brachytherapy; 2–12 channels,* 77787, *Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels).* Based on our review of these codes and comments received, we requested that the AMA RUC consider these CPT codes for additional review.

Comment: The AMA RUC reviewed these CPT codes based on our request and recommended revisions to the clinical labor staff type, supplies, and equipment. The AMA RUC also recommended further discussion between the specialty and CMS regarding a resolution regarding the useful life of Iridium-192 source. The AMA RUC and other commenters stated that the useful life of the Iridium-192 source is 70 to 90 days. However, many commenters stated that physician offices enter into 1 year contracts for its replacement.

Several commenters supported the AMA RUC's recommended changes to the practice expense inputs for these codes. The commenters agreed that certain direct PE inputs were previously omitted.

Response: We accept the AMA RUC's recommendations regarding the direct PE inputs for these CPT codes. Based on the comments received and further analysis, we are changing the useful life of the Iridium-192 source from 5 years to 1 year and it will be considered as equipment. We are also revising the direct PE inputs for clinical labor staff type, supplies, and equipment.

e. AMA RUC Recommendations for Direct PE Inputs

The AMA RUC provided recommendations for PE inputs for the codes listed in Table 3 (74 FR 33532).

TABLE 3—CODES WITH AMA RUC PE RECOMMENDATIONS

CPT [1] code	Description
37183	Remove hepatic shunt (tips).
47382	Percut ablate liver rf.
50200	Biopsy of kidney.
55873	Cryoablate prostate.
93025	Microvolt t-wave assess.

[1] CPT codes and descriptions are Copyright 2009 American Medical Association.

In the proposed rule, we stated that we were in agreement with the AMA RUC recommendations for the direct PE inputs for the codes listed in Table 3 and proposed to adopt these for CY 2010.

Comment: Several commenters stated that it did not appear that we had adopted the AMA RUC recommendations for these codes. Commenters requested that we review their direct PE inputs to determine if we had adopted the RUC's recommendations.

Response: We have reviewed the direct PE inputs for these codes and it appears that some were omitted in error. We have now updated the PE inputs for these codes consistent with the RUC recommendation.

f. Practice Expense for Intranasal Vaccine Administration Codes (CPT Codes 90467, 90468, 90473, and 90474)

Comment: We received a comment from a manufacturer that the payment for the intranasal vaccine administration codes (represented by CPT codes 90467, 90468, 90473, and 90474) is approximately half the rate of the injected vaccine administration codes (represented by CPT codes 90465, 90466, 90471, and 90472). The commenter stated that the apparent source of the difference is the clinical staff time inputs of the PE component of the RVUs for these codes. The commenter noted that these codes are used to administer the intranasal form

of the influenza vaccine to healthy individuals between 2 to 49 years of age.

Response: We responded to a similar comment in the CY 2008 PFS final rule with comment period (72 FR 66242). At that time, we stated that a manufacturer had expressed concern that the PE RVUs for intranasal administration of vaccines (CPT codes 90467/8 and 90473/4) are inappropriately low and should be equalized to the injectable immunization administration PE RVUs. The commenter stated that when the codes were re-evaluated in 2004 there was not enough experience in the office to fully understand the time associated with providing an intranasal vaccine. The commenter stated that specialty organizations have indicated that this issue is worth reexamining and indicated that they had been encouraged to communicate with the AMA RUC in support of equalizing payment for the codes. In our response we stated that we appreciated the commenter's concerns about the disparity in the PE RVUs for the intranasal and injectable immunization administration procedures. To the extent that these concerns related to the direct PE inputs, we encouraged the commenters to work with the specialty organizations to determine if it was appropriate to bring these codes forward for further AMA RUC review.

The AMA RUC reviewed the immunization administration services (CPT codes 90465 through 90474) in February 2008. It recommended similar PE inputs for the intramuscular and intranasal immunization administration codes. In the CY 2009 PFS final rule with comment period (73 FR 38512), we stated that we accepted all of the AMA RUC recommendations, except for inclusion of the clinical staff time related to quality activities for the codes. In the CY 2009 PFS final rule with comment period (73 FR 69736), we stated that we had reexamined the issue and that there was evidence to support the inclusion of QA time in this case. We revised the PE database to reflect QA time for these codes.

B. Geographic Practice Cost Indices (GPCIs): Locality Discussion

1. Update—Expiration of 1.0 Work GPCI Floor

Section 1848(e)(1)(A) of the Act requires us to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE and malpractice). While requiring that the PE and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs at least every 3 years. This section also specifies that if more than 1 year has elapsed since the last GPCI revision, we must phase in the adjustment over 2 years, applying only one-half of any adjustment in each year. As discussed in the CY 2009 PFS final rule with comment period (73 FR 69740), the CY 2009 adjustment to the GPCIs reflected the fully implemented fifth comprehensive GPCI update. We noted that a 1.0 work GPCI floor was enacted and implemented for CY 2006, and was set to expire on June 30, 2008. We also noted that section 134 of the MIPPA extended the 1.0 work GPCI floor from July 1, 2008, through December 31, 2009. Additionally, section 1848(e)(1)(G) of the Act, as amended by section 134(b) of the MIPPA, set a permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009. Therefore, as required by the MIPPA, beginning on January 1, 2010, the 1.0 work GPCI floor will be removed. However, the 1.5 work GPCI floor for Alaska will remain in place. See Addenda D and E of this final rule for the GPCIs and summarized geographic adjustment factors (GAFs), respectively.

Comment: A few commenters urged us to make the 1.0 work GPCI floor permanent.

Response: With regard to the 1.0 work GPCI floor, we do not have the authority to extend this provision beyond December 31, 2009. As explained in the CY 2010 PFS proposed rule (74 FR 33533), section 134 of the MIPPA only extended the 1.0 work GPCI floor from July 1, 2008, through December 31, 2009.

2. Payment Localities

a. Background

As stated above in this section, section 1848(e)(1)(A) of the Act requires us to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (this is, work, PE, and malpractice). Payments under the PFS are based on the relative resources involved in furnishing physicians' services, and are adjusted for differences in relative resource costs among payment localities using the GPCIs. As a result, PFS payments vary between localities.

The current PFS locality structure was developed and implemented in 1997. There are currently 89 localities including 37 higher-cost areas; 16 Rest of State areas (comprising the remaining counties not located in a higher-cost area within a State); 34 Statewide areas; and Puerto Rico and the Virgin Islands which are designated as ''territory-wide'' localities. The development of the current locality structure is described in detail in the CY 1997 PFS proposed rule (61 FR 34615) and the subsequent final rule (61 FR 59494).

As we have frequently noted, any changes to the locality configuration must be made in a budget neutral manner within a State and can lead to significant redistributions in payments. For many years, we have not considered making changes to localities without the support of a State medical association in order to demonstrate consensus for the change among the professionals whose payments would be affected (with some increasing and some decreasing). However, we have recognized that, over time, changes in demographics or local economic conditions may lead us to conduct a more comprehensive examination of existing payment localities.

Payment Locality Approaches Discussed in the CY 2008 PFS Proposed Rule

For the past several years, we have been involved in discussions with California physicians and their representatives about recent shifts in relative demographics and economic conditions among a number of counties within the current California payment locality structure. In the CY 2008 PFS proposed and final rules with comment period, we described three potential options for changing the payment localities in California (72 FR 38139 and 72 FR 66245, respectively).

After reviewing the comments on these options, we decided not to proceed with implementing any of them at that time. We explained that there was no consensus among the California medical community as to which, if any, of the options would be most acceptable. We also received suggestions from the Medicare Payment Advisory Commission (MedPAC) for developing changes in payment localities for the entire country and other States expressed interest in having their payment localities reconfigured as well. In addition, other commenters wanted us to consider a national reconfiguration of localities rather than just making changes one State at a time. Because of the divergent views

expressed in comments, we explained in the CY 2008 PFS final rule with comment period that we intended to conduct a thorough analysis of potential approaches to reconfiguring localities and would address this issue again in future rulemaking.

Interim Study of Alternative Payment Localities Under the PFS

As a follow-up to the CY 2008 PFS final rule with comment period, we contracted with Acumen, LLC (Acumen), to conduct a preliminary study of several options for revising the payment localities on a nationwide basis. The contractor's interim report was posted on the CMS Web site on August 21, 2008, and we requested comments from the public. The report entitled, ''Review of Alternative GPCI Payment Locality Structures,'' is still accessible from the CMS PFS Web page under the heading ''Interim Study of Alternative Payment Localities under the PFS.'' The report may also be accessed directly from the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/10_Interim_Study.asp#TopOfPage.* We accepted comments on the interim report through November 3, 2008. The alternative locality configurations discussed in the report are described briefly below in this section.

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

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

Option 2: Separate High Cost Counties From Existing Localities (Separate Counties)

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

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

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

Option 4: Group Counties Within a State Into Locality Tiers Based on Costs (Statewide Tiers)

This option creates tiers of counties (within each State) that may or may not be contiguous but share similar practice costs. This option would increase the number of localities from 89 to 140 using a 5 percent GAF differential to group similar counties into Statewide tiers.

Additionally, as discussed in the interim locality study report, our contractor, Acumen, applied a ''smoothing'' adjustment to the current PFS locality structure, as well as to each of the alternative locality configurations (except option 4: Statewide Tiers). The ''smoothing'' adjustment was applied to mitigate large payment differences (or payment ''cliffs'') between adjacent counties. Since large payment differences between adjacent counties could influence a physician's decision on a practice location (and possibly impact access to care), the ''smoothing'' adjustment was applied to ensure that GAF differences between adjacent counties do not exceed 10 percent. (For more information on the ''smoothing'' adjustment see the interim locality study report on the PFS Web page via the link provided above).

b. Summary of Public Comments on Interim Locality Study Report

In the CY 2009 PFS proposed rule (73 FR 38514), we encouraged interested parties to submit comments on the options presented both in the proposed rule and in the interim report posted on our Web site. We also requested comments and suggestions on other potential alternative locality configurations (in addition to the options described in the report). Additionally, we requested comments on the administrative and operational issues associated with the various options under consideration. We also emphasized that we would not be proposing any changes to the current PFS locality structure for CY 2009 and that we would provide extensive opportunities for public comment before proposing any change.

In the CY 2010 PFS proposed rule (74 FR 33533), we noted that approximately 200 industry comments were submitted on the alternative locality options discussed in the CY 2009 PFS proposed rule and on the interim locality study report. Comments were submitted from various specialty groups, medical societies, state medical associations, individual practitioners, and beneficiaries. Commenters generally commended us for acknowledging the need to reconfigure PFS payment localities and expressed support for our study of alternative locality configurations. Some urged us to expedite any changes while other commenters requested that we take a cautious approach.

Several commenters who supported the adoption of an MSA-based PFS locality structure suggested that option 3 could be used as a transition to the CMS CBSA locality configuration (option 1). Many commenters from the State of California supported option 3 (Separate High Cost MSAs) because the commenters believe it would improve payment accuracy (over the current locality configuration) and mitigate possible payment reductions to rural areas as compared to option 1 (CMS CBSA) and option 4 (Statewide Tiers. Because of the payment reductions to rural areas, most commenters did not support option 4 (Statewide Tiers).

Many commenters also acknowledged the significant redistribution of payments that would occur under each option and requested that we minimize the payment discrepancy between urban and rural areas to ensure continued access to services. One medical association stated that ''budget neutral redistributions would only exacerbate an already flawed and under-funded Medicare PFS'' and suggested that States with a Statewide locality be given the option of remaining a Statewide locality. The commenter also requested that we continue our policy of allowing any State the option of converting to a Statewide locality.

For a more detailed discussion of the comments submitted on the interim locality study, see the CY 2010 PFS proposed rule (74 FR 33534).

We did not make a specific proposal for changing the PFS locality structure in the CY 2010 PFS proposed rule. As noted by the commenters and reflected in the report, significant payment redistribution would occur if a nationwide change in the PFS locality configuration were undertaken. All four of the potential alternative payment locality configurations reviewed in the report would increase the number of localities and separate higher cost,

typically urban areas from lower cost, typically rural ''Rest of State'' areas. In general, payments to urban areas would increase while rural areas would see a decrease in payment under each of the options studied because they would no longer be grouped with higher cost ''urbanized'' areas. We intend to continue our review of the suggestions made by the commenters and consider the impact of each of the potential alternative locality configurations.

Comment: We received some comments on the locality discussion from various specialty groups and medical societies. A few commenters expressed support for our decision to defer proposing changes to the PFS locality reconfiguration and recommended that we continue pursuing a cautious approach. One State Medical Association stated that it is hopeful that the Congress will provide a method to update all payment localities in a manner that prevents cuts to payments in lower-cost counties. However, in the event the Congress does not provide additional funding to hold lower cost counties harmless, the commenter supports a PFS locality configuration based on MSAs. Another commenter noted that the redistribution of payments could have a negative impact on access to care. The commenter stated that geographic location should not be a detriment as to whether a physician can provide care to a Medicare beneficiary. One specialty group stated that changes in localities should only be made to improve the relative accuracy of Medicare payment. In the event we make a proposal to change the PFS locality structure, the commenter urged us to provide sufficient data for the public to ascertain the impact on specific geographic areas.

Response: We agree that a nationwide locality reconfiguration requires a cautious approach and will carefully consider the commenter's suggestion regarding an MSA-based locality configuration. We would also like to thank the public again for the many thoughtful comments on the interim locality study report entitled, ''Review of Alternative GPCI Payment Locality Structures''. A final report will be posted to the CMS Web site after further review of the studied alternative locality approaches. As explained in the CY 2010 PFS proposed rule, we are not proposing changes in the PFS locality structure at this time. In the event we decide to make a specific proposal for changing the locality configuration, we would provide data on the impact of the changes. We would also provide extensive opportunities for public input (for example, Town Hall meetings or Open Door Forums, as well as opportunities for public comments afforded by the rulemaking process).

C. Malpractice Relative Value Units (RVUs)

1. Background

Section 1848(c) of the Act requires that each service paid under the PFS be comprised of three components: Work, PE, and malpractice. From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Initial implementation of resource-based malpractice RVUs occurred in 2000. The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource based malpractice RVUs was addressed in the CY 2005 PFS final rule (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule (70 FR 70153). In the CY 2010 PFS proposed rule, we proposed to implement the second review and update of malpractice RVUs.

2. Methodology for the Revision of Resource-Based Malpractice RVUs

The proposed malpractice RVUs were developed by Acumen, LLC (Acumen) under contract to us (74 FR 33537).

The methodology used in calculating the proposed second review and update of resource-based malpractice RVUs largely parallels the process used in the CY 2005 update. The calculation requires information on malpractice premiums, linked to the physician work conducted by different specialties that furnish Medicare services. Because malpractice costs vary by State and specialty, the malpractice premium information must be weighted geographically and across specialties. Accordingly, the malpractice expense RVUs that we proposed are based upon three data sources:

- Actual CY 2006 and CY 2007 malpractice premium data.
- CY 2008 Medicare payment data on allowed services and charges.
- CY 2008 Geographic adjustment data for malpractice premiums.

Similar to the previous update of the resource-based malpractice expense RVUs, we proposed to revise the RVUs using specialty-specific malpractice premium data because they represent the actual malpractice expense to the physician. In addition, malpractice premium data are widely available through State Departments of Insurance. We proposed to use actual CY 2006 and CY 2007 malpractice premium data because they are the most current data available (CY 2008 malpractice premium data were not consistently available during the data collection process). Accounting for market share, three fourths of all included rate filings were implemented in CY 2006 and CY 2007. The remaining rate filings were implemented in CY 2003 through CY 2005 but still effective in CY 2006 and CY 2007. Carriers submit rate filings to their State Departments of Insurance listing the premiums and other features of their coverage. The rate filings include an effective date, which is the date the premiums go into effect. Some States require premium changes to be approved before their effective date; others just require the rate filings to be submitted. We attempted to capture at least 2 companies and at least 50 percent of the market share, starting with the largest carriers in a State.

The primary determinants of malpractice liability costs continue to be physician specialty, level of surgical involvement, and the physician's malpractice history. We collected malpractice premium data from 49 States and the District of Columbia for all physician specialties represented by major insurance providers. Rate filings were not available through Departments of Insurance in Mississippi or Puerto Rico. Premiums were for $1 million/$3 million, mature, claims-made policies (policies covering claims made, rather than services furnished during the policy term). A $1 million/$3 million liability limit policy means that the most that would be paid on any claim is $1 million and that the most that the policy would pay for several claims over the timeframe of the policy is $3 million. We collected data from commercial and physician-owned insurers and from joint underwriting associations (JUAs). A JUA is a State government-administered risk pooling insurance arrangement in areas where commercial insurers have left the market. Adjustments were made to reflect mandatory surcharges for patient compensation funds (PCFs) (funds to pay for any claim beyond the statutory amount, thereby limiting an individual physician's liability in cases of a large suit) in States where PCF participation is mandatory. We sought to collect premium data representing at least 50

percent of physician malpractice premiums paid in each State as identified by State Departments of Insurance and by the National Association of Insurance Commissioners (NAIC).

Rather than select the top 20 physician specialties as we did when the malpractice RVU were originally established and updated, we included premium information for all physician and surgeon specialties, and risk classifications available in the collected rate filings. Most insurance companies provided crosswalks from insurance service office (ISO) codes to named specialties; we matched these crosswalks to CMS specialty codes. We also preserved information obtained regarding surgery classes, which are categorizations that affect premium rates. For example, many insurance companies grouped general practice physicians into nonsurgical, minor-surgical and major-surgical classes, each with different malpractice premiums. Some companies provided additional surgical subclasses; for example, distinguishing general practice physicians that conducted obstetric procedures, which further impacted malpractice rates. We standardized this information to CMS specialty codes.

We proposed a resource based methodology for developing malpractice RVUs for technical component (TC) services (for example diagnostic tests). Currently, the MP RVUs for TC services and the TC portion of global services are based on historical allowed charges and have not been made resource based due to a lack of available malpractice premium data for nonphysician suppliers. Over the last few years, we have requested malpractice premium data for nonphysician suppliers, but had not received any data prior to last year. In response to our request in last year's rulemaking cycle, one commenter did provide information on one of the largest insurance companies that provides liability insurance for medical physicists employed by imaging facilities. After our contractor, Acumen, verified the medical physicist premium information submitted in response to last year's proposed rule, we proposed to use the medical physicist premium data as a proxy for the malpractice premiums paid by all entities providing TC services; primarily independent diagnostic testing facilities (IDTFs).

Other than the change in methodology for developing malpractice RVUs for TC services, our proposed methodology for updating malpractice RVUs conceptually followed the same approach, with some minor refinements, used to originally develop the resource based malpractice RVUs in CY 2000 and used in the CY 2005 update. These refinements included an expansion in the malpractice premium data collection to include additional specialties, a distinction between major and minor surgical risk factors, and a proposal to use the malpractice risk factor of the specialty that performs a given service the most (dominant specialty) for services with less than 100 occurrences. We solicited comments on our proposed methodology for updating the malpractice RVUs and posted the Acumen report, ''Interim Report on Malpractice RVUs for the CY 2010 Medicare Physician Fee Schedule Proposed Rule'' on the CMS Web site. The interim report on Malpractice RVUs for the CY 2010 PFS proposed rule and Malpractice premium amounts and risk factors by specialty, which was produced by Acumen, LLC under contract to CMS, is accessible from the CMS PFS Web page under the heading ''Interim Report on Malpractice RVUs for the CY 2010 Medicare PFS Proposed rule.'' The report and malpractice premiums may also be accessed directly on the CMS Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/05_Malpractice_Report.asp#TopOfPage.*

A more detailed explanation of our proposed malpractice RVU update can be found in the CY 2010 PFS proposed rule (74 FR 33537).

We received over 250 industry comments on the CY 2010 proposed malpractice RVU update.

Comment: Many commenters commended us for employing an expanded data collection that included premium information for all physician specialties, rather than just the top 20 Medicare physician specialties. Commenters also applauded our use of the most current PLI premium data available from State filings.

Response: We agree with the commenters that the use of the most current PLI data and the expanded data collection is appropriate.

Comment: Some commenters supported the use of medical physicist data as a proxy for developing malpractice RVUs for TC services. The commenters expressed their belief that using medical physicist data provide a better reflection of PLI premiums paid by entities furnishing TC services than the current charge-based approach or cross-walking to physician specialties. Many commenters did not support the proposed change to resource-based MP RVUs for TC services because premium amounts paid by medical physicists were used as a proxy for all entities furnishing TC services. The commenters objected to our proposed use of medical physicist data, stating that the use of this data will result in inappropriately low MP RVUs for the affected services. The commenters indicated that we should use premium data from the suppliers of these TC services, such as IDTFs and audiologists. Some commenters requested that we work with the Radiology Business Management Association (RBMA) to obtain PLI premium information for IDTFs. Other suppliers of TC services, including suppliers of imaging services and remote cardiac monitoring services, also submitted liability policy information. Several commenters requested that we use the current charge-based malpractice RVUs until data from TC suppliers can be collected.

Response: We appreciate all the comments received on this issue. While we agree with the commenters who stated that the medical physicist data provide a better reflection of PLI premiums paid by entities furnishing TC services than the current charge-based approach or crosswalking to physician specialties, we also agree with the commenters who indicated that we should use premium data from the suppliers of these services, if the data are available and meet the same standards as the other premium data collected for use in the development of the malpractice RVUs. As noted earlier, we have repeatedly requested PLI data sources for suppliers of TC services. Our proposal for TC services was based on the first verifiable data source provided to us. In the comment period, alternative PLI sources were recommended for use with the TC services. In some circumstances, the information submitted by the commenters included insurance coverage beyond the scope of the malpractice RVUs (for example, property liability, errors and omissions liability) and/or coverage limits beyond the $1 million/$3 million coverage malpractice premium collection parameters used for professional services. However, these same commenters also submitted the names of several insurance companies who provide malpractice insurance for IDTFs. We contacted these insurance companies in an attempt to collect premium data for the suppliers of TC services. We were able to verify the premium information for IDTFs consistent with the information collected for physician specialties. Therefore, we are using this verified premium data in the calculation of the malpractice RVUs for TC services.

Comment: Many commenters stated that all services have some level of malpractice risk and that it was

inappropriate for CMS to allow rounding to result in zero malpractice RVUs for some services.

Response: After considering the comments on this issue, we agree that it would be inappropriate for services to receive zero payment for malpractice due to rounding. These services will be assigned 0.01 malpractice RVUs for CY 2010.

Comment: One commenter did not support the use of work RVUs to account for differences in risk-of-service for drug administration services and that these services were being inappropriately penalized in the malpractice risk allocation.

Response: When developing the current resource-based PE RVU methodology, we received similar comments since the work RVUs are also a component of the indirect PE allocation. In response to those comments, we modified the resource-based PE methodology to allow the allocation to be done using the greater of the clinical labor involved in the service or the work RVUs. In light of similar comments on this issue in the malpractice allocation, we will make a similar modification. Specifically, we will use the greater of the clinical labor involved in the service or the work RVUs in the malpractice allocation.

Comment: The AMA RUC and other commenters requested that we use the generally lower malpractice survey data from the Physician Practice Information Survey (PPIS) for NPPs instead of crosswalking NPPs to the lowest *physician* specialty (allergy/immunology). One commenter also noted that the average premiums collected for diagnostic radiology were lower than the average reported premium from the AMA PPIS data.

Response: The resource-based malpractice RVUs are based on verifiable PLI premium data. We do not believe it would be appropriate to base the malpractice RVUs for nonphysician specialties or selected specialties on survey data and use premium data for all other specialties. Therefore, we do not agree with the commenters who suggested the use of survey data for NPPs or selected specialties.

Comment: The AMA RUC and two other commenters requested that we crosswalk gynecologic oncology to general surgery and surgical oncology (instead of crosswalking it to medical oncology) because gynecologic oncologists are predominantly cancer surgeons.

Response: We agree with the commenters and will crosswalk gynecologic oncology to general surgery premium data.

Comment: Some commenters raised questions about our proposal to crosswalk maxillofacial surgery and oral surgery to allergy/immunology. The commenters suggested that we use PLI data collected from the American Association of Maxillofacial Surgery (AAOMS) or the PPIS data instead of crosswalking to the lowest physician specialty.

Response: As noted earlier, the resource-based malpractice RVUs are based on verifiable premium data. We do not agree with the commenters who suggested the use of unverified maxillofacial surgery and oral surgery PLI information. However, we do agree that it would be more appropriate to use a surgical specialty's premium data rather than allergy/immunology premium data for surgical specialties. Therefore, we will crosswalk these specialties to the similar specialty of plastic surgery.

Comment: Some commenters did not support using the global surgery indicator for assigning the major or minor risk factor to surgical procedures. The commenters stated that using this methodology for determining the surgical class will not adequately address all the instances in which a surgical procedure should be classified as major. The commenters requested that we work with PLI insurance companies and the AMA RUC to determine a more comprehensive definition of major and minor surgical classifications. One commenter requested that we assign the surgical risk factor to injection procedures performed during cardiac catheterization as described by CPT codes 93501 through 93572.

Response: For the original implementation of resource-based MP RVUs (CY 2000), we assigned one of two risk factors to each service based on code range: surgery and nonsurgery (the surgery risk factor did not distinguish between major and minor). This methodology of assigning risk factors to specific services was also used in the first Five-Year Review. For the second malpractice RVU update, we proposed to assign each service code to one of the following three risk factors: Nonsurgical; minor surgical; and major surgical (74 FR 33539). Risk factor classes for each service were assigned based on procedure code ranges and whether or not the service had a 90-day global period. The 90-day global period was used to assign surgical codes to major surgery.

After consideration of the comments, we will not finalize our proposal but will continue to use our current approach for assigning risk factors to individual services while we study this issue further. We will consider the request to assign the surgical risk factor to injection procedures as part of our further study and would propose any changes through future rulemaking.

As is done under the current methodology, we will continue to assign each service to either a nonsurgical or surgical risk factor based on CPT code ranges: Surgery (CPT code range 10000 through 69999; 92980 through 92998; 93501 through 93536; 92973 through 92974; 93501 through 93533; 93580 through 93581; 93600 through 93613; 93650 through 93652; 92975; 92980 through 92998; 93617 through 93641); and nonsurgery (all other CPT codes). Consistent with current practice, the surgery risk factor would not distinguish between major and minor.

Comment: While commenters agreed with most of our proposed claims based dominant specialty designations for codes with less than 100 allowed services, the commenters disagreed with our proposal for some services. The commenters believe that the claims have been miscoded, resulting in erroneous specialty designations.

Response: Service specific malpractice RVUs are determined based on the weighted average risk factor(s) of the specialties that furnish the service. For rarely-billed Medicare services (that is, when allowed services are less than 100), we proposed to use the risk factor of the dominant specialty as reflected in our claims data. In the past, we had used all the specialties performing these low volume services as reflected in our claims data. Approximately 2,000 services met the criteria for ''low volume.'' The dominant specialty for each 'low volume' service was determined from CY 2008 Medicare claims data.

By using the dominant specialty from our claims data to assign the specialty for these low volume services, we attempted to strike a balance between our preference for the empirical, objective use of all of our claims data in the development of the malpractice RVUs and the desire of commenters to override our claims data for these low volume services using less objective criteria. After careful consideration of the comments, we continue to believe that a more balanced approach between the complete reliance on all of the specialties in our claims data and the subjective review of each low volume service is the most appropriate way of approaching the development of malpractice RVUs for these low volume services. We disagree with the commenters that we should override the dominant specialty from the claims data

with the recommended specialty. Therefore, we will finalize our proposal to use Medicare claims data to assign a dominant specialty to low volume services.

D. Medicare Telehealth Services

1. Requests for Adding Services to the List of Medicare Telehealth Services

Section 1834(m)(4)(F) of the Act defines telehealth services as professional consultations, office visits, and office psychiatry services, and any additional service specified by the Secretary. In addition, the statute requires us to establish a process for adding services to or deleting services from the list of telehealth services on an annual basis.

In the December 31, 2002 **Federal Register** (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public with an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of Medicare telehealth services to one of the following categories:

- *Category #1:* Services that are similar to professional consultations, office visits, and office psychiatry services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.
- *Category #2:* Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the face-to-face ''hands on'' delivery of the same service. Requestors should submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to a face-to-face delivery of the requested service.

Since establishing the process, we have added the following to the list of Medicare telehealth services: psychiatric diagnostic interview examination; ESRD services with two to three visits per month and four or more visits per month (although we require at least one visit a month to be furnished in-person ''hands on'', by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA) to examine the vascular access site); individual medical nutrition therapy; neurobehavioral status exam; and follow-up inpatient telehealth consultations.

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2009 are considered for the CY 2011 proposed rule. Each request for adding a service to the list of Medicare telehealth services must include any supporting documentation you wish us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requestors should be advised that any information submitted is subject to disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth/.*

2. Submitted Requests for Addition to the List of Telehealth Services

We received requests in CY 2008 to add the following services as Medicare telehealth services effective for CY 2010: (1) Health and behavior assessment and intervention (HBAI) procedures; and (2) nursing facility services. In addition, we received a number of requests to add services that we did not approve as Medicare telehealth services in previous PFS rules. These requested services include critical care services; initial and subsequent hospital care; group medical nutrition therapy; diabetes self-management training; speech and language pathology services; and physical and occupational therapy services.

In the CY 2010 PFS proposed rule (74 FR 33543), we responded to these requests. We proposed to add individual HBAI services to the list of Medicare telehealth services, and we proposed to revise our regulations at § 410.78 and § 414.65 accordingly. We proposed to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c). We proposed to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HPCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs. We did not propose to add group HBAI, family-with-patient HBAI, nursing facility services, critical care services, or any of the other requested services to the list of Medicare telehealth services. The following is a summary of the discussion from the proposed rule, a summary of comments we received, and our responses.

a. Health and Behavior Assessment and Intervention (HBAI)

The American Psychological Association (APA) submitted a request to add HBAI services (as described by HCPCS codes 96150 through 96154) to the list of approved telehealth services. The APA asked us to evaluate and approve HBAI services as a Category #1 service because they are comparable to the psychotherapy services currently approved for telehealth.

As discussed in the CY 2010 PFS proposed rule (74 FR 33543), clinical psychologists furnish HBAI services to beneficiaries to help them manage or improve their behavior in response to physical problems. Elements of HBAI services typically include interviewing, observing, and counseling beneficiaries to help them modify their behavior. These elements are also common to the office psychiatry services currently approved for telehealth. In the proposed rule, we stated that we believe the interaction between a practitioner and a beneficiary receiving individual HBAI services (as described by HCPCS codes 96150 through 96152) is similar to the assessment and counseling elements of the individual office psychiatry services currently approved for telehealth. Therefore, we proposed to revise § 410.78 and § 414.65 to include individual HBAI services as Medicare telehealth services.

With regard to group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154), we noted that group services are not currently approved as Medicare telehealth services. Group counseling services have a different interactive dynamic between the physician or practitioner and his or her patients as compared to individual services. Since the interactive dynamic for group HBAI services is not similar to that for individual HBAI services or any other approved telehealth services, we stated that we do not believe that group HBAI or family-with-patient HBAI services should be considered as Category #1 requests. To be considered as a Category #1 request, a service must be similar to the current list of Medicare telehealth services. (See 70 FR 45787 and 70157, and 73 FR 38516 and 69743). Instead,

we believe that group HBAI and family-with-patient HBAI must be evaluated as Category #2 services. Accordingly, we need to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requestor did not submit evidence suggesting that the use of a telecommunications system to deliver these services would produce similar diagnostic findings or therapeutic interventions as compared to the face-to-face delivery of these services. Therefore, we did not propose to add group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154) to the list of approved Medicare telehealth services.

Comment: The APA stated that it was pleased that we proposed to add individual HBAI to the list of approved telehealth services and that it may wish to resume the discussion of adding other HBAI services in the future. Other commenters were also pleased that we proposed to add individual HBAI to the list of approved telehealth services. However, they disagreed with our proposal not to add the other HBAI services to the list of approved Medicare telehealth services. The commenters noted that CMS has no evidence that it is not appropriate to furnish group services via telehealth. In addition, the commenters believe that the involvement of family members in patient counseling can often be critical in developing an appropriate plan of care.

Response: Office psychiatry services currently approved for telehealth are individual rather than group services. There are no group services approved for telehealth. In order to add services for Medicare telehealth that are not similar to the existing list of Medicare telehealth services, we evaluate comparative studies to assess whether the use of an interactive audio and video telecommunications system is an adequate substitute for the in-person (face-to-face) delivery of the requested service. Requestors did not submit sufficient comparative analyses showing that the use of a telecommunications system is an adequate substitute for group counseling services furnished in person.

b. Nursing Facility Services

Section 149 of the MIPPA added SNFs as telehealth originating sites effective for services furnished on or after January 1, 2009. We received a request from the American Telemedicine Association (ATA) to add subsequent nursing facility care; nursing facility discharge services; and other nursing facility services to the list of approved telehealth services. The Center for Telehealth and e-Health Law submitted a request to add the same nursing facility services and indicated its support of ATA's request. We also received a request from the Marshfield Clinic to add the same services requested by the ATA, plus the initial nursing facility care services.

The procedure codes included in these requests are used to report evaluation and management (E/M) services furnished onsite to patients in SNFs. The requestors drew analogies to the E/M services currently approved for Medicare telehealth, and they provided evidence in support of their belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

As discussed in the CY 2010 PFS proposed rule (74 FR 33543), the long-term care regulations at § 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay. We believe that these Federally-mandated visits should be conducted in-person, and not as Medicare telehealth services. We proposed to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c).

We reviewed the use of telehealth for each of the subcategories of nursing facility services included in these requests. We identified the E/M services that fulfill Federal requirements for personal visits under § 483.40 and we did not propose to add any procedure codes that are used exclusively to describe these Federally-mandated visits.

Initial Nursing Facility Care

The initial nursing facility care procedure codes (as described by HCPCS codes 99304 through 99306) are used to report the initial E/M visit in a SNF or NF that fulfills Federally-mandated requirements under § 483.40(c). We did not propose to add the initial nursing facility care services (as described by HCPCS codes 99304 through 99306) to the list of approved Medicare telehealth services because these procedure codes are used exclusively to describe E/M services that fulfill Federal requirements for personal visits under § 483.40.

Subsequent Nursing Facility Care

The subsequent nursing facility care procedure codes (as described by HCPCS codes 99307 through 99310) are used to report either a Federally-mandated periodic visit under § 483.40(c), or any E/M visit, prior to and after the initial physician visit, that is reasonable and medically necessary to meet the medical needs of the individual resident. In the past, we have not added hospital E/M visits to the list of approved Medicare telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (See 69 FR 47511, 69 FR 66276, 72 FR 38144, 72 FR 66250, 73 FR 38517, and 73 FR 69745.) Many residents of SNFs also require medically complex care, and we have similar concerns about allowing physicians or NPPs to furnish E/M visits via telehealth to residents of SNFs.

The complexity of care required by many residents of SNFs may be significantly greater than the complexity of care generally associated with patients receiving the office visits approved for telehealth. Accordingly, we do not consider E/M visits furnished to residents of SNFs similar to the office visits on the current list of Medicare telehealth services. Therefore, we believe the use of subsequent nursing facility care for medically necessary E/M visits that are in addition to Federally-mandated periodic personal visits must be evaluated as a Category #2 service.

We evaluated whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requestors submitted supporting documentation to demonstrate that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care. However, we did not receive sufficient comparative analysis or other compelling evidence to demonstrate that furnishing E/M visits via telehealth to residents of SNFs is an adequate substitute for the face-to-face encounter between the practitioner and the resident, especially in cases where the resident requires medically complex care. We were also concerned that one study demonstrated that services provided via telehealth do not elicit adequate participation in informed medical decision-making from residents with low to moderate illness when compared to face-to-face encounters. We determined that telehealth is not an adequate substitute for the face-to-face delivery of E/M visits to residents of SNFs. Therefore, we did not propose to

add subsequent nursing facility care services to the list of approved Medicare telehealth services.

Nursing Facility Discharge Day Management

The nursing facility discharge day management codes (as described by HCPCS codes 99315 and 99316) are used to report an E/M visit that prepares a resident for discharge from a nursing facility. We note that there is no Medicare Part B requirement to furnish and bill an E/M visit in preparation for a resident's discharge from a SNF. However, if a physician or qualified NPP bills a Nursing Facility Discharge Services code, we believe that a face-to-face encounter will better insure that the resident is prepared for discharge. We do not have evidence that nursing facility discharge services furnished via telehealth are equivalent to face-to-face provision of this service. We did not propose to add the nursing facility discharge day management services to the list of approved Medicare telehealth services.

Other Nursing Facility Service

In 2006, CPT added a procedure code for Other Nursing Facility Service (CPT code 99318) to describe an annual nursing facility assessment. An annual assessment is not one of the required visits under the long-term care regulations at § 483.40. For Medicare purposes, this code can be used in lieu of a Subsequent Nursing Facility Care code to report a Federally-mandated periodic personal visit furnished under § 483.40(c). An annual assessment visit billed using CPT code 99318 does not represent a distinct benefit service for Medicare Part B physician services, and it cannot be billed in addition to the required number of Federally-mandated periodic personal visits. Under Medicare Part B, we cover this procedure code if the visit fully meets the CPT code 99318 requirements for an annual nursing facility assessment. In order to cover and pay for this service, we also require that this annual assessment falls on the 60-day mandated visit cycle. We did not propose to add the other nursing facility care services described by this code to the list of approved Medicare telehealth services because this code is payable by Medicare only if the visit is substituted for a Federally-mandated visit under § 483.40(c). We believe all of the Federally-mandated periodic visits must be conducted in person.

Follow-up Inpatient Consultations

Prior to 2006, follow-up inpatient consultations (as described by CPT codes 99261 through 99263) were approved telehealth services. In 2006, the CPT Editorial Panel of the American Medical Association (AMA) deleted the codes for follow-up inpatient consultations. In the hospital setting, the AMA advised practitioners to bill for services that would previously have been billed as follow-up inpatient consultations using the procedure codes for subsequent hospital care (as described by CPT codes 99231 through 99233). In the nursing facility setting, the AMA advised practitioners to bill for these services using the procedure codes for subsequent nursing facility care (as described by CPT codes 99307 through 99310).

In the CY 2009 PFS final rule with comment period (73 FR 69745), we created follow-up inpatient telehealth consultation codes (as described by HCPCS codes G0406 through G0408) to furnish care to hospital inpatients, and we added these G-codes to the list of Medicare telehealth services. These HCPCS codes are limited to the range of services included in the scope of the previous CPT codes for follow-up inpatient consultations, and the descriptions limit the use of such services for telehealth.

In the CY 2010 PFS proposed rule (74 FR 33547), we stated that if the former codes for follow-up consultations (as described by CPT codes 99261 through 99263) still existed, these procedure codes would also be available to practitioners providing follow-up consultations via telehealth to SNF patients. Although we did not receive a public request to add follow-up inpatient consultations for SNF patients to the list of approved Medicare telehealth services, we stated that we also recognized a need to establish a method for practitioners to provide these services. For CY 2010, we proposed to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up inpatient telehealth consultations furnished to beneficiaries in SNFs, as well as in hospitals. The HCPCS codes clearly designate these services as follow-up consultations provided via telehealth, and not as subsequent care used for E/M visits. Utilization of these codes for patients in SNFs will facilitate payment for these services, as well as enable us to monitor whether the codes are used appropriately. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190, for the definition of follow-up inpatient telehealth consultations.)

The following is a summary of the comments we received regarding our proposed decisions on Nursing Facility Services.

Comment: Commenters supported our proposal to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c). Commenters also supported our proposal to expand the definition of Follow-Up Inpatient Telehealth Consultations (as described by HCPCS codes G0406–G0408) to allow their use for residents of SNFs. Commenters noted that this change would be a positive step towards increasing access to care for Medicare beneficiaries in rural areas.

Some commenters disagreed with our proposal not to add Nursing Facility Services to the list of approved Medicare telehealth services. Commenters acknowledged Congressional intent expressed in section 413 of the MMA that the use of telehealth should not be a substitute for the Federally-mandated periodic personal visits required under § 483.40(c). All commenters agreed with our proposal not to add any procedure codes that are used exclusively to describe these Federally-mandated visits. Commenters stated that they believed that the Congress intended to allow the use of telehealth to furnish E/M medically necessary visits onsite to residents of SNFs that are in addition to Federally-mandated periodic personal visits. Some commenters also noted that due to health professional shortages in rural areas, many SNFs lack essential onsite services. Some commenters believe adding nursing facility visits to the list of approved telehealth services will improve the quality of care furnished to residents of SNFs. Commenters also noted that not adding nursing facility visits to the list of approved Medicare telehealth services will not prevent the use of telehealth to furnish services to residents of SNFs, including those residents requiring medically complex care. These same residents could be transported to physicians' offices or hospitals where they could receive similar E/M visits via telehealth.

Response: We did not receive sufficient comparative analysis or other compelling evidence to demonstrate that furnishing E/M visits via telehealth to residents of SNFs is an adequate substitute for the face-to-face encounter between the practitioner and the resident, especially in cases where the resident requires medically complex care. We are further concerned that the use of telehealth may not elicit adequate participation from residents of SNFs in

making informed medical decisions with their clinicians when compared to face-to-face encounters.

We agree with the commenters who noted that expanding the definition of Follow-Up Inpatient Telehealth Consultations (G0406–G0408) to allow their use for residents of SNFs will increase access to care for Medicare beneficiaries in rural areas. We believe the availability of inpatient consultations to furnish care via telehealth to residents of SNFs is consistent with the addition of SNFs as approved telehealth originating sites. Physicians and NPPs who furnish inpatient consultations via telehealth complement the care provided by the SNF and furnished onsite by the attending physician or physician of record.

c. Critical Care Services

In the CY 2009 PFS final rule with comment period (73 FR 69744), we did not add critical care services to the list of approved Medicare telehealth services. In 2009, Philips Healthcare submitted an expanded request to add critical care services to the list of approved Medicare telehealth services. It stated that critical care services can be approved as a Category #1 service based on their similarity to the inpatient consultation services currently approved for Medicare telehealth. The requestor also stated that many of the components of critical care are similar to a high-level inpatient consultation service, which is currently approved for Medicare telehealth. Common components include obtaining a patient history, conducting an examination, and engaging in complex medical decision-making for patients who may be severely ill. Because we classified critical care as a Category #2 service last year, the requestor also submitted evidence to support its belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

In the CY 2010 PFS proposed rule (74 FR 33548), we stated that remote critical care services are different than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). We did not propose adding critical care services (as described by HCPCS codes 99291 and 99292) to the list of approved Medicare telehealth services. We reiterated that our decision not to add critical care services to the list of approved telehealth services does not preclude physicians from furnishing telehealth consultations to critically ill patients.

Comment: A commenter disagreed with our proposal not to add critical care services to the list of approved Medicare telehealth services. The commenter submitted a new study to support its belief that these services are comparable to critical care furnished in-person. The commenter asserted that the role of the intensivist, whether in-person or remotely, is to provide the required expertise and ability to direct onsite clinical staff to perform any necessary hands-on intervention, not necessarily to effectuate them personally. To support this, the commenter submitted a vignette describing critical care services, including an analysis detailing the types of services furnished when critical care (as described by HCPCS codes 99291 and 99292) was billed by a sample of intensivists. The commenter noted that the critical care services included in this sample did not require hands-on intervention.

Another commenter who submitted the CY 2009 request submitted descriptions of telestroke technology to support the assertion that the elements of a stroke-related neurological assessment performed by a neurologist are effectively the same whether furnished in-person or via telehealth. The commenter acknowledges that some telestroke services satisfy the criteria for billing consultations via telehealth, but noted that the payment is less than the same neurological assessment furnished in-person and billed as a critical care service. The commenter requested that we consider adding critical care services to the list of approved Medicare telehealth services when the underlying diagnosis is stroke-related.

Response: We continue to believe that remote critical care services are different from the telehealth delivery of critical care services (as described by HCPCS codes 99291 and 99292). The AMA created remote critical care tracking codes. Such codes track utilization of a service, facilitating data collection on, and assessment of, new services and procedures. We believe that the data collected for these tracking codes will help provide useful information on how to best categorize and value remote critical care services in the future.

We did not find the studies submitted during the comment period persuasive that telehealth can be an adequate substitute for the face-to-face delivery of critical care services (as described by HCPCS codes 99291 and 99292). As described in these studies, the role of the physician furnishing remote critical care services includes monitoring patients and directing on-site staff to intervene, as necessary. Within the current standards of practice, we believe that critical care services (as described by HCPCS codes 99291 and 99292) require the physical presence of a physician who is available to furnish any hands-on intervention. We continue to believe that remote critical care services are different services than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). As noted above, we believe that the data collected for the remote critical care tracking codes will help provide useful information on how to best categorize and value remote critical care services in the future.

d. Other Requests

We received a number of requests to add services that we reviewed and did not accept in previous PFS Rules. The following are brief summaries of our discussions from the proposed rule, summaries of comments received, and our responses.

Initial and Subsequent Hospital Care

We received a request to add initial hospital care (as described by HCPCS codes 99221 through 99223) and subsequent hospital care (as described by HCPCS codes 99231 through 99233) to the list of approved Medicare telehealth services. In response to previous requests, we did not add initial or subsequent hospital care to the list of approved telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (See 69 FR 47510 and 66276, 72 FR 38144 and 66250, and 73 FR 38517 and 69745.) We did not receive any new information with this request that would alter our previous decision. Therefore, we did not propose adding initial hospital care or subsequent hospital care to the list of approved Medicare telehealth services. We did not receive any comments on this proposal.

Group Medical Nutrition Therapy Services

We received a request to add group medical nutrition therapy (MNT) services (as described by HCPCS codes G0271 and 97804) to the list of approved Medicare telehealth services. In response to a previous request, we did not add group MNT to the list of approved telehealth services because we believe that group services are not appropriately delivered through telehealth. (See 70 FR 45787 and 70157.) We did not receive any new information with this request that would alter our previous decision. Therefore, we did not propose adding group MNT to the list of approved Medicare telehealth services. We did

not receive any comments on this proposal.

Diabetes Self-Management Training (DSMT)

We received a request to add diabetes self-management training (DSMT) (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services. In response to previous requests, we did not add DSMT to the list of approved telehealth services because of the statutory requirement that DSMT include teaching beneficiaries to self-administer injectable drugs. Furthermore, DSMT is often performed in group settings and we believe that group services are not appropriately delivered through telehealth. (See 70 FR 45787 and 70157, and 73 FR 38516 and 69743.) We did not receive any new information with this request that would alter our previous decision. Therefore, we did not propose to add DSMT to the list of approved Medicare telehealth services.

Comment: We received two comments opposing our proposal not to add DSMT to the list of approved Medicare telehealth services. The American Association of Diabetes Educators (AADE) agrees that telehealth is not an appropriate venue for initial DSMT when it includes teaching beneficiaries to self-administer injectable drugs. One commenter submitted studies to support its belief that the use of a telecommunications system was equivalent to the face-to-face delivery of follow-up DSMT.

Response: We believe that skill-based training, such as teaching patients how to inject insulin, would be difficult to accomplish effectively without the physical presence of the teaching practitioner. We disagree that this training element should be carved out of individual DSMT for purposes of providing Medicare telehealth services. The training involved in teaching beneficiaries the skills necessary for the self-administration of injectable drugs is a key component of this statutorily described benefit (and therefore inherent in the codes that describe DSMT). We continue to believe that it would not be appropriate to add individual follow-up DSMT to the list of approved Medicare telehealth services.

Speech and Language Pathology Services

We received a request to add various speech and language pathology services to the list of approved telehealth services. Speech-language pathologists are not permitted under current law to furnish and receive payment for Medicare telehealth services. Therefore, we did not propose to add any speech and language pathology services to the list of approved Medicare telehealth services. (For further discussion, see 69 FR 47512 and 66276, and 71 FR 48995 and 69657.)

Comment: The American Speech-Language Hearing Association (ASHA) commented that telehealth has been successfully applied to speech-language pathology and audiology services. ASHA requested that CMS support expansion of Medicare telehealth coverage for speech-language pathologists in communications with Congress. The American Academy of Audiology commented on the shortage of audiologists in rural areas. The group requested that we use our administrative authority to add audiology services to the list of approved Medicare telehealth services.

Response: It is not within our administrative authority to pay speech-language pathologists and audiologists for services furnished via telehealth. The statute authorizes the Secretary to pay only for telehealth services furnished by a physician or a practitioner as those terms are defined in the statute.

Physical and Occupational Therapy Services

We received a request to add various physical and occupational therapy services to the list of approved Medicare telehealth services. The statute does not authorize Medicare payment to physical and occupational therapists for Medicare telehealth services. Therefore, we did not propose to add any physical and occupational therapy services to the list of approved Medicare telehealth services. (For further discussion, see 71 FR 48995 and 69657.)

e. Summary: Result of Evaluation of 2010 Requests

We will finalize our proposal to add the individual HBAI services (as described by HCPCS codes 96150 through 96152) and not to add group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154) to the list of approved Medicare telehealth services. We will also finalize our proposal to add individual HBAI services to the list of approved Medicare telehealth services at § 410.78 and § 414.65.

We will finalize our proposal to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c). We will finalize our proposal not to add Nursing Facility Services (as described by HCPCS codes 99304 through 99318) to the list of approved Medicare telehealth services. We will also finalize our proposal to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HPCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs.

We will finalize our proposals not to add critical care services (as described by HCPCS codes 99291 and 99292) or any of the other requested services to the list of approved Medicare telehealth services.

3. Other Issues

We received other comments on matters related to Medicare telehealth services that were not the subject of proposals in the CY 2010 PFS proposed rule. We thank the commenters for sharing their views and suggestions. Because we did not make any proposals regarding these matters, we do not generally summarize or respond to such comments in this final rule. However, we have chosen to summarize and respond to the following comments in order to furnish more information.

Comment: The American Society of Nephrology requested clarification on whether Medicare would pay for kidney disease patient education furnished via telehealth. Other commenters specifically requested that we add kidney disease patient education services to the list of approved telehealth services.

Response: Kidney disease patient education services are not approved Medicare telehealth services. Any interested parties may submit requests to add services to the list of Medicare telehealth services. Requests submitted before the end of CY 2009 will be considered for the CY 2011 PFS proposed rule. Requestors should be advised that each request to add a service to the list of Medicare telehealth services must include any supporting documentation the requestor wishes us to consider as we review the request. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to directly mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth*.

Comment: We received a few comments that questioned our criteria and process for reviewing requests to add to the list of approved Medicare telehealth services. The commenters stated that our standards interfere with appropriate physician medical judgment under section 1801 of the Act. One commenter noted that since the

standards are not specified in regulation text, we can change them without formal rulemaking.

Response: Our established criteria and process for reviewing requests to add to the list of approved Medicare telehealth services were subject to full notice and comment procedures in the CY 2003 PFS proposed and final rules. Since we did not make any proposals relating to the criteria or process, any potential revisions to the process for adding or deleting services from the list of approved Medicare telehealth services are outside the scope of this final rule.

Comment: We received a request to provide a list of physician services that can be furnished without an in-person examination.

Response: General guidance regarding physician services that can be furnished by visualizing some aspect of the patient's condition without an in-person examination is provided in the CMS Internet-Only Medicare Benefits Policy Manual, Pub. 100–02, Chapter 15, § 30.

E. Specific Coding Issues Related to the Physician Fee Schedule

1. Canalith Repositioning

In 2008, the CPT Editorial Panel created a new code for canalith repositioning (CRP). This procedure is a treatment for vertigo which involves therapeutic maneuvering of the patient's body and head in order to use the force of gravity to redeposit the calcium crystal debris in the semicircular canal system.

In the CY 2009 PFS final rule with comment period (73 FR 69896), new CPT code 95992, *Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day*, was assigned the bundled status indicator (B). We explained that this procedure previously was billed as part of an evaluation and management (E/M) service or under a number of CPT codes, including CPT code 97112, *Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.* We also explained that because neurologists and therapists are the predominant providers of this service to Medicare patients (each at 22 percent), it was assigned as a ''sometimes therapy'' service under the therapy code abstract file.

After publication of the CY 2009 PFS final rule with comment period, we received comments on this issue from an organization representing physical therapists, as well as others expressing opposition to our decision to bundle the new code. Commenters stated that they believe that our decision to bundle CPT code 95992 was flawed since physical therapists are unable to bill E/M services. One commenter also stated that therapists would be precluded from using another code for billing for this service because CPT correct coding instructions require that the provider/supplier select the procedure that most accurately defines the service provided.

Based upon the commenters' feedback, we realized that we had failed to address how therapists would bill for the service since they cannot bill E/M services. In order to address this situation so that access to this service would not be impacted we released a MedLearn article informing PTs to continue using one of the more generally defined ''always therapy'' CPT codes (97112) as a temporary measure. See *http://www.cms.hhs.gov/transmittals/downloads/R1691CP.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6397.pdf*.

In response to the concerns raised and upon additional review of this issue in the CY 2010 PFS proposed rule, we proposed to change the status indicator for this code from B (Bundled) to I (Not valid for Medicare purposes). We proposed that physicians would continue to be paid for CRP as a part of an E/M service. Physical therapists would continue to use one of the more generally defined ''always therapy'' CPT codes (97112). We stated that we believe that this will enable beneficiaries to continue to receive this service while at the same time it will address our concerns about the potential for duplicate billing for this service to the extent that this service is paid as a part of an E/M service. As a result of this proposal, CPT code 95992 would be removed as a ''sometimes'' therapy code from the therapy code list.

The following is a summary of the comments we received regarding the canalith repositioning proposal.

Comment: Some commenters stated that the canalith repositioning treatment requires 20 minutes of intraservice time as valued by the AMA RUC and that the pre-time was specifically removed because the service is typically performed with an E/M code. The commenters also stated that they believe we expected physicians to forgo payment for CRP and asked that we pay it separately from an E/M service. The commenters requested that CMS recognize the service as separate and distinct from an E/M service.

Response: As we stated in the CY PFS final rule (73 FR 69896) canalith repositioning has been billed using E/M codes and therapy service codes in the past and we believe it should continue to be billed this way. Physicians will continue to be paid for the work performed when CRP is billed using E/M codes.

Comment: Some commenters opposed designating CPT code 95992 as not valid for Medicare purposes. The commenters stated that the code was developed to describe and value CRP and that it should be utilized. Another commenter stated that it is not consistent with CPT coding principles to direct therapists to use a less specific code.

Response: As stated in the CY 2010 PFS proposed rule we initially decided to bundle this code, but upon further review proposed to change the status indicator to ''I'' (not valid for Medicare purposes). Physicians will continue to be paid for CRP as part of an E/M service. Physical therapists will continue to use an ''always therapy'' CPT code as they have in the past. The code will be removed from the ''sometimes'' therapy list. This change will address our concerns about the potential for duplicate billing of this service while still allowing physicians and therapists to perform the service.

Comment: Some commenters are concerned that audiologists have no way to bill for CRP. They requested that CMS reconsider allowing payment to audiologists for this treatment.

Response: Audiological tests are covered under the benefit category for other diagnostic tests. There is no statutory authority to allow audiologists to bill Medicare for treatment services, such as CRP. CRP may be covered under the benefit category for physician services or physical therapy services. If covered as a physician service, it may be furnished incident to a physician's service by any qualified staff.

We will finalize our proposal to designate CPT code 95992 as ''I'', not valid for Medicare purposes. We will also remove it from the ''sometimes'' therapy code list in order to allow therapists to bill appropriately for the service, using one of the more generally defined ''always therapy'' codes.

2. Payment for an Initial Preventive Physical Examination (IPPE)

In the CY 2010 PFS proposed rule, we proposed to increase the payment for an initial preventive physical examination (IPPE) furnished face-to-face with the patient and billed with HCPCS code G0402, *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment* beginning January 1, 2010. The IPPE service includes a broad array of

components and focuses on primary care, health promotion, and disease prevention.

Section 101(b) of the MIPPA changed the IPPE benefit by adding to the IPPE visit the measurement of an individual's body mass index and, upon an individual's consent, end-of-life planning. Section 101(b) of the MIPPA also removed the screening electrocardiogram (EKG) as a mandatory service of the IPPE.

In order to implement this MIPPA provision, in the CY 2009 PFS final rule with comment period (73 FR 69870), we created HCPCS code G0402 as a new HCPCS code and retained, on an interim basis, the work RVUs of 1.34 assigned to HCPCS code G0344, the code that was previously used to bill for the IPPE. While we did not believe the revisions to the IPPE required by MIPPA impacted the work RVUs associated with this service, we solicited public comments on this issue, as well as suggested valuations of this service to reflect resources involved in furnishing the service. (For a summary of the comments received on the CY 2009 PFS final rule with comment period, see the CY 2010 PFS proposed rule (74 FR 33549)).

Based on a review of the comments received on the CY 2009 PFS final rule with comment period and upon further evaluation of the component services of the IPPE, we stated in the CY 2010 PFS proposed rule that we believe the services, in the context of work and intensity, contained in HCPCS code G0402 are most equivalent to those services contained in CPT code 99204, *Evaluation and management new patient, office or other outpatient visit*, and proposed increasing the work RVUs for HCPCS code G0402 to 2.30 effective for services furnished beginning on January 1, 2010.

The following is a summary of the comments we received regarding the proposed increase to the payment for the IPPE billed with HCPCS code G0402.

Comment: All commenters strongly supported CMS' proposal to increase the payment for the IPPE. Commenters believe that the CY 2010 payment will fairly account for the services rendered.

Response: We are finalizing our proposal to increase the work RVUs for the IPPE to 2.30 effective for services furnished beginning January 1, 2010.

3. Audiology Codes: Policy Clarification of Existing CPT Codes

In the CY 2009 PFS final rule with comment period (73 FR 69890), we noted that the AMA RUC reviewed and recommended work RVUs for 6 audiology codes with which we agreed (that is, CPT codes 92620, 92621, 92625, 92626, 92627, and 92640). We also noted that in the Medicare program, audiology services are covered under the diagnostic test benefit and that some of the work descriptors for these services include ''counseling,'' ''potential for remediation,'' and ''establishment of interventional goals.''

Since audiology services fall under the diagnostic test benefit, aspects of services that are therapeutic or management activities are not payable to audiologists. This distinction is of particular importance since CPT codes 92620, 92621, 92626, 92627, and 92640 are ''timed'' codes. These codes are billed based on the actual time spent furnishing the service.

We noted that we do not believe these aspects fit within the diagnostic test benefit. We solicited comments on this issue. For a summary of the comments received and our responses to those comments, see the CY 2010 PFS proposed rule (74 FR 33550).

The following is summary of the comments we received regarding the policy clarification of existing CPT codes for audiology services.

Comment: We received additional comments reiterating the comments to which we had responded previously in the proposed rule that ''counseling,'' ''potential for remediation,'' and ''establishment of interventional goals'' were part of the diagnostic test and were not therapeutic or management activities. Other commenters agreed with the clarification as it was presented in the proposed rule.

Response: After a careful consideration of all the comments, we are finalizing the clarification of audiology services with respect to CPT codes 92620, 92621, 92625, 92626, 92627, 92640, and other audiologist services as discussed in the proposed rule. Although we understand that test results are sometimes appropriately and briefly conveyed to the patient at the time of the diagnostic test, any therapeutic activities or activities that should be billed as E/M services associated with these audiology codes are not payable to audiologists because they do not fall within the benefit category under which these tests are covered.

4. Consultation Services

a. Background

The current physician visit and consultation codes were developed by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel in November 1990. A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified NPP at the request of another physician or appropriate source. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 A for more information.) A consultation service must be documented and a written report given to the requesting professional. Currently, consultation services are predominantly billed by specialty physicians. Primary care physicians infrequently furnish these services.

The required documentation supports the accuracy and medical necessity of a consultation service that is requested and provided. Medicare pays for a consultation service when the request and report are documented as a consultation service, regardless of whether treatment is initiated during the consultation evaluation service. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 B.) A consultation request between professionals may be done orally by telephone, face-to-face, or by written prescription brought from one professional to another by the patient. The request must be documented in the medical record.

In the Physician Fee Schedule Final Rule issued June 5, 1991, (56 FR 25828) we stated that the agency's goal for the development of the new visit and consultation codes was that they meet two criteria: (1) They should be used reliably and consistently by all physicians and carriers; that is, the same service should be coded the same way by different physicians; and (2) they should be defined in a way that enables us to properly crosswalk the new codes to the relative values for the Harvard vignettes so valid RVUs for work are assigned to the new codes.

Based on requests from the physician community to clarify our consultation payment policy and to provide consultation examples, we convened an internal workgroup of medical officers within CMS (then called the Health Care Financing Administration, or HCFA) and revised the payment policy instructions in August 1999 in the Medicare Claims Processing Manual (at § 30.6.10 as cited above). We provided examples of consultation services and examples of clinical scenarios that did not satisfy Medicare criteria for consultation services. Without explicit instructions for every possible clinical scenario outlined in national policy

instructions or in AMA coding definitions or coding instructions, the local policy interpretations by Medicare contractors were not universally equivalent or acceptable to the physician community and resulted in denials in different localities. Some Medicare contractors would consider a consultation service with treatment to be an initial visit rather than a consultation thus resulting in a denial for the billed consultation. We clarified in the 1999 revision that Medicare would pay for a consultation whether treatment was initiated at the consultation visit or not. The physician community has stated that terms such as referral, transfer and consultation, used interchangeably by physicians in clinical settings, confuse the actual meaning of a consultation service and that interpretation of these words varies greatly among members of that community as some label a transfer as a referral and others label a consultation as a referral. Although we clarified the terms referral and consultation in the 1999 revision, there was disagreement with our policy by physicians in the health care community and by AMA CPT staff. We provided our documentation guidance so physicians would be in compliance with our payment policy. The consultation definition in the AMA CPT simply stated that the consultant's opinion or other information must be communicated to the requesting physician.

Additional manual revisions in both January and September 2001 (at § 30.6.10 as cited above) clarified that NPPs can both request and furnish consultation services within their scope of practice and licensure requirements. We continued to explain our documentation requirements to the physician community through our Medicare contractors and in our discussions with the AMA CPT staff. Under our current policy and in the AMA CPT definition, a consultation service must have a request from another physician or other professional and be followed by a report to the requesting professional. The AMA CPT definition does not state that the request must be written in the requesting physician's medical record. However, we require the request to be documented in the requesting physician's plan of care in the medical record as a condition for Medicare payment. The E/M documentation guidelines which apply to all E/M visits or consultations (*http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*) clearly state that when referrals are made, consultations are requested, or advice is sought, the medical record should indicate to whom and where the referral or consultation is made or from whom the advice is requested. Our Medicare contractors are responsible for reviewing and paying consultation claims when submitted. When there is a question that triggers a review of a consultation service, our Medicare contractors will look at both the requesting physician's medical record (where the request should be noted) and the consultant's medical record where the consultation is reported and at the report generated for the requesting physician. Medicare contractors do not look for evidence of documentation on every claim, only when there is a concern raised during random sampling or during a specific audit performed by a contractor. The AMA CPT coding manual, which is not a payment manual, does not specify these requirements, and, therefore, as we understand it, many physicians do not agree with the CMS policy.

In March 2006, the Office of the Inspector General (OIG) published a report entitled, ''Consultations in Medicare: Coding and Reimbursement'' (OEI–09–02–00030). The stated purpose of the report was to assess whether Medicare's payments for consultation services were appropriate. While the OIG study was being conducted, we continued our ongoing discussions with the AMA CPT staff for potential changes to the consultation definition and guidance in CPT. The findings in the OIG report (based on claims paid by Medicare in 2001) indicated that Medicare allowed approximately $1.1 billion more in 2001 than it should have for services that were billed as consultations. Approximately 75 percent of services paid as consultations did not meet all applicable program requirements (per the Medicare instructions) resulting in improper payments. The majority of these errors (47 percent of the claims reviewed) were billed as the wrong type or level of consultation. The second most frequent error was for services that did not meet the definition of a consultation (19 percent of the claims reviewed). The third category of improperly paid claims was a lack of appropriate documentation (9 percent of the claims reviewed). The OIG recommended that CMS, through our Medicare contractors, should educate physicians and other health care practitioners about Medicare criteria and proper billing for all types and levels of consultations with emphasis on the highest levels and follow-up inpatient consultation services.

We agreed with the OIG findings that additional education would help physicians understand the differences in the requirements for a consultation service from those for other E/M services. With each additional revision from 1999 until the OIG study began, we continually educated physicians through the guidance provided by our Medicare contractors. However, there remained discrepancies with unclear and ambiguous terms and instructions in the AMA CPT definition of a consultation, transfer of care and documentation, and the feedback from the physician community that indicated they disagreed with Medicare guidance.

Prior to the official publication of the OIG report, we issued a Medlearn Matters article, effective January 2006, to educate the physician community about requirements and proper billing for all types and levels of consultation services as requested by the OIG in their report. The Medlearn Matters article reflected the manual changes we made in 2006 and the AMA CPT coding changes as noted below. (This article and related documents can be accessed at *http://www.cms.hhs.gov/MLNMattersArticles/2005MMA/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=7&sortOrder=ascending&itemID=CMS053630&intNumPerPage=2000*.)

Our consultation policy revisions continued as a work-in-progress over several years as disagreements were raised by the physician community. We continued to work with AMA CPT coding staff in an attempt to have improved guidance for consultation services in the CPT coding definition. In looking at physician claims data (for example, the low usage of confirmatory consultation services) and in response to concerns from the physician community regarding how to correctly use the follow-up consultation codes, the AMA CPT Editorial Panel chose to delete some of the consultation codes for 2006. The Follow-Up Inpatient Consultation codes (CPT codes 99261 through 99263) and the Confirmatory Consultation codes (CPT codes 99271 through 99275) were deleted. During our ongoing discussions, the AMA CPT staff maintained that physicians did not fully understand the use of these codes and historically submitted them inappropriately for payment as was reflected in the OIG study.

We issued a manual revision in the Medicare Claims Processing Manual (at § 30.6.10 as cited above) simultaneously with the publication of AMA CPT 2006

coding changes removing the follow-up consultation codes, and instructed physicians to use the existing subsequent hospital care code(s) and subsequent nursing facility care codes for visits following a consultation service. The confirmatory consultation codes (which were typically used for second opinions) were also removed and we instructed physicians to use the existing E/M codes for a second opinion service. We further clarified the documentation requirements by making it easier to document a request for a consultation service from another physician and to submit a consultation report to the requesting professional. Again, physicians stated that a consultant has no control over what a requesting or referring physician writes in a medical record, and that they should not be penalized for the behavior of others. However, our consultation policy instructions apply to all physicians, whether they request a consultation or furnish a consultation. As noted above, documentation by both the requesting physician and the physician who furnishes the consultation is required under the E/M documentation guidelines. The E/M documentation guidelines have been in use since 1995. In our discussions with the AMA CPT staff and physician groups, and national physician open door conference calls, we have emphasized that the requesting physician medical record is not reviewed unless there is a specific audit or random sampling performed. The physician furnishing the consultation service should document in the medical record from whom a request is received.

We continue to hear from the AMA and from specific national physician specialty representatives that physicians are dissatisfied with Medicare documentation requirements and guidance that distinguish a consultation service from other E/M services such as transfer of care. CPT has not clarified transfer of care. Many physician groups disagree with our requirements for documentation of transfer of care. Interpretation differs from one physician to another as to whether transfer of care should be reported as an initial E/M service or as a consultation service.

Despite our efforts, the physician community disagrees with Medicare interpretation and guidance for documentation of transfer of care and consultation. The existing consultation coding definition in the AMA CPT definition has been ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care. The CPT consultation codes are used by physicians and qualified NPPs to identify their services for Medicare payment. There has been an absence of any guidance in the AMA CPT consultation coding definition that distinguishes a transfer of care service (when a new patient visit is billed) from a consultation service (when a consultation service is billed). Although Medicare has provided guidance, there has continued to be disagreement with our policy from AMA CPT staff and some members of the physician community. Because of the disparity between AMA coding guidance and Medicare policy, some physicians have stated that they have difficulty in choosing the appropriate code to bill. The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient. The payment for a consultation service has been set higher than for initial visits because a written report must be made to the requesting professional. However, all medically necessary Medicare services require documentation in some form in a patient's medical record. Over the past several years, some physicians have asked CMS to recognize the provision of the consultation report via a different form of communication in lieu of a written letter report to the requesting physician so as to lessen any paperwork burden on physicians. We have eased the consultation reporting requirements by lessening the required level of formality and permitting the report to be made in any written form of communication, (including submission of a copy of the evaluation examination taken directly from the medical record and submitted without a letter format) as long as the identity of the physician who furnished the consultation is evident. Although preparation and submission of the consultant's report is no longer the major defining aspect of consultation services, the higher payment has remained. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 F.)

Both AMA CPT coding rules and Medicare Part B payment policy have always required that there is only one admitting physician of record for a particular patient in the hospital or nursing facility setting. (AMA CPT 2009, Hospital Inpatient Services, Initial Hospital Care, p.12) This physician has been the only one permitted to bill the initial hospital care codes or initial nursing facility codes. All other physicians must bill either the subsequent hospital care codes, subsequent nursing facility care codes or consultation codes. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.9.1 G.)

Beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, we instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. Regardless of all of our efforts to educate physicians on Medicare guidance for documentation, transfer of care, and consultation policy, disagreement in the physician community prevails.

b. Summary of CY 2010 Proposal

In the CY 2010 PFS proposed rule (74 FR 33551), we proposed, beginning January 1, 2010, to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.

We noted that section 1834(m) of the Act includes ''professional consultations'' (including the initial inpatient consultation codes ''as subsequently modified by the Secretary'') in the definition of telehealth services. We recognize that consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site. Therefore, for CY 2010, we proposed to create HCPCS codes specific to the telehealth delivery of initial inpatient consultations. The purpose of these codes would be solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners would use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via

telehealth. The proposed HCPCS codes would be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions would be modified to limit the use of such services for telehealth. The HCPCS codes would clearly designate these as initial inpatient consultations provided via telehealth, and not initial hospital care or initial nursing facility care used for inpatient visits. Utilization of these codes would allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately.

We also stated that, if we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, then we would crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). We believed this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care codes.

We considered creating separate G-codes to enable practitioners to bill initial inpatient telehealth consultations when furnished to residents of SNFs and crosswalking the RVUs to initial nursing facility care (as described by CPT codes 99304 through 99306). For the sake of administrative simplicity, if we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, they will be defined in § 410.78 and in our manuals as appropriate for use to deliver care to beneficiaries in hospitals or skilled nursing facilities.

We stated in the CY 2010 PFS proposed rule that if we adopt this proposal, we would then make corresponding changes to our regulations at § 410.78 and § 414.65. In addition, we would add the definition of these codes to the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in § 483.40(c)(4). In the nursing facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. (See this exception in the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.13 A). An NPP, who is enrolled in the Medicare program, is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy.

Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

We believe that the rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. To be consistent with OPPS policy, as noted above, we will pay only new and established office or other clinic visits under the PFS.

We proposed that this change would be implemented in a budget neutral manner, meaning it would not increase or decrease PFS expenditures. We proposed to make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the facility consultation codes. We crosswalked the utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits. We proposed that this change would be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization.

We solicited comments on the proposal to eliminate payment for all consultation services codes under the PFS and to allow all physicians to bill, in lieu of a consultation service code, an initial hospital care visit or initial nursing facility care visit for their first visit during a patient's admission to the hospital or nursing facility. Additionally, we solicited comments on the proposal to create HCPCS G-codes to identify the telehealth delivery of initial inpatient consultations.

We received many comments on our proposal. MedPAC also commented on our proposal. The following is a summary of the comments we received regarding the discussion of the proposed changes to consultation services and our responses.

Comment: One commenter noted that ''there may be both advantages and disadvantages to this proposal,'' but urged that we refrain from finalizing it for January 1, 2010. The commenter expressed concerns about whether there would be sufficient time to educate physicians who currently employ the consultation codes in order to avoid ''a flood of claim denials and appeals.'' Other commenters raised similar concerns about whether there would be adequate time to educate physicians and billing personnel about the change and to assess the effects of the proposal.

Response: We agree that adoption of this proposal would call for appropriate measures to educate physicians and billing personnel about the change. However, we do not believe that the requisite educational efforts are extensive and complex enough as to warrant delaying implementation of the proposal. Essentially, the proposal would require physicians to cease submitting the consultation codes on their Medicare claims, and to employ the appropriate visit codes in their place. The determination of the appropriate visit code would be made solely on the basis of the existing rules and guidelines for the use of these codes, without any reference to the guidelines that have been employed for the use of the consultation codes. The guidelines for use of the visit codes are well established and well known and used by nearly all physicians. It is not necessary to develop any complicated coding crosswalk or guidelines for translating the consultation code

requirements for purposes of applying the visit codes. The major effects of the provision may actually simplify coding because physicians will use the office and hospital visit codes in place of consultations and will not have to determine whether the requirements to bill a consult are met. For these reasons, we believe the proposal should be implemented beginning January 1, 2010.

Comment: Some commenters urged delay or deferral of the proposal in order to allow time to determine whether the new CPT definition of ''transfer of care'' that goes into effect for 2010 would address concerns about the use of consultation codes. Other commenters stated more generally that the proposed change is not the appropriate way to resolve the confusion about using consultation codes versus patient visits.

Response: As we discussed in presenting our proposal, the confusion and disagreement about the proper use of the consultation codes have persisted for a long time. We discussed in detail our efforts over a period of years to clarify the guidelines and to resolve the persistent disagreements. As a result of this experience, we are skeptical that any further changes in guidelines or definitions would resolve these issues. We appreciate the efforts by the CPT committee to develop a new definition of transfer of care. However, we do not believe that this new definition will clarify all the ambiguities and resolve all the differences about the appropriate use of these codes.

As we stated when we implemented the PFS in 1992, one of our goals for the development of new visit and consultation codes was that they should be used reliably and consistently by all physicians and carriers, that is, that the same service should be coded the same way by different physicians. In addition, as we discussed in the CY 2010 PFS proposed rule, we believe that the confusion and disagreement about the use of the consultation codes have produced a situation in which that goal is far from being met.

As we also discussed in the proposed rule, we believe that a good deal of this confusion and disagreement arises from the use of terms such as referral, transfer, and consultation which are used sometimes interchangeably and sometimes inconsistently, by physicians in clinical settings.

The divergent interpretations and uses of these terms have served to confuse the meaning of a consultation service, as some label a transfer as a referral while others label a consultation as a referral. Even with the new definition of ''transfer of care,'' we foresee many clinical situations in which two physicians may not agree as to whether the referral was for consultation or transfer of care, and it may be difficult to resolve the issue based upon the conflicting interpretations reflected in the two physicians' medical records.

Comment: A number of commenters recommended a delay in order to develop alternative approaches on this issue. The commenters recommended that we revise the consultation codes or provide additional payments to physicians who provide thorough consultation reports to referring physicians.

Response: As we discussed in the proposed rule, we have considered numerous approaches to the issues posed by the use of the consultation codes over a period of years, and we have adopted some measures in an attempt to resolve those issues. We believe that, if there any other realistic and reasonable resolution to the issues surrounding the consultation codes, it would have emerged by now during the discussions that we have recounted above. The specific proposal mentioned by the commenter would have us pay more to physicians that provide thorough consultation reports to the referring physicians. However, we previously have tried to resolve the issues surrounding consultations in part by revising the documentation requirements, with the result that the documentation requirements for consultation codes have been reduced to the point where there is no longer a sufficient difference between the requirements for consultations and those for visits to justify a payment differential. The commenter's idea would have us return to increasing documentation requirements to receive higher payment for providing a thorough consultation report. We believe that any attempt to increase documentation requirements again to justify a payment differential will lead to objections from some physicians, and that it would be very difficult or impossible to define the requirements for a ''detailed report'' with sufficient precision to justify the provision of an additional payment.

Comment: Other commenters disagreed with our assessment that there is no substantial difference in work between consultations and visits. The commenters observed that consultations necessarily involve more complex cases that the referring physician is unable to treat. Furthermore, the commenters stated that these services require greater cognitive work and more complex medical decision making. Several commenters emphasized that consultation services required greater knowledge and expertise, acquired through additional training and experience, than is required for initial hospital and office visits. The preparation of a written report to the referring physician also requires additional time, regardless of the format in which the report is provided. One commenter expressed disagreement with our statement that ''the higher work value for consultations is entirely related to the provision of a written report to the requesting physicians.'' However, other commenters agreed with our assessment that there is no substantial difference in work between consultations and visits.

Response: To some degree, greater complexity and cognitive effort may be relative to the training and specialization of the physician. A case that presents clinical complexity and complex medical decision-making for one physician may be relatively simple and straightforward to another physician because of their repeated experience evaluating the same or similar problems. Evaluation and management services, although similar in the types of activities that occur during the encounter, may vary widely in the types of conditions being evaluated. The major difference between the work of a hospital or office visit and a consultation is that the patient has been referred to the consultant to obtain a specialized opinion. However, with the requirements lessened upon the consultant, the actual work done during the encounter with a patient for a consultation or an office or hospital visit has become harder to distinguish in terms of clinical complexity and medical decisionmaking. Further, many physicians contend that a new patient office visit may actually require more work than a consultation service because of the post work involvement with a new patient. As we discussed in the proposed rule, the documentation requirements for consultation services have been reduced to the point where it is difficult to justify a payment differential between consultations and new visits. Therefore, for these reasons, we support the view of those commenters who contend that in most cases, there is no substantial difference in work between consultations and visits.

Comment: Several commenters objected to the proposal on the grounds that it constitutes an unprecedented elimination of a set of CPT codes widely used by large numbers of physicians. Some commenters also stated that the proposal circumvents the CPT and AMA RUC processes.

Response: We do not agree that discontinuing the use of these codes for Medicare purposes is unprecedented. On the contrary, our proposal follows existing program precedent. As we noted in the proposed rule, beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, we instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. We also do not believe that we have in any way circumvented the existing CPT and AMA RUC processes. We described in the CY 2010 PFS proposed rule the numerous attempts that we have made to resolve the relevant issues with AMA CPT staff. Despite all of our efforts to devise and implement relevant guidance, and educate physicians regarding documentation, transfer of care, and consultation policy, there is still substantial disagreement and inconsistency within the physician community regarding these issues.

Comment: Some commenters stated that the overall payment decreases that various specialists would face as a result of the proposed change are unwarranted.

Response: In making the proposal to eliminate use of the consultation codes under the PFS, it has not been our intention to increase or to decrease overall payments for any group or groups of physicians. Rather, our intent has been to provide for correct and consistent coding for services provided by physicians, as well as to provide for appropriate payment for the specific services that have been billed using the consultation codes, specifically, as well as the evaluation and management codes. It is in the nature of any budget neutral payment system for changes such as this to have a somewhat differential impact on various groups of providers and/or practitioners. In this particular case, we do not believe that these impacts are disproportionate to the goals we have sought to achieve in making and finalizing this proposal. It is important to keep in mind that, while elimination of the differential payment for consultation services will have a greater negative impact on some physician specialties than on others, all physicians will benefit from the budget neutral increase in the payment levels for the visit codes.

For more information on the impact of the changes in this rule, see section XIII. of this final rule with comment period.

Comment: Some commenters objected to our failure to increase the bundled payments for post-operative visits occurring over a 10-day or 90-day global period. For example, one major specialty society recommended extending the incremental work RVU increase to the E/M codes that are built into the 10-day and 90-day global codes. ''Arbitrarily changing the work RVUs for some E/M codes without adjusting the E/M components of other procedural codes undermines the relative value scale on which physician payment is based.'' The commenters otherwise supported the proposal, but strongly recommended that the global codes be increased for the sake of consistency. However, some other commenters who supported the proposal urged us to maintain this position in the final rule on the grounds that these services, by their very nature, were never billed as consultations.

Response: Payment for major surgeries includes bundled payment for the related post-operative visits occurring over a 10-day or 90-day global period. Historically, when payments for new and established office visits were increased after the third Five-Year Review, we also increased the bundled payments for these post-operative visits in the global period. However, we did not propose to increase the payments for the major surgeries to reflect the increase in the visits. We agree with those commenters who contended that consistency requires that we increase the bundled payments for these services proportionately in order to account for the increase in the visits that are incorporated into these bundles. We have accordingly increased the payments for those services in conjunction with finalizing our proposal to eliminate use of the consultation codes in the PFS. However, the increases in the payments for these services due specifically to this change are quite small because visits are a relatively small proportion of the total global payment amount.

Comment: A few commenters objected that we did not make available the crosswalk we used to relate the consultation codes to visit codes for purposes of ensuring BN. Other commenters expressed concerns about the assumptions we used in crosswalking the consultation codes to existing E/M codes. For example, one commenter stated that, for E/M services, a physician must consider three elements (extent of history obtained, extent of examination performed, and complexity of medical decision making) in determining the appropriate code level. However, for subsequent hospital care or hospital outpatient E/M services, only two of these three elements are necessary. In contrast, all three elements must be considered in determining the appropriate coding level for consultation services, both initial and follow-up consultations. There is no established patient visit code or subsequent hospital care code that adequately describes the work of consultation codes (CPT codes 99245 and 99255) when a patient is seen for follow-up consultation. One of these commenters noted that while there are five consultation codes, there are only three initial visit codes, and expressed concern that it would be difficult for physicians to accurately employ the visit codes for the services previously billed under the consultation codes. Another commenter observed that none of the E/M codes reflect the face-to-face times reflected in the highest level consultation codes (for example, 80 minutes for CPT code 99245 and 110 minutes for CPT code 99255). Still other commenters took issue with some elements of the destination mapping in our crosswalk, for example, the assumption that 50 percent of the cases represented as office consultation code (CPT code 99245) would be coded as a new patient office visit code (CPT code 99205), and 50 percent as an established patient office visit code (CPT code 99215).

Response: We made the relevant crosswalk available on our Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1223902&intNumPerPage=10*.

As we have noted above, we did not develop that crosswalk for purposes of providing any guidelines or principles for using the visit codes in place of the consultation codes that physicians have employed prior to the implementation of this proposal. Rather, the crosswalk was developed solely for purposes of making the requisite BN calculations. For purposes of coding specific cases, adoption of this proposal will essentially require physicians to cease submitting the consultation codes on their Medicare claims, and to employ the appropriate visit codes in their place. The determination of the appropriate visit code should be made solely on the basis of the existing rules and guidelines for the use of the relevant visit codes (for example, office visit or inpatient visit), without any reference to the guidelines that have been employed for the use of the consultation codes. The guidelines for use of the visit codes are well established and well understood. Therefore, we do not believe that it is necessary to provide any coding

crosswalk or guidelines for translating the consultation code requirements into the appropriate visit codes. Commenters are correct that while there are five consultation codes, there are only three initial visit codes, that none of the E/M codes reflect the face-to-face times reflected in the highest level consultation codes, and various other differences between the two sets of codes. Nevertheless, it remains possible to determine the appropriate visit code for the services in question by applying the appropriate guidelines and requirements for using those codes. There are, for example, legitimate coding measures to take into account face-to-face times over and above the times specified in the relevant visit codes. Since we ordinarily refrain from providing coding advice in this context, we recommend that physicians, coders, and billing personnel consult the appropriate manuals and coding authorities about how to make the appropriate coding determinations for services previously coded under the consultation codes.

In crosswalking the codes for purposes of making the requisite BN calculations, we employed the same estimating techniques that we normally employ in such calculations. In the absence of concrete data on certain factors in the calculation, we also employed standard assumptions that are appropriate in a system based on averages. For example, office consultation CPT code 99245 was employed to report consultations provided to new *or* established patients in a physician's office or other ambulatory setting. For purposes of making the BN calculations, it was necessary to apportion the utilization of that code between the separate office visit codes for new patients (CPT code 99205) and established patients (CPT code 99215). In the absence of concrete data on the number of new and established patients reported under CPT 99245, we employed the standard technique of assuming that half the patients were new patients, and half the patients were established patients. Such an assumption minimizes the range of potential error and negative impacts in a system based of averages. Similarly, with respect to the new or established patient initial inpatient consultation codes such as CPT code 99251, it was necessary to apportion the utilization estimates between inpatient visits in a hospital setting and in nursing homes. In this case, we believe that there would be far fewer consultation visits in nursing homes than in the inpatient hospital setting. Therefore, we adopted a standard assumption that 70 percent of the cases would be in inpatient hospitals (CPT initial hospital inpatient visit code 99221) and 30 percent in nursing homes (CPT initial nursing care facility visit code 99304). We employed similar assumptions throughout the crosswalk.

Comment: Several commenters maintained that we had not adequately responded to the OIG report about the use of consultation codes prior to developing this proposal. These commenters noted that the majority of the billing errors detected by the OIG were created by lack of documentation and/or services that did not meet the definition of consultation, and that the OIG recommended education and outreach to physicians to reduce such errors. The commenters recommended that we not proceed with the proposal until we can demonstrate that education and outreach efforts cannot improve the situation.

Response: Prior to the official publication of the OIG report, we issued a Medlearn Matters article, effective January 2006, to educate the physician community about requirements and proper billing for all types and levels of consultation services as requested by the OIG in their report. The Medlearn Matters article reflected the manual changes we made in 2006 and the AMA CPT coding changes as noted below. We have also answered numerous questions and inquiries regarding the use of these codes at open door forums and other settings.

With each additional revision from 1999 until the OIG study began, we made repeated efforts to educate physicians through the guidance provided by, and through, our Medicare contractors. However, there were continued discrepancies with unclear and ambiguous terms and instructions in the AMA CPT consultation coding definition, transfer of care and documentation, and the feedback from the physician community indicated they disagreed with Medicare guidance. Despite our best, these disagreements and misunderstandings among the physician community with Medicare interpretations and guidance relating to documentation of transfer of care and consultation have continued.

Comment: A number of commenters expressed concern about the effects of this proposal on coordination of payment between CMS and other payers. The commenters believe that if other payers continue to recognize consultation codes, the result could be confusion, erroneous billings, and serious delays or even denials of payment.

Response: We do not have the authority to determine which services will be recognized and paid by other third party payers. Some payers may choose to adopt this policy subsequent to this final rule. In cases where other payers do not adopt this policy, physicians and their billing personnel will need to take into consideration that Medicare will no longer recognize consultation codes submitted on bills, whether those bills are for primary or secondary payment. In those cases where Medicare is the primary payer, physicians must submit claims with the appropriate visit code in order to receive payment from Medicare for these services. In these cases, physicians should consult with the secondary payers in order to determine how to bill those services in order to receive secondary payment. In those cases where Medicare is the secondary payer, physicians and billing personnel will first need to determine whether the primary payer continues to recognize the consultation codes. If the primary payer does continue to recognize those codes, the physician will need to decide whether to bill the primary payer using visit codes, which will preserve the possibility of receiving a secondary Medicare payment, or to bill the primary payer with the consultation codes, which will result in a denial of payment for invalid codes.

Comment: One commenter stated that we had not responded to several letters over the last few years requesting clarification of the confusion over consultation and transfer of care, and providing suggested language to clarify the confusion. In addition, the commenter stated that the agency has never responded to a request that the contractors suspend audits of consultation services pending resolution of the confusion.

Response: We have received many similar requests and suggestions regarding the confusion over consultation and transfer of care over many years. We have continuously discussed these issues in the appropriate forums, including proposed and final rules, manual instructions, Medlearn matters articles, and meetings of the AMA CPT Committee. We recounted this extensive history in the proposed rule. As for the status of audits of consultation services, we generally do not discuss the specific audit measures and priorities that we are currently pursuing. In general, the goal of medical review is to identify, through analysis of data and evaluation of other information, program vulnerabilities concerning coverage and coding made by individual providers and to take the

necessary action to prevent or address the identified vulnerabilities.

Comment: A few commenters stated that it was inconsistent to continue separate payment for consultation services under the telehealth benefit, but to discontinue them in other contexts in which physician services are provided. Some commenters also stated that discontinuing the consultation codes may be contrary to the statute. Specifically, section 1845(c)(5) of the Act, states:

> Coding.—The Secretary shall establish a uniform coding system for the coding of all physician services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

Response: We note that section 1845(c)(5) of the Act calls for the Secretary to provide for ''an appropriate coding structure for visits and consultations.'' We believe the use of the adjective ''appropriate'' indicates that the statute is granting the Secretary discretion to determine the structure of coding for these services. For the reasons given above and in our proposed rule, we believe that we are creating an appropriate coding structure for visits and consultations by employing a set of codes that accurately describes, and permits appropriate payment for, those services. We also note that discontinuing the use of the consultation codes does not imply discontinuing payment for consultation services, but only discontinuing the payment differential between consultations and visits. These services will continue to be reported, coded, and paid under the PFS. On the other hand, as we noted previously, section 1834(m) of the Act merely states that the definition of telehealth services includes ''professional consultations,'' and points to the initial inpatient consultation codes (''as subsequently modified by the Secretary'') as part of the coding structure for such services. We believe it is more consistent with legislative intent, as expressed in this provision, to retain the separate recognition of consultation services in the context of telehealth services. We believe that we have appropriately exercised the Secretary's discretion under section 1845(c)(5) of the Act in eliminating the consultation codes under the PFS, while at the same time respecting the legislative intent underlying section 1834(m) of the Act for separate recognition of consultation services in the context of telehealth.

Comment: MedPAC commented that the proposed change ''seems an appropriate policy response'' to the relaxation of documentation requirements. However, the Commission noted that:

> * * * reduced consultation documentation may not sufficiently meet the needs of the requesting physician, and thus not help achieve the goals and benefits of well-coordinated care. While CMS' proposed payment policy for consultation may be appropriate in the light of current practice, in the future, the agency may wish to consider whether to increase the requirements for consultations in order to better coordinate care and increase consultation payments commensurately.

Other commenters expressed similar concerns that the elimination of the consultation codes might financially discourage coordination of care and communication among physicians.

Response: We appreciate MedPAC's evaluation that our proposal has merit as a response to the reduction in the documentation requirements for consultation services. We also agree with MedPAC that promoting effective coordination of care must be an essential goal of our payment systems. However, we are not aware of any evidence that the reduced consultation documentation requirements are currently failing to sufficiently meet the needs of referring physicians, or that the benefits of effective coordination of care are otherwise not being realized as result of these reduced requirements. If we become aware of such evidence in the future, we would certainly consider whether there is an appropriate policy response to promote more effective coordination of care. It is, however, premature to consider what the appropriate responses might be until and unless specific evidence of an issue comes to our attention. Nevertheless, we will certainly be attentive to any concerns that develop about the effects of this policy on the goal of promoting effective coordination of care.

Comment: Many other commenters supported the proposal. The commenters agreed with us that the documentation requirements are now generally similar among consultation services, office visits, and hospital and facility visits. The commenters also agreed that the proposed change would simplify documentation and resolve the confusion surrounding the billing of consultation codes, ''transfer of care,'' and other matters.

Response: We appreciate the support of the commenters, and we continue to believe that the approach we proposed is the most appropriate policy response to the confusion, disagreement, and problems that have beset the use of the consultation codes under the PFS. Accordingly, we are adopting our proposal in this final rule.

Specifically, beginning January 1, 2010, we will eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) on a budget neutral basis by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.

Since section 1834(m) of the Act includes ''professional consultations'' (including the initial inpatient consultation codes ''as subsequently modified by the Secretary'') in the definition of telehealth services, we will not eliminate the use of these codes in the telehealth context. Therefore, for CY 2010, we will create HCPCS codes specific to the telehealth delivery of initial inpatient consultations. Specifically, we are establishing the following HCPCS codes to describe initial inpatient consultations approved for telehealth:

- G0425, *Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth.*
- G0426, *Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth.*
- G0427, *Initial inpatient telehealth consultation, typically 70 minutes or more communicating with the patient via telehealth.*

The purpose of these codes is solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners will use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via telehealth. The new HCPCS codes will be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions will limit the use of such services for telehealth. Utilization of these codes will allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately.

As we also stated in the CY 2010 PFS proposed rule, we will crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). We believed this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care codes. As we stated in the CY 2010 PFS proposed rule, we also will make corresponding changes to our regulations at § 410.78 and § 414.65. In addition, we will add the definition of these codes to the CMS Internet-Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in § 483.40(c)(4). In the nursing facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. (See this exception in the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.13 A). An NPP, who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

As proposed, this change will be implemented in a budget neutral manner, meaning that it will not increase or decrease aggregate PFS expenditures. We will make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 0.3 percent to reflect the elimination of the facility consultation codes. As discussed above, in this final rule we are also increasing the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes. As we did for the CY 2010 PFS proposed rule, we have crosswalked the utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits. And, as we proposed, this change will be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization.

F. Potentially Misvalued Services Under the Physician Fee Schedule

1. Valuing Services Under the Physician Fee Schedule

As explained in the CY 2010 PFS proposed rule (74 FR 33554), the American Medical Association's (AMA) Relative Value System Update Committee (RUC) provides recommendations to CMS for the valuation of new and revised codes, as well as codes identified as misvalued. On an ongoing basis, the AMA RUC's Practice Expense (PE) Subcommittee reviews direct PE (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of PE relative value units (RVUs).

To address concerns expressed by stakeholders with regard to the process we use to price services paid under the PFS, the AMA RUC created the Five-Year Review Identification Workgroup. As we stated in the CY 2009 PFS proposed rule (73 FR 38582), the workgroup identified some potentially misvalued codes through several vehicles. It focused on codes for which there have been shifts in the site of service (site of service anomalies), codes with a high intra-service work per unit of time (IWPUT), high volume codes, new technology designation, and shifts from practice expense to work. We also identified other methods that the AMA RUC could undertake to assist in identifying potentially misvalued services including reviewing the fastest growing procedures, Harvard-valued codes, and practice expense RVUs. There were 204 potentially misvalued services identified in 2008.

We believe that there are additional steps we can take to address the issue of potentially misvalued services. In the CY 2009 PFS proposed rule, we identified approaches to address this issue including reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional nonsurgical procedures and the update of high cost supplies.

Comment: We received several comments concerning the misvalued code initiative. One commenter, representing a physician specialty organization, expressed concern about the ongoing misuse of intraservice work per unit of time (IWPUT) as a means to determine appropriate work values. The commenter states that IWPUT was never intended to compare intensity or work across specialties and was to be used only as a measure of relativity between codes or in families of codes. Commenters also expressed concern about the need for transparency concerning the development of values for codes, including the review of PE inputs; the need for CMS to consider the underlying reasons why utilization for certain services may increase; and the economic and public health implications of appropriate valuation of services. A commenter also recommended that the agency become more proactive in identifying problematic trends in utilization and in re-evaluating new technology. The commenter recognized that additional resources would be needed and acknowledged that the Congress may need to ensure adequate resources are available but believes that such an investment could result in lower overall costs in the system over the long-term.

Response: We thank the commenters for sharing their concerns and will consider them as we continue examining the valuation of services under the misvalued code initiative.

We also share some the concerns expressed by the commenter with regards to IWPUT, which is a

calculation that was used as the primary tool to value physician services for some codes during the third Five-Year Review. This calculation poorly assesses intensity for services that are short in time duration and also services that are short in time duration and of high intensity. The IWPUT has also been used to align procedures within a family of codes. It has value in some instances, such as in validating the RVUs for a given procedure using the building block methodology. However, the IWPUT has not proven to be a valuable tool in evaluating or validating cognitive services. The building block methodology is the accepted methodology used by the AMA RUC and CMS for valuing all physician procedures and services. We believe that the building block methodology should be consistently used when the AMA RUC considers valuation of physician services for its recommendations.

2. High Cost Supplies

In the CY 2010 PFS proposed rule (74 33554), we referenced our CY 2009 PFS proposal concerning updating prices for high cost supplies (73 FR 38582) and (73 FR 69882), and stated that we are continuing to examine alternatives on the best way to obtain accurate pricing information and will propose a revised process in future rulemaking.

The following is a summary of the comments received to date regarding high cost supplies and our response.

Comment: Several commenters expressed support for this initiative. A few commenters were disappointed that we did not propose any new methodologies in the CY 2010 PFS proposed rule.

Commenters were in agreement that we must ensure accurate pricing of supplies, as the cost of supplies plays an important role in the payment calculation for services under the PFS.

Commenters also offered the following suggestions for pricing high cost supplies including:

- Identify high cost disposable supplies (that is, over $200) with separate HCPCS codes;
- Use the supply pricing methodology used by the Veterans Administration;
- Work with specialty societies to obtain invoices for high priced items from a designated group of physicians that are geographically representative; and
- Work with the industry or physicians directly to get current pricing information.

MedPAC stated it is important for us to update the prices of higher priced supplies on a regular basis as inaccurate prices can distort PE RVUs over time. MedPAC believes that prices drop over time as items diffuse through the market and as other companies begin to produce them, and encouraged us to regularly update information.

A few commenters also recommended that any pricing proposal should be available for public comment through future rulemaking, possibly on an annual basis. This would enable stakeholders to evaluate and provide feedback to the agency on pricing accuracy as well as practical availability of the item itself.

Response: We want to thank the commenters for sharing their suggestions and will take these comments into consideration as we explore the best way to address this issue.

3. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Nonsurgical Procedures

In the CY 2009 PFS final rule with comment period (73 FR 69882), we stated that we planned to perform a data analysis of nonsurgical CPT codes that are often billed together. We stated that we would identify whether there are inequities in PFS payments that are a result of variations between services in the comprehensiveness of the codes used to report the services or in the payment policies applied to each (for example, global surgery and MPPRs). The rationale for the MPPR is that certain clinical labor activities, supplies, and equipment are not performed or furnished twice when multiple procedures are performed. The MPPR currently applies to certain diagnostic and surgical procedures (73 FR 38586). We stated that we would consider developing a proposal either to bundle more services or expand application of the MPPR to additional procedures. Additionally, the Medicare Payment Advisory Committee (MedPAC) requested that we consider duplicative physician work and PE in any expansion of the MPPR.

In the CY 2010 PFS proposed rule (74 FR 33554), we stated that we planned to analyze codes furnished together more than 75 percent of the time, excluding E/M codes. We also stated that we planned to analyze both physician work and PE inputs. If duplications are found, we said that we would consider whether to propose to implement an MPPR or to bundle the services involved. We stated that we would propose any changes through future rulemaking.

Comment: Several commenters did not support the analysis of codes furnished together more than 75 percent of the time. The commenters stated that limiting the review to codes performed together 90 to 95 percent of the time was more appropriate. A few commenters suggested that 75 percent should not be the only criterion we use when considering whether to implement an MPPR or bundle services. Some commenters requested that we postpone our review of services that are often billed together and rely on the work that is being done in this area by the AMA RUC. The commenters believe that the work the AMA RUC is doing will be informative regarding which services should be considered in the future in determining whether to propose to expand the MPPR or to bundle services. The AMA RUC stated that it wants to work with CMS to accurately assess these services.

A few commenters generally supported the analysis of codes furnished together more than 75 percent of the time. One commenter stated that almost all imaging procedures and equipment have become more efficient in recent years allowing more procedures in a given time.

Most commenters were in agreement that this policy should not be expanded until CMS has additional data and there is an opportunity for public comment through future rulemaking.

Response: We appreciate the comments received and will consider these comments as we explore the best way to address this issue. We also look forward to working with the AMA RUC to accurately assess these services.

4. AMA RUC Review of Potentially Misvalued Codes

a. Site of Service

In the CY 2009 PFS final rule with comment period (73 FR 69883), we said that although we would accept the AMA RUC valuation for these site of service anomaly codes for 2009, we indicated that we had concerns about the methodology used by the AMA RUC to review these services because they may have resulted in removal of hospital days and deletion or reallocation of office visits without extraction of the associated RVUs from the valuation of the code. We also stated that we would continue to examine these codes and would consider whether it would be appropriate to propose additional changes in future rulemaking.

In the CY 2010 PFS proposed rule (74 FR 33554), we proposed work RVU changes to several of the codes where the valuation had been adjusted to

reflect changes in the site of service but the RVUs had not been extracted by the AMA RUC. The proposed work RVUs were recalculated based upon the AMA RUC-recommended inputs (that is, changes in pre-service and post-service times and associated E/M services). The proposed work RVUs for each CPT code were recalculated using the pre-AMA RUC review work RVUs as a starting point, and adjusted for the addition or extraction of pre-service and post-service times, inpatient hospital days, discharge day management services and outpatient visits as recommended by the AMA RUC.

In addition to the proposed revisions to the AMA RUC-recommended RVUs, we encouraged the AMA RUC to utilize the building block methodology as described in the CY 2007 PFS proposed rule (71 FR 37172) in the future when revaluing codes with site of service anomalies. We recognized that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. However, we stated that we believed that the relative value scale requires each service to be valued based on the resources used in furnishing the service.

We also sought public comment on alternative methodologies that could be used to establish work RVUs for codes that would have a negative valuation under the methodology we utilized to develop proposed revisions to the AMA RUC-recommended values described above.

The following is summary of the comments we received regarding the proposed revisions to the codes with site of service anomalies.

Comment: Some commenters supported CMS' attempt to account for recognized changes in physician work for certain procedures in which the typical site of service has changed. However, other commenters opposed the proposed work RVUs and found the methodology unclear and problematic since some cases resulted in negative work values. Many commenters recommended the acceptance of the AMA RUC recommended values and encouraged CMS to work with them to develop a clearer methodology.

Response: As a result of the comments, we are not finalizing our proposal to change the work RVUs for codes with site of service anomalies that were included in Table 8 of the CY 2010 proposed rule (74 FR 33555). Although we still have concerns about the methodology used by the AMA RUC to review the services, we are accepting the AMA RUC-recommended work RVUs in the interim and request that the AMA RUC utilize the building block methodology to revalue the services listed in Table 4.

TABLE 4—CY 2010 CMS INTERIM WORK RVUS FOR SITE OF SERVICE ANOMALIES REVIEWED BY THE AMA RUC IN CY 2009

CPT code [1]	Descriptor	2009 AMA RUC recommended work RVU	CMS decision	2010 CMS interim work RVU [2]
21025	Excision of bone, lower jaw	9.87	Agree	10.03
23415	Release of shoulder ligament	9.07	Agree	9.23
25116	Remove wrist/forearm lesion	7.38	Agree	7.56
42440	Excise submaxillary gland	7.05	Agree	7.13
52341	Cysto w/ureter stricture tx	5.35	Agree	5.35
52342	Cysto w/up stricture tx	5.85	Agree	5.85
52343	Cysto w/renal stricture tx	6.55	Agree	6.55
52344	Cysto/uretero, stricture tx	7.05	Agree	7.05
52345	Cysto/uretero w/up stricture	7.55	Agree	7.55
52346	Cystouretero w/renal strict	8.58	Agree	8.58
52400	Cystouretero w/congen repr	8.66	Agree	8.69
52500	Revision of bladder neck	7.99	Agree	8.14
52640	Relieve bladder contracture	4.73	Agree	4.79
53445	Insert uro/ves nck sphincter	15.21	Agree	15.39
54410	Remove/replace penis prosth	15.00	Agree	15.18
54530	Removal of testis	8.35	Agree	8.46
57287	Revise/remove sling repair	10.97	Agree	11.15
62263	Epidural lysis mult sessions	6.41	Agree	6.54
62350	Implant spinal canal cath	6.00	Agree	6.05
63650	Implant neuroelectrodes	7.15	Agree	7.20
63685	Insrt/redo spine n generator	6.00	Agree	6.05
64708	Revise arm/leg nerve	6.22	Agree	6.36
64831	Repair of digit nerve	9.00	Agree	9.16
65285	Repair of eye wound	14.43	Agree	14.71

[1] All CPT codes copyright 2009 American Medical Association.

[2] 2010 CMS Interim Work RVUs may differ from AMA RUC-recommended work RVU due to work increases in 10 and 90 day global codes as a result of the elimination of the consultation codes.

b. ''23-Hour'' Stay

Services that are performed in the hospital outpatient setting and require a stay of less than 24 hours are considered outpatient services. We received recommendations from the AMA RUC for inclusion of inpatient services for services that are typically performed in an outpatient setting.

In the 2010 PFS proposed rule (74 FR 33556), we stated that we believed the use of E/M codes for services rendered in the post-service period for procedures requiring less than a 24-hour hospital stay would result in overpayment for pre- and post-service work that would not be provided. Therefore, we stated that we would not allow an additional E/M service to be billed for care furnished during the post procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay.

The following is summary of the comments we received regarding the proposed revisions to the ''23-Hour'' stay.

Comment: The majority of commenters disagreed with CMS'

proposal because they believed it would result in surgeons not being paid for the work they perform. Commenters urged CMS to engage in a discussion at CPT and/or the AMA RUC regarding alternative E/M coding solutions.

Response: As a result of the comments, we are not finalizing our proposal and will work with CPT and the AMA RUC regarding alternative E/M coding solutions to address our concerns about using inpatient hospital visit codes as a proxy for the work being performed.

c. AMA RUC Review of Potentially Misvalued Codes for CY 2010

We are addressing the AMA RUC's recommendations from the February and April 2009 meetings for potentially misvalued codes in this final rule with comment period in a manner consistent with the way we address other AMA RUC recommendations. Specifically, we completed our own review of the AMA RUC recommendations and we describe the AMA RUC's recommendations, indicate whether or not we accept them, and provide a rationale for our decision in this final rule with comment period. The values for these services are interim values for the next calendar year.

The AMA RUC continued its review of potentially misvalued codes using various screens, including codes with site of anomalies, high IWPUT, high volume, fastest growing procedures, and other CMS requests. For CY 2010, the AMA RUC submitted recommendations for 113 codes. Of those codes 1 was recommended for a reduction in valuation; 7 were recommended for an increase in valuation; 11 were recommended to maintain the same valuation; 45 were referred to CPT for further code clarification, 33 were recommended for PE changes and 16 were recommended for clinical labor revisions.

We have agreed to accept the valuation for these codes for CY 2010 as interim, including the conforming changes to the PE inputs for these codes, as applicable with the exception of CPT 92597, *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech.* With the enactment of the MIPPA, speech-language pathologists were able to bill the Medicare program independently as private practitioners effective July 1, 2009. In response, speech-language pathologists requested that the AMA RUC value the work of certain codes. Previously, the work of the speech-language pathologists had been accounted for and paid under the PE component for these codes. CPT code 92597 was evaluated by the AMA RUC, after which the AMA RUC recommended a work RVU of 1.48 based upon a survey that included speech-language pathologists and otolaryngologists, the most frequent providers of the service. The work description for CPT code 92597 includes initial fitting of a prosthesis. The code descriptor for CPT code 31611, *Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis),* with a work RVU of 5.92 also includes insertion or fitting of a speech prosthesis. Otolaryngologists perform this service a majority of the time. It appears that both codes include fitting a prosthesis and that there is an overlap of work between CPT codes 92597 and 31611. To account for the overlap of work between these two codes, for CPT code 92597 we have assigned a work RVU value at the 25th percentile, 1.26 work RVUs. We note that the work RVU for CPT code 31611 may not have been reviewed by the RUC since 1995. We invite the RUC to review these two codes and any others for which work may overlap.

We continue to have concerns about the methodology used by the AMA RUC to review services with site of service anomalies. We request that the AMA RUC utilize the building block methodology to revalue these services.

The AMA RUC also recommended that we review claims data for CPT codes 76970, *Ultrasound study follow-up (specify),* 94450, *Breathing response to hypoxia (hypoxia response curve),* 94014, *Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation,* 94015, *Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)* and 94016, *Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only.* We will take the AMA RUC's suggestions under consideration and further investigate these claims.

5. PE Issues—Arthoscopy

Previously, the AMA RUC recommended that an arthoscopic procedure (CPT code 29870, *Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure*)) not be valued in the non-facility setting because they believed the procedure was unsafe to perform outside of the facility setting. In the CY 2008 PFS final rule (72 FR 66238), we deferred proposing non-facility inputs for these types of procedures. We stated that the physicians performing arthroscopic services in the non-facility setting should be given the opportunity to have a multi-specialty review by the AMA RUC.

Comment: We have received many inquiries about why CPT code 29870 was not valued in the non-facility setting. For CY 2010, in response to a request from CMS, the AMA RUC has recommended PE inputs for CPT code 29870.

Response: We accept the AMA RUC's recommended PE inputs for this procedure and are valuing this code in the non-facility setting.

BILLING CODE 4120–01–P

TABLE 5: CY 2010 CMS Interim Work RVUs for Potentially Misvalued Codes Reviewed by the AMA RUC in CY 2010

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
11040	DEBRIDE SKIN, PARTIAL	CPT	Agree	0.50	X							
11041	DEBRIDE SKIN, FULL	CPT	Agree	0.60	X							
11042	DEBRIDE SKIN/TISSUE	CPT	Agree	0.80	X							
13120	REPAIR OF WOUND OR LESION	CPT	Agree	3.35				X				
13121	REPAIR OF WOUND OR LESION	CPT	Agree	4.42				X				
13122	REPAIR WOUND/LESION ADD-ON	CPT	Agree	1.44				X				
19340	IMMEDIATE BREAST PROSTHESIS	13.78; Change in global period from ZZZ to 090	Agree	13.78								X
22520	PERCUT VERTEBROPLASTY THOR	New PE Inputs	Agree	a							X	
22521	PERCUT VERTEBROPLASTY LUMB	New PE Inputs	Agree	a	X						X	
22533	LAT LUMBAR SPINE FUSION	CPT	Agree	24.79				X				
22849	REINSERT SPINAL FIXATION	CPT	Agree	19.17				X				
26080	EXPLORE/TREAT FINGER JOINT	CPT	Agree	4.47	X							
26480	TRANSPLANT HAND TENDON	6.76	Agree	6.90				X				
27370	INJECTION FOR KNEE X-RAY	CPT	Agree	0.96			X	X				
28120	PART REMOVAL OF ANKLE/HEEL	8.08	Agree	8.27	X							
28122	PARTIAL REMOVAL OF FOOT BONE	7.56	Agree	7.72	X							
28725	FUSION OF FOOT BONES	11.97	Agree	12.18	X							
28730	FUSION OF FOOT BONES	12.21	Agree	12.42	X							

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
29870	KNEE ARTHROSCOPY, DX	New PE Inputs - Non-Facility Setting	Agree	(a)							X	
35471	REPAIR ARTERIAL BLOCKAGE	CPT	Agree	10.05				X				
35472	REPAIR ARTERIAL BLOCKAGE	CPT	Agree	6.90				X				
35473	REPAIR ARTERIAL BLOCKAGE	CPT	Agree	6.03				X				
35475	REPAIR ARTERIAL BLOCKAGE	CPT	Agree	9.48				X				
35476	REPAIR VENOUS BLOCKAGE	CPT	Agree	6.03				X				
36481	INSERTION OF CATHETER, VEIN	New PE Inputs	Agree	(a)							X	
36516	APHERESIS, SELECTIVE	CPT	Agree	1.22				X				
36825	ARTERY-VEIN AUTOGRAFT	15.00	Agree	15.13	X							
37183	REMOVE HEPATIC SHUNT (TIPS)	New PE Inputs	Agree	(a)							X	
42415	EXCISE PAROTID GLAND/LESION	17.99	Agree	18.12	X							
42420	EXCISE PAROTID GLAND/LESION	20.87	Agree	21.00	X							
47382	PERCUT ABLATE LIVER RF	New PE Inputs	Agree	(a)							X	
47490	INCISION OF GALLBLADDER	CPT and recommended 000 day global review	Agree	8.13				X				
49421	INSERT ABDOM DRAIN, PERM	CPT	Agree	5.90	X							
49507	PRP I/HERN INIT BLOCK >5 YR	9.97	Agree	10.05	X							
49521	REREPAIR ING HERNIA, BLOCKED	12.36	Agree	12.44	X							
49587	RPR UMBIL HERN, BLOCK > 5 YR	7.96	Agree	8.04	X							
50200	RENAL BIOPSY PERQ	New PE Inputs	Agree	(a)							X	

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
52214	CYSTOSCOPY AND TREATMENT	CPT	Agree	3.70			X					
52224	CYSTOSCOPY AND TREATMENT	CPT	Agree	3.14			X					
55873	CRYOABLATE PROSTATE	13.45 and Revised PE Inputs	Agree	13.60							X	
58555	HYSTEROSCOPY, DX, SEP PROC	New PE inputs	Agree	(a)							X	
58558	HYSTEROSCOPY, BIOPSY	New PE inputs	Agree	(a)							X	
58562	HYSTEROSCOPY, REMOVE FB	New PE inputs	Agree	(a)							X	
58563	HYSTEROSCOPY, ABLATION	New PE inputs	Agree	(a)							X	
61795	BRAIN SURGERY USING COMPUTER	CPT	Agree	4.03				X				
61885	INSRT/REDO NEUROSTIM 1 ARRAY	CPT	Agree	7.57	X							
63056	DECOMPRESS SPINAL CORD	CPT	Agree	21.86				X				
64510	N BLOCK, STELLATE GANGLION	New PE inputs	Agree	(a)								
64520	N BLOCK, LUMBAR/THORACIC	PE Review - no change	Agree	(a)								
64573	IMPLANT NEUROELECTRODES	CPT	Agree	8.25	X							
64622	DESTR PARAVERTEBRL NERVE L/S	PE Review - no change	Agree	(a)			X	X			X	
64626	DESTR PARAVERTEBRL NERVE C/T	PE Review - no change	Agree	(a)			X	X			X	
65780	OCULAR RECONST, TRANSPLANT	CPT	Agree	10.73				X				

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
66982	CATARACT SURGERY, COMPLEX	CPT	Agree	15.02	X	X		X				
69100	BIOPSY OF EXTERNAL EAR	0.81	Agree	0.81				X				
71275	CT ANGIOGRAPHY, CHEST	CPT	Agree	1.92				X				
73218	MRI UPPER EXTREMITY W/O DYE	CPT	Agree	1.35				X				
73580	CONTRAST X-RAY OF KNEE JOINT	CPT	Agree	0.54			X	X				
75885	VEIN X-RAY, LIVER	New PE inputs	Agree	(a)							X	
75887	VEIN X-RAY, LIVER	New PE inputs	Agree	(a)							X	
76100	X-RAY EXAM OF BODY SECTION	New PE inputs	Agree	(a)							X	
76101	COMPLEX BODY SECTION X-RAY	New PE inputs	Agree	(a)							X	
76102	COMPLEX BODY SECTION X-RAYS	New PE inputs	Agree	(a)							X	
76536	US EXAM OF HEAD AND NECK	0.56	Agree	0.56				X				
77301	RADIOTHERAPY DOSE PLAN, IMRT	CPT	Agree	7.99				X				
77371	SRS, MULTISOURCE	New PE inputs	Agree	(a)							X	
77418	RADIATION TX DELIVERY, IMRT	CPT	Agree	0.00				X				
77785	HDR BRACHYTX, 1 CHANNEL	New PE Inputs	Agree	(a)							X	
77786	HDR BRACHYTX, 2-12 CHANNEL	New PE Inputs	Agree	(a)							X	
77787	HDR BRACHYTX OVER 12 CHAN	New PE Inputs	Agree	(a)							X	
90951	ESRD SERV, 4 VISITS P MO, <2	Revised clinical staff time	Agree	(b)							X	

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
90952	ESRD SERV, 2-3 VSTS P MO, <2	Revised clinical staff time	Agree	(b)							X	
90953	ESRD SERV, 1 VISIT P MO, <2	Revised clinical staff time	Agree	(b)							X	
90954	ESRD SERV, 4 VSTS P MO, 2-11	Revised clinical staff time	Agree	(b)							X	
90955	ESRD SRV 2-3 VSTS P MO, 2-11	Revised clinical staff time	Agree	(b)							X	
90956	ESRD SRV, 1 VISIT P MO, 2-11	Revised clinical staff time	Agree	(b)							X	
90957	ESRD SRV, 4 VSTS P MO, 12-19	Revised clinical staff time	Agree	(b)							X	
90958	ESRD SRV 2-3 VSTS P MO 12-19	Revised clinical staff time	Agree	(b)							X	
90959	ESRD SERV, 1 VST P MO, 12-19	Revised clinical staff time	Agree	(b)							X	
90960	ESRD SRV, 4 VISITS P MO, 20+	Revised physician and clinical staff time	Agree	(b)							X	
90961	ESRD SRV, 2-3 VSTS P MO, 20+	Revised physician and clinical staff time	Agree	(b)							X	
90962	ESRD SERV, 1 VISIT P MO, 20+	Revised clinical staff time	Agree	(b)							X	

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
90963	ESRD HOME PT, SERV P MO, <2	Revised clinical staff time	Agree	(b)							X	
90964	ESRD HOME PT SERV P MO, 2-11	Revised clinical staff time	Agree	(b)							X	
90965	ESRD HOME PT SERV P MO 12-19	Revised clinical staff time	Agree	(b)							X	
90966	ESRD HOME PT, SERV P MO, 20+	Revised clinical staff time	Agree	(b)							X	
92526	ORAL FUNCTION THERAPY	1.34 work RVU and clinical staff time removed	Agree	1.34					X			
92587	EVOKED AUDITORY TEST	CPT	Agree	0.13				X				
92597	ORAL SPEECH DEVICE EVAL	1.48 work RVU and clinical staff time removed	Disagree	1.26					X			
92610	EVALUATE SWALLOWING FUNCTION	1.30 work RVU and clinical staff time removed	Agree	1.30					X			
92611	MOTION FLUOROSCOPY/SWALLOW	1.34 work RVU and clinical staff time removed	Agree	1.34					X			
93017	CARDIOVASCULAR STRESS TEST	PE Review - no change	Agree	(a)			X				X	
93230	ECG MONITOR/REPORT, 24 HRS	CPT	Agree	0.52								X
93233	ECG MONITOR/REVIEW, 24 HRS	CPT	Agree	0.52								X

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
93307	TTE W/O DOPPLER, COMPLETE	New PE inputs	Agree	(a)							X	
93320	DOPPLER ECHO EXAM, HEART	New PE inputs	Agree	(a)							X	
93325	DOPPLER COLOR FLOW ADD-ON	New PE inputs	Agree	(a)							X	
93510	LEFT HEART CATHETERIZATION	CPT	Agree	4.32						X	X	
93543	INJECTION FOR HEART X-RAYS	CPT	Agree	0.29						X	X	
93545	INJECT FOR CORONARY X-RAYS	CPT	Agree	0.40						X	X	
93555	IMAGING, CARDIAC CATH	CPT	Agree	0.81						X	X	
93556	IMAGING, CARDIAC CATH	CPT	Agree	0.83						X	X	
93922	EXTREMITY STUDY	CPT	Agree	0.25				X				
93923	EXTREMITY STUDY	CPT	Agree	0.45				X				
93924	EXTREMITY STUDY	CPT	Agree	0.50				X				
94760	MEASURE BLOOD OXYGEN LEVEL	New PE inputs	Agree	(a)							X	
94761	MEASURE BLOOD OXYGEN LEVEL	New PE inputs	Agree	(a)							X	
94762	MEASURE BLOOD OXYGEN LEVEL	New PE inputs	Agree	(a)				X			X	
94770	EXHALED CARBON DIOXIDE TEST	Should be N/A for Non-Facility PE	Agree	(a)			X					
95803	ACTIGRAPHY TESTING	New PE inputs	Agree	(a)							X	
95922	AUTONOMIC NERV FUNCTION TEST	CPT	Agree	0.96			X	X				
95956	EEG MONITORING, CABLE/RADIO	CPT	Agree	3.08				X				
G0180	MD CERTIFICATION HHA PATIENT	CPT	Agree	0.67				X				

[1] CPT codes and descriptors only are copyright 2009 American Medical Association.

[2] Work RVUs recommended by CMS may differ from the AMA RUC recommended value due to work increases in 10 and 90 day global codes as a result of the elimination of the consultation codes.

(a) Work RVU unchanged; code was reviewed for PE only.

(b) Work RVU unchanged; code was reviewed for clinical staff time only.

BILLING CODE 4120-01-C

6. Establishing Appropriate Relative Values for Physician Fee Schedule Services

In MedPAC's March 2006 Report to Congress, MedPAC made a number of recommendations to improve the review of the relative values for PFS services. Since that time, we have taken significant actions to improve the accuracy of the RVUs. As MedPAC noted in its recent March 2009 Report to Congress, ''CMS and the AMA RUC have taken several steps to improve the review process'' in the intervening years since those initial recommendations. Many of our efforts to improve the accuracy of RVUs have also resulted in substantial increases in the payments for primary care services.

The original March 2006 recommendation was summarized in the March 2008 Report to Congress:

> We also recommended that CMS establish a group of experts, separate from the AMA RUC, to help the agency conduct these and other activities. This recommendation was intended not to supplant the AMA RUC but to augment it. To that end, the panel should include members who do not directly benefit from changes to Medicare's payment rates, such as experts in medical economics and technology diffusion and physicians who are employed by managed care organizations and academic medical centers.

The idea of a group of experts separate from the AMA RUC, to help the agency improve the review of relative values, raises a number of issues. In the proposed rule, we solicited input on specific points concerning the creation of such a group, including:

- How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations?
- What specifically would be the roles of a group of experts (for example, identify potentially misvalued services, provide recommendations on valuation of specified services, review AMA RUC recommendations selected by the Secretary, etc.)?
- What should be the composition of a group of experts? How could such a group provide expertise on services that clinician group members do not furnish?
- How would such a group relate to the AMA RUC and existing Secretarial advisory panels such as the Practicing Physician Advisory Committee?

We also requested comments on the resources required to establish and maintain such a group. We stated that we would consider these comments as we consider the establishment of a group of experts to assist us in our ongoing reviews of the PFS RVUs.

Comments: We received comments from many organizations, specialty societies, and groups, including the AMA, the AMA RUC, and MedPAC concerning the creation of a group of experts.

Some commenters expressed support of such a panel. The commenters offered suggestions concerning its establishment and operations. The commenters stated that adequate resources and funding would be needed. The commenters viewed the panel as a vehicle to independently assess the AMA RUC recommendations. Several commenters stressed the importance of including consumers or purchasing representatives on such a panel and that the current process is too narrowly focused on resource costs. Commenters stated there is a need to restructure the payment system so that it appropriately values coordinated care delivery, encourages appropriate use of services, and rewards value and not volume.

Other commenters opposed creation of such a panel. The commenters stated that the current process has been successful, is transparent, and the rulemaking process provides additional oversight of the AMA RUC's recommendations. The commenters also stated that the AMA RUC has the technical knowledge and objective judgment to assist CMS in maintenance of the RVUs and that a superimposed panel would lack its insight. Commenters also stated that the addition of a separate group would increase demands on CMS; create coordination problems; and would be fiscally unsound and imprudent. Commenters noted that CMS and the AMA RUC have made strides in the misvalued codes initiative. Some of the commenters suggested that we consider enhancing the existing refinement panel process used to address the comments received on interim work RVUs (see section III for additional information on this process). Some commenters expressed concern that the refinement panels have not been adequately developed and that there is a lack of transparency.

MedPAC stated there are valid reasons that a panel should be established. It stated that CMS needs a regular source of expertise available to assist in valuing services and that such expertise is not solely the domain of the AMA RUC.

Response: We appreciate all of the comments and suggestions provided regarding the creation of a group of experts. We will take these comments into consideration as we continue to explore this issue.

We also appreciate the comments raised concerning the existing refinement panel process. Any revisions to this process would be discussed in future rulemaking.

G. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

This section addresses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275). We proposed to revise our policies and regulations as described below in order to conform them to the statutory amendments.

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

Prior to the enactment of the MIPPA, section 1833(c) of the Act provided that for expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital, only 62½ percent of such expenses are considered to be incurred under Medicare Part B when determining the amount of payment and application of the Part B deductible in any calendar year. This provision is known as the outpatient mental health treatment limitation (the limitation), and has resulted in Medicare paying only 50 percent of the approved amount for outpatient mental health treatment, rather than the 80 percent that is paid for most other outpatient services.

Section 102 of the MIPPA amends the statute to phase out the limitation on recognition of expenses incurred for outpatient mental health treatment, which will result in an increase in the Medicare Part B payment for outpatient mental health services to 80 percent by CY 2014. When this section is fully implemented in 2014, Medicare will pay for outpatient mental health services at the same level as other Part B services. For CY 2010, section 102 of the MIPPA provides that Medicare will recognize 68¾ percent of expenses incurred for outpatient mental health treatment, which translates to a payment of 55 percent of the Medicare-approved amount. Section 102 of the MIPPA specifies that the phase out of the limitation will be implemented as shown in Table 6 provided that the patient has satisfied his or her deductible.

TABLE 6—IMPLEMENTATION OF SECTION 102 OF THE MIPPA

Calendar year	Recognized incurred expenses	Patient pays	Medicare pays
CY 2009 and prior calendar years	62.50%	50%	50%
CY 2010 and CY 2011	68.75%	45%	55%
CY 2012	75.00%	40%	60%
CY 2013	81.25%	35%	65%
CY 2014	100.00%	20%	80%

At present, § 410.155(c) of the regulations includes examples to illustrate application of the current limitation. We proposed to remove these examples from the regulations and, instead, provided examples in the CY 2010 PFS proposed rule (74 FR 33521), in our manual, and under provider education materials as needed. (See the CY 2010 PFS proposed rule (74 FR 33557) for the examples illustrating the application of the limitation in various circumstances as it is gradually reduced under section 102 of the MIPPA.) Section 102 of the MIPPA did not make any other changes to the outpatient mental health treatment limitation. Therefore, other aspects of the limitation will remain unchanged during the transition period between CYs 2010 and 2014. The limitation will continue to be applied as it has been in accordance with our regulation at § 410.155(b) which specifies that the limitation applies to outpatient treatment of a mental, psychoneurotic, or personality disorder, identified under the International Classification of Diseases (ICD) diagnosis code range 290–319. We use this ICD diagnosis code range, place of service code, and the procedure code to identify services to which the limitation applies.

Additionally, we proposed to make technical corrections to § 410.155(b)(2) in order to update and clarify the services already under these regulations to which the limitation does not apply. We proposed the following technical changes:

- Under § 410.155(b)(2)(ii), revise the regulation to specify the HCPCS code, M0064 (or any successor code), that represents the statutory exception to the limitation for brief office visits for the sole purpose of monitoring or changing drug prescriptions used in mental health treatment.
- At § 410.155(b)(2)(iv), we proposed to revise the regulation to add neuropsychological tests and diagnostic psychological tests to the examples of diagnostic services that are not subject to the limitation when performed to establish a diagnosis.
- Under § 410.155(b)(2)(v), we proposed to revise the regulation to specify the CPT code 90862 (or any successor code) that represents pharmacologic management services to which the limitation does not apply when furnished to treat a patient who is diagnosed with Alzheimer's disease or a related disorder.

Finally, we proposed to add a new paragraph (c) to § 410.155 that provides a basic formula for computing the limitation during the phase-out period from CY 2010 through CY 2013, as well as after the limitation is fully removed from CY 2014 onward.

The following is a summary of the comments we received regarding the proposed implementation of section 102 of the MIPPA.

Comment: All of the comments on section 102 of the MIPPA support the enactment by the Congress and implementation by CMS of this provision that will eventually achieve parity in payment for outpatient mental health services under the Medicare Part B program with the program's payment for other outpatient services. Most of the commenters describe the limitation as discriminatory and inequitable, and believe that it should have been eliminated a long time ago. The majority of the commenters believe that the elimination of the limitation will increase access to outpatient mental health services in the Medicare population. Therefore, elimination of the limitation will have a positive impact on Medicare beneficiaries because they will have to pay less out-of-pocket. Also, commenters believe that physicians and other providers of outpatient mental health care will be ''held harmless'' with respect to this change because, although they will collect less from the patient, they will ultimately be able to collect from the program the full Medicare approved amount for outpatient mental health services. The commenters that embrace our proposal to implement section 102 of the MIPPA, request that we maintain our proposal in the final rule, and encourage CMS to finalize section 102 of the MIPPA in a timely fashion.

Response: We appreciate the supportive comments received on our proposal to implement section 102 of the MIPPA and the encouragement to finalize our proposal. Also, we are grateful for the offerings made by a few commenters to assist in educating the provider community about section 102 of the MIPPA.

Comment: One commenter opposed two of our technical corrections to current regulations on the limitation at § 410.155(b)(2) and provided suggested changes. Specifically, under § 410.155(b)(2)(iv), we proposed to insert neuropsychological tests along with diagnostic tests that are performed to establish a diagnosis as diagnostic services that are not subject to the limitation. While this commenter has no issue with including neuropsychological tests, the commenter believes that a complete list of services would include outpatient consultation codes, all outpatient new patient and initial visit evaluation and management (E/M) codes, and the psychiatric diagnostic and evaluation interview codes (90801 and 90802). Accordingly, the commenter believes that if we expand the list of identified services not subject to the limitation by inserting neuropsychological tests only, without including the complete listing of services, we could be subjecting services inappropriately to the limitation.

On this particular technical correction, another commenter suggested that we should consider including a definition of ''diagnostic services'' to provide further guidance to the field on this issue.

The other technical correction that the commenter opposed is the provision under § 410.155(b)(2)(v) that lists medical management services billed under CPT code 90862 (or its successor code), as opposed to psychotherapy, as not being subject to the limitation when furnished to treat a patient who is diagnosed with Alzheimer's disease or a related disorder. The commenter believes that medical management services are not limited to those billed under CPT code 90862, but also

includes E/M of a patient with a mental illness using the outpatient E/M codes (CPT codes 99211 through 99215), and in a nursing facility, the subsequent nursing facility care E/M CPT codes (CPT codes 99307 through 99310). Hence, this commenter suggests that the proposed technical correction would unnecessarily and improperly limit the exception to only those instances when CPT code 90862 is billed. This commenter urged that the exception to the limitation for the treatment of a patient who is diagnosed with Alzheimer's disease or a related disorder should continue to include all non-psychotherapy services. Accordingly, this commenter suggested that the current language under regulations should be retained or that new language clarify that any outpatient service including CPT code 90862, E/M codes, and any other non-psychotherapy service provided to a patient with Alzheimer's disease or a related condition is not subject to the limitation.

One commenter who supports our implementation of the MIPPA provision commented that it is appropriate to update the list of services to which the limitation does not apply by specifying HCPCS code M0064, neuropsychological tests and diagnostic psychological tests, as well as CPT code 90862 when reporting services provided to a patient with Alzheimer's disease or a related disorder.

Response: The intent of our technical corrections to § 410.155 was to clarify, not to expand, our current policy. We intended to amend the existing regulations in a way that would update and clarify the already stated policy. Diagnostic psychological and neuropsychological tests are diagnostic services that are excluded from the limitation when performed to establish a diagnosis. The neuropsychological test codes were established years after the CPT codes for diagnostic psychological tests and that is why the reference to neuropsychological tests had not been included under current regulations. Additionally, in the context of psychiatric mental health services, the specific diagnostic services for which we have national policy regarding the limitation are the psychiatric diagnostic services under CPT codes 90801 and 90802, and, the CPT codes for diagnostic psychological and neuropsychological testing. In the absence of national policy concerning application of the limitation to diagnostic services billed under the outpatient consultation codes or the outpatient new patient and initial visit E/M codes, contractors use their discretion in making decisions about whether the limitation should be applied to such services under a variety of circumstances. To list these additional outpatient consultation and E/M codes as suggested by the commenter would represent an expansion of the current regulatory exception at § 410.155(b)(2)(iv).

However, we believe that if we revise the wording under § 410.155(b)(2)(iv) to specify that *psychiatric* diagnostic services billed under CPT codes 90801 and 90802 (or successor codes) and diagnostic psychological and neuropsychological tests billed under CPT code range 96101 through 96125 (or any successor code range) that are performed to establish a diagnosis are not subject to the limitation, we will address the commenter's concerns. Also, such a change will provide the field with specific guidance on our definition of ''diagnostic services'' in terms of mental health services.

We agree with the commenter that our technical correction to § 410.155(b)(2)(v) might have been read to restrict application of the exception to CPT code 90862. We will refrain from addressing specifically in the regulation outpatient E/M codes or nursing facility E/M codes. Rather, we will continue to leave in the hands of our contractors decisions as to whether the exception applies for these codes under particular circumstances. We have provided policy guidance to our contractors that medical management services furnished under CPT code 90862 to treat a patient diagnosed with Alzheimer's disease or a related disorder are not subject to the limitation. Therefore, we believe it is consistent with current national policy to amend the regulatory exception under § 410.155(b)(2)(v) to read, ''medical management such as that furnished under CPT code 90862 (or its successor code), as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.''

We received comments on issues that are outside the scope of our proposals for section 102 of MIPPA. These comments are not addressed in this final rule with comment.

2. Section 131: Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

a. Program Background and Statutory Authority

The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program that provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered professional services during a specified reporting period. Under section 1848(k)(3)(B) of the Act, the term ''eligible professional'' means any of the following a: (1) physician; (2) practitioner described in section 1842(b)(18)(C); (3) physical or occupational therapist or a qualified speech-language pathologist; or (4) qualified audiologist. The PQRI was first implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006—the Medicare Improvements and Extension Act of 2006 (Pub. L. 109–432) (MIEA–TRHCA), which was enacted on December 20, 2006. The PQRI was extended and further enhanced as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA), which was enacted on December 29, 2007, and the MIPPA, which was enacted on July 15, 2008. Changes to the PQRI as a result of these laws, as well as information about the PQRI in 2007, 2008, and 2009, are discussed in detail in the CY 2008 PFS proposed rule (72 FR 38196 through 38204), CY 2008 PFS final rule with comment period (72 FR 66336 through 66353), CY 2009 PFS proposed rule (73 FR 38558 through 38575), and CY 2009 PFS final rule with comment period (73 FR 69817 through 69847). In addition, detailed information about the PQRI is available on the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

We received several comments from the public on the CY 2010 PFS proposed rule related to the PQRI. General comments about the PQRI are addressed immediately below.

Comment: Many commenters supported proposed program changes for 2010, in particular those that make reporting flexible and less burdensome such as changes to the criteria for satisfactory reporting of measures groups (specifically, the removal of the requirement to report on consecutive patients), the proposed electronic health record-based (EHR-based) reporting mechanism, and the group practice reporting option.

Response: We appreciate the commenters' support of the changes proposed for the 2010 PQRI, many of which are finalized herein. We agree with commenters that many of the changes that we are finalizing for the 2010 PQRI, including the ones listed above, provide eligible professionals with greater flexibility and make reporting less burdensome.

Comment: Several commenters suggested that we consider and recommend to the Congress a modified version of the proposed option

presented by the Senate Finance Committee in the April 29, 2009, ''Description of Policy Options, Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs'' to add a new participation option allowing eligible professionals to receive PQRI incentive payments for 3 successive years if, on a triennial (every 3 year) basis, the eligible professional: (1) participates in a qualified American Board of Medical Specialties (ABMS) certification known as the Maintenance of Certification (MOC), or equivalent programs; and (2) completes a qualified MOC practice assessment. Such practice assessments typically consist of the use of performance measures to evaluate practice activities, which includes documentation of evidence of practice changes to improve quality, and re-evaluation to determine the effect of a change in the practice process or structure of care.

Response: Section 1848(m)(1) of the Act specifies the PQRI incentive amount for each program year and how the incentive payment amount is to be calculated for each reporting period during the program year. We do not have the authority to change how the incentive payment amount is determined and, therefore, cannot continue payments beyond the authorized program year.

With respect to the commenters' suggestion to provide PQRI incentive payments to eligible professionals who participate in an ABMS MOC program and complete a qualified MOC practice assessment, section 1848(m)(3)(A) of the Act dictates the criteria that eligible professionals must meet in order to be treated as satisfactorily submitting data on quality measures. These criteria include the reporting, by eligible professionals, of quality data on a standardized set of national consensus-based measures. For years after 2009, section 1848(m)(3)(D) of the Act gives us the discretion to revise the criteria for satisfactorily submitting data on quality measures. The proposed criteria for 2010, which did not explicitly include the option suggested by the commenters, were discussed in the CY 2010 PFS proposed rule (74 FR 33565 through 33569). We believe that basing criteria for satisfactory reporting solely on participation in an ABMS MOC and completion of a qualified MOC practice assessment without the submission of PQRI measures results would defeat the ability of CMS to analyze and compare eligible professional performance based on a standardized set of measures. PQRI is not based upon such qualifications, but rather on the submission of data on quality measures to measure eligible professional performance.

However, to the extent that ABMS member certification boards collect information on PQRI quality measures from eligible professionals, the ABMS member boards may qualify as registries under the PQRI and report such information to CMS on behalf of eligible professionals. Currently, one of the ABMS member boards has qualified as a CMS PQRI registry and successfully submitted data on PQRI measures on behalf of eligible professionals. This would allow eligible professionals to concurrently participate in an ABMS MOC and PQRI.

Comment: Several commenters suggested that we expand our education and outreach efforts so that professionals can gain a better understanding of the program, coding, and how to participate satisfactorily. Specifically, commenters suggested that we:

- Publish a list of professions that have participated in PQRI.
- Communicate potential incentive amounts that could be earned by an individual participant.
- Work with the AMA and other national stakeholder organizations to increase education and outreach for professionals about the requirements for satisfactorily reporting under various options.
- Use provider-neutral language, such as ''clinician'' or ''provider'' in describing the array of eligible professionals.

Response: We value the input received from stakeholders and participants who have provided constructive feedback and have collaborated with us to disseminate educational PQRI materials to eligible professionals in the health care community. We will continue to work with national and regional stakeholder organizations to educate their members on program requirements for satisfactory reporting.

We also plan to continue to host monthly national provider calls in which we expect to provide guidance on specific topics, including having our PQRI subject matter experts available to answer questions on the PQRI. Information about upcoming calls can be obtained from the CMS Sponsored Calls page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/04_CMSSponsoredCalls.asp#TopOfPage.* We will continue to make PQRI educational materials and other resources available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as well. Updated educational materials and resources for the 2010 PQRI will be made available as soon as possible following publication of this final rule with comment period. Where appropriate, we will consistently use inclusive terminology such as ''eligible professionals'' rather than ''physicians'' in PQRI educational resources and related documents. We encourage eligible professionals to visit this Web site and to review the frequently asked questions (FAQs) found on this Web site. Eligible professionals are also encouraged to join the physician listserv to obtain periodic updates about the PQRI. Instructions for joining the listserv can be found at *https://list.nih.gov/archives/physicians-1.html*.

Finally, we anticipate conducting and publishing an evaluation of the 2008 PQRI similar to the ''PQRI 2007 Reporting Experience'' posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf.* Although we have not yet finalized the operational details of our evaluation strategy, we expect the report to include participation rates by specialty/profession, associated trends in clinical performance and beneficiary outcomes, and other observable impacts on participants, the Medicare program, and beneficiaries.

Comment: Several commenters requested that we provide more detailed educational resources well in advance of the 2010 PQRI start date and provide enough lead time so that electronic systems may be updated to allow data capture for new or revised 2010 PQRI measures.

Response: We agree with the commenters that it is desirable to provide final measure specifications and other educational resources sufficiently in advance of the start of a new program year to allow reasonable time for professionals to analyze new or revised reporting options and measures, and implement any needed changes in their office workflows so that they may accurately capture and satisfactorily submit data on a selection of measures applicable to their practice. We are aware that such lead time would also help the eligible professionals' specialty or professional societies to prepare to support the professionals' selection of relevant measures. Having detailed information on measures available in advance also enhances the ability of vendors (such as practice-management software, billing services, and electronic health record vendors) to support professionals' successful implementation of revised data capture processes for the measures. We are

targeting finalization and publication of the detailed specifications for all 2010 PQRI measures on the CMS Web site, by November 15, 2009, but no later than December 31, 2009. The detailed specifications include instructions for reporting and identifying the circumstances in which each measure is applicable. The specifications for measures in the final listing for the 2010 PQRI, including a measure's title, remain potentially subject to corrections until the start of the 2010 reporting period. We are also committed to making other educational resources for the 2010 PQRI available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as quickly as possible after publication of this final rule with comment period.

As discussed below, to assist eligible professionals who may need additional time to make updates to their electronic systems or practice workflows, we also are finalizing a 6-month reporting period beginning July 1, 2010, for claims-based reporting of individual measures. Thus, the 6-month reporting period will be available for both those who wish to report individual measures, as well as measures groups through claims or a qualified registry.

Comment: Some commenters requested that we provide detailed data used to determine that a professional failed to report on 80 percent of eligible cases and to inform them about what they need to do to rectify errors.

Response: We considered recommendations about PQRI participant feedback reports as part of an ongoing dialogue with the stakeholder and participant community. We convened a multi-specialty focus group and have revised the design and content of the 2008 PQRI feedback reports, which were recently released. These revised feedback reports include more detailed information at the individual eligible professional level than was provided in the 2007 PQRI feedback reports.

Comment: Several commenters stated that the 2007 feedback reports were too difficult to obtain, did not provide sufficient detailed information to allow correction, and were not available on an interim basis to prevent eligible professionals from making the same errors in the following program year.

Response: To address concerns expressed about our secure method used to obtain the feedback reports (which requires eligible professionals to register and obtain an Individuals Authorized Access to CMS Computer Services, or IACS, account), we identified an alternative feedback report request process for individual eligible professionals requesting NPI level reports, which allows an individual participant to obtain his or her own feedback report through their carrier or MAC after providing appropriate identification. Information about this new process is available on the PQRI section of the CMS Web site and was discussed on the October 15, 2009, PQRI national provider call.

We have assessed the feasibility of providing some type of interim feedback report to participants. We have determined, however, detailed, accurate, participant-level interim feedback reports cannot be provided in an appropriately secure access environment. However, given that the most prevalent underlying reasons for failure to meet incentive eligibility are due to (1) failure by the professional to identify and report on at least 80 percent of denominator-eligible cases for the measures selected, and (2) quality data code errors due to incorrect or insufficient coding, we have determined that an aggregate-level quality data submission error report could be published on a quarterly basis on the PQRI section of the CMS Web site, to provide information on the types of submission errors found for each measure. Following the posting of the ''PQRI 2007 Reporting Experience'' report, we have continued to post updated error reports on a quarterly basis on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

Comment: Several commenters who participated in the 2008 PQRI have commented on the lack of timely feedback reports and incentive payments.

Response: For claims-based reporting, PQRI analysis of individual professionals' claims begins after the conclusion of the program year when all claims have been processed. Conducting individual-level analysis on a portion of a professional's claims during the program year would result in inaccurate data and presents a significant expense to CMS. We acknowledge participating professionals' need for interim information on the accuracy of their quality reporting through claims. Therefore, we have posted aggregate-level information on the PQRI section of the CMS Web site on a quarterly basis describing quality-data code submission errors that we observe on claims for each PQRI measure and anticipate continuing to do so in the future.

In addition, many registries provide interim feedback to their clients. Therefore, eligible professionals who participate in PQRI through a qualified registry may be able to receive interim feedback from the registry and have the opportunity to correct those errors prior to the program year data submission deadline.

Comment: Several commenters requested that we establish a formal appeals process for those professionals who participate in PQRI but do not qualify for the incentive payment.

Response: Section 1848(m)(5)(e) of the Act provides that with respect to the PQRI there shall be no administrative or judicial review under section 1869, section 1879, or otherwise of (1) The determination of measures applicable to services furnished by eligible professionals; (2) the determination of satisfactory reporting; and (3) the determination of any incentive payment. Since 2007, we have addressed inquiries about the PQRI through the question-and-answer sessions held during monthly PQRI national provider calls and open door forums. More recently, a dedicated Help Desk has been implemented to respond to participants' inquiries related to all aspects of the PQRI, including assisting eligible professionals in understanding why they did not receive a PQRI incentive payment. The Help Desk is available from 7 a.m. to 7 p.m. CT and can be reached by phone at (866) 288–8912 or via e-mail at *qnetsupport@sdps.org*.

Comment: Several commenters expressed the need to evaluate the impact of PQRI and make evaluation results available to stakeholders. Some commenters stated that an evaluation of outcomes achieved is needed before deciding whether to expand the program, impose penalties, or make participation mandatory. One commenter noted that such an evaluation is needed to restore confidence in the PQRI since the program's validity within the eligible professional community has been compromised due to the PQRI being rushed. Other commenters urged us to provide medical specialty organizations with the PQRI data files so that they may perform an independent analysis to assist CMS to improve the clinical appropriateness of physician quality measures and better understand or correct potential barriers to satisfactory reporting.

Response: We have conducted and published an evaluation of the 2007 PQRI and have posted the ''PQRI 2007 Reporting Experience'' on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf*. We anticipate conducting a similar evaluation of the 2008 PQRI and expect to include participation rates by

specialty/profession, associated trends in clinical performance and beneficiary outcomes, and other observable impacts on participants, the Medicare program, and beneficiaries. Although we have not yet finalized the operational details of our evaluation strategy for the 2008 PQRI and beyond, we do anticipate making the results of the evaluation, at the national level, available to the public. We also may make publicly available the results of such analyses aggregated at other meaningful levels (for example, State, specialty, or profession). We do not at this time plan to make results publicly available in a format or with content that would enable identification of individual professionals or specific practices' reporting or performance results.

Comment: Several commenters urged CMS to expand PQRI in a manner that would allow participation by therapy professionals who practice in institutional settings such as hospitals, rehabilitation facilities, and skilled nursing facilities and submit their individual National Provider Identifier (NPI) either through claims or through registry-based reporting.

Response: As we stated in the CY 2008 PFS final rule with comment period (74 FR 69820 through 69821), we agree with the goal of offering the opportunity to participate in PQRI to as many eligible professionals as feasible and practical, consistent with the statutory requirements. Except for group practices participating in the group practice reporting option, which begins in 2010, the determination of satisfactory reporting and the calculation of any earned incentive payment amount must be determined at the individual professional level, regardless of the method of reporting quality data. For therapy professionals who practice in institutional settings, we cannot make the determination of satisfactory reporting and calculate earned incentive payment amounts at the individual eligible professional level without extensive modifications to the claims processing systems of CMS and providers, which would represent a material administrative burden to us and to providers. It would also require modifications to the industry standard claims formats, which would require substantial time to effect through established processes and structures that we do not maintain or control. We have also found that most institutions that employ therapists do not tie the individual therapist to the service rendered to an individual patient. Instead, therapists are hired for a fixed number of hours per day per week. In this case, there are no provider identifiers available to use in processing these claims.

Comment: Several commenters indicated that we should convert PQRI from a pay-for-reporting program to a pay-for performance program, stating that reporting on quality measures is not sufficient and that consumers need performance data for informed choice based on quality and value.

Response: Our plans for a report to Congress on transitioning to a physician value-based purchasing program are discussed in section II.G.4. of this final rule with comment period.

Comment: Some commenters expressed concern that the impact analysis of the estimated costs for participation by professionals for claims-based, registry-based, and EHR-based reporting contained in the CY 2010 PFS proposed rule (74 FR 33664 through 33665) are too low or inaccurate and should be rectified in the final rule. One commenter noted that one estimate of the cost for a practice to participate in PQRI ranges from $55,000 to $1.3 million. Other commenters cited an example from a practice with 1 full-time eligible professional and 1 part-time eligible professional where it was determined that the cost for claims-based reporting in PQRI was $1,780 per year, or $1,186 per eligible professional. Some commenters suggested that we conduct a survey of successful PQRI participants and/or data submission vendors to determine all participation costs and publish survey results in future rules.

Response: As stated in the CY 2010 PFS proposed rule (74 FR 33664), individual eligible professionals and group practices may have different processes for integrating the PQRI into their practices' work flows. Therefore, it is difficult for us to accurately quantify the cost burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the number of measures on which an eligible professional chooses to report, the complexity of the measure(s) chosen by the eligible professional, the eligible professional's patient population and how frequently the professional's selected measure(s) apply to the professional's patient population, the eligible professional's familiarity, understanding, and experience with the PQRI, and the reporting option selected by the eligible professional. To be able to provide any cost estimates we had to use certain assumptions with respect to the number of measures reported on and the number of reporting instances per eligible professional. Given that practices vary in size and patient population, these assumptions will not hold true for every practice participating in PQRI and some practices' costs associated with PQRI participation will exceed the estimates provided in our cost estimates while other practices will have costs below our estimates. We cannot assess the examples offered by commenters without additional information on the number of measures reported by each eligible professional in the practice and the number of reporting instances per eligible professional. We will consider, however, the commenters' suggestions for future years but believe that it would be unlikely that we would be able to obtain a representative sample of survey respondents given the many variables that impact participation costs.

Comment: A specific concern cited by commenters with respect to the impact analysis was that reliance on historical data from the Physician Voluntary Reporting Program (PVRP) is inappropriate and does not take into consideration the development and maintenance of new workflows necessary to participate in PQRI and the new measure, measure specification changes and reporting option changes that occur on an annual basis.

Response: Information from the PVRP was used solely for developing cost estimates for participation in PQRI through the claims-based reporting mechanism; not through other reporting mechanisms. To develop our cost estimates for claims-based reporting, we applied information from PVRP on how much time it takes one eligible professional, in a median practice, to report one measure one time through claims to our assumptions. We recognize that the PVRP cost estimates are historical, but we do not believe that the process for reporting measures through claims has changed significantly from PVRP to PQRI in a way to considerably change the amount of time it takes one eligible professional to report one measure one time through claims. However, for our impact analysis, we did use a higher average practice labor cost than what was indicated in the information from the PVRP (that is, we used $55 per hour instead of $50 per hour) to account for increases in labor costs over time (74 FR 33655).

Comment: Other commenters had specific concerns about the estimates provided for participation in PQRI via registries. Some commenters offered anecdotal information that the annual cost to one practice of participating in a specific registry is approximately $3,000. Another commenter believed that more than 5 minutes is needed for

an eligible professional to authorize a registry to submit quality measure results and numerator and denominator data on their behalf. Other commenters were concerned that our estimate of $1,500 to $5,000 to purchase an EHR product was too low. One commenter noted that EHR systems have capital costs of over $1 million per year. Another commenter noted that researchers recently found that it would cost about $124,000 for a single doctor or small practice to upgrade to EHRs over 5 years.

Response: We appreciate the input from commenters and have taken the additional information provided by commenters into consideration to revise the estimates associated with registry and EHR reporting where appropriate in sections XIII.E.2 and XI. of this final rule with comment period.

For registry reporting, however, we note that many registries offer additional services beyond what is required to participate in PQRI. In the example provided by commenters, it is not clear whether those costs that are not related to reporting PQRI quality measure results and numerator and denominator data on PQRI measures have been taken into consideration and excluded. Our impact analysis is limited to the incremental cost of participating in PQRI.

b. Incentive Payments for the 2010 PQRI

For 2010, section 1848(m)(1)(B) of the Act authorizes the Secretary to provide an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished during the reporting period for 2010. Although PQRI incentive payments are only authorized through 2010 under section 1848(m)(1)(A) of the Act, section 1848(k)(2)(C) of the Act provides for the use of consensus-based quality measures for the PQRI for 2010 and subsequent years.

The PQRI incentive payment amount is calculated using estimated Medicare Part B PFS allowed charges for all covered professional services, not just those charges associated with the reported quality measures. ''Allowed charges'' refers to total charges, including the beneficiary deductible and coinsurance, and is not limited to the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is secondary payer. Amounts billed above the PFS amounts for assigned and non-assigned claims will not be included in the calculation of the incentive payment amount. In addition, since, by definition under section 1848(k)(3)(A) of the Act, ''covered professional services'' are limited to services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional, other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the Medicare Part B PFS are not included in the calculation of the incentive payment amount.

Under section 1848(m)(6)(C) of the Act, the ''reporting period'' for the 2008 through 2011 PQRI is defined to be the entire year, but the Secretary is authorized to revise the reporting period for years after 2009 if the Secretary determines such ''revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden.''

We are also required by section 1848(m)(5)(F) of the Act to establish alternative criteria for satisfactorily reporting and alternative reporting periods for registry-based reporting and for reporting measures groups. Therefore, eligible professionals who meet the alternative criteria for satisfactorily reporting for registry-based reporting and for reporting measures groups for the 2010 alternative reporting periods for registry-based reporting and for reporting measures groups will also be eligible to earn an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the alternative reporting periods for 2010 PQRI registry-based reporting or for reporting measures groups.

Prior to 2010, the PQRI was an incentive program in which determination of whether an eligible professional satisfactorily reported quality data was made only at the individual professional level, based on the NPI. Although the incentive payments were made to the practice(s) represented by the Tax Identification Number (TIN) to which payments are made for the individual professional's services, there were no incentive payments made to the group practice based on a determination that the group practice, as a whole, satisfactorily reported PQRI quality measures data. To the extent individuals (based on the individuals' NPIs) satisfactorily reported data on PQRI quality measures that were associated with more than one practice or TIN, the determination of whether an eligible professional satisfactorily reported PQRI quality measures data was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN.

However, section 1848(m)(3)(C)(i) of the Act requires that by January 1, 2010, the Secretary establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures for the PQRI for covered professional services for a reporting period, if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary. Therefore, beginning with the 2010 PQRI, group practices that satisfactorily submit data on quality measures also would be eligible to earn an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges for all covered professional services furnished by the group practice during the applicable reporting period. As required by section 1848(m)(3)(C)(iii) of the Act, payments to a group practice by reason of the process described above would be in lieu of the PQRI incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures. Therefore, an individual eligible professional who is participating in the group practice reporting option as a member of a group practice would not be able to separately earn a PQRI incentive payment as an individual eligible professional under that same TIN (that is, for the same TIN/NPI combination).

The following is summary of the comments we received regarding the 2010 PQRI incentive payment amount.

Comment: One commenter expressed support of the proposed extension of the PQRI incentive related to the group practice reporting option.

Response: We appreciate the commenter's support of the extension of the PQRI incentive to group practices.

Commenter: One commenter expressed a concern that the PQRI incentive payment is calculated as a percentage of the total Medicare billing of the individual eligible professional. The commenter expressed concern that for an equal amount of relative value unit work, eligible professionals in lower GPCI localities will receive as

much as 38 percent less PQRI payment for the same work, time, and effort used in providing quality care than eligible professionals in higher GPCI localities. The commenter suggested that PQRI incentive payment calculations should not be geographically adjusted and recommended that we change the basis of the incentive to RVUs rather than dollars billed to Medicare.

Response: While we acknowledge the effect of the GPCI on the calculation of the PQRI incentive amount, we do not have authority to change the basis for the calculation of the incentive amount, which is defined by section 1848(m)(1) of the Act.

Comment: A commenter requested clarification on whether radiopharmaceuticals are included in the PQRI and electronic prescribing incentive payments (see section II.G.5. of this final rule with comment period for further discussion of the E-Prescribing Incentive Program).

Response: Medicare Part B PFS allowed charges for radiopharmaceuticals have been included for determining the PQRI and electronic prescribing incentive payments. Radiopharmaceuticals are included as part of section 1861(s)(4) of the Act, which is incorporated into the list of PFS services cited in section 1848(j)(3) of the Act, and therefore, are part of the PQRI and electronic prescribing incentive calculations.

The relevant radiopharmaceutical codes are paid on the basis of invoices submitted by physicians. Such invoices are considered similar to contractor priced items or services. In addition, radiopharmaceuticals are classified as A codes (A9500–A9699) which inadvertently have not previously been included in Addendum B. Commencing with CY 2010, radiopharmaceuticals will be included in Addendum B as MPFSDB covered charges.

Furthermore, FAQ 8545, which can be accessed via the PQRI section of the CMS Web site, states that for ''PQRI participants who report satisfactorily, radiopharmaceuticals furnished as part of a covered professional service will be included in the basis of total Medicare Part B PFS allowed charges on which the incentive is calculated.''

No changes in radiopharmaceutical payment will be necessary. Payment will continue to be contractor-priced on the basis of invoices under the physician fee schedule.

c. 2010 Reporting Periods for Individual Eligible Professionals

As we indicated above, section 1848(m)(6)(C) of the Act defines ''reporting period'' for 2010 to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period for years after 2009, if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. In addition, section 1848(m)(5)(F) of the Act requires, for 2008 and subsequent years, the Secretary to establish alternative reporting periods for reporting groups of measures and for registry-based reporting.

In the CY 2010 PFS proposed rule (74 FR 33560), we proposed that the 2010 PQRI reporting period for the reporting of individual PQRI quality measures through claims or a qualified EHR would be the entire year (that is, January 1, 2010 through December 31, 2010). We also proposed to retain the 2 alternative reporting periods from the 2008 and 2009 PQRI for reporting measures groups and for registry-based reporting: (1) the entire year; and (2) a 6-month reporting period beginning July 1.

We solicited comments on these proposals and the decision not to propose a 6-month reporting period for claims-based reporting of individual PQRI quality measures. The following is a summary of the comments received regarding the proposed reporting periods.

Comment: Although a majority of the commenters supported the proposed reporting periods, we received several comments requesting that CMS retain or add a 6-month reporting period for claims-based reporting of individual measures. Many commenters requested this additional reporting period because they believe that doing so would encourage PQRI participation by allowing more time for eligible professionals to implement PQRI into their practice workflows and providing an opportunity for those who are hesitant to continue participating in PQRI until they receive feedback from the previous year to do so as well. Many commenters noted that reporting measures groups or reporting through a registry is not an option for them. Other commenters suggested that we maintain the 6-month reporting period for claims-based reporting of individual measures to maintain flexibility and uniformity in reporting periods for all PQRI reporting options to reduce confusion since many eligible professionals already believe that they can start claims-based reporting of individual measures in July.

Some commenters also requested that we have a 6-month reporting period for claims-based reporting of individual measures for situations in which an eligible professional who was planning to report through an alternative reporting mechanism may have to revert to claims-based reporting during the year, such as when an eligible professional's EHR system requires re-installation or significant maintenance or upgrades or when it takes longer for a practice to acquire a new EHR system than anticipated.

Response: Although many commenters requested that we ''retain'' the 6-month reporting period for claims-based reporting of individual measures, we would like to clarify there was no 6-month reporting period for claims-based reporting of individual quality measures available for either the 2008 or 2009 PQRI. In the 2008 and 2009 PQRI, the 6-month reporting period beginning July 1 was only available to eligible professionals who chose to report on measures groups or chose registry-based reporting (of either individual measures or measures groups). Prior to 2010 we did not have the authority to change the reporting period for claims-based reporting of individual measures, which is defined by section 1848(m)(6)(C)(i)(II) of the Act to be the entire year for 2008, 2009, 2010, and 2011. The only program year in which the reporting period was defined by statute to be the 6-month period beginning July 1 was the 2007 PQRI.

However, as a result of the compelling arguments presented by commenters, we will exercise our authority under section 1848(m)(6)(C)(ii) of the Act to revise the reporting period for the 2010 PQRI. Thus, in addition to the 12-month reporting period beginning January 1, 2010, we are finalizing a 6-month reporting period beginning July 1, 2010, available for claims-based reporting of individual measures for the 2010 PQRI.

Comment: One commenter supported not adding a 6-month reporting period for claims-based reporting of individual measures based on the assumption that we would eliminate claims-based reporting after 2010.

Response: As we stated in the CY 2010 PFS proposed rule (74 FR 33561), our ability to reduce or eliminate our reliance on claims-based reporting is contingent on there being an adequate number and variety of registries available and/or EHR reporting options. Since it is unlikely that there will be an adequate number of measures available for EHR reporting in 2011 for us to solely rely on registry and EHR reporting, we anticipate continuing to offer claims-based reporting options for the PQRI beyond 2010. Therefore, for the reasons discussed above, we believe that a 6-month reporting period for claims-based reporting of individual

measures should be available to the extent that claims-based reporting of individual measures continues to be an available option for eligible professionals.

Comment: One commenter requested that we provide a ''clarifying definition of the term 'qualified' '' with respect to the proposed 2010 PQRI reporting periods. The commenter noted that there is a similar term in industry use and a definition would help to avoid confusion.

Response: We are unclear as to how the term ''qualified'' relates to the PQRI reporting periods and believe that the commenter may be referring to our use of the term ''qualified'' with respect to registry and EHR reporting. As proposed for the 2010 PQRI (74 FR 33563 through 33565), for purposes of the PQRI, a ''qualified'' registry is one that has self-nominated to be able to submit PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of eligible professionals and that has been vetted by CMS to ensure the registry's meets certain technical and other requirements. Similarly, a ''qualified'' EHR vendor is one that has self-nominated to have one or more of its EHR products vetted by CMS to ensure that the product(s) meets certain technical and other requirements. Eligible professionals who wish to submit PQRI measures via an EHR may only use qualified EHR products to do so.

For the reasons discussed above and based on the comments, for 2010, we will retain a 12-month reporting period beginning January 1, 2010, which will be available for all reporting mechanisms and regardless of whether an individual eligible professional chooses to report on 2010 PQRI individual measures or measures groups. In addition, we are adopting a 6-month reporting beginning July 1, 2010, for claims-based and registry-based reporting of 2010 PQRI individual measures or measures groups. This 6-month reporting period will not be available for EHR-based reporting in 2010. Once we have additional experience with EHR reporting in PQRI we may consider including a 6-month reporting period for EHR reporting in future years.

In addition, an eligible professional who satisfactorily reports 2010 PQRI measures or measures groups through claims or a qualified registry for the 6-month reporting period will qualify to earn a PQRI incentive payment equal to 2.0 percent of his or her total estimated Medicare Part B PFS allowed charges for covered professional services furnished between July 1, 2010 and December 31, 2010 only. As required by section 1848(m)(1)(A) of the Act, the incentive payment will be calculated based on the eligible professional's charges for covered professional services furnished during the applicable reporting period only.

d. 2010 PQRI Reporting Mechanisms for Individual Eligible Professionals

When the PQRI was first implemented in 2007, there was only 1 reporting mechanism available to submit data on PQRI quality measures. For the 2007 PQRI, the only way that eligible professionals could submit data on PQRI quality measures was by reporting the appropriate quality data codes on their Medicare Part B claims (claims-based reporting). For the 2008 PQRI, we added a second reporting mechanism as required by section 1848(k)(4) of the Act, so that eligible professionals could submit data on PQRI quality measures to a qualified PQRI registry and request the registry to submit PQRI quality measures results and numerator and denominator data on the 2008 PQRI quality measures or measures groups on their behalf (registry-based reporting). For the 2009 PQRI, we retained the 2 reporting mechanisms used in the 2008 PQRI (that is, claims-based reporting and registry-based reporting) for reporting individual PQRI quality measures and for reporting measures groups.

To promote the adoption of EHRs, we also conducted limited testing of a third reporting mechanism for the 2008 and 2009 PQRI, which was the submission of clinical quality data extracted from an EHR, or the EHR-based reporting mechanism. No incentive payment was available to those eligible professionals who participated in testing the EHR-based reporting mechanism.

For the 2010 PQRI, we proposed to retain the claims-based reporting mechanism and the registry-based reporting mechanism. In addition, we proposed to accept PQRI quality measure data extracted from a qualified EHR product (that is, an EHR successfully completing the 2009 EHR Testing Program) for a limited subset of the proposed 2010 PQRI quality measures, as identified in Table 20 of the CY 2010 PFS proposed rule, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination based on that testing process that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. We solicited comments on the proposed reporting mechanisms for the 2010 PQRI, including the proposal to add an EHR-based reporting mechanism to the 2010 PQRI, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible.

We also discussed in the CY 2010 PFS proposed rule how we may consider significantly limiting the claims-based mechanism of reporting clinical quality measures for the PQRI after 2010. We solicited comments on our intent to lessen our reliance on the claims-based reporting mechanism for the PQRI beyond 2010.

The following is a summary of the comments received with regard to the proposed 2010 PQRI reporting mechanisms and our intent to lessen reliance on the claims-based reporting mechanism for the PQRI beyond 2010.

Comment: A majority of the commenters agreed with our reasons for lessening our reliance of claims-based reporting, supported alternative reporting mechanisms, or agreed that we should eventually transition away from claims-based reporting. At the same time, however, many of these same commenters urged us to reconsider limiting or eliminating claims-based reporting in 2011. Many commenters noted that claims-based reporting is currently the only option available for many eligible professionals and is the only reporting mechanism that is available to all eligible professionals. Other commenters cited claims-based reporting as the most convenient and cost-effective reporting mechanism available to eligible professionals, particularly solo practitioners and those in small practices. Also, the commenters noted that the EHR-based reporting mechanism initially will only be available on a limited basis so we should wait until EHR-based reporting becomes well established before transitioning away from claims-based reporting.

Response: We acknowledge the commenters' concerns that prematurely eliminating the claims-based reporting mechanism could create barriers to participation. While our goal continues to be to eventually phase-out claims-based reporting, our ability to reduce or eliminate our reliance on claims-based reporting is contingent on there being an adequate number and variety of registries available and/or EHR reporting options. As we stated previously, since it is unlikely that there will be an adequate number of measures available for EHR reporting in 2011 for us to completely eliminate the claims-based reporting mechanism, we

anticipate continuing to offer claims-based reporting options for the PQRI beyond 2010. We may, however, avoid introducing new claims-based measures and increasingly limit the circumstances in which claims-based reporting is an available reporting mechanism in order to encourage wider adoption of registry or EHR-based reporting.

Comment: One commenter recommended that, as we move towards reducing reliance on claims-based reporting for PQRI and increase registry-based and EHR-based options, we require registries and EHR vendors to seek and obtain a license to use the measures from the measure developers.

Response: PQRI measure specifications are developed in consultation with the measure developers and are made available to the public via posting on the PQRI section of the CMS Web site. Registries must use the PQRI measure specifications posted on the PQRI section of the CMS Web site to calculate reporting or performance unless otherwise stated. Similarly, eligible professionals who choose to participate in PQRI via the EHR-based reporting mechanism must use PQRI measure specifications to do so. We believe use of these measure specifications, regardless of the method by which quality data is submitted to PQRI for analysis, ensures consistent use and reporting of the measures.

Comment: One commenter expressed concern that registry and EHR-based reporting may not account for changes in patient condition over the course of the reporting period, and suggested reporting options be restructured so that results submitted using any method for a given patient population and a specific time period are identical.

Response: Regardless of the reporting mechanism an eligible professional selects to participate in PQRI, measure specifications and instructions for reporting a measure are consistent across mechanisms. If the measure specifications are analyzed properly by a registry or EHR vendor, the results should be very close or identical to the results for claims-based reporting, as the commenter requested.

Comment: Several commenters recommended uniform data submission deadlines be established across all reporting mechanisms. The commenter noted specifically that the proposed deadline for submission of data on PQRI quality measures for EHR-based reporting and for registry reporting was March 31, 2011 while the proposed deadline for submission of data on PQRI quality measures for other reporting mechanisms was February 28, 2011.

Response: We agree that the deadline for submission of data on PQRI quality measures for EHR-based reporting should be consistent with the deadline for submission of data on PQRI quality measures for claims-based reporting. Therefore, eligible professionals participating in the 2010 PQRI via EHR reporting or claims reporting will be required to submit all data on 2010 PQRI quality measures by no later than February 28, 2011 in order for the data to be included in the 2010 PQRI data analysis. Whereas CMS receives the raw data elements from eligible professionals for EHR and claims-based reporting and calculates the eligible professionals' reporting and performance results, registries must calculate and submit eligible professionals' quality measure reporting and performance results to us. In implementing registry-based reporting for the 2008 PQRI, we determined that a February deadline for submission of data on PQRI quality measures would be insufficient for registries to collect the data from their participants, calculate PQRI quality measure results, and submit the quality measure results and numerator and denominator data to CMS. Thus, registries are given additional time beyond February 28, 2011, to submit their data on behalf of participating eligible professionals. Eligible professionals participating in the 2010 PQRI via registry reporting should check with their selected registry regarding the registry's deadline for submission of data on PQRI quality measures from eligible professionals.

For the reasons discussed above and based on the comments received, as well as our experience with the EHR testing process to date, we are finalizing the option for an eligible professional to be able to choose to report data on 2010 PQRI quality measures through claims, through a qualified registry, or through a qualified EHR product (contingent on there being a qualified 2010 EHR product). Depending on which PQRI individual quality measures or measures groups an eligible professional selects, however, one or more of the 2010 reporting mechanisms may not be available for reporting a particular 2010 PQRI individual quality measure or measures group. The 2010 reporting mechanism(s) through which each 2010 PQRI individual quality measure and measures group can be reported is identified in Tables 11 through 27 of this final rule with comment period.

Regardless of the reporting mechanism chosen by an eligible professional, there is no requirement for the eligible professional to sign up or register to participate in the PQRI. However, there may be some requirements for participation through a specific reporting mechanism that are unique to that particular reporting mechanism. In addition to the criteria for satisfactory reporting of individual measures and measures groups described in sections II.G.2.e. and II.G.2.f. of this final rule with comment period, eligible professionals must ensure that they meet all requirements for their chosen reporting mechanism as described in sections II.G.2.d.1. through II.G.2.d.3. of this final rule.

(1) Final Requirements for Individual Eligible Professionals Who Choose the Claims-Based Reporting Mechanism

For eligible professionals who choose to participate in the 2010 PQRI by submitting data on individual quality measures or measures groups through the claims-based reporting mechanism, we proposed that the eligible professional would be required to submit the appropriate PQRI quality data codes on the professionals' Medicare Part B claims. As in previous years, an eligible professional would be permitted to start submitting the quality data codes for the eligible professional's selected individual PQRI quality measures or measures group at any time during 2010. Please note, however, that as required by section 1848(m)(1)(A) of the Act, all claims for services furnished between January 1, 2010 and December 31, 2010, would need to be processed by no later than February 28, 2011, to be included in the 2010 PQRI analysis.

We did not receive any comments specific to the requirements for individual eligible professionals who choose claims-based reporting. Therefore, we are finalizing the requirements as proposed. Eligible professionals should refer to the ''2010 PQRI Implementation Guide'' to facilitate satisfactory reporting of quality data codes for 2010 PQRI individual measures on claims and to the ''Getting Started with 2010 PQRI Reporting of Measures Groups'' to facilitate satisfactory reporting of quality data codes for 2010 PQRI measures groups on claims. By no later than December 31, 2009, both of these documents will be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri.*

(2) Final Requirements for Individual Eligible Professionals Who Choose the Registry-Based Reporting Mechanism

In order to report quality measures results and numerator and denominator data on the 2010 PQRI individual quality measures or measures group through a qualified clinical registry, we

proposed that eligible professionals would need to enter into and maintain an appropriate legal arrangement with a qualified 2010 PQRI registry. Such arrangements would provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of the eligible professional to CMS. Thus, the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as ''data submission vendors.'' The ''data submission vendors'' would have the requisite legal authority to provide clinical quality measures results and numerator and denominator data on individual quality measures or measures groups on behalf of the eligible professional for the PQRI. The registry, acting as a data submission vendor, would submit CMS-defined registry-derived measures information to the CMS designated database for the PQRI, using a CMS-specified record layout. The record layout will be provided to the registry by CMS.

To maintain compliance with applicable statutes and regulations, our program and its data system must maintain compliance with the HIPAA requirements for requesting, processing, storing, and transmitting data. Eligible professionals that conduct HIPAA covered transactions also would need to maintain compliance with the HIPAA requirements.

We proposed that eligible professionals choosing to participate in PQRI by submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures groups through the registry-based reporting mechanism for 2010 would be required to select a qualified PQRI registry and submit information on PQRI individual quality measures or measures groups to the selected registry in the form and manner and by the deadline specified by the registry (74 FR 33562).

In addition to meeting the above proposed requirements specific to registry-based reporting, we proposed that eligible professionals who choose to participate in PQRI through the registry-based reporting mechanism would need to meet the relevant criteria proposed for satisfactory reporting of individual measures or measures groups that all eligible professionals must meet in order to qualify to earn a 2010 PQRI incentive payment (74 FR 33563).

The following is a summary of the comments we received regarding the proposed requirements for individual eligible professionals who choose the registry-based reporting mechanism for the 2010 PQRI.

Comment: We received multiple comments requesting that we not wait until the qualified 2009 registries successfully submit their 2009 PQRI data to publish the list of qualified registries for 2010 PQRI. Commenters suggested that approved registries and the vetting of the self-nominated registries must occur earlier in the reporting year to allow eligible providers time to review and select an appropriate registry for their needs. A few commenters suggested that the list of eligible registries be made available prior to the start of the reporting period and one commenter recommended these registries be announced at least one month prior to the reporting period. Another commenter suggested the delay in listing qualified registries for 2010 PQRI would penalize 2009 qualified registries and could lead to an unintended consequence of decreasing the number of participating eligible professionals in 2010.

Response: We understand the concern posed by the commenters. We make every effort to increase the likelihood of successful data submission to PQRI on behalf of eligible professionals from qualified registries. While we cannot guarantee that a qualified registry will be able to send the quality measure data on behalf of their eligible professionals, a thorough vetting process has been established in order to qualify new registries. Part of this process includes determining the success of the 2009 PQRI registries with respect to their data submission. As in 2009, we are again requiring a self-nomination process for registries wishing to submit quality measures results and numerator and denominator data on 2010 PQRI quality measures or measure groups on behalf of eligible professionals for services furnished during the applicable reporting periods in 2010. Similar to previous years, the 2010 PQRI registry self-nomination process is based on a registry meeting specific technical and other requirements. While we strive to announce the qualified 2010 registries in advance of our target date, the selection process to determine qualified registries for 2010 PQRI is time-consuming. We anticipate posting the complete list of qualified 2010 registries as soon as we have completed vetting the registries interested in participating in the 2010 PQRI and identified the qualified registries for the 2010 PQRI. We expect to post the qualified registries no later than Summer 2010. In an attempt to address the commenters' requests, however, we do intend to post the names of the successful 2008 registries who intend to continue their participation in the 2010 PQRI. As stated in the CY 2010 PFS proposed rule (74 FR 33562 through 33563), this initial list of 2010 qualified registries will be available on the Web site by no later than December 31, 2009.

Comment: One commenter suggested we consider implementing a registry submission process that allows registries to demonstrate the recording and feedback of quality information, rather than go through a cumbersome method to transform the data for submission to CMS. The commenter noted that the current registry requirements appear to be designed in a way that would allow registry data to be transformed to claims data.

Response: We believe the commenter is reacting to the fact that the PQRI originated as a claims-based quality reporting program and he or she believes that registry requirements are still being designed to allow registry data to be transformed to claims data. We do not require registries to transform the quality data that they collect into a claims data format, as such a requirement would be overly prescriptive. In accordance with the registry qualifications set forth in section II.G.2.d.4. of this final rule with comment period, registries may collect and analyze data on PQRI measures and measures groups on behalf of eligible professionals pursuing incentive payment for the 2010 PQRI in any manner they deem appropriate for successful business operations. Therefore, an eligible professional who chooses registry-based reporting must submit data on PQRI quality measures or measures groups in whatever manner that is required by his or her selected qualified registry.

Comment: A commenter suggested that individual eligible professionals and small practices be offered a mechanism by which registry data could be cross-referenced with claims data to see if any other provider has supplied the appropriate care. The commenter remarked that this would allow eligible professionals to participate in registry-based reporting even if they do not have access to the quality information needed to report.

Response: The PQRI does not allow for one eligible professional's data to be ''cross-referenced'' with other eligible professional's data at the individual eligible professional level. This is however, consistent with one of the benefits of the physician group option

method of PQRI reporting, which will start in 2010 and is discussed in further detail in section II.G.2.g. of this final rule with comment period. Satisfactory participation in PQRI for individuals looks at reporting rates at the individual TIN/NPI level.

As a result of the comments, we are finalizing the requirements for individual eligible professionals who choose the registry-based reporting mechanism as proposed (74 FR 33562 through 33563) and discussed above.

We will post on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov* a list of qualified registries for the 2010 PQRI, including the registry name, contact information, and the 2010 measure(s) and/or measures group(s) for which the registry is qualified and intends to report. As proposed in the CY 2010 PFS proposed rule (74 FR 33562 through 33563), we will post the names of 2010 PQRI qualified registries in 2 phases. In either event, even though a registry is listed as ''qualified,'' we cannot guarantee or assume responsibility for the registry's successful submission of PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of eligible professionals.

In the first phase, we will post, by December 31, 2009, a list of those registries qualified for the 2010 PQRI based on: (1) Being a qualified registry for the 2008 and 2009 PQRI that successfully submitted 2008 PQRI quality measures results and numerator and denominator data on the quality measures; (2) having received a letter indicating their continued interest in being a PQRI registry for 2010; and (3) the registry's compliance with the 2010 PQRI registry requirements. By posting this first list of qualified registries for the 2010 PQRI, we seek to make available the names of registries that can be qualified at the start of the 2010 reporting period.

In the second phase, we will complete posting of the list of qualified 2010 registries as soon as we have completed vetting the additional registries interested in participating in the 2010 PQRI and identified the qualified registries for the 2010 PQRI, which we anticipate will be completed by no later than Summer 2010. An eligible professional's ability to report PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups using the registry-based reporting mechanism should not be impacted by the complete list of qualified registries for the 2010 PQRI being made available after the start of the reporting period. First, registries will not begin submitting eligible professionals' PQRI quality measures results and numerator and denominator data on the quality measures or measures groups to CMS until 2011. Second, if an eligible professional decides that he or she is no longer interested in submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures group through the registry-based reporting mechanism after the complete list of qualified registries becomes available, this does not preclude the eligible professional from attempting to meet the criteria for satisfactory reporting through another 2010 PQRI reporting mechanism.

The process and requirements that will be used to determine whether a registry is qualified to submit quality measures results and numerator data on PQRI quality measures or measures groups on an eligible professional's behalf in 2010 are described in section II.G.2.d.4. of this final rule with comment period.

(3) Requirements for Individual Eligible Professionals Who Choose the EHR-Based Reporting Mechanism

For eligible professionals who choose to participate in the 2010 PQRI by submitting data on individual quality measures through the EHR-based reporting mechanism, the requirements we proposed associated with EHR-based reporting other than meeting the criteria for satisfactory reporting of individual measures were to: (1) select a qualified EHR product and (2) submit clinical quality data extracted from the EHR to a CMS clinical data warehouse (74 FR 33563). Provided that our 2009 EHR data submission testing process is successful, we proposed to begin accepting submission of clinical quality data extracted from ''qualified'' EHRs on January 1, 2010, or as soon thereafter as is technically feasible. We proposed that eligible professionals will have until March 31, 2011, to complete data submission through qualified EHRs for services furnished during the 2010 PQRI reporting period.

We did not propose any option to report measures groups through EHR-based reporting on services furnished during 2010. Because EHR-based reporting to CMS of data on quality measures would be new to PQRI for 2010, we proposed, for EHR-based reporting, to make available only the criteria applicable to reporting of individual PQRI measures. The criteria applicable to reporting of measures groups were not proposed to be available for EHR-based reporting for 2010.

The following is a summary of the comments we received regarding the proposed requirements for individual eligible professionals who choose the EHR-based reporting mechanism.

Comment: Some commenters urged CMS to conduct extensive education and outreach prior to implementation of EHR reporting for PQRI.

Response: We agree that it is necessary to educate eligible professionals regarding this new reporting mechanism prior to implementation. We anticipate doing so through PQRI National Provider Calls, or other CMS-sponsored calls, and through educational materials to be posted on the PQRI section of CMS Web site once qualified EHR vendors have been identified for the 2010 PQRI.

Comment: One commenter noted his or her expectation that the 2009 EHR Testing Program would be a success. Another commenter suggested we include a discussion of the 2009 EHR submission testing experience in this final rule.

Response: We appreciate the positive comment and anticipate the ongoing 2009 EHR data submission testing process will be a success. However, we have not completed the final beta test as of the writing of this final rule with comment period and therefore, we are unable to discuss the results of the testing process in this final rule with comment period.

Comment: Many commenters supported further expanding reporting mechanisms and moving forward with accepting quality measures data through EHRs for the PQRI program. Several commenters were pleased with our proposal to accept PQRI quality measure data extracted from qualified EHRs in 2010 and one commenter urged us to quickly finalize testing for the EHR-based reporting mechanism and allow participation in 2010 PQRI through the use of qualified EHRs. One commenter indicated the use of EHR data submission will result in the reporting of more robust quality measures.

Response: We encourage the adoption and use of EHRs and are appreciative of the commenters' support. We believe EHR-based reporting will enhance the quality of PQRI data reported by eligible professionals participating in the PQRI program and, compared to claims-based reporting, will relieve some of the reporting burden on eligible professionals.

Comment: One commenter remarked that all eligible professionals should have the option to report measures through an EHR. Similarly, another

commenter indicated opposition to the decision to limit EHR based reporting initially to a narrow subset of the universe of approved quality measures.

Response: We have selected 10 measures which can be reported from an EHR in this initial phase of quality data reporting from EHRs for PQRI. As we gain experience accepting quality measures data electronically, we will evaluate the feasibility of expanding the list of measures for which we have this capability.

Comment: A commenter suggested we allow hospital EHR systems to qualify as a reporting method for PQRI, as some eligible professionals are employed in a hospital facility which may be using an EHR (for example, Registered Dietitians).

Response: To the extent that a hospital utilizes an EHR system that is ''qualified'' for the 2010 PQRI, eligible professionals employed by the hospital can participate in the 2010 PQRI by submitting PQRI quality measures data extracted from the hospital's EHR system. We do not place restrictions on who can self-nominate to have one or more of their EHR products become qualified PQRI EHR products as long as the vendor successfully completes the self-nomination process described in section II.G.2.d.5. of this final rule with comment period.

Comment: One commenter concurred that we cannot assume responsibility for the successful submission of data from an eligible professional's EHRs.

Response: As discussed in the proposed rule (74 FR 33563), we cannot assume responsibility for the successful submission of data from any eligible professional's EHR. It is each EHR vendor's responsibility to ensure that it has updated its EHR product(s) to facilitate PQRI quality measures data submission.

Comment: One commenter recommended a more streamlined approach to simplify the reporting criteria and time-periods for EHR users, by allowing EHR users to report on all their patients throughout the year.

Response: For satisfactory PQRI reporting via a qualified EHR, we are requiring all PQRI quality data to be submitted at one time. This will allow us to finish the infrastructure development and will also allow CMS and eligible professionals to avoid redundant reporting by inadvertently submitting data previously reported. Also, we believe one-time reporting is more convenient for eligible professionals.

Comment: One commenter commended CMS for acknowledging the Health Information Technology for Economic and Clinical Health (HITECH) Act and its focus on EHR implementation for incentive payments, meaningful use, and quality reporting. Some commenters suggested that we align initiatives in response to the health information technology (HIT) incentives and with applicable provisions in the HITECH Act regarding EHR certification requirements (that is, HITECH requires eligible professionals to use certified technology) so that eligible professionals can follow similar qualification and/or certification requirements as they prepare for quality reporting for both PQRI and the HITECH Act incentive programs. Another commenter remarked that EHR systems may require reinstallation or significant maintenance/upgrades to meet ''meaningful use'' criteria, which could potentially take months to achieve. Coordinating reporting standards may help minimize preparation and reporting requirements for program participants. Another commenter suggested we advocate to the Certification Commission of Health Information Technology for the inclusion of PQRI reporting capabilities in the certification criteria.

Response: Any EHR quality data submission will be required to comply with all current regulations regarding security and privacy. ''Meaningful use'' criteria will be reviewed as they are finalized and we will endeavor to align our work in the future, as appropriate. However, since meaningful use criteria have not yet been finalized, this comment is currently beyond the scope of this final rule with comment period.

Comment: One commenter remarked that an EHR is a tool that allows physicians to improve work flow and efficiency by electronically documenting data, however it does not, in all cases, have a quality feedback loop for providers. One commenter recommended that we provide back to the submitter, feedback on the extracted data that is received and then that feedback should be provided back to the eligible professional. The commenter also suggested we require that this process include return receipt for the data content prior to scoring for PQRI participation and calculation of incentive payment.

Response: With regard to a ''feedback loop,'' we note that the EHR data submission process is such that the eligible professional will know if the file he or she sent to us has been successfully submitted and accepted. A file which is not accepted will be returned with an error code. We note, however, that successful submission of a data file does not indicate that the eligible professional met the criteria for satisfactory reporting; it just indicates that we received the data file that was sent to us.

As is the case for other eligible professionals participating in PQRI, eligible professionals submitting their quality data through an EHR will receive a feedback report from us that will be accessible in the same manner as other feedback reports we provide for other reporting mechanisms.

As a result of the comments and our experience thus far with the ongoing 2009 EHR Testing Program, eligible professionals who choose the EHR-based reporting mechanism for the 2010 PQRI will be required to (in addition to meeting the criteria for satisfactory reporting of individual measures):

- Have a qualified EHR product;
- Have an active IACS user account that will be used to submit clinical quality data extracted from the EHR to a CMS clinical data warehouse;
- Submit a test file containing real or dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse via IACS between July 1, 2010 and September 30, 2010 (if technically feasible); and
- Submit a file containing the eligible professional's 2010 PQRI clinical quality data extracted from the EHR for the entire reporting period (that is January 1, 2010 through December 31, 2010) via IACS between January 1, 2011 through February 28, 2011.

As stated above, however, the 2009 EHR Testing Program is still ongoing. Since only EHR vendors that self-nominated to participate in the 2009 EHR Testing Program and successfully complete the 2009 EHR Testing Program will be considered qualified EHR vendors for the 2010 PQRI, there is no guarantee that there will be any qualified EHR vendors available for the 2010 PQRI. In addition, as we complete the 2009 EHR Testing Program and are better able to determine what is technically feasible, the actual dates on which eligible professionals are required to submit their test files and/or to begin submitting the actual 2010 PQRI data are subject to change.

As stated above, we also cannot assume responsibility for the successful submission of data from eligible professionals' EHRs. Any eligible professional who chooses to submit PQRI data extracted from an EHR should contact the EHR product's vendor to determine if the product is qualified and has been updated to facilitate PQRI quality measures data submission. Such professionals also should begin attempting submission soon after the opening of the clinical

data warehouse in order to assure the professional has a reasonable period of time to work with his or her EHR and/or its vendor to correct any problems that may complicate or preclude successful quality measures data submission through that EHR. As we indicated above, data submission for the 2010 PQRI will need to be completed by February 28, 2011.

The specifications for the electronic transmission of the 2010 PQRI measures identified in Table 14 of this final rule as being available for EHR-based reporting in 2010 are posted on Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site.

(4) Qualification Requirements for Registries

For the 2010 PQRI, we proposed to require a self-nomination process for registries wishing to submit 2010 PQRI quality measures or measures groups on behalf of eligible professionals for services furnished during the applicable reporting periods in 2010 (74 FR 33563). The proposed registry self-nomination process for the 2010 PQRI would be based on a registry meeting specific technical and other requirements.

To be considered a qualified registry for purposes of submitting individual quality measures and measures groups on behalf of eligible professionals who choose to report using this reporting mechanism under the 2010 PQRI, we proposed that a registry would need to:

- Be in existence as of January 1, 2009;
- Be able to collect all needed data elements and calculate results for at least 3 measures in the 2010 PQRI program (according to the posted 2010 PQRI Measure Specifications);
- Be able to calculate and submit measure-level reporting rates by TIN/NPI;
- Be able to calculate and submit, by TIN/NPI, a performance rate (that is, the percentage of a defined population who receive a particular process of care or achieve a particular outcome) for each measure on which the TIN/NPI reports;
- Be able to separate out and report on Medicare Part B FFS patients;
- Provide the name of the registry;
- Provide the reporting period start date the registry will cover;
- Provide the reporting period end date the registry will cover;
- Provide the measure numbers for the PQRI quality measures on which the registry is reporting;
- Provide the measure title for the PQRI quality measures on which the registry is reporting;
- Report the number of eligible instances (reporting denominator);
- Report the number of instances of quality service performed (numerator);
- Report the number of performance exclusions;
- Report the number of reported instances, performance not met (eligible professional receives credit for reporting, not for performance);
- Be able to transmit this data in a CMS-approved XML format. We expect that this CMS-specified record layout will be substantially the same as for the 2008 and 2009 PQRI. This layout will be provided to registries in 2010;
- Comply with a CMS-specified secure method for data submission, such as submitting its data in an XML file through an IACS user account;
- Submit an acceptable ''validation strategy'' to CMS by March 31, 2010. A validation strategy ascertains whether eligible professionals have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their participants' data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method;
- Enter into and maintain with its participating professionals an appropriate Business Associate agreement that provides for the registry's receipt of patient-specific data from the eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program;
- Obtain and keep on file signed documentation that each holder of an NPI whose data are submitted to the registry has authorized the registry to submit quality measures results and numerator and denominator data to CMS for the purpose of PQRI participation. This documentation must be obtained at the time the eligible professional signs up with the registry to submit PQRI quality measures data to the registry and must meet any applicable laws, regulations, and contractual business associate agreements;
- Provide CMS access (if requested) to review the Medicare beneficiary data on which 2010 PQRI registry-based submissions are founded;
- Provide the reporting option (reporting period and reporting criteria) that the eligible professional has satisfied or chosen; and
- Provide CMS a signed, written attestation statement via mail or e-mail which states that the quality measure results and numerator and denominator data provided to CMS are accurate and complete (74 FR 33563 through 33564).

With respect to the submission of 2010 measure results and numerator and denominator data on measures groups, we proposed to retain in 2010 the following registry requirements from the 2009 PQRI:

- Indicate the reporting period chosen for each eligible professional who chooses to submit data on measures groups;
- Base reported information on measures groups only on patients to whom services were furnished during the 12-month reporting period of January through December 2010 or the 6-month reporting period of July 2010 through December 2010;
- Agree that the registry's data may be inspected by CMS under our oversight authority if non-Medicare patients are included in the patient sample;
- Be able to report data on all of the measures in a given measures group and on either 30 patients from January 1 through December 31, 2010 (note this patient sample must include some Medicare Part B FFS beneficiaries) or on 80 percent of applicable Medicare Part B FFS patients for each eligible professional (with a minimum of 15 patients during the January 1, 2010 through December 31, 2010 reporting period or a minimum of 8 patients during the July 1, 2010 through December 31, 2010 reporting period); and
- Be able to report the number of Medicare FFS patients and the number of Medicare Advantage patients that are included in the patient sample for a given measures group (74 FR 33564).

In addition to the above requirements, we proposed the following new requirements for registries for the 2010 PQRI:

- Registries must have at least 25 participants;
- Registries must provide at least 1 feedback report per year to participating eligible professionals;
- Registries must not be owned and managed by an individual locally-owned single-specialty group (in other words, single-specialty practices with only 1 practice location or solo practitioner practices would be prohibited from self-nominating to become a qualified PQRI registry);
- Registries must participate in ongoing 2010 PQRI mandatory support conference calls hosted by CMS

(approximately 1 call per month), including an in-person registry kick-off meeting to be held at CMS headquarters in Baltimore, MD;

- Registries must provide a flow and XML of a measure's calculation process for each measure type that the registry intends to calculate; and
- Registries must use PQRI measure specifications to calculate reporting or performance unless otherwise stated (74 FR 33654).

The following is summary of the comments we received regarding the proposed qualification requirements and self-nomination process for registries for the 2010 PQRI.

Comment: We received several comments supporting many of the proposed qualification requirements for registries. A number of commenters agreed with the proposed requirement that registries must have a minimum of 25 participants. Similarly, one commenter remarked that the rationale for restricting a single practice site or solo practitioners from becoming a qualified registry is unclear and suggested that such entities should not be prohibited from becoming a qualified registry if they otherwise meet the requirements.

Response: We appreciate the supportive comments and believe that the additional requirements will improve registry based reporting. We limited registry participation to registries with at least 25 participants to conserve both CMS and eligible professionals' resources. Every registry goes through a vetting process which includes providing a sample measure flow illustrating how that registry will calculate an example of each type of measure it plans to submit to CMS. Additionally, registries must send in a sample XML file per the CMS specifications. This process occurs over a 2–3 month period and requires resources on the part of CMS, as well as the potential registry. Finally, a mandatory in-person registry kick-off meeting is held each year at CMS headquarters in Baltimore, MD. We believe the time and expense for a solo practitioner or single practice site to go through these steps would be prohibitive for most practitioners or practice sites. We do not believe that a majority of solo practitioners or single practice sites do not have the information technology (IT) staffing and resources needed to successfully complete the vetting process. Furthermore, we do not have the resources to provide IT support to such entities.

Comment: Numerous commenters strongly supported the requirement for registries to provide at least one feedback report per year to participating eligible professionals. Several commenters suggested the feedback reports from registries be issued to eligible professionals at some point during the reporting year so as to allow practices to assess their performance both on reporting and on performance, which may inform and promote internal quality improvement. One commenter stated providing eligible professionals with access to feedback reports during the reporting year would allow more accurate assessment of their performance before the close of the reporting period.

Response: We agree that the requirement for registries to provide at least one feedback report per year is an essential tool for quality improvement and must be provided to participating eligible professionals. The information contained within feedback reports will allow the eligible professional to assess the quality of care they provided to their patients during the specific reporting timeframe of the report. Furthermore the report may provide information for the promotion of internal quality improvement. While we will not require registries to provide more than the minimum number of feedback reports per year (one) to participating eligible professionals, we would be supportive of such a decision by a registry.

Comment: One commenter recommended we develop an audit program for registry vendors, as the PQRI program moves away from claims-based reporting. The commenter suggested eligible professionals participating in the PQRI look to CMS for assurance that registry vendors are regularly inspected for quality.

Response: As we gain more experience with registry submission, we would expect to further specify through rulemaking qualification requirements for registries that may include more comprehensive validation requirements. As we evaluate our policies, we plan to continue a dialogue with stakeholders to discuss opportunities for program efficiency and flexibility.

As a result of the comments, we are finalizing the 2010 qualification requirements for registries as proposed (74 FR 33563 through 33565).

We will post the 2010 PQRI registry requirements, including the exact date by which registries that wish to qualify for 2010 must submit a self-nomination letter and instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by November 15, 2009. We anticipate that new registries that wish to self-nominate for 2010 will be required to do so by January 31, 2010.

We are finalizing our proposal (74 FR 33563 through 33565) that registries that were ''qualified'' for 2009 and wish to continue to participate in 2010 will not need to be ''re-qualified'' for 2010 unless they are unsuccessful at submitting 2009 PQRI data (that is, fail to submit 2009 PQRI data per the 2009 PQRI registry requirements). Registries that are ''qualified'' for 2009 and wish to continue to participate in 2010 were required to indicate their desire to continue participation for 2010 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2010 and their compliance with the 2010 PQRI registry requirements by no later than October 31, 2009. Instructions regarding the procedures for submitting this letter were provided to qualified 2009 PQRI registries on the 2009 PQRI registry support conference calls.

If a qualified 2009 PQRI registry fails to submit 2009 PQRI data per the 2009 PQRI registry requirements, the registry will be considered unsuccessful at submitting 2009 PQRI data and will need to go through the full self-nomination process again to participate in the 2010 PQRI. By March 31, 2010, registries that are unsuccessful submitting quality measures results and numerator and denominator data for 2009 will need to be able to meet the 2010 PQRI registry requirements and go through the full vetting process again.

As stated in the proposed rule, the above registry requirements will apply not only for the purpose of a registry qualifying to report 2010 PQRI quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups, but also for the purpose of a registry qualifying to submit the proposed electronic prescribing measure for the 2010 E-Prescribing Incentive Program (see section II.G.5. of this final rule with comment period.

(5) Qualification Requirements for EHR Vendors and Their Products

As stated in the proposed rule (74 FR 33565), we proposed that EHR products listed on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a ''qualified'' EHR product (that is, the name of the vendor software product and the version that is qualified), would be available for the product's users to submit quality data to CMS directly from their system for the 2010 PQRI. We also proposed that we would post this list of qualified EHR vendors and products upon completion of the 2009 EHR Testing Program. We

anticipate the 2009 EHR Testing Program will be complete in early 2010.

Vendors' EHR products that are listed as ''qualified'' products were selected because the vendor self-nominated to participate in the 2009 EHR Testing Program and demonstrated that their products met the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program'' that were posted on the Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage* on December 31, 2008. Additionally, a vendor's EHR system must be updated according to the Draft 2010 EHR specifications posted on the Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site in order for an EHR vendor and its product to be qualified to submit information on 2010 PQRI measures.

As stated in the proposed rule (74 FR 33565), we proposed that the EHR vendor requirements described above would apply not only for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to submit data extracted from the EHR for the 2010 PQRI, but also for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to electronically submit data extracted from the EHR for the electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

The following is a summary of the comments received regarding the proposed 2010 EHR vendor qualification requirements and/or process.

Comment: One commenter recommended we implement an ongoing qualification process for new vendors and systems to enable inclusion of vendors that did not self-nominate or did not exist prior to the reporting year.

Response: Currently there is an ongoing qualification process for new EHR vendors and their products. EHR vendors interested in enabling their customers to submit data on PQRI that is extracted from their customers' EHRs must complete the EHR vendor quality data submission qualification process to be considered. For the 2010 PQRI, we will consider those EHR vendors who successfully completed the 2009 EHR Testing Program to be qualified for purposes of the 2010 PQRI. We will list the vendors qualified for the 2010 PQRI on the PQRI section of the CMS Web site upon completion of the 2009 PQRI EHR Testing Process. We anticipate completing the 2009 PQRI EHR Testing Process in early 2010.

During 2010, we expect to use a similar self-nomination process described in the ''Requirements for Electronic Heath Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program'' posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage* to qualify additional vendors for the 2011 PQRI. This document is subject to modification for the 2011 EHR self-nomination process. In any case, a vendor must self-nominate no later than January 31, 2010 to be eligible to participate in the 2011 PQRI Testing Process in 2010. Sometime in 2010, those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section page of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a ''qualified'' EHR product, which indicates that the vendor's product's users may submit quality data to CMS for the 2011 PQRI or subsequent years.

Comment: Some commenters commended the establishment of electronic standards for EHR-based reporting.

Response: We appreciate the supportive comments regarding the establishment of standard qualification requirements for EHR reporting.

Comment: A few of commenters expressed concern regarding the criteria set forth to rigidly define ''qualified'' EHRs. These concerns stem from the fact that some EHR products are developed for health care professionals specific to their needs (such as physical therapists, oncologists, etc.). Another commenter remarked that vendors for specialty-specific EHR products, such as oncology-specific EHR products, should not have to adjust their software to comply with certification procedures designed for a general ambulatory system. This commenter stated that the goal of EHRs should be to contain comprehensive information relevant to each patient's condition, their treatment plan and outcomes, but in some cases, specific terminology and data collection to support the eligible professional.

Response: We recognize that some EHR products have been designed to accommodate specific specialties, however, we are unclear how this would prevent the EHR product from meeting the EHR qualification requirements other than that there are no measures available for reporting via EHR. As we analyze the EHR reporting mechanism for 2010, we will consider expanding the measures available for electronic submission in the future.

Comment: One commenter recommended that we develop an audit program for EHR vendors, as the PQRI moves away from claims-based reporting. The commenter suggested eligible professionals participating in the PQRI look to CMS for assurance that vendors are regularly inspected for quality.

Response: Ensuring that vendors meet and perform properly would fall under the purview of their certifying body, which is currently CCHIT (if the product is CCHIT certified). During the qualification process (in which we conduct testing to ensure that the EHR can extract and transmit the necessary quality data elements), we evaluate the vendor and their program to see if the system is capable of performing the necessary tasks required for quality reporting to us for PQRI.

Comment: One commenter noted that some practitioners do not have authority under state law to prescribe medications, and thus products developed to meet the needs of these eligible professionals need not incorporate electronic prescribing functionality at this time.

Response: We recognize the concerns cited by the commenter and note that PQRI does not require qualified EHRs to have an electronic prescribing module in order for eligible professionals to participate in the PQRI via a qualified EHR. We believe the commenter is referring to the idea of ''meaningful use'' with respect to requiring an electronic prescribing module in the EHR system for purposes of the HITECH Act incentive programs. The issue of ''meaningful use'' is beyond the scope of this rule.

As previously stated above, only EHR vendors that self-nominated to participate in the 2009 EHR Testing Program and successfully complete the 2009 EHR Testing Program will be considered qualified EHR vendors for the 2010 PQRI. There is no guarantee that there will be any qualified EHR vendors available for the 2010 PQRI since the 2009 EHR Testing Program is still ongoing.

During 2010, we expect to use the self-nomination process described in the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program'' posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_AlternativeReporting Mechanisms.asp#TopOfPage,* to qualify additional EHR vendors and their EHR products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for program years after 2010. We anticipate that the requirements will be similar to those used to qualify EHR products for

the 2009 PQRI EHR Testing Program, but they may be modified based on the results of our 2009 EHR testing. Any updates to the EHR vendor requirements, which would be based on our experience with the 2009 EHR Testing Program and would be non-substantive in nature, will be made December 15, 2009, and will be posted on the PQRI section of CMS Web site at *http://www.cms.hhs.gov/PQRI.* As stated previously, any EHR vendor interested in having one or more of their EHR products ''qualified'' to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for 2011 and subsequent years must submit their self-nomination letter by January 31, 2010. Instructions for submitting the self-nomination letter will be provided in the 2011 EHR vendor requirements. At the conclusion of this process, those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section of the CMS Web site as a ''qualified'' EHR product, which indicates that the product's users may submit quality data to CMS for the 2011 PQRI or subsequent years.

e. Criteria for Satisfactory Reporting of Individual Quality Measures for Individual Eligible Professionals

As discussed in the proposed rule (74 33565 through 33568), for years after 2009, section 1848(m)(3)(D) of the Act authorizes the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily reporting data on quality measures. Based on this authority and the input we have received from stakeholders via the invitation to submit suggestions for the 2010 PQRI reporting options posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* in April 2009, we proposed 3 criteria for satisfactory reporting of individual PQRI quality measures for 2010. In an effort to continue to be consistent with the criteria of satisfactory reporting used in prior PQRI program years, we proposed to retain the following 2 criteria with respect to satisfactorily reporting data on individual quality measures in circumstances where 3 or more individual quality measures apply to the services furnished by an eligible professional:

- Report on at least 3 2010 PQRI measures; and
- Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

These criteria would apply to all 2010 PQRI reporting mechanisms available for reporting individual PQRI quality measures.

If an eligible professional has fewer than 3 PQRI measures that apply to the professional's services, then the professional would be able to meet the criteria for satisfactorily reporting data on individual quality measures by meeting the following 2 criteria:

- Reporting on all measures that apply to the services furnished by the professional (that is 1 to 2 measures); and
- Reporting each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We proposed that, as in previous years, these criteria for satisfactorily reporting data on fewer than 3 individual quality measures would be available for the claims-based reporting mechanism only. An eligible professional who has fewer than 3 PQRI measures that apply to the professional's services would not be able to meet the criteria for satisfactory reporting by reporting on all applicable measures (that is, 1 or 2 measures) through the registry-based or EHR-based reporting mechanisms.

We also proposed that an eligible professional who reports on fewer than 3 measures through the claims-based reporting mechanism in 2010 may be subject to the Measure Applicability Validation (MAV) process, which allows us to determine whether an eligible professional should have reported quality data codes for additional measures. When an eligible professional reports on fewer than 3 measures, we proposed to review whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of professional). If an eligible professional who reports on fewer than 3 measures in 2010 reports on a measure that is part of an identified cluster of closely related measures and did not report on any other measure that is part of that identified cluster of closely related measures, then the professional would not qualify to receive a 2010 PQRI incentive payment. Additional information on the MAV process can be found on the Analysis and Payment page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

In addition to the above criteria related to the number of measures on which an eligible professional would be required to report and the frequency of reporting, we proposed a third criterion for satisfactory reporting of individual measures. Based on our authority to revise the criteria for satisfactory reporting under section 1848(m)(3)(D) of the Act, we proposed (74 FR 33566) that an eligible professional also be required to report data on at least one individual measure on a minimum number of Medicare Part B FFS patients seen during the reporting period, as detailed below.

Regardless of the reporting mechanism chosen by the eligible professional, we proposed (74 FR 33567) that the minimum patient sample size for reporting individual quality measures be 15 Medicare Part B FFS patients for the 12-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report. Similarly, for the 6-month reporting period (which was proposed to be available for registry-based reporting only), we proposed that the minimum patient sample size for reporting on individual quality measures be 8 Medicare Part B FFS patients seen during the 6-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report.

We solicited comments on the proposal to add a minimum patient sample size criterion to the criteria for satisfactory reporting of data on individual quality measures. In addition, we solicited comments on the specific thresholds proposed for the 12-month reporting period (which was proposed to be available for claims-based, registry-based, and EHR-based reporting) and for the 6-month reporting period (which was proposed to be available for registry-based reporting only) for reporting individual quality measures.

The following is summary of the comments we received regarding the criteria for satisfactory reporting of individual quality measures for individual eligible professionals.

Comment: We received several comments supporting the proposed minimum patient sample size requirement for PQRI reporting of individual measures (that is, at least 15 patients for at least 1 measure for the 12-month reporting period and at least 8 patients for at least 1 measure for the 6-month reporting period). A few commenters supported the proposed minimum patient sample requirement

only if eligible professionals are required to meet the proposed threshold(s) for only 1 measure on which they report. Many commenters remarked that the minimum patient sample size requirement would encourage eligible professionals to select more applicable measures while discouraging eligible professionals from selectively reporting measures that are not representative of the types of services they normally provide in their practice. The commenters also remarked that the minimum sample size requirements will enhance the scientific validity of eligible professionals' performance results.

Response: We agree with the reasons cited by commenters for why the minimum patient sample size requirement is important. However, analysis of preliminary data from the 2008 PQRI indicates that a significant number of eligible professionals who would otherwise meet the criteria for satisfactory reporting would be adversely impacted by the addition of a minimum patient sample size requirement to the criteria for satisfactory reporting of individual measures by individual eligible professionals. Therefore, we are not finalizing the proposed minimum patient sample requirement. We will reconsider adding a minimum patient sample requirement to the criteria for satisfactory reporting of individual measures for future years upon further analysis of the PQRI data.

Comment: We also received comments requesting that we withdraw the proposed minimum patient sample requirement. The commenters were concerned that this requirement would create a participation barrier for certain eligible professionals, such as those who treat patients with rare conditions, those with small practices, and/or those with relatively few Medicare patients.

Response: For the reasons stated above and based on the commenters' concerns that such a requirement would create participation barriers for certain eligible professionals, we are not finalizing the proposed minimum patient sample size requirement for the PQRI reporting options for individual measures reporting. However, upon further analysis of the PQRI data, we will reconsider adding a minimum patient sample requirement to the criteria for satisfactory reporting of individual measures and explore other means of enhancing the PQRI criteria for satisfactory reporting for future years.

Comment: A majority of commenters believed that the proposed minimum patient sample size thresholds were appropriate. Some commenters, however, believed that the thresholds should be lowered to 10 or 15 for the 12-month reporting period and 6 for the 6-month reporting period. Other commenters believed that the thresholds should be higher, such as 25 or 30 for the 12-month reporting period.

Response: As stated previously, we are not finalizing the proposed minimum patient sample size requirement for reporting of 2010 PQRI individual measures. As we reassess this requirement for future years, we anticipate that we will continue to monitor the PQRI data on an ongoing basis and reassess the thresholds as needed for future years.

Comment: One commenter suggested that we reconsider allowing registry-based reporting for fewer than 3 measures, primarily to encourage eligible professionals to transition to registry-based reporting, as the claims-based option becomes phased out. This option may also allow greater flexibility for the program.

Response: We appreciate the intent of this comment, however, as in previous years, satisfactorily reporting data on fewer than 3 individual quality measures will only be available for the claims-based reporting mechanism. While we have received similar comments in the past, we continue to believe that permitting an eligible professional to report fewer than 3 measures through the registry-based reporting mechanism, (if fewer than 3 measures apply to him or her) would be inefficient at this time. Analytically it would be difficult to implement in that if an eligible professional submits fewer than 3 measures via registries, we would not know whether the eligible professional did so because only 2 measures applied to him or her or because the registry only accepts data for 2 of the provider's measures and he or she is reporting their third measure via claims. We also look for the most favorable method of reporting (that is, did the eligible professional report via a different method for a longer reporting period as well as whether an eligible professional satisfactorily reported under a different reporting option if he or she did not satisfactorily report for a particular reporting option). Accepting fewer than 3 measures from registries would increase the amount of cross-checking already required and makes it impractical to implement the commenter's suggestions at this time. Should the claims-based reporting mechanism be removed entirely from the PQRI program at some point in the future, we may revisit the issue of allowing registries to submit data for eligible professionals on fewer than 3 measures.

Comment: One commenter remarked that limiting EHR-based reporting to reporting on individual measures would limit the ability of some eligible professionals to report on the measures most relevant to them by eliminating one reporting mechanism (such as electronic reporting of the back pain measures for spine care).

Response: The EHR reporting mechanism for PQRI is still in an early development phase. This mechanism will be closely examined in the future, and may be expanded as appropriate. We believe that the first set of measures specified electronically have broad appeal in that they deal with common conditions such as diabetes and prevention.

Comment: Some commenters recommended significant changes to the criteria for satisfactory reporting that would not be consistent with the criteria for satisfactory reporting for prior years. For example, one commenter recommended that as the PQRI moves forward, the definition of satisfactory reporting should not be determined by what the commenter believed were somewhat arbitrary formulas but rather by accurate data that is able to reflect the ways in which a provider attempted to relay the quality of their patient care. Another commenter recommended that CMS phase out the existing process by which participating professionals select the measures on which they will be report. Instead CMS should assign each participating individual eligible professional with sets of measures for high volume conditions, based on services provided to their patient population. Similarly, another commenter recommended more criteria to guide measure selection by eligible professionals and that we require eligible professionals to report on 6 measures.

Response: We agree with commenters that as the PQRI matures, we will need to reassess the criteria for satisfactory reporting so that the information that we collect becomes more representative of the quality of care provided by eligible professionals. We also generally agree with the goals cited by the commenters, but have concerns that the specific suggestions offered by the commenters are not operationally practical and feasible when we take into account the vast numbers of eligible professionals and the diversity of their practices.

In addition, we believe that such significant changes should occur gradually. The criteria for satisfactory reporting are specifically defined under section 1848(m)(3)(A) of the Act. With

the authority under section 1848(m)(3)(D) of the Act to revise the criteria for satisfactory reporting for years after 2009, we have started to move towards the direction recommended by commenters with the introduction of the minimum patient sample size requirement for individual measures reporting for the 2010 PQRI. In addition, the new PQRI group practice reporting option also moves the PQRI towards the direction recommended by commenters in that we assign participating group practices both the measures and patients on which they are required to report. We will consider additional changes to the criteria for satisfactory reporting for 2011 and beyond and look forward to receiving stakeholder input on how we can revise the criteria for satisfactory reporting in an operationally practical and feasible manner to achieve the goals cited by commenters.

Comment: One comment was received with respect to the MAV, which allows us to determine whether an eligible professional should have reported quality data codes for additional measures when an eligible professional submits fewer than 3 individual PQRI measures. The commenter requested that CMS provide updates on newly identified clusters of closely related measures that will be employed in the MAV for 2010.

Response: No changes are planned for the MAV process for 2010. Additional information on the MAV process are listed on the Analysis and Payment page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.* However, we are contemplating some changes to the clusters of closely related measures based on the addition or removal of measures in the 2010 PQRI or the fact that certain measures included in these clusters will become registry-only measures for 2010. For example, if measures in an existing cluster are retired for the 2010 PQRI or are made registry-only then the cluster will be revised or deleted as appropriate.

Based on the new 2010 PQRI measures, the only new clusters being contemplated are a second preventive cluster, 2 new anesthesia care clusters, an ear care cluster, and an Ischemic Vascular (IVD) cluster. The second preventive cluster would consist of the following 2 measures: (1) Measure #114 Preventive Care and Screening: Inquiry Regarding Tobacco Use and (2) Measure #115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit. The first anesthesia care cluster would consist of 2 measures: (1) Measure #30 Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics and (2) Measure #76 Prevention of Catheter-Related Bloodstream Infections (CRBI): Central Venous Catheter (CVC) Insertion Protocol. The second anesthesia care cluster would consist of Measure #76 and the new Perioperative Temperature Management measure. For both of the anesthesia care clusters, however, the MAV would not apply if an eligible professional reports only Measure #76. Measure # 76 is a broadly applicable measure that encompasses services often provided by eligible professionals for whom Measure #30 and the Perioperative Temperature Management measure do not apply such as intensivists, hospitalists, internists, and emergency physicians. The ear care cluster would consist of the 3 new referral for otologic evaluation measures listed in Table 13 of this final rule. The IVD cluster would consist of the following 4 new PQRI measures:

- Ischemic Vascular Disease (IVD): Blood Pressure Management Control;
- Ischemic Vascular Disease (IVD): Complete Lipid Profile;
- Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control; and
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-Thrombotic.

By no later than December 31, 2009, we will post the final MAV process for 2010 and the final 2010 MAV clusters on the Analysis and Payment page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage.*

After considering the comments and the new 6-month reporting period for claims-based reporting of individual PQRI quality measures that we are adding to the 2010 PQRI at the request of commenters, the final 2010 criteria for satisfactory reporting of data on individual PQRI quality measures are summarized in Table 7 and are arranged by reporting mechanism and reporting period. The criteria for satisfactory reporting for claims-based reporting of individual PQRI quality measures for the 6-month reporting period are consistent with the criteria for satisfactory reporting of individual PQRI quality measures.

For the 2010 PQRI, there are a total of 5 reporting options, or ways, in which an eligible professional may meet the criteria for satisfactory reporting on individual quality measures. Each reporting option consists of the criteria for satisfactory reporting such data and results on individual quality measures relevant to a given reporting mechanism and reporting period. While eligible professionals may potentially qualify as satisfactorily reporting individual quality measures under more than one of the reporting criteria, reporting mechanisms, and/or for more than one reporting period, only one incentive payment will be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

TABLE 7—2010 CRITERIA FOR SATISFACTORY REPORTING OF DATA ON INDIVIDUAL PQRI QUALITY MEASURES, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the eligible professional; and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	January 1, 2010–December 31, 2010.
Claims-based reporting	• Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the eligible professional; and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	July 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 3 PQRI measures; and	January 1, 2010–December 31, 2010.

TABLE 7—2010 CRITERIA FOR SATISFACTORY REPORTING OF DATA ON INDIVIDUAL PQRI QUALITY MEASURES, BY REPORTING MECHANISM AND REPORTING PERIOD—Continued

Reporting mechanism	Reporting criteria	Reporting period
Registry-based reporting	• Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies. • Report at least 3 PQRI measures; and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	July 1, 2010–December 31, 2010.
EHR-based reporting	• Report at least 3 PQRI measures; and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	January 1, 2010–December 31, 2010.

f. Proposed Criteria for Satisfactory Reporting Measures Groups for Individual Eligible Professionals

For the 2010 PQRI, we proposed 2 basic sets of criteria for satisfactory reporting on a measures group (74 FR 33568). Both sets of criteria would apply to the claims-based and registry-based reporting mechanism. We did not propose to make the EHR-based reporting mechanism available for reporting on measures groups in 2010.

The first set of proposed criteria, which we proposed to make available for either the 12-month or 6-month reporting period in 2010, would be consistent with the 2009 criteria for satisfactory reporting of measures groups through registry-based reporting, which require the reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the applicable reporting period (with reporting required on a minimum number of Medicare Part B FFS patients commensurate with the reporting period duration). In the 2009 PQRI, there was a requirement under these criteria to report each measures group on at least 30 Medicare Part B FFS patients for the 12-month reporting period and at least 15 Medicare Part B FFS patients for the 6-month reporting period for registry-based reporting of measures groups. For the 2010 PQRI, we proposed to revise the requirement by making these criteria applicable to both registry-based and claims-based reporting and to change the number of Medicare Part B FFS patients on which an eligible professional would be required to report a measures group. We proposed to require an eligible professional who chooses to report on measures groups based on reporting on 80 percent of applicable patients to report on a minimum of 15 Medicare Part B FFS patients for the 12-month reporting period and a minimum of 8 Medicare Part B FFS patients for the 6-month reporting period, regardless of whether the eligible professional chooses to report the measures group through claims-based reporting or registry-based reporting.

The second set of proposed criteria, which we proposed to make available for the 12-month reporting period only, would be based on reporting on a measures group on a specified minimum number of patients (74 FR 33568). The second set of criteria would require reporting on at least 1 measures group for at least 30 patients seen between January 1, 2010 and December 31, 2010 to whom the measures group applies. Unlike the 2009 PQRI, which required that eligible professionals report on consecutive patients (that is, patients seen in order, by date of service), the 30 patients on which an eligible professional would need to report a measures group for 2010 would not need to be consecutive patients. The eligible professional would be able to report on *any* 30 unique patients seen during the reporting period to which the measures group applies. As in previous years, we proposed that for 2010, the patients, for claims-based reporting, would be limited to Medicare Part B FFS patients. For registry-based reporting, however, we proposed that the patients could include some, but not be exclusively, non-Medicare Part B FFS patients.

We solicited comments on our proposal to make the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures, including our proposal to revise the minimum sample size requirement related to satisfactory reporting on measures group through the registry-based reporting mechanism so that the criteria for satisfactory reporting of measures groups, regardless of reporting mechanism, would be identical to those proposed for reporting individual measures. We also solicited comments on our proposal to allow eligible professionals to report on measures groups on any 30 patients rather than a consecutive patient sample.

The following is summary of the comments we received regarding the criteria for satisfactory reporting measures groups for individual eligible professionals.

Comment: A few commenters agreed with the proposal to make the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures. One commenter cited that doing so makes the program more accessible and improves the commenter's ability to educate their members.

Response: We agree that making the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures should facilitate participation and enhance education efforts. For the reasons cited in section II.G.2.e. of this final rule with comment period, we are not finalizing our proposal to add a minimum patient sample requirement to the criteria for satisfactory reporting of individual measures. For the 2010 PQRI criteria for satisfactory reporting of measures groups, however, we will retain the minimum patient sample size requirement for those eligible professionals who choose to report on measures groups based on reporting on 80 percent of applicable patients and will finalize the lower thresholds for the minimum patient sample size requirement proposed for 2010.

Comment: We received numerous comments in support of our proposal to allow eligible professionals to report on measures groups on any 30 patients rather than a consecutive patient sample.

Response: We appreciate the commenters' positive feedback and hope that this change will make measures group reporting a more

attractive option for eligible professionals.

Comment: A few commenters were opposed to removing the requirement that the 30 patients be consecutive. A few commenters expressed that reporting of measures groups on consecutive patients reduces opportunities for selectively reporting patients or cases with more favorable results or would result in reporting on non-representative patient samples. Another commenter suggested the CMS eliminate the option of reporting on 30 patients through claims altogether or allow eligible professionals to report on non-consecutive patients but require a reporting period within which the 30 patients must be selected.

Response: We believe that retaining the option to report on 30 patients provides an incentive to eligible professionals to consider reporting measures groups instead of individual PQRI measures. As we have stated previously, we believe that measures groups enable a more comprehensive assessment of patient care for a given clinical condition or focus by addressing several aspects of care for that particular clinical condition or focus. Because we believe that measures groups may often provide more meaningful information about the care being furnished to Medicare beneficiaries than individual measures reported in isolation, we would like to encourage measures group reporting where possible.

With respect to commenters' concerns that removing the requirement that eligible professionals report on 30 patients, we reiterate that we believe that it would be difficult for eligible professionals to selectively choose which patients to report on since they must report on multiple measures for a given clinical condition or focus. We will, however, continue to monitor the PQRI data to determine whether this needs to be reassessed in future years.

Comment: We received some comments supporting the proposed revisions to the minimum patient sample size requirement for PQRI reporting of measures group (that is, reducing the thresholds from reporting at least 30 patients for at least 1 measures group for the 12-month reporting period and at least 15 patients for at least 1 measures group for the 6-month reporting period to 15 and 8 patients, respectively). Some commenters also remarked that the proposed thresholds were reasonable and appropriate. One commenter, however, remarked that the proposed thresholds were not adequate.

Response: We are finalizing the thresholds as proposed to provide eligible professionals with fewer than 30 patients an opportunity to report on PQRI measures groups for 2010. As identified in Table 8, the new minimum patient sample size thresholds for measures groups reporting for the 2010 PQRI will be 15 patients for at least 1 measures group for the 12-month reporting period and 8 patients for at least 1 measures group for the 6-month reporting period.

As suggested by another commenter, however, we will continue to monitor the PQRI data on an ongoing basis to determine whether the criteria for satisfactory reporting of measures groups, including the minimum patient sample size requirements, need to be re-evaluated for future years.

After considering the comments and for the reasons discussed previously, the final 2010 criteria for satisfactory reporting of data on measures groups are summarized in Table 8 and are arranged by reporting mechanism and reporting period. Accordingly, there are a total of 6 reporting options, or ways in which an eligible professional may meet the criteria for satisfactory reporting of measures groups for the 2010 PQRI. Each reporting option consists of the criteria for satisfactory reporting relevant to a given reporting mechanism and reporting period. As stated previously, while eligible professionals may potentially qualify as satisfactorily reporting on measures groups under more than one of the reporting criteria, reporting mechanisms, and/or for more than one reporting period, only one incentive payment will be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports. Similarly, an eligible professional could also potentially qualify for the PQRI incentive payment by satisfactorily reporting both individual measures and measures groups. However, only one incentive payment will be made to the eligible professional based on the longest reporting period for which the professional satisfactorily reports.

TABLE 8—2010 CRITERIA FOR SATISFACTORY REPORTING ON MEASURES GROUPS, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1, 2010—December 31, 2010.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2010—December 31, 2010.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 patients. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients.	January 1, 2010–December 31, 2010.

TABLE 8—2010 CRITERIA FOR SATISFACTORY REPORTING ON MEASURES GROUPS, BY REPORTING MECHANISM AND REPORTING PERIOD—Continued

Reporting mechanism	Reporting criteria	Reporting period
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2010–December 31, 2010.

g. Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices

As discussed above, for 2010, incentive payments will be available to group practices based on the determination that the group practice, as a whole (that is, for the TIN), satisfactorily reports on PQRI quality measures for 2010. If, however, an individual eligible professional is affiliated with a group practice participating in the group practice reporting option and the group practice satisfactorily reports under the group practice reporting option, the eligible professional will not be eligible to earn a separate PQRI incentive payment for 2010 on the basis of his or her satisfactorily reporting PQRI quality measures data at the individual level under that same TIN (that is, for the same TIN/NPI combination).

(1) Definition of ''Group Practice''

As stated in the proposed rule (74 FR 33570), section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define ''group practice.'' For purposes of determining whether a group practice satisfactorily submits PQRI quality measures data, we proposed that a ''group practice'' would consist of a physician group practice, as defined by a single TIN, with at least 200 or more individual eligible professionals (as identified by Individual NPIs) who have reassigned their billing rights to the TIN. We solicited comments on the proposed definition of ''group practice'' and our proposal to limit initial implementation of the PQRI group practice reporting option in 2010 to practices with 200 or more individual eligible professionals.

We also proposed to require group practices to complete a self-nomination process and to meet certain technical and other requirements in order to participate in the 2010 PQRI through the group practice reporting option (74 FR 33570). Group practices interested in participating in the 2010 PQRI through the group practice reporting option would be required to submit a self-nomination letter to CMS requesting to participate in the 2010 PQRI group practice reporting option. The following is a summary of the comments received regarding the proposed definition of ''group practice'' and the proposed self-nomination requirements.

Comment: Several commenters requested that we consider allowing smaller group practices to participate in this reporting option. Commenters were concerned that defining a group practice as 200 or more eligible professionals will lead to inaccurate data and further bias. Commenters encouraged us to look for ways to make the option more accessible for most group practices, including those that are not large group practices. Commenters requested that we consider whether in the future smaller group practice sizes should be allowed to participate in this option. Commenters also requested an alternative reporting option that uses statistical sampling for primary care oriented group practices that report measures only applicable to primary care physicians.

Response: We are appreciative of the commenters' thoughtful and constructive feedback and will take these concerns into consideration as we further develop the group practice reporting option. However, the group practice reporting option draws from the experiences of the Physician Group Practice (PGP) demonstration and the Medicare Care Management Performance (MCMP) demonstration. Each of these demonstrations included physician groups, but of different sizes. The PGP demonstration, which the group practice reporting option statistical sampling method is primarily modeled after, has been successful. We recognize that the group practice size of 200 or more individual eligible professionals limits participation. The inclusion of smaller group practices that is those with less than 200 individual eligible professionals, in the group practice reporting option was not proposed at this time because we believe it is unlikely that the smaller groups would be able to achieve 411 assigned Medicare beneficiaries per disease module or preventive care measure that we use under the demonstration. We will use this initial implementation year to further develop and refine aspects of the group practice reporting option and anticipate adapting and expanding this option to group practices less than 200 individual eligible professionals in future program years.

Comment: Several commenters were supportive of the group practice reporting option and thought that the group level data would be more meaningful. Commenters expressed that they are pleased to see the group practice reporting option which has many benefits and that CMS has taken a logical step of initially basing the group reporting process on the PGP and MCMP demonstrations. A commenter stated that group practice reporting option encourages voluntary reporting and promotes better care coordination and a team-based approach to care. One commenter suggested that the group practice reporting option reduces the significant resources which practices currently need to report measures. Another commenter stated the group

practice reporting option allows for increased provider participation and greater transparency in the healthcare provided to Medicare beneficiaries and suggested that the group practice reporting option will bring greater attention to a range of important therapeutic areas.

Response: The group practice reporting option is based on certain aspects of the PGP and the MCMP demonstrations. As defined, the group practice reporting option is intended for large physician groups to report on the high-cost chronic care quality measures for the specific disease modules and preventive care.

Comment: A few commenters supported the proposal for public reporting of group practices' performance results. One commenter, however, did so with the caveat that CMS monitors the results to ensure that there are no unintended consequences.

Response: We appreciate the commenters' positive feedback. As we have stated previously, it is our desire to be able to move towards public reporting of performance results for physicians and other eligible professionals. We believe that public reporting of group practice performance results provides an opportunity to move towards achieving that goal with PQRI data.

Comment: Several commenters were opposed to public reporting of the group practices' PQRI performance results because they believe:

- The reporting process for group practices needs to be further tested to ensure that there are no problems when we implement this process into PQRI, that validity and accuracy of the measures as a reflection of performance, and that there are no unintended consequences;
- CMS does not have specific authority from the Congress to post performance results;
- Doing so would be premature and discourage groups from participating in this option;
- Many issues identified in the CMS Issue Paper: Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services should be addressed prior to public reporting of performance results. Once addressed, public reporting of performance results should be conducted for all PQRI participants, not just group practices;

For similar reasons, other commenters requested that we delay public reporting of the group practices' performance results for at least 1 year or wait until we are fully satisfied with the reliability and validity of the performance data collected from group practices.

Response: Section 1848(m)(3)(C) of the Act requires us to establish a process under which eligible professionals in a group practice shall be treated as satisfactorily submitting data on PQRI quality measures and provides the Secretary with the discretion to determine how to set up this process. For group practices that choose to participate in the PQRI, participation in the group practice reporting option is voluntary. Group practices have a choice as to whether they wish to participate in PQRI with each eligible professional in the group participating individually using one of the reporting options available to individual eligible professionals or to participate as a group through the group practice reporting option.

Furthermore, we believe that public reporting of performance information at the group level does not present some of the same issues that public reporting of performance information at the individual eligible professional would. For example, as we stated in the CY 2010 PFS proposed rule, no performance results would be calculated based on small denominator sizes due to the reporting criteria for the group practice reporting option, which require that group practices report each disease module or preventive care measure under the group practice reporting option for 411 patients. Nevertheless, we take note of the importance of working through the concerns raised by commenters about publicly posting groups' performance results, especially commenters' concerns about doing so in the first year of implementation of the group practice reporting option and the importance of giving participating group practices an opportunity to review their results from the first year of the group practice reporting option before any information is publicly reported. Therefore, we are not finalizing our proposal to require group practices that wish to utilize the group practice reporting option in 2010 to agree to have their PQRI performance results publicly reported. In addition, we will not report any 2010 group practice performance results publicly except as otherwise required by law and will limit public reporting of information on the PQRI group practice reporting for 2010 to the information required by section 1848(m)(5)(G)(i) of the Act (that is, the names of group practices that satisfactorily submitted data on 2010 PQRI quality measures). Instead, we will consider implementing public reporting of group practices' performance results in the 2011 PQRI program year.

For the reasons discussed above and based on these comments, a group practice, for purposes of finalizing the 2010 PQRI group practice reporting option, a group practice will consist of a single TIN with at least 200 or more individual eligible professionals (as identified by Individual NPIs) who have reassigned their billing rights to the TIN. Additionally, the TIN and all Individual NPIs must be established Medicare providers.

To participate in the 2010 PQRI group practice reporting option, a group practice will be required to submit a self-nomination letter indicating the group practice's interest in participating in the 2010 PQRI group practice reporting option. Also, the letter must be accompanied by an electronic file submitted in a format specified by CMS (such as, a Microsoft Excel file) that includes the group practice's TIN and the Individual NPI numbers, name of the group practice, and names of all eligible professionals who will be participating as part of the group practice (that is, all Individual NPI numbers, which are established Medicare providers and associated with the group practice's TIN), a single point of contact for handling administrative issues as well as a single point of contact for technical support purposes. In addition, the self-nomination letter must also indicate the group practice's compliance with the following requirements:

- Have an active IACS user account;
- Agree to attend and participate in all mandatory training sessions; and
- Have billed Medicare Part A and Part B on or after January 1, 2009 and prior to October 29, 2009.

The final participation requirements listed above for group practices, including instructions for submitting the self-nomination letter and other requested information, will be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by November 15, 2009. Group practices that wish to self-nominate for 2010 will be required to do so by January 31, 2010. Upon receipt of the self-nomination letters we will assess whether the participation requirements were met by each self-nominated group practice using 2009 Medicare claims data.

As discussed further in section II.G.5. of this final rule, participation in the E-Prescribing Incentive Program is voluntary for group practices selected to participate in the PQRI group practice reporting option. However, we are requiring group practices to participate in the PQRI group practice reporting option in order to be eligible to

participate in the electronic prescribing group practice reporting option. Therefore, a group practice that wishes to participate in both the PQRI group practice reporting option and the electronic prescribing group practice reporting must notify CMS of its desire to do so at the time that it self-nominates to participate in the PQRI group practice reporting option.

(2) Process for Physician Group Practices to Participate as Group Practices and Criteria for Satisfactory Reporting Data on Quality Measures by Group Practices

For physician groups selected to participate in the PQRI group practice reporting option for 2010, we proposed (74 FR 33570) the reporting period would be the 12-month reporting period beginning January 1, 2010. We proposed that group practices would be required to submit information on these measures using a data collection tool based on the data collection tool used in CMS' MCMP demonstration and the quality measurement and reporting methods used in CMS' PGP demonstration. We proposed that physician groups selected to participate in the 2010 PQRI through the group practice reporting option would be required to report on a common set of 26 NQF-endorsed quality measures that are based on measures currently used in the MCMP and/or PGP demonstration and that target high-cost chronic conditions and preventive care.

As part of the data submission process, we proposed that, beginning in 2011, each group practice would be required to report quality measures with respect to services furnished during the 2010 reporting period (that is, January 1, 2010 through December 31, 2010) on an assigned sample of Medicare beneficiaries. We proposed to analyze the January 1, 2010 through October 29, 2010 (that is, the last business day of October 2010) National Claims History (NCH) file to assign Medicare beneficiaries to each physician group practice using the same patient assignment methodology used in the PGP demonstration.

We solicited comments on our proposal to adopt the PGP demonstration's quality measurement and reporting methods for the PQRI group practice reporting option. We specifically requested comments on the proposed patient assignment methodology and our proposal to use a data collection tool based on the one used in the MCMP demonstration as the reporting mechanism for physician groups selected to participate in the PQRI group practice reporting option.

We also proposed 2 criteria for satisfactory reporting of quality measures by a physician group (74 FR 33571). First, the physician group would be required to report completely on all of the proposed modules and measures listed in Table 34 of the proposed rule (74 FR 33588). Second, the physician group would be required to report completely on the first 411 consecutively assigned and ranked Medicare beneficiaries per disease module or preventive care measure.

The following is a summary of the comments we received regarding the proposed reporting option for satisfactory reporting on quality measures by group practices under PQRI.

Comment: One commenter was troubled by our proposal to model the PQRI group practice reporting option on the PGP demonstration since only half of PGP participants earned the incentive payment in the 3rd year of the demonstration. Another commenter noted that transitioning from individual eligible professional reporting to group practice reporting and from pay-for-reporting to pay-for-performance are major and challenging steps.

Response: Although we are planning to model the data collection and sampling process for the PQRI group practice reporting option after the PGP demonstration, we reiterate that the PQRI group practice reporting option is distinct from the PGP demonstration. The requirements to qualify for the incentive for PQRI are different from the requirements to qualify for an incentive payment under the demonstration. Whereas the PGP demonstration is a pay-for-performance demonstration, the PQRI group practice reporting option, like the remainder of the PQRI program, is solely a pay-for-reporting program. Group practices will qualify for a PQRI incentive payment based on meeting the reporting criteria. The PQRI incentive is *not* based on the group practice's performance on the measures nor on cost savings.

Comment: Several Commenters were concerned with the proposed patient assignment methodology. A few commenters asked CMS to reconsider requirements in order to refine the attribution methodology. One commenter opposed the retrospective attribution. One commenter suggested that we limit the E/M visits to primary care physicians selected other specialists, such as endocrinologists and cardiologists, who frequently provide and coordinate care for Medicare beneficiaries. Another commenter recommended the following refinements: (1) Use claims that have the CPT code for ''established'' patients only; (2) use claims that show the place of service code 11 (the code for office visits); and (3) require that the patients have had at least two office visits during the year in order to get into the sample.

Response: For the group practice reporting option, the patient sample will be based on Medicare Part B claims submitted by the group practices' TIN for services provided from January 1, 2010 through October 29, 2010. Only claims appearing in CMS NCH by October 29, 2010, will be considered in the patient sampling and assignment processes. Patients will be assigned to the group practice if they receive the plurality of their Office or Other Outpatient E/M services from the practice. The assigned patients who are selected for quality reporting must have received Office or Other Outpatient E/M services from the practice at least two times in the 10-month period. Furthermore, part-year and managed care patients will not be considered since we have incomplete claims for these individuals and groups may not have had sufficient time to impact the quality of their care. The retrospective attribution will allow CMS to more accurately assign patients using Medicare Part B claims that have been submitted by the group practices' TIN and processed into the NCH.

Comment: One commenter stated that the eligible professionals' affiliation with a group practice will dictate participation. A commenter asked us to allow group practices the flexibility to decide at any stage in the reporting process whether they want to continue with the group reporting process.

Response: The group practice reporting option provides an additional method of participating in PQRI. We do not dictate participation in PQRI, nor do we dictate whether an eligible professional participates in PQRI as an individual or as part of a group. PQRI is a voluntary program. The decision to participate in PQRI is at the discretion of the eligible professional. The eligible professional may participate in PQRI under multiple unique TIN/NPI combinations. An eligible professional may also report via more than one reporting option. The eligible professional cannot, however, receive a duplicate incentive payment for the same TIN/NPI combination.

The eligible professional can receive separate incentive payments by participating and qualifying under one or more unique TIN/NPI combinations. For example, if an eligible professional with TIN/NPI 003/001 participates in the group practice reporting option for one practice and also participates as an

individual using TIN/NPI 005/001 the eligible professional can qualify and earn a separate incentive payment for both TIN/NPI combinations because this is under a different TIN/NPI combination. In the event that a group practice is unsuccessful with the group practice reporting option, we will not conduct analysis to determine if the TIN/NPI qualified and is incentive eligible for other methods of PQRI participation. There is no appeals process for PQRI.

Comment: One commenter asked that we provide a mechanism for allowing group practices to deselect patients who have been assigned to the group practice.

Response: We understand that due to circumstances out of the groups' control (that is, death, unable to locate a medical record, etc.) that the group practice may not be able to report completely on 100 percent of the first 411 consecutively ranked assigned patient sample. The reporting tool allows for exclusions in certain instances and the group will not be required to populate the tool when these circumstances arise. In order to accommodate for such issues, each group practice will be assigned an over sample of patients, which will assure that the group practice reports completely on 411 consecutively assigned patients per disease module and preventive care measure to report on. The experience from the PGP demonstration has shown that this sampling method provides a sufficient number of assigned patients in the event that the deselection of assigned patients is warranted.

Comment: One commenter specifically supported using the Performance Assessment Tool (PAT), which is the data collection tool used in the PGP and MCMP demonstrations and proposed for use in PQRI group practice reporting option. Another commenter supports using the PAT and applauds quick turnaround time we anticipate for providing pre-populated results to practices.

Response: We appreciate the commenters' support for the data collection tool. We anticipate providing the selected group practices with a pre-populated data collection tool. Data fields will be pre-populated based on Medicare claims and demographic information for dates of service between January 1, 2010 and October 29, 2010. This tool will be modeled after the PAT currently in use for the MCMP program, with some modifications. The tool will require, at a minimum, standard PC image with Microsoft Office and Microsoft Access software installed and minimum software configurations for the group practices to successfully complete the data collection tool. The data collection tool may potentially provide a high level feedback (submission) report to the group practice, including such information as percentage of patients that have been completed in the sample and percentage of positive measure results. These features will allow the group practices to verify data prior to submitting it to us. We reserve the right to audit the data submitted by the group practices.

Comment: One commenter stated that only those group practices that have participated in the PGP demonstration will be successful in completing the tool and participating in the group practice reporting option.

Response: Group practices participating in the PGP demonstration will not be allowed to participate in the PQRI group practice reporting option in 2010. We acknowledge that there will be a learning period needed to become familiar with and to complete the tool. Group practices that are selected to participate in the PQRI group practice reporting option will be required to attend mandatory training sessions. Prior to these mandatory training sessions, we anticipate providing the group practices with a sample tool to become familiar with its functionality and reporting process. Additionally, we may establish periodic conference calls with the group practices, with most calls being held during the tool data entry period, to provide technical support to practices. The group practices will be required to designate administrative and technical points of contact to streamline and assist with communication.

Comment: One commenter stated that it would be challenging for group practices to report on 26 measures.

Response: We disagree that it would be challenging for group practices to report on 26 measures. We will be prepopulating the data collection tool that will be used for the PQRI group practice reporting option with claims and other demographic information on the group practices' assigned Medicare beneficiaries prior to sending the data collection tool to the groups to complete. Furthermore, we believe the burden of reporting the 26 measures is outweighed by the potential incentive payment. Completion of this data collection tool on all 26 measures for the required number of patients essentially qualifies the group practice for an incentive payment equal to 2.0 percent of the group practice's estimated total Medicare Part B PFS allowed charges for services furnished during the reporting period.

For the reasons discussed above and after taking into consideration the comments, we are finalizing the process group practices will be required to use to report data on quality measures for the 2010 PQRI as a group practice and the associated criteria for satisfactory reporting of data on quality measures by group practices, which are summarized in Table 9. Group practices participating in PQRI as a group practice will be required to report on all of the measures listed in Table 28 of this final rule with comment period. These quality measures are grouped into preventive care measures and four disease modules: diabetes; heart failure; coronary artery disease; and hypertension.

Although the process for physician groups to participate in PQRI as a group practice incorporates some characteristics and methods from the PGP demonstration and the MCMP demonstration, the PQRI group practice reporting option is a separate program with its own specifications and methodology from the PGP and MCMP demonstration programs. The reporting process for the group practice reporting option, including the use of a data collection tool as the reporting mechanism, will not be available to individual eligible professionals participating in the 2010 PQRI.

As stated in the proposed rule (74 FR 33570 through 33571), we will analyze the January 1, 2010 through October 29, 2010, NCH file to assign Medicare beneficiaries to each physician group practice using the same patient assignment methodology used in the PGP demonstration. Assigned beneficiaries will be limited to those Medicare FFS beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Assigned beneficiaries will not include Medicare Advantage enrollees. A beneficiary will be assigned to the physician group that provides the plurality of a beneficiary's office or other outpatient E/M allowed charges (based on Medicare Part B claims submitted for the beneficiary for dates of services between January 1, 2010 and October 29, 2010). Beneficiaries with only 1 visit to the group practice between January 1, 2010 and October 29, 2010, will be eliminated from the group practice's assigned patient sample. For inclusion in the sample, beneficiaries will be required to have at least 2 visits to the group practice between January 1, 2010 and October 29, 2010.

Once the beneficiary assignment has been made for each physician group

during the fourth quarter of 2010, we will provide each physician group selected to participate in the group practice reporting option with access to a database (that is, a data collection tool) that will include the group's assigned beneficiary samples and the quality measures listed in Table 28. We will prepopulate the data collection tool with the assigned beneficiaries' demographic and utilization information based on all of their Medicare claims data. We intend to provide the selected physician groups with access to this prepopulated database by no later than the first quarter of 2011. The physician group will be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Numerators for each of the quality measures will include all beneficiaries in the denominator population who also satisfy the quality performance criteria for that measure. Denominators for each quality measure will include a sample of the assigned beneficiaries who meet the eligibility criteria for that disease module or each preventive care quality measure. All of the assigned patients' inpatient, outpatient, and physician claims will be used in determining clinical eligibility for each module. Identical to the sampling method used in the PGP demonstration, the random sample must consist of at least 411 assigned beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent, or all, of the assigned beneficiaries to satisfactorily participate in the group practice reporting option. For each disease module or preventive care measure, the physician group will be required to report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively).

TABLE 9—2010 PROCESS FOR PHYSICIAN GROUP PRACTICES TO PARTICIPATE AS GROUP PRACTICES AND CRITERIA FOR SATISFACTORY REPORTING OF DATA ON QUALITY MEASURES BY GROUP PRACTICES

Reporting mechanism	Reporting criteria	Reporting period
• A pre-populated data collection tool provided by CMS.	• Report on all measures included in the data collection tool (26 measures); and • Complete the tool for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.	January 1, 2010–December 31, 2010.

h. Statutory Requirements and Other Considerations for 2010 PQRI Measures

(1) Statutory Requirements for 2010 PQRI Measures

As discussed in the proposed rule (74 FR 33571 through 33572), the statutory requirements with respect to the use of quality measures for the 2010 PQRI are different from the statutory requirements for previous program years. For purposes of reporting data on quality measures for covered professional services furnished during 2010 and subsequent years for the PQRI, subject to the exception noted below, section 1848(k)(2)(C)(i) of the Act, as added by MIPPA, requires that the quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act (that is, the National Quality Forum, or NQF). In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, however, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

Finally, section 1848(k)(2)(D) of the Act requires that for each 2010 PQRI quality measure, ''the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.''

(2) Other Considerations for Measures Selected for Inclusion in the 2010 PQRI

Based on the statutory requirements described above, we stated in the CY 2010 PFS proposed rule (74 FR 33572 through 33573) that we proposed to apply the following considerations with respect to the selection of 2009 PQRI quality measures for inclusion in the 2010 PQRI quality measure set:

• Where some 2009 PQRI quality measures have been endorsed by the NQF and others have not, those 2009 PQRI quality measures that have been specifically considered by NQF for possible endorsement, but NQF has declined to endorse it, will not be included in the 2010 PQRI quality measure set (that is, we will retire the measure for 2010).

• In circumstances where no NQF-endorsed measure is available, we will exercise the exception under section 1848 (k)(2)(C)(ii) of the Act. Under these circumstances, a 2009 PQRI quality measure that previously (that is, prior to January 31, 2009) has been adopted by the AQA will meet the requirements under the Act and it would be appropriate for eligible professionals to use the measure to submit quality measures data and/or quality measures results and numerator and denominator data on quality measures, as appropriate.

• Although we are not including any 2009 PQRI measures that have not been endorsed by the NQF or adopted by the AQA in the final 2010 PQRI quality measure set, we acknowledge that section 1848(k)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF) as long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been endorsed by the NQF and/or, prior to January 31, 2009, adopted by the AQA.

• The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for

developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.

• 2009 PQRI measures that were part of the 2007 and/or 2008 PQRI in which the 2007 and 2008 PQRI analytics indicate a lack of significant reporting and usage were not considered for inclusion in the 2010 PQRI.

In addition to reviewing the 2009 PQRI measures and previously retired measures, for purposes of developing the proposed 2010 PQRI measures, we reviewed and considered measure suggestions including comments received in response to the CY 2009 PFS proposed rule and final rule with comment period. Additionally, suggestions and input received through other venues, such as an invitation for measures suggestions posted on the PQRI section of the CMS Web site in February 2009 were also reviewed and considered for purposes of our development of the list of proposed 2010 PQRI quality measures. All measures and measures groups reviewed for potential inclusion in the 2010 PQRI measure set are listed in the ''Table of 2010 Measure Suggestions'' posted on the Statute/Regulations/Program Instructions page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/05_StatuteRegulationsProgramInstructions.asp#TopOfPage.*

With respect to the selection of new measures (that is, measures that have never been selected as part of a PQRI quality measure set for 2009 or any prior year), we stated in the CY 2010 PFS proposed rule (74 FR 33572 through 33573) that we would apply the following considerations, which include many of the same considerations applied to the selection of 2009 PQRI quality measures for inclusion in the 2010 PQRI quality measure set described above:

• High Impact on Healthcare.

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

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

• NQF Endorsement.

+ Measures must be NQF-endorsed by July 1, 2009, in order to be considered for inclusion in the 2010 PQRI quality measure set.

+ Although we did not propose to include any new measures that were not endorsed by the NQF by July 1, 2009 in the final 2010 PQRI quality measure set, we acknowledge that section(k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF). As long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been adopted by the AQA or other consensus organization identified by the Secretary.

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

• Address Gaps in PQRI Measure Set.

+ Measures that increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI. We seek to achieve broad ability to assess the quality of care furnished to Medicare beneficiaries, and ultimately to compare performance among professionals. We seek to increase the circumstances where eligible professionals have at least three measures applicable to their practice and measures that help expand the number of measures groups with at least four measures in a group.

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

Other considerations that we proposed to apply to the selection of measures for 2010, regardless of whether the measure is a 2009 PQRI measure or not, were:

• Measures that are functional, which is to say measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. This leads to preference for measures that reflect readiness for implementation, such as those that are currently in the 2009 PQRI program or have been through testing. The purpose of measure testing is to reveal the measure's strengths and weaknesses so that the limitations can be addressed and the measure refined and strengthened prior to implementation. For new measures, preference is given to those that can be most efficiently implemented for data collection and submission. Therefore, any measures that have been found to be technically impractical to report because they are analytically challenging due to any number of factors, including those that are claims-based, have not been included in the 2010 PQRI. For example, in some cases, we are replacing existing 2009 PQRI measures with updated and improved measures that are less technically challenging to report.

• For some measures that are useful, but where data submission is not feasible through all otherwise available PQRI reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s)

in which its submission is feasible. For example, we proposed to limit reporting of some measures that previously were available for claims-based reporting and registry-based reporting to registry-based reporting only because they were technically challenging to report and/or analyze through the claims-based reporting mechanism (74 FR 33579 through 33580).

We also reviewed 33 measures that have been retired from the PQRI in previous years using the considerations for selecting measures for the 2010 PQRI discussed above (74 FR 33573). None were found to be eligible for inclusion in the 2010 PQRI quality measure set because they did not meet the criteria described above.

We solicited comments on the implication of including or excluding any given measure or measures in the final 2010 PQRI quality measure set and to our approach in selecting measures. As we stated in the proposed rule, we recognize that some commenters may also wish to recommend additional measures for inclusion in the 2010 PQRI measures that we did not propose (74 FR 33573). While we may consider such recommended measures for inclusion in future measure sets for PQRI and/or other programs to which such measures may be relevant, we will not be able to consider such additional measures for inclusion in the 2010 measure set.

(3) Summary of Comments and Responses

The following is a summary of the comments we received regarding the statutory requirements and other considerations for the selection of 2010 PQRI measures.

Comment: Some commenters appreciated our continued efforts to expand the PQRI quality measure set with measures that are scientifically valid and minimize eligible professional burden. In order to promote the provisions that reflect up-to-date care for beneficiaries as the program matures, these commenters urged us to revise its quality measures regularly to reflect current guidelines.

Response: We appreciate these supportive comments regarding our continued efforts to expand the PQRI quality measure set. As the program evolves, we will continue to consider more effective processes to update and/or revise the PQRI quality measure set to reflect the most current guidelines of care.

Comment: Several commenters supported our proposal to only use quality measures that have been endorsed by the NQF, thereby ensuring a rigorous evaluation of the measures by multiple stakeholders and providing an opportunity for public comment from those various stakeholders. These commenters suggested the utilization of NQF endorsed measures reflect areas that are common to providers, allow for appropriate measurement of services provided in Medicare, and provide a thorough standardized review framework. One commenter, however, was unclear whether NQF or consensus organization endorsement or adoption is required for all suggested measures for 2010 or 2011 or whether the Secretary can suggest measures of her own accord when measures do not already exist with this endorsement.

Response: We appreciate the commenters' supportive feedback and agree with the points raised by the commenters with respect to the benefits of NQF endorsement. As we stated above, subject to the exception under section 1848(k)(2)(C)(ii) of the Act, measures selected for the 2010 PQRI are required by section 1848(k)(2)(C)(i) of the Act to be endorsed by Secretary. Section 1848(k)(2)(C)(ii) of the Act authorizes us to select measures for the 2010 PQRI and subsequent years that have not been endorsed by the NQF in a specified area or medical topic for which a feasible and practical measure has not been so endorsed as long as we give due to consideration to measures that have been endorsed or adopted by other consensus organizations identified by the Secretary.

Comment: One commenter notes that the proposed rule makes allowance for measures used in the 2009 PQRI that have not been endorsed by the NQF but were previously approved by the AQA. The commenter believes that for new measures, NQF endorsement should be a requirement not only for the PQRI measures but also for measures for the hospital outpatient quality data reporting program, or HOP QDRP. While the underlying statutes for both reporting programs differ, the commenter believes CMS has the discretion to adopt a consistent policy with respect to NQF endorsement.

Response: As discussed previously, the requirements for measures selected for the PQRI are defined in statute. The requirements for other quality data reporting programs are beyond the scope of this rule.

Comment: Some commenters recommended that we require NQF endorsement not only of individual measures, but also NQF endorsement of measures groups.

Response: When we create measures groups, we only utilize individual measures that meet statutory requirements. All measures in current measures groups meet the statutory requirements. We are unaware of any efforts by NQF to review groups of measures for separate endorsement. Section 1848(m)(5)(F) of the Act required us to establish alternative criteria for satisfactorily reporting and alternative reporting periods for reporting groups of measures for 2008 and subsequent years but did not establish any additional limitations on the discretion of the Secretary.

Comment: Some commenters urged us to recognize additional consensus organizations to endorse quality measures for the PQRI. The commenters suggested we recognize measure development organizations such as the American Medical Association's Physician Consortium for Performance Improvement (AMA–PCPI) or the National Committee for Quality Assurance (NCQA) as consensus endorsement organizations.

Response: MIPPA modified the requirements for measure selection by the Secretary for PQRI as previously described. Further, as we stated in response to similar comments in previous years, we are unaware of other consensus organizations that are comparable to the NQF in terms of meeting the formal requirements of the NTTAA or of organizations other than AQA that do not strictly meet the requirements of the National Institute of Standards and Technology Act (NISTA), as amended by the NTTAA but that feature the breadth of stakeholder involvement in the consensus process necessary to meet the intent of the Act.

Comment: One commenter suggested that the measure development process should not be restricted to physician-controlled organizations but that the measure development process must include relevant physician input due to their expertise in the subject areas.

Response: We are in agreement that while physician expertise is an important ingredient in measure development and in the consensus process, physicians should not be in complete control of the process of measure development. Any such restriction would unduly limit the basic development of physician quality measures.

Comment: A few commenters did not believe that endorsement or adoption by the NQF or the AQA, respectively, was a necessary condition for inclusion of a measure in the PQRI for 2010 or subsequent years. One commenter urged us to use measures from other nationally recognized sources in areas for which NQF-endorsed measures are not available on the condition that the

measures are expedited through the NQF endorsement process.

Response: We agree that NQF endorsement or AQA adoption is not a necessary condition for all measures included in the PQRI quality measure set. As stated previously, section 1848(k)(2)(C)(ii) of the Act does permit us to select measures for the 2010 PQRI and subsequent years that have not been endorsed by the NQF in a specified area or medical topic for which a feasible and practical measure has not been so endorsed as long as we give due consideration to measures that have been endorsed or adopted by other consensus organizations identified by the Secretary.

We proposed to exercise this authority for 2010 in the CY 2010 PFS proposed rule (74 FR 33576 through 33579) by proposing to include in the 2010 PQRI several 2009 PQRI measures that had not yet achieved NQF endorsement but that were AQA adopted. As we stated in the proposed rule, we would include such measures in the 2010 PQRI as long as a measure had not been reviewed by the NQF prior to July 1, 2009 and specifically declined for endorsement.

We are also exercising this authority with respect to our decision to finalize 3 proposed new measures (that is, Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear; Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days; and Referral for Otologic Evaluation for Patients with History of Sudden or Rapidly Progressive Hearing Loss) that were neither NQF endorsed prior to July 1, 2009 nor AQA adopted prior to January 31, 2009. We decided to finalize these 3 measures despite the lack of consensus endorsement or adoption due to the lack of measures available for audiologists to report on. Audiologists are a new a category of eligible professionals that were added to the list of professionals eligible to participate in the PQRI beginning with the 2009 PQRI.

We stress, however, that inclusion of measures that are not NQF endorsed or AQA adopted is an exception to the requirement under section 1848(k)(2)(C)(i) of the Act that measures be endorsed by the NQF. Therefore, we do believe that this exception authority should be exercised in very limited circumstances, such as when few or no measures are available for a particular specialty or category of eligible professionals to report.

Comment: Several commenters suggested what the PQRI quality measure set should focus on and how the PQRI quality measure set should evolve. One commenter believes the PQRI quality measure set should evolve with the development of better clinical evidence and a greater understanding of the benefit-cost tradeoffs of particular services and treatments. Another commenter urged us to adopt quality measures that would address the existing gaps in quality and that focus on services with the potential to deliver high value to Medicare beneficiaries and to avoid services that may have little or no value to beneficiaries, such as high-cost or high-volume services. One commenter suggested additional criteria that should be utilized in the selection of measures, which include selecting: (1) More outcome and resource use measures; (2) care coordination measures; (3) measures addressing appropriateness of care which deliver high value to Medicare patients; (4) measures that allow for assessing and reporting on disparities of care. Some commenters also believe the measures selected for PQRI should not reward eligible professionals for providing marginally effective care or care that is already routinely furnished.

Response: In the 2010 PFS proposed rule, we listed the considerations that we applied for the selection of proposed 2010 PQRI quality measures. As described above, many of these considerations reflect the commenters' suggestions, particularly our focus on:

- Measures with high impact on healthcare.
- Measures that support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries (such as, prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT).
- Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.
- Measures that address gaps in the PQRI measure set in order to increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI.

Comment: Some commenters encouraged us to identify and add more quality measures and to develop interim opportunities for eligible professionals that have a dearth of available measures to participate in PQRI. One commenter specifically recommended that we expand the number of measures to reflect all types of services provided to all beneficiaries.

Response: Despite our efforts to expand the PQRI quality measure set to increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI, we are aware that there remains some gaps in the PQRI quality measure set. However, we largely depend on the development of measures by professional organizations and other measure developers. Although we had significant involvement in the development of measures applicable to eligible professionals at the start of the PQRI, ideally we would not need to be closely involved in the development of clinician-level quality measures but would select from measures that meet the statutory requirements. Thus, we encourage professional organizations and other measure developers to fund and develop measures that address some of the gaps identified by the commenters.

Comment: Some commenters recommended we utilize data from previous reporting periods to determine the appropriateness and effectiveness of the measures. The commenters recommended that we continually evaluate and revise the criteria for measure selection to ensure measures align with clinical practice and can be reported with minimal administrative burden.

Response: We will continue to evaluate data from previous reporting periods to assess the appropriateness and effectiveness of the PQRI measures. We will also continue to work with measure developers to urge alignment of the PQRI measures with clinical practice as the program evolves and matures.

i. The Final 2010 PQRI Quality Measures for Individual Eligible Professionals

For 2010, we proposed that final PQRI quality measures would be selected from 153 of the 2009 PQRI measures and the measures listed in the ''Table of 2010 Measure Suggestions'' posted on the Statute/Regulations/Program Instructions page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/05_StatuteRegulationsProgramInstructions.asp#*

TopOfPage. We proposed to include a total of 176 measures (this includes both individual measures and measures that are part of a proposed 2010 measures group) on which individual eligible professionals can report for the 2010 PQRI (74 FR 33574 through 33587, and 39032). In addition, we proposed to retire 7 measures because they did not meet one or more of the considerations for selection of proposed 2010 measures (74 FR 33574). In addition we proposed 13 measures groups for the 2010 PQRI (74 FR 33582 through 33587).

The following is a summary of the comments received on the 2010 PQRI measures in general and comments on the measures from the 2009 PQRI not proposed for inclusion in the 2010 PQRI, which are addressed below. Comments specific to measures proposed for inclusion in the 2010 PQRI are addressed in sections II.G.2.i.1. through II.G.2.i.5. below.

Comment: Several commenters requested or recommended that we make readily available on an ongoing basis more detailed information on the measure development process and on measures in development.

Response: We agree that it is desirable for the public to have information on the measures development process and measures in development. To this end, we have developed a standardized process to be used for CMS contracted measures development. This standardized process is detailed in the ''Measures Management System Blueprint'' found on the CMS Web site at *http://www.cms.hhs.gov/apps/QMIS/mmsBlueprint.asp*.

As stated previously, however, we largely depend on the development of measures by professional organizations and other measure developers for the PQRI. Many major measures developers follow a similar process for the measures that they develop, in that they publish measures and specifications during development and seek public comment. Both the NQF and AQA also publish measures and specifications during their consensus processes and seek public comment.

Comment: Numerous commenters requested final measure specifications for the 2010 PQRI be published as far in advance of the beginning of the reporting period as possible, and that more detailed information about measures proposed or finalized for use in PQRI be published at the same time as or in advance of future rulemaking.

Response: We agree with the commenters that it is desirable to provide final measure specifications sufficiently in advance of the reporting period to allow reasonable time for professionals to analyze new or revised measures and implement any needed changes in their office workflows to accurately capture and successfully submit data on a selection of measures applicable to their practice on which they can act to improve the quality of the services they furnish.

Having detailed information on measures available in advance of the reporting period also enhances the ability of vendors (such as practice management software, billing services, and electronic health records vendors) to support professionals' successful implementation of revised data-capture processes for the measures. Our intent is to provide the final list of 2010 PQRI measures and the detailed measures specifications on the PQRI section of the CMS Web site by November 15, 2009, but no later than December 31, 2009. These detailed specifications will include instructions for reporting and identifying the circumstances in which each measure is applicable. The detailed technical specifications for measures in the final listing for the 2010 PQRI remain potentially subject to corrections until the start of the 2010 reporting period, as we stated in the proposed rule.

Comment: One commenter supported removal from the PQRI quality measure set for 2010 and 2009 PQRI measure that was part of the 2007 and/or 2008 PQRI for which the 2007 and 2008 PQRI analytics indicate a lack of significant reporting and usage. The commenter remarked that continued review and revision of the measures list will help to refine the process and validity of the program and reduce undue burden on participants, increasing meaningful participation.

Response: We appreciate the commenter's constructive feedback and agree that it is necessary to review and revise the PQRI quality measure set on an ongoing basis as we gain more experience with particular measures and/or new measures become available to replace existing measures.

We are unclear, however, with respect to the commenter's remark that continued revision of the PQRI quality measure set will reduce undue burden on participants. Although there are several measures available in the PQRI quality measure set, participants are not required, nor are they expected to, report on all measures included in the PQRI quality measure set. As discussed further in sections II.G.2.e. and II.G.2.f. above, an individual eligible professional generally needs to report on only 3 individual 2010 PQRI quality measures or 1 2010 PQRI measures group in order to meet the criteria for satisfactory reporting for 2010.

Comment: Some commenters specifically suggested that Measure #143 Oncology: Medical and Radiation—Pain Intensity Quantified and Measure #144 Oncology: Medical and Radiation Plan of Care for Pain be retained for the 2010 PQRI because they believe the measures address quality of life issue for patients with cancer. One commenter requested that if the measures are analytically challenging as claims-based measures, we retain the measures as registry-only measures instead.

Response: We only proposed to retire these measures because they were too complex to calculate via claims. Based on the commenter's suggestion to retain these measures as registry-only measures for the 2010 PQRI, we are finalizing and including them in the measures listed in ''Table 11: 2010 Measures Selected From the 2009 PQRI Quality Measure Set Available for Registry-based Reporting Only.''

Comment: One commenter requested that Measure #94 Otitis Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility and Measure #95 Otitis Media with Effusion (OME) Hearing Testing not be retired since audiologists were just added to the list of eligible professionals with the 2009 PQRI and there are few measures on which they can report. The commenter requested that we retain both measures for at least an additional year to reassess the level of use since PQRI reporting, for audiologists, is a new process that requires extensive training.

Response: We agree that in order to provide audiologists with opportunities to participate in the PQRI, it is necessary to retain at least one of these measures for at least another year. Thus, we have decided to retain Measure #94 Otitits Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility and retire only Measure #95 Otitis Media with Effusion (OME) Hearing Testing for 2010. Measure #94, in conjunction with the 3 new measures developed by the Audiology Quality Consortium (AQC) listed in Table 13, will provide audiologists with at least 4 measures on which they can report for the 2010 PQRI.

Comment: One commenter was not clear on which measure was being proposed to replace Measure #34 Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (tPA) Considered and requested that CMS not retire Measure #34 until clarification is provided. Another commenter,

however, supported the retirement of Measure #34 and CMS' decision to replace this measure with the proposed new Stroke and Stroke Rehabilitation: Thrombolytic Therapy measure (see Table 19 of the CY 2010 PFS proposed rule).

Response: As indicated by the commenter, we are replacing Measure #34 with the Stroke and Stroke Rehabilitation: Thrombolytic Therapy measure listed in Table 13 of this final rule with comment period.

Comment: One commenter expressed support for a proposed revision of Measure #11 for 2010 PQRI that expands the eligible denominator patient population.

Response: We wish to clarify that at the request of the measure developer, we are retiring Measure #11 and replacing it with the proposed new NQF-endorsed measure: Stenosis Management in Cardiac Imaging Studies (see Table 13 of this final rule with comment period).

Based on the criteria discussed above and our review of these comments, we are retiring the 4 measures listed in Table 10 and are including the 175 individual measures listed in Tables 11 through 13 in the final 2010 PQRI individual quality measure set. We are also including 13 measures groups in the final 2010 PQRI quality measure set, which are listed in Tables 15 through 27. The individual measures selected for the 2010 PQRI can be categorized as follows:

(1) 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-Based Reporting;

(2) 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-based Reporting Only;

(3) New Individual Quality Measures Selected for 2010; and

(4) 2010 Measures Available for EHR-based Reporting.

TABLE 10—2009 PQRI QUALITY MEASURES NOT INCLUDED IN THE 2010 PQRI

Measure No.	Measure title
11	Stroke and Stroke Rehabilitation: Carotid Imaging Reporting.
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (tPA) Considered.
95	Otitis Media with Effusion (OME): Hearing Testing.
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD.

(1) 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-based Reporting

We proposed to include in the 2010 PQRI quality measure set 116 of the 2009 PQRI measures, which would be available for either claims-based reporting or registry-based reporting as individual quality measures (74 FR 33574 through 33579). We also noted that one of the proposed measures, Measure #46 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility, is reportable through the registry-based reporting mechanism only in the 2009 PQRI. However, for the 2010 PQRI, we proposed to make this measure available for either claims-based reporting or registry-based reporting.

These 116 proposed measures did not include any measures that were proposed to be included as part of the 2010 Back Pain measures group. Similar to the 2009 PQRI, we proposed that any 2010 PQRI measure that is included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting.

The following is a summary of the comments received on the 116 proposed measures selected from the 2009 PQRI quality measure set.

Comment: We received numerous comments in support of the 2009 PQRI quality measures proposed for inclusion in the 2010 PQRI. Several commenters supported the retention of all the 2009 PQRI measures proposed for 2010. Other commenters supported inclusion of specific 2009 PQRI measures in the 2010 PQRI. Measures on which we received specific support include:

- Measure #1 Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus;
- Measure #2 Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus;
- Measure #3 Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus;
- Measure #9 Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD;
- Measure #18 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy;
- Measure #19 Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care;
- Measure #67 Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow;
- Measure #68 Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythopoietin Therapy;
- Measure #102 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients;
- Measure #104 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients;
- Measure #105 Prostate Cancer: Three-Dimensional (3D) Radiotherapy;
- Measure #106 Major Depressive Disorder (MDD): Diagnostic Evaluation;
- Measure #107 Major Depressive Disorder (MDD): Suicide Risk Assessment;
- Measure #110 Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Old;
- Measure #111 Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older;
- Measure #112 Preventive Care and Screening: Screening Mammography;
- Measure #113 Preventive Care and Screening: Colorectal Cancer Screening;
- Measure #114 Preventive Care and Screening: Inquiry Regarding Tobacco Use;
- Measure #115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit;
- Measure #117 Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient;
- Measure #119 Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients;
- Measure #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR);
- Measure #126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation;
- Measure #127 Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention—Evaluation of Footwear;
- Measure #134 Screening for Clinical Depression and Follow-Up Plan;
- Measure #136 Melanoma: Follow-Up Aspects of Care;
- Measure #137 Melanoma: Continuity of Care—Recall System;
- Measure #138 Melanoma: Coordination of Care;
- Measure #156 Oncology: Radiation Dose Limits to Normal Tissues; and
- Measure #163 Diabetes Mellitus: Foot exam.

Response: All 116 of the proposed measures listed in Table 17 of the proposed rule (74 FR 33575 through 33579), including all of the measures specifically supported by commenters, have been finalized for the 2010 PQRI, and are included in Table 11.

Comment: One commenter commended CMS on the format of Table 17 of the proposed rule (74 FR 33575 through 33579) which clearly stated the status of NQF endorsement, AQA adoption, and the measure developer for each proposed measure. The commenter encouraged us to use this format in future rules.

Response: We appreciate the positive feedback on the newly formatted tables in the proposed rule.

Comment: One commenter urged us to finalize the proposed new measures related to age-related macular degeneration, osteoporosis, and cancer care and to work with the community to ensure these measures are appropriately reported.

Response: We note that the measures referenced by the commenter are existing 2009 PQRI measures that will be included for 2010 PQRI. As noted previously, we have developed an education and outreach plan that is continuously expanding in scope in our efforts to educate eligible professionals on the nuances of the PQRI, including educating eligible professionals and office staff on appropriate reporting of the PQRI measures.

Comment: Several commenters recommended changes to specific quality measures' titles, definitions, and detailed specifications or coding. Many of these recommendations were based on alternative interpretations of clinical evidence or concerns about the utility of the measures. Some requests were specifically concerned that measures be expanded to include specific professionals to whom the measure may be applicable such as physical therapists, audiologists, and hospitalists.

Specifically, one commenter suggested that in order to maximize the impact of Measure #1 Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus, the PQRI specification should continue to require a performance period of 12 months and reporting that identifies whether A1c control is good (that is, A1c ≤ 7.0 percent), moderate (that is, A1c ≤ 9.0 percent, but > 7.0 percent), or poor (that is, A1c > 9.0 percent).

Another commenter suggested that audiologists should be included in Measure #154 Falls: Risk Assessment. The commenter noted that audiologists are consulted to provide vestibular rehabilitation that results in improved quality of care for these patients and reduces unnecessary and excessive cost.

Another commenter requested that Measure #52 Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation needs to be re-evaluated and CMS should consider modifying this measure or creating a new one that addresses the appropriate use of LABA.

We received one comment regarding Measure #158 Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy, expressing concern that there is no reliable data, controlled or otherwise, that shows that use of patch graft results in better outcomes.

Finally, one commenter suggested that the following proposed 2010 measures selected from the 2009 PQRI quality measure set available for either claims-based reporting or registry-based reporting may not promote quality care because they do not adequately address concerns of patient groups that rely on plasma derived treatments such as those with primary immune deficiency or alpha-1 antitrypsin deficiency:

- Measure #51 Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation;
- Measure #64 Asthma: Asthma Assessment;
- Measure #65 Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use;
- Measure #110 Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old; and
- Measure #126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation.

The commenter suggested that we focus on aligning these measures with accepted clinical practices for patients that rely on plasma-derived treatments.

Response: Health care quality measures are currently developed by a variety of organizations and used by a variety of governmental and nongovernmental, and public-private initiatives which have various and at times differing priorities and programmatic needs for quality measures. As reflected by the considerations for identifying proposed PQRI quality measures described above, we are committed to having a broad and robust set of quality measures for the PQRI. However, we largely depend on the development of measures by professional organizations and other measure developers. Although we had significant involvement in the development of measures applicable to eligible professionals at the start of the PQRI, currently we are not directly involved in the development of clinician-level quality measures for PQRI, but do select from measures that meet the statutory requirements and other considerations described above.

Quality measures that have completed the consensus processes of NQF or AQA have a designated party (generally the measure developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make substantive changes to a measure, including any updates to the measure to reflect the current clinical evidence such as the changes suggested by the commenters above. The measure maintainer and/or the developer/owner of a measure included in the final set of quality measures selected for the 2010 PQRI is identified as the ''Measure Developer'' in Tables 11 through 28. In addition, NQF has, for its endorsed measures, an established maintenance process which may be accessed. The Secretary is required to provide opportunities for public comment on selected measures and do so through notice and comment rulemaking. We do not, however, use notice and comment rulemaking as a means to update or modify measure specifications. We retain the ability to update or modify specifications to the measures until December 31, 2009.

After that date, there will be no changes to the measure for the 2010 reporting period(s).

Comment: One commenter was concerned about the potential retention of claims-based reporting for Measure #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR). The commenter assumes that if an eligible professional had an EHR, he or she would be able to submit this type of data directly from the EHR rather through claims. This also appears to conflict with the statement that Measure #124 is proposed to be an EHR measure. The commenter requests further clarification.

Response: As reflected in Tables 11 and 14, Measure #124 is available for reporting via claims, a qualified registry, or a qualified EHR for the 2010 PQRI. We decided to continue to allow eligible professionals to report Measure #124 via claims for the 2010 PQRI because we do not anticipate that there will be a sufficient number of qualified EHR vendors for the 2010 PQRI to permit a majority of those who adopt and use an EHR to report this measure via their EHR.

Comment: One commenter supported the proposal that Measure #46 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility would be available for claims and registry reporting since registries reported difficulty capturing the required information for the 2009 PQRI.

Response: We agree. As such, Measure #46 is listed in Table 11 as a measure that is available for claims and registry reporting in the 2010 PQRI.

Comment: With respect to Measure #52 Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy, one commenter pointed out that Medicare DMERC coverage criteria for LABA are not consistent with clinical guidelines.

Response: Medicare coverage policy is beyond the scope of this section of the final rule. Questions or concerns about Medicare coverage policy should be directed to *CMS_caginquiries@cms.hhs.gov.*

For the reasons discussed above and based on the comments received, we are finalizing in the 2010 PQRI quality measure set the 116 2009 PQRI measures that were proposed to be available in the 2010 PQRI for claims and registry reporting identified in Table 11. In addition, Table 11 includes 1 2009 PQRI measure that was proposed for retirement in 2010 and 2 2009 PQRI measures that were proposed to be available for registry reporting only (see sections II.G.2.i. and II.G.2.i.2., respectively, of this final rule for further details). The 119 individual 2009 PQRI measures selected for inclusion in the 2010 PQRI quality measure set as individual quality measures for either claims-based reporting or registry-based reporting are listed by their Measure Number and Title in Table 11, along with the name of the measure's developer/owner. The PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again to identify a different measure, even if the original measure to which the number was assigned is subsequently retired from the PQRI measure set. A description of the measures listed in Table 11 can be found in the ''2009 PQRI Quality Measures List,'' which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

BILLING CODE 4120–01–P

TABLE 11: 2010 Measures Selected From the 2009 PQRI Quality Measure Set Available for Either Claims-based Reporting or Registry-based Reporting

Measure Number	Measure Title	Measure Developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD	NCQA
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	AMA-PCPI/NCQA
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	AMA-PCPI/NCQA
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	AMA-PCPI/NCQA
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	AMA-PCPI/NCQA
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	AMA-PCPI/NCQA
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	AMA-PCPI/NCQA
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	AMA-PCPI/NCQA
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	AMA-PCPI/NCQA
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	AMA-PCPI/NCQA

Measure Number	Measure Title	Measure Developer
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	AMA-PCPI/NCQA
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	AMA-PCPI/NCQA
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	AMA-PCPI/NCQA
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	AMA-PCPI/NCQA
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	AMA-PCPI/NCQA
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	AMA-PCPI/NCQA
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA-PCPI/NCQA
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	Society of Thoracic Surgeons (STS)
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	STS
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	AMA-PCPI/NCQA
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	AMA-PCPI/NCQA
47	Advance Care Plan	AMA-PCPI/NCQA

Measure Number	Measure Title	Measure Developer
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	AMA-PCPI
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	AMA-PCPI
53	Asthma: Pharmacologic Therapy	AMA-PCPI
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	AMA-PCPI/NCQA
55	12-Lead Electrocardiogram (ECG) Performed for Syncope	AMA-PCPI/NCQA
56	Community-Acquired Pneumonia (CAP): Vital Signs	AMA-PCPI/NCQA
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	AMA-PCPI/NCQA
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	AMA-PCPI/NCQA
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	AMA-PCPI/NCQA
64	Asthma: Asthma Assessment	AMA-PCPI
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use	NCQA
66	Appropriate Testing for Children with Pharyngitis	NCQA
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	AMA-PCPI/American Society of Hematology (ASH)
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	AMA-PCPI/ASH

Measure Number	Measure Title	Measure Developer
69	Multiple Myeloma: Treatment with Bisphosphonates	AMA-PCPI/ASH
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	AMA-PCPI/ASH
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	AMA-PCPI/American Society of Clinical Oncology (ASCO)/National Comprehensive Cancer Network (NCCN)
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	AMA-PCPI/ASCO/NCCN
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	AMA-PCPI
79	End-Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	AMA-PCPI
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	AMA-PCPI
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	AMA-PCPI
86	Hepatitis C: Antiviral Treatment Prescribed	AMA-PCPI
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	AMA-PCPI
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	AMA-PCPI
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	AMA-PCPI
91	Acute Otitis Externa (ACE): Topical Therapy	AMA-PCPI
92	Acute Otitis Externa (ACE): Pain Assessment	AMA-PCPI
93	Acute Otitis Externa (ACE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	AMA-PCPI

Measure Number	Measure Title	Measure Developer
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	AMA-PCPI
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	AMA-PCPI/College of American Pathologists (CAP)
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grace	AMA-PCPI/CAP
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	AMA-PCPI
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	AMA-PCPI
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	AMA-PCPI
106	Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA-PCPI
107	Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	NCQA
109	Osteoarthritis: Function and Pain Assessment	AMA-PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA
112	Preventive Care and Screening: Screening Mammography	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA

Measure Number	Measure Title	Measure Developer
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	NCQA
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorous, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	AMA-PCPI
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AMA-PCPI
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	AMA-PCPI
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	CMS/Quality Insights of Pennsylvania (QIP)
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association (APMA)
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	APMA
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS/QIP
130	Documentation and Verification of Current Medications in the Medical Record	CMS/QIP
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	CMS/QIP
134	Screening for Clinical Depression and Follow-Up Plan	CMS/QIP
135	Chronic Kidney Disease (CKD): Influenza Immunization	AMA-PCPI
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	AMA-PCPI/NCQA

Measure Number	Measure Title	Measure Developer
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	AMA-PCPI/NCQA
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of Plan of Care	AMA-PCPI/NCQA
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	AMA-PCPI
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	AMA-PCPI/NCQA
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	AMA-PCPI/NCQA
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	AMA-PCPI
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA-PCPI
154	Falls: Risk Assessment	AMA-PCPI/NCQA
155	Falls: Plan of Care	AMA-PCPI/NCQA
156	Oncology: Radiation Dose Limits to Normal Tissues	AMA-PCPI
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection	STS
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy	Society of Vascular Surgeons (SVS)
163	Diabetes Mellitus: Foot Exam	NCQA
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	SVS
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	AMA-PCPI
175	Pediatric End-Stage Renal Disease (ESRD): Influenza Immunization	AMA-PCPI
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AMA-PCPI/NCQA

Measure Number	Measure Title	Measure Developer
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AMA-PCPI/NCQA
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AMA-PCPI/NCQA
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AMA-PCPI/NCQA
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AMA-PCPI/NCQA
181	Elder Maltreatment Screen and Follow-Up Plan	CMS/QIP
182	Functional Outcome Assessment in Chiropractic Care	CMS/QIP
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	AMA-PCPI
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	AMA-PCPI
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	AMA-PCPI/NCQA
186	Wound Care: Use of Compression System in Patients with Venous Ulcers	AMA-PCPI/NCQA

BILLING CODE 4120–01–C

Please note that detailed measure specifications, including the measure's title, for 2009 individual PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. The 2010 PQRI quality measure specifications for any given individual quality measure may, therefore, be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(2) 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-Based Reporting Only

We proposed to select 26 registry-only individual measures from the 2009 PQRI for the 2010 PQRI (74 FR 33579 through 33580). Nine of the 26 proposed measures were previously available for either claims-based reporting or registry-based reporting. We solicited comments on our proposal to increase the number of registry-only measures for the 2010 PQRI.

The following is a summary of the comments received on the 26 proposed registry-only measures.

Comment: We received one comment in support of the following registry-only measures:

- Measure #136 Melanoma: Follow-Up Aspects of Care;
- Measure #137 Melanoma: Continuity of Care—Recall System; and
- Measure #138 Melanoma: Coordination of Care.

Response: We appreciate the commenters' positive feedback. These final measures are listed in Table 12 as 2009 PQRI measures selected for the 2010 PQRI available for registry reporting only.

Comment: We received several comments regarding the proposed reporting mechanism(s) available for proposed 2010 measures. There were several recommendations that the following 2009 PQRI quality measures, which were available for claims or registry reporting in the 2009 PQRI, should not be limited to registry reporting for the 2010 PQRI:

- Measure #83 Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia;
- Measure #136 Melanoma: Follow-Up Aspects of Care;
- Measure #137 Melanoma: Continuity of Care—Recall System;
- Measure #138 Melanoma: Coordination of Care;
- Measure #139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement; and
- Measure #141 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15 percent OR Documentation of a Plan of Care.

The primary reason cited by commenters for opposing limiting certain measures to registry reporting is the lack of an available registry.

Response: With respect to the limited availability of registries for certain eligible professionals, we reiterate that there are qualified registries in our 2009 PQRI program that do report all of the PQRI measures. These registries are accepting eligible professionals who wish to sign up as new clients of the

registry. While we acknowledge that there may be costs associated with participating through registries, we note that the decision to participate via a registry is voluntary.

We do, however, agree with commenters' concerns about limiting Measures #139 and #141 to registry reporting. These measures were first introduced in the PQRI quality measure set for the 2009 PQRI and are currently available for claims and registry reporting for 2009. Keeping these measures as measures available for claims and registry reporting for 2010 will allow us to collect more data to analyze the measures' feasibility via claims reporting. Therefore, the measures are listed in Table 11 of this final rule with comment period as 2009 PQRI measures selected for the 2010 PQRI that are available for registry and claims reporting.

Comment: Some commenters were specifically opposed to continuing to limit Measure #174 Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis to registry reporting for the 2010 PQRI. Specifically, the commenters suggested that CMS permit claims-based reporting of the measure for 2010 since there are only two pediatric ESRD measures included in PQRI for 2010. One of the pediatric ESRD measures, Measure #175 Pediatric ESRD Influenza Immunization Measure, was proposed to be available for either claims or registry reporting. Because eligible professionals must report on at least 3 measures when using the registry-based reporting mechanism, the commenter felt that making Measure #174 registry only will exclude pediatric nephrologists from participating in the PQRI. In addition, a registry is not available for pediatricians who participate in small academic departments.

Response: The commenter is correct in that eligible professionals who wish to have a qualified registry submit PQRI measure results and numerator and denominator data on PQRI quality measures are required to report at least 3 PQRI quality measures when reporting on individual quality measures or to report all measures in at least 1 measure group when reporting on measure groups. Measure #174 Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis was registry only for 2009 PQRI. Due to complexities surrounding the timing of the expected quality action (once per month) this measure will remain registry only for the 2010 PQRI.

However, in response to the commenters' concern that there are only 2 2010 PQRI measures that apply to pediatric nephrologists and only 1 of them (that is, Measure #175) is available for claims-based reporting, eligible professionals who have fewer than 3 applicable measures can still participate in the 2010 PQRI via claims. Such eligible professionals would need to report on all applicable measures that are available for claims-based reporting via claims and meet the appropriate criteria for satisfactory reporting of individual measures in order to qualify for a 2010 PQRI incentive payment.

For the reasons discussed above and based on the comments received, we are finalizing in the 2010 PQRI quality measure set 24 of the 26 proposed 2009 PQRI measures identified in Table 18 of the proposed rule for registry reporting only. As stated above, 2 of the 26 2009 PQRI measures that were proposed to be available for registry reporting only for the 2010 PQRI (that is, Measure #139 and Measure #141), will be available for both registry and claims reporting in the 2010 PQRI and are listed in Table 11 of this final rule with comment period. In addition, we are also retaining 2 2009 PQRI measures that were proposed for retirement for 2010, but we are limiting reporting of these measures to registry reporting for the 2010 PQRI. The 26 2009 PQRI measures selected for the 2010 PQRI that are available for registry reporting only are listed in Table 12 of this final rule with comment period. The 26 individual 2009 PQRI measures selected for inclusion in the 2010 PQRI quality measure set as individual quality measures for registry-based reporting only are listed by their Measure Number and Title in Table 12, along with the name of the measure's developer/owner. A description of the measures listed in Table 12 can be found in the ''2009 PQRI Quality Measures List,'' which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.* Measures that were available for either claims-based reporting or registry-based reporting in the 2009 PQRI but are available for registry-based reporting only in the 2010 PQRI are identified by an asterisk (*) in Table 12.

TABLE 12—2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY

Measure Number	Measure title	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	AMA–PCPI
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	AMA–PCPI
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	AMA–PCPI
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge.	AMA–PCPI/NCQA
81	End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients.	AMA–PCPI
82	End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis.	AMA–PCPI
83	Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia*.	AMA–PCPI
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD)*.	AMA–PCPI
136	Melanoma: Follow-Up Aspects of Care*	AMA–PCPI/NCQA
137	Melanoma: Continuity of Care—Recall System*	AMA–PCPI/NCQA
138	Melanoma: Coordination of Care*	AMA–PCPI/NCQA

TABLE 12—2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY—Continued

Measure Number	Measure title	Measure developer
143	Oncology: Medical and Radiation—Pain Intensity Quantified*.	AMA–PCPI
144	Oncology: Medical and Radiation—Plan of Care for Pain*	AMA–PCPI
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA–PCPI/NCQA
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	AMA–PCPI/NCQA
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	AMA–PCPI/NCQA
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	AMA–PCPI/NCQA
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	STS
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	STS
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	STS
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	STS
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration.	STS
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	STS
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	STS
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	STS
174	Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis.	AMA–PCPI

* Individual 2009 PQRI measures that were available for both claims-based and registry-based reporting but will be available for registry-based reporting only for the 2010 PQRI.

Although we are designating certain measures as registry-only measures, we cannot guarantee that there will be a registry qualified to submit each registry-only measure for 2010. We rely on registries to self-nominate and identify the types of measures for which they would like to be qualified to submit quality measures results and numerator and denominator data on quality measures. If no registry self-nominates to submit measure results and numerator and denominator data on a particular type of measure for 2010, then an eligible professional would not be able to report that particular measure type.

We note also that detailed measure specifications, including a measure's title, for 2009 PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. Therefore, the 2010 PQRI quality measure specifications for any given quality measure may be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(3) New Individual Quality Measures Selected for 2010

We proposed to include in the 2010 PQRI quality measure set 30 measures that were not included in the 2009 PQRI quality measures provided that each measure obtains NQF endorsement by July 1, 2009 and its detailed specifications are completed and ready for implementation in PQRI by August 15, 2009. Besides having NQF endorsement, we proposed that the development of a measure is considered complete for the purposes of the 2010 PQRI if by August 15, 2009—(1) the final, detailed specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure have been established and will be effective for CMS claims data submission on or before January 1, 2010.

Due to the complexity of their measure specifications, we proposed that 24 of these 30 measures would be available as registry-only measures for the 2010 PQRI. The remaining 6 measures were proposed to be available for reporting through either claims-based reporting or registry-based reporting.

The following is a summary of the comments received on the 30 new individual quality measures proposed for 2010.

Comment: We received numerous comments in support of the proposed additional quality measures for 2010 PQRI. Several commenters stated that these measures ''continue to build upon potential gaps that exist in the prevention and management of chronic conditions.'' One commenter was pleased to see the use of evidence-based clinical quality measures in the 2010 PQRI proposed measures. Comments were received specifically in support of the following measures:

- Functional Communication—Spoken Language Comprehension;
- Functional Communication—Attention;
- Functional Communication—Memory;
- Functional Communication—Motor Speech;
- Functional Communication—Reading;
- Functional Communication—Spoken Language Expression;
- Functional Communication—Writing;

• Functional Communication—Swallowing;
• Perioperative Temperature Management;
• Oncology: Cancer Stage Documented;
• Cataracts: 20/40 or Better Visual Acuity within 90 days following Cataract Surgery;
• Cataracts: Complications within 30 days following Cataract Surgery requiring Additional Surgical;
• Ischemic Vascular Disease (IVD): Blood Pressure Management Control;
• Stenosis Management in Cardiac Imaging Studies;
• Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear;
• Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days;
• Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss;
• Coronary Artery Disease (CAD): Symptom and Activity Assessment;
• Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL–Cholesterol;
• Heart Failure: Left Ventricular Function (LVF) Assessment;
• Heart Failure: Patient Education; and
• Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation.

Response: We appreciate the commenters' support and are finalizing all of the 30 proposed new measures, which are identified in Table 13 of this final rule with comment period.

Comment: We received many comments opposed to limiting one or more new measures proposed for the 2010 PQRI to registry reporting, including the 2 new proposed cataract measures and the 11 new proposed cardiology measures. The commenters suggested that the measures be available for both claims-based and registry reporting for the 2010 PQRI so that practices may choose the best reporting option for them. One commenter also remarked that we should resolve any analytic reporting difficulties with claims-based reporting of these measures internally and not place the burden on eligible professionals.

Response: While we proposed that 19 of the 30 proposed new measures would be available for registry reporting only for 2010 PQRI, we agree, after consideration of the comments received, that it would be feasible to make some of these measures available for either claims or registry reporting. Therefore, the following measures originally proposed for registry only reporting will be available for either claims or registry reporting for the 2010 PQRI:

• Ischemic Vascular Disease (IVD): Blood Pressure Management Control.
• Ischemic Vascular Disease (IVD): Complete Lipid Profile.
• Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control.
• Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-Thrombotic.

The measure specifications developed by the measure developer for the remaining 15 measures are too complex for claims-based reporting.

Based on the reasons discussed above and comments received, we are finalizing in the 2010 PQRI quality measure set all of 30 proposed 2010 PQRI measures identified in Table 19 of the proposed rule. Please note that 4 measures that were proposed to be available for registry only will be made available for either registry or claims reporting in the 2010 PQRI. These measures are:

• Ischemic Vascular Disease (IVD): Blood Pressure Management Control;
• Ischemic Vascular Disease (IVD): Complete Lipid Profile;
• Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control; and
• Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-Thrombotic.

The titles of the 30 additional, or new, PQRI measures for 2010 are listed in Table 13 along with the name of the measure developer and the reporting mechanism(s) available (that is, whether the measure will be reportable using claims, registries, or both).

TABLE 13—NEW INDIVIDUAL QUALITY MEASURES SELECTED FOR 2010

Measure title	NQF Endorsement status as of 5/1/09	AQA Adoption status as of 1/31/09	Measure developer	Reporting mechanism(s)
Stroke and Stroke Rehabilitation: Thrombolytic Therapy.	Yes	No	American Heart Association (AHA)/American Stroke Association (ASA).	Registry.
Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear.	Pending NQF review	No	Audiology Quality Consortium (AQC).	Claims, Registry.
Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days.	Pending NQF review	No	AQC	Claims, Registry.
Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss.	Pending NQF review	No	AQC	Claims, Registry.
Cataracts: 20/40 or Better Visual Acuity within 90 days Following Cataract Surgery.	Pending NQF review	Yes	AMA–PCPI/NCQA	Registry.
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures.	Pending NQF review	Yes	AMA–PCPI/NCQA	Registry.
Perioperative Temperature Management	Yes	Yes	AMA–PCPI	Claims, Registry.
Oncology: Cancer Stage Documented	Yes	Yes	AMA–PCPI/ASCO	Claims, Registry.
Stenosis Measurement in Carotid Imaging Studies.	Yes	Yes	AMA–PCPI/NCQA	Claims, Registry.
Coronary Artery Disease (CAD): Symptom and Activity Assessment.	Yes	No	AMA–PCPI	Registry.
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Yes	No	AMA–PCPI	Registry.

TABLE 13—NEW INDIVIDUAL QUALITY MEASURES SELECTED FOR 2010—Continued

Measure title	NQF Endorsement status as of 5/1/09	AQA Adoption status as of 1/31/09	Measure developer	Reporting mechanism(s)
Heart Failure: Left Ventricular Function (LVF) Assessment.	Yes	No	AMA–PCPI	Registry.
Heart Failure: Patient Education	Yes	No	AMA–PCPI	Registry.
Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation.	Yes	No	AMA–PCPI	Registry.
Ischemic Vascular Disease (IVD): Blood Pressure Management Control.	Yes	No	NCQA	Claims, Registry.
Ischemic Vascular Disease (IVD): Complete Lipid Profile.	Yes	No	NCQA	Claims, Registry.
Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control.	Yes	No	NCQA	Claims, Registry.
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-thrombotic.	Yes	No	NCQA	Claims, Registry.
HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Screening for High Risk Sexual Behaviors.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Screening for Injection Drug Use	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis.	Yes	No	AMA–PCPI/NCQA	Registry.
Functional Communication Measure—Spoken Language Comprehension.	Yes	No	American Speech Language Hearing Association (ASHA).	Registry.
Functional Communication Measure—Attention.	Yes	No	ASHA	Registry.
Functional Communication Measure—Memory.	Yes	No	ASHA	Registry.
Functional Communication Measure—Motor Speech.	Yes	No	ASHA	Registry.
Functional Communication Measure—Reading.	Yes	No	ASHA	Registry.
Functional Communication Measure—Spoken Language Expression.	Yes	No	ASHA	Registry.
Functional Communication Measure—Writing	Yes	No	ASHA	Registry.
Functional Communication Measure—Swallowing.	Yes	No	ASHA	Registry.

We note also that we are finalizing the following new measures for the 2010 PQRI even though they are still pending NQF endorsement and were not AQA adopted as of January 31, 2009:

- Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear;
- Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days; and
- Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss. As stated above, we are exercising our exception authority under section 1848(k)(2)(C)(ii) of the Act due to the lack of available measures for audiologists. Measures for audiologists represent a specific area for which there are a dearth of measures that have been endorsed by the NQF and/or adopted by the AQA.

(4) 2010 Individual Quality Measures Available for EHR-Based Reporting

We proposed to accept PQRI data from EHRs for a limited subset (10) of the proposed 2010 PQRI quality measures, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible (74 FR 33582).

The following is a summary of the comments received on the proposed electronic submission of these 10 measures.

Comment: One commenter requested that the 2010 EHR measure specifications be released in an expedited fashion so that vendors may properly configure their software in time for the 2010 PQRI.

Response: We agree with the commenter that vendors need sufficient time to adapt their products to support EHR-based capture and submission of data for PQRI measures. To that end, the specifications for the electronic transmission of 2010 PQRI measures were posted on the QualityNet Web site in April 2009 and were updated and reposted in July and September 2009 on the Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage.*

We should note that only eligible professionals using EHR systems that have been ''qualified'' by CMS by virtue of passing our self-nomination and testing process will be able to report their quality data to CMS via their EHR.

Comment: Several comments voiced support for EHR-based reporting of Measure #124, Measure #112, and Measure #113. One commenter was disappointed that no measures relevant to oncology were proposed to be available for 2010 PQRI EHR reporting. Another commenter recommended that the new CAD and heart failure measures proposed for 2010 PQRI registry only reporting also be available for EHR reporting for 2010. One commenter recommended that any potential

retooling of measures for reporting through EHRs should not undermine the scientific basis of the measure.

Response: We appreciate the commenters' support for EHR-based reporting of measures. However, the number of measures available for EHR reporting is limited because in order for measures to be available for EHR-based reporting, measure specifications for the electronic reporting of those measures must be available. We will consider adding new measures for future PQRI program years as specifications become available. The retooling of measures will not change the intent of the measure. We believe that all PQRI measures are evidence-based and consistent with standards of care.

Comment: One commenter suggested that increasing the number of PQRI measures is discriminatory to those that cannot or have not incorporated electronic prescribing due to expense of initiating EHRs and electronic prescribing for small provider offices.

Response: With respect to practices that have not implemented technology that would allow for participation in PQRI via an EHR, there are other 2010 PQRI reporting options available for such practices. There are a total of 125 individual quality measures available for claims or registry reporting for the 2010 PQRI. In addition, 8 of the 13 2010 PQRI measures groups are available for claims or registry reporting (see section II.G.2.i.5. of this final rule with comment period for discussion of the final 2010 PQRI measures groups). The remaining 50 individual PQRI quality measures and 4 measures groups are available for registry reporting in 2010.

With respect to practices that have not implemented technology that would allow for electronic prescribing, we reiterate that the E-Prescribing Incentive Program is a separate and distinct incentive program for eligible professionals. Participation in the E-Prescribing Incentive Program is voluntary and is not required for participation in the 2010 PQRI. Details of the 2010 E-Prescribing Incentive Program can be found in section II.G.5. of this final rule with comment period.

Based on the reasons discussed above and the comments received, we are finalizing the option of accepting clinical quality data extracted from qualified EHRs on all 10 of the proposed 2010 PQRI quality measures identified in Table 20 of the proposed rule. The final 2010 measures available for EHR-based reporting are identified in Table 14 of this final rule with comment period.

TABLE 14—2010 MEASURES AVAILABLE FOR EHR-BASED REPORTING

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	Yes	Yes	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	Yes	No	NCQA
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA–PCPI
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Yes	Yes	AMA–PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	Yes	No	AMA–PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA
112	Preventive Care and Screening: Screening Mammography	Yes	Yes	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	Yes	Yes	NCQA
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	Yes	Yes	CMS/QIP

(5) Measures Selected for Inclusion in 2010 Measures Groups

We proposed to retain the 7 2009 PQRI measures groups for the 2010 PQRI: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; and (7) Back Pain (74 FR 33582 through 33587). As in 2009, we proposed the CABG measures group would be reportable through the registry-based reporting mechanism only for 2010 while the remaining 6 2009 PQRI measures groups would be reportable through either claims-based reporting or registry-based reporting for the 2010 PQRI.

In addition to the 7 measures groups that we proposed to retain from the 2009 PQRI, we proposed 6 new measures groups for the 2010 PQRI, for a total of 13 CY 2010 measures groups. The 6 new measures groups proposed for the 2010 PQRI were: (1) Coronary Artery Disease (CAD); (2) Heart Failure; (3) Ischemic Vascular Disease (IVD); (4) Hepatitis C; (5) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); and (6) Community Acquired Pneumonia (CAP). Since many of the 6 new measures groups proposed for 2010 contained proposed new registry-only measures, only 8 proposed 2010 measures groups would be reportable through either claims-based reporting or registry-based reporting: Diabetes Mellitus; CKD; Preventive Care; Perioperative Care; Rheumatoid Arthritis; Back Pain; Hepatitis C; and Community Acquired Pneumonia. We solicited comments on our proposal to limit claims-based reporting of measures groups in 2010.

Finally, we also proposed that except for the measures included in the Back Pain measures group, the measures included in any proposed 2010 measures group would be reportable either as individual measures or as part of a measures group. Similar to the 2009 PQRI, we proposed that the measures proposed for inclusion in the Back Pain measures group would be reportable only as part of a measures group and not as individual measures in 2010.

The measures proposed for inclusion in each of the proposed 2010 measures groups were identified in Tables 21 through 33 of the CY 2010 PFS proposed rule (74 FR 33582 through 33587).

The following is a summary of the comments received on the proposed 2010 measures groups.

Comment: We received several comments in support of the proposed 2010 PQRI measures groups. Specifically, we received comments in support of the Preventive Care, CAP, HIV/AIDS, Hepatitis C, Rheumatoid Arthritis, IVD, and Heart Failure measures groups. Some commenters also commended CMS for the inclusion of specific measures in certain measures groups.

Response: We appreciate the commenters' feedback. As identified in Tables 15 through 27 of this final rule with comment period, we are finalizing all of the 13 proposed 2010 PQRI measures groups. No changes were made to the measures included in the measures groups. However, as a result of 4 measures proposed for inclusion in the IVD measures group that were proposed to be registry only measures now being available for either claims or registry reporting, the IVD measures group will also be available for either claims or registry reporting.

Comment: Some commenters suggested changes to our definition of ''measures group.'' One commenter urged us to reduce the number of measures required for reporting a measure group to a minimum of 3 measures. Another commenter requested that we define ''measures group'' to be any 3 measures. One commenter recommended that we implement measures groups with complex denominators to allow for reporting on measures that have an associated impact on patient care and positive outcomes.

Response: As stated in the CY 2010 PFS proposed rule (74 FR 33568), ''measures group'' has been previously defined as a subset of 4 or more PQRI measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures groups identifies the condition or focus that is shared across the measures within a particular measures group. If we change this definition as suggested by commenters, then there would be no difference in terms of reporting measures groups and reporting PQRI individual quality measures since eligible professionals who choose to report on individual PQRI quality measures are already generally required to report on 3 measures. The only exception that permits eligible professionals to report on fewer than 3 measures is when an eligible professional has fewer than 3 applicable measures. For eligible professionals in this situation, the only option is to report applicable measures via claims.

Comment: One commenter recommended that we monitor Measure #115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit for the CAD measures group for ''appropriate conclusion as more evidence is released which will show whether advising smokers to quit increases the chances that they actually will quit.''

Response: We assume that that the commenter is requesting that we monitor Measure #115 for appropriate inclusion in CAD the measures groups. As with all measures and measures groups selected for inclusion in the PQRI quality measure set, we will continue to monitor the appropriateness of including Measure #115 in the CAD measures group on an ongoing basis for future program years.

Comment: One commenter recommended that claims-based reporting be available for all measures groups. Other commenters recommended that claims-based reporting be available for specific measures groups, such as the CAD, IVD, Heart Failure, HIV/AIDS measures groups.

Response: The following 2010 PQRI measures groups will be reportable only via registry-based reporting: (1) CABG; (2) CAD; (3) Heart Failure; and (4) HIV/AIDS. These measures groups will be registry-only because they include individual 2010 PQRI registry-only measures that cannot be feasibly specified for claims based reporting.

Although we proposed that the IVD measures group would also be registry-only for 2010, we determined, based on comments that it is feasible to make the proposed registry-only measures proposed for inclusion in the IVD measures group available for either claims or registry reporting for 2010. Therefore, the IVD measures group will be available for either claims or registry reporting.

Comment: Some commenters recommended the addition of specific codes to particular measures that were proposed for inclusion in a measures group. Specifically, one commenter recommended the addition of 2 physical therapy codes to the back pain measures for the proposed Back Pain measures group. Another commenter recommended the addition of inpatient codes for the measures proposed for inclusion in the CAP measures group.

Response: As stated previously, it is generally the role of the measure owner, developer, or maintainer to make substantive changes to a measure. The addition of physical therapy codes would mean that it is appropriate to hold such professionals accountable for the measure, which we believe constitutes such a substantive issue. The measure maintainer and/or the developer/owner of a measure included in the final set of 2010 PQRI measures groups is identified as the ''Measure Developer'' in Tables 15 through 27 of this final rule with comment period. In addition, NQF has, for its endorsed measures, an established maintenance process which may be accessed. Both venues would be available to seek such substantive changes to the measures. Although we are required by section 1848(k)(2)(D) of the Act to give the public an opportunity to provide input on the selection of PQRI measures and do so via notice and comment rulemaking, we do not use notice and comment rulemaking as a means to make substantive changes to measures nor to update or modify measure specifications. We retain the ability to update or modify specifications to the measures until December 31, 2009. After that date, there will be no changes to the measure for the 2010 reporting period(s).

Based on the reasons discussed above and comments received, we are finalizing the following proposed 2010 measures groups: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; (7) Back Pain; (8) CAD; (9) Heart Failure; (10) IVD; (11) Hepatitis C; (12) HIV/AIDS; and (13) CAP. The following 4 measures groups are reportable through the registry-based reporting mechanism only: (1) CABG; (2) CAD; (3) Heart Failure; and (4) HIV/AIDS. The IVD measures group is no longer limited to registry only reporting since 4 measures included in the group that were proposed to be registry-only measures are now available for either claims or registry reporting for 2010 (see section II.G.2.i.2. above).

The measures selected for inclusion in each of the 2010 measures groups are identified in Tables 15 through 27 of this final rule with comment period. Some measures selected for inclusion in these 6 measures group are current 2009 individual PQRI measures. The title of each such measure is preceded with its PQRI Measure Number in Tables 15 through 27. As stated previously, the PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the PQRI measure set. Measures that are not preceded by a number (in other words, those preceded

by ''TBD'') in Tables 15 through 27 were never part of a PQRI measure set prior to 2010. A number will be assigned to such measures for 2010.

In addition, some measures selected for inclusion in some of these measures groups for 2010 were not included in the measures groups in 2009. The 2009 measures selected for inclusion in a 2010 measures group that were not included in the measures group for 2009 are identified with an asterisk (*).

We also note that the proposed 2010 Heart Failure measures group included the measure Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation, which is not included in the final 2010 Heart Failure measures group. The measure does not meet the common denominator criteria for the Heart Failure measures group because it requires an additional denominator code for atrial fibrillation. This additional code is not in the other 7 measures included in the Heart Failure measures group. As stated previously, measures groups must have a particular condition or focus in common, as identified by the denominator definition and coding of the measures group.

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

BILLING CODE 4120–01–P

TABLE 15: Measures Selected for 2010 Diabetes Mellitus Measures Group

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

TABLE 16: Measures Selected for 2010 CKD Measures Group

Measure Number	Measure Title	Measure Developer
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	AMA-PCPI
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AMA-PCPI
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	AMA-PCPI
135	Chronic Kidney Disease (CKD): Influenza Immunization	AMA-PCPI
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA-PCPI

TABLE 17: Measures Selected for 2010 Preventive Care Measures Group

Measure Number	Measure Title	Measure Developer
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA-PCPI/NCQA
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA
112	Preventive Care and Screening: Screening Mammography	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS/QIP
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening*	AMA-PCPI

*This 2009 PQRI measure was not part of this measures group for 2009, but was selected for inclusion in this measures group for 2010.

TABLE 18: Measures Selected for 2010 CABG Measures Group[+]

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

[+] This measures group is reportable through registry-based reporting only.

TABLE 19: Measures Selected for 2010 Rheumatoid Arthritis Measures Group

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

TABLE 20: Measures Selected for 2010 Perioperative Care Measures Group

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

TABLE 21: Measures Selected for 2010 Back Pain Measures Group

Measure Number	Measure Title	Measure Developer
148	Back Pain: Initial Visit	NCQA
149	Back Pain: Physical Exam	NCQA
150	Back Pain: Advice for Normal Activities	NCQA
151	Back Pain: Advice Against Bed Rest	NCQA

TABLE 22: Measures Selected for 2010 CAD Measures Group[+]

Measure Number	Measure Title	Measure Developer
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA
TBD	Coronary Artery Disease (CAD): Symptom and Activity Assessment	AMA-PCPI
TBD	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	AMA-PCPI

[+] This measures group is reportable through registry-based reporting only.

TABLE 23: Measures Selected for 2010 Heart Failure Measures Group[+]

Measure Number	Measure Title	Measure Developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA
TBD	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA-PCPI
TBD	Heart Failure: Patient Education	AMA-PCPI

[+] This measures group is reportable through registry-based reporting only.

TABLE 24: Measures Selected for 2010 IVD Measures Group

Measure Number	Measure Title	Measure Developer
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA
TBD	Ischemic Vascular Disease (IVD): Blood Pressure Management Control	NCQA
TBD	Ischemic Vascular Disease (IVD): Complete Lipid Profile	NCQA
TBD	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	NCQA
TBD	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-thrombotic	NCQA

TABLE 25: Measures Selected for 2010 Hepatitis C Measures Group

Measure Number	Measure Title	Measure Developer
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	AMA-PCPI
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	AMA-PCPI
86	Hepatitis C: Antiviral Treatment Prescribed	AMA-PCPI
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	AMA-PCPI
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	AMA-PCPI
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	AMA-PCPI
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	AMA-PCPI
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	AMA-PCPI

TABLE 26: Measures Selected for 2010 HIV/AIDS Measures Group[+]

Measure Number	Measure Title	Measure Developer
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA-PCPI/NCQA
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	AMA-PCPI/NCQA
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	AMA-PCPI/NCQA
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	AMA-PCPI/NCQA
TBD	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea	AMA-PCPI/NCQA
TBD	HIV/AIDS: Screening for High Risk Sexual Behaviors	AMA-PCPI/NCQA
TBD	HIV/AIDS: Screening for Injection Drug Use	AMA-PCPI/NCQA
TBD	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	AMA-PCPI/NCQA

[+] This measures group is selected to be reportable through registry-based reporting only.

TABLE 27: Measures Selected for 2010 CAP Measures Group

Measure Number	Measure Title	Measure Developer
56	Community-Acquired Pneumonia (CAP): Vital Signs	AMA-PCPI/NCQA
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	AMA-PCPI/NCQA
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	AMA-PCPI/NCQA
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	AMA-PCPI/NCQA

BILLING CODE 4120–01–C

We note that the specifications for measures groups do not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the individual 2010 PQRI measures. We will post the detailed specifications and specific instructions for reporting measures groups on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by no later than December 31, 2008.

Additionally, the detailed measure specifications and instructions for submitting data on those 2010 measures groups that were also included as 2009 PQRI measures groups may be updated or modified prior to 2010. Therefore, the 2010 PQRI measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2009. These measure specification changes do not materially impact the intended meaning of the measures or the strength of the measures.

(6) Request for Public Comment on Measure Suggestions for Future PQRI Quality Measure Sets

In the CY 2010 PFS proposed rule (74 FR 33587), we invited commenters to submit suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions for the composition of measures groups) for consideration for possible inclusion in the proposed set of quality measures for use in the 2011 PQRI. We asked individuals or organizations submitting suggestions to provide us with the following information:

- Requestor contact information, such as name and title, organization/practice name, phone number and e-mail address;
- Measure title;
- Measure description;
- Measure owner/developer;
- NQF endorsement status, including the date of endorsement or anticipated endorsement (if not NQF-endorsed) and type of endorsement (for example, time-limited endorsement);
- AQA adoption status, including date of AQA adoption or anticipated AQA adoption;
- Preferred PQRI reporting option for the suggested measure(s) (that is, claims, registry, registry-only, measures group, measures group only, EHRs); and
- The measure specifications.

The following is summary of the comments we received regarding suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions) for the 2011 PQRI.

Comment: Several commenters suggested quality measures or measures groups for the 2010 PQRI in addition to the quality measures and measures groups for individual eligible professionals we had proposed in Tables 19 through 33 of the CY 2010 PFS proposed rule (74 FR 33575 through 33587).

Response: We have not included in this final rule with comment period for the 2010 PQRI any individual quality measures that were not identified in the CY 2010 PFS proposed rule as proposed 2010 PQRI measures. As discussed above in this final rule with comment period, we are obligated by section 1848(k)(2)(D) of the Act to give eligible professionals an opportunity to provide input during the selection of measures for the 2010 PQRI and subsequent years. Eligible professionals have not had an opportunity to provide input on measures recommended for selection via comments on the proposed rule that were not specifically included in the proposed rule. Thus, such additional measures recommended via comments on the proposed rule cannot be included in the 2010 PQRI quality measure set. However, we have captured these recommendations and will have them available for consideration in identifying measure sets for future years' PQRI and other initiatives to which those measures may be pertinent.

Comment: As we requested in the CY 2010 PFS proposed rule (74 FR 33587), several commenters suggested quality measures or measures groups for the 2011 PQRI.

Response: We have captured these recommendations. To the extent information provided is complete (that is, includes the measure or measure group details requested in the proposed rule), we will consider the commenters' recommendations in identifying measure sets for future years' PQRI and other initiatives to which those measures may be pertinent. As we stated in the CY 2010 PFS proposed rule, suggesting individual measures or measures for new or proposed measures groups does not mean that the measure(s) or measures group(s) will be included in the proposed or final sets of measures or measures groups of any proposed or final rules that address the 2011 PQRI. We will determine what individual measures and measures group to include in the proposed set of quality measures, and after a period of public comment, we will make the final determination with regard to the final set of quality measures for the 2011 PQRI.

Comment: Some commenters urged us to expand the opportunities for measures to be presented to CMS for potential inclusion in the PQRI. One commenter elaborated that the process to develop and endorse measures takes a considerable amount of time and measure developers should have greater opportunities to bring measures forward. The commenter also requested that we review the process by which PQRI measures are selected to ensure transparency and greater communication with measure developers. The commenter stated that currently the process leaves little opportunity for the measure developer to dialogue with CMS if the measure is denied. The commenter believes we should provide feedback on suggested measures prior to publication of the proposed rule.

Response: We understand the commenters' concerns. As stated previously, we largely depend on the development of measures by professional organizations and other measure developers. As such, we depend on the measure developers and other stakeholders to bring forth potential measures to our attention. We are continuing to look for ways to improve the process for allowing stakeholders to bring forth suggested measures and are considering some changes in the process future years PQRI. For example, in addition to our invitation to submit suggestions for measures and measures groups for potential inclusion in the 2011 PQRI contained in CY 2010 PFS proposed rule (74 FR 33587), we are considering a Call for 2011 Measures that will allow stakeholders to submit additional measures and/or measures groups suggestions for the 2011 PQRI after publication of this final rule followed by a listening session in early 2010 to promote a dialogue with stakeholders with respect to the measure or measures group suggestions we receive.

j. 2010 PQRI Quality Measures for Physician Groups Selected To Participate in the Group Practice Reporting Option

We proposed that physician groups selected to participate in the 2010 PQRI group practice reporting option would be required to report on 26 measures (74 FR 33587). These measures are NQF-endorsed measures currently collected

as part of the PGP and/or MCMP demonstrations.

The following is summary of the comments we received regarding the proposed 2010 PQRI Quality Measures for physician groups selected to participate in the PQRI group practice reporting option.

Comment: Some commenters suggested that we broaden the scope of measures so that the measures would be applicable to specialty care such as emergency medicine, gastroenterology, and surgical specialties. A few commenters felt that group practices are being required to report on too many measures. Several commenters believe that it is appropriate for CMS to first implement the group practice reporting option by focusing on the high-cost chronic conditions and preventive care reflected by the proposed measures.

Response: We recognize that the measures largely apply to primary care. However, as required by statute, the measures shall target high-cost chronic conditions and preventive care. This reporting option is for group practices with 200 or more eligible professionals. On average, these group practices typically have 20,000 patients assigned to each group practice. Each group practice will be required to complete the data collection tool on a total of no more than 3,699 consecutively assigned and ranked patients, which is 411 patients per disease module and preventive care measure. Thus, the number of measures is considered to be equitable for practices with this volume of patients and eligible professionals. We will continue to evaluate the number and types of measures and modules for future program years.

Comment: We received some comments in support of the proposed measures for the group practice reporting option. A few commenters expressed support for specific proposed measures, including:

- Measure #1 Diabetes Mellitus: Hemoglobin A1c Poor Control;
- Measure #5 Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD);
- Measure #6 Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD;
- Measure #7 Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI);
- Measure #8 Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD); Measure #118 Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD);
- Heart Failure: Left Ventricular Function (LVF) Testing;
- Heart Failure: Left Ventricular Function (LVF) Assessment;
- Heart Failure: Weight Measurement;
- Heart Failure: Patient Education;
- Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation; and
- Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.

Response: We appreciate the commenters support. The final measures for physician groups participating in the 2010 PQRI group practice reporting option are identified in Table 28.

Comment: One commenter noted that the 2 proposed hypertension measures (Hypertension (HTN): Blood Pressure Control and Hypertension (HTN): Plan of Care) are not included in the larger list of 2010 PQRI measures for individual eligible professionals. The commenter recommended that we include these 2 measures as 2010 PQRI individual quality measures for individual eligible professionals.

Response: The commenter is correct; these 2 measures are not available to individual eligible professionals to report for the 2010 PQRI. Since these measures were not proposed to be included in the 2010 PQRI quality measure set for individual eligible professionals, however, we are unable to add them to the PQRI quality measure set for individual quality measures for 2010. As stated previously, section 1848(k)(2)(D) of the Act requires us to give the public an opportunity to provide input on the selection of measures for the PQRI, which we accomplish through notice and comment rulemaking. Since these measures have not been placed before the public as potential measures for individual eligible professionals for the 2010 PQRI, eligible professionals and other stakeholders have not had an opportunity to provide input on the inclusion of these 2 measures in the 2010 PQRI quality measure set for individual eligible professionals.

Comment: The measure developer/owner of the Heart Failure: Weight measurement measure requested that we remove the measure from the group reporting option since the measure owner's measure workgroup is planning to retire the measure from its heart failure measure set in the upcoming months.

Response: We value the input of the measure developer/owner. Furthermore, we look to the measure developer/owner to maintain and update measures based on the standards of care and evidence base. We believe, however, that the Heart Failure: Weight Measurement measure targets a high-cost chronic condition. The measure is a valuable measure in the evaluation of patients with heart failure and continues to have a significant impact on the care and improvement in outcomes. Additionally, the measure has undergone the scientific rigor of achieving consensus endorsement by the NQF. Therefore, we will retain this measure, as proposed, in the group practice reporting option. The final measure specifications for the group practice reporting option will be posted on the CMS Web site *http://www.cms.hhs.gov/pqri* no later than December 31, 2009.

Comment: One commenter noted that measure developer listed in the proposed rule for the ''Preventive Care: Blood Pressure Management'' measure was incorrect and should be corrected in the final rule.

Response: The measure title was incorrectly listed as ''Preventive Care: Blood Pressure Management.'' The correct title is ''Hypertension: Blood Pressure Measurement.'' This correction is reflected in Table 28.

Based on the reasons discussed above and after considering the comments, for the 2010 PQRI, group practices selected to participate in the PQRI group practice reporting option will be required to report on all measures listed in Table 28. To the extent that a measure is an existing PQRI measure available for reporting by individual eligible professionals, the Measure Title is preceded by the measure's PQRI Measure Number. If there is no number in the PQRI Measure Number column of the table, then the measure is not an existing PQRI measure and will be added to the 2010 PQRI for purposes of the group practice reporting option.

A separate measures specifications manual and other supporting documents will be available for group practices participating in the 2010 PQRI group practice reporting option. We anticipate that the group practice measures specifications manual will be available by November 15, 2009 on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

TABLE 28—MEASURES FOR PHYSICIAN GROUPS PARTICIPATING IN THE 2010 PQRI GROUP PRACTICE REPORTING OPTION

PQRI Measure No.	Measure title	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA–PCPI
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	AMA–PCPI
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA–PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA–PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA
112	Preventive Care and Screening: Screening Mammography	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA/AMA–PCPI
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	NCQA
163	Diabetes Mellitus: Foot Exam	NCQA
TBD	Diabetes Mellitus: Hemoglobin A1c Testing	NCQA
TBD	Diabetes Mellitus: Lipid Profile	NCQA
TBD	Heart Failure: Left Ventricular Function (LVF) Testing	CMS
TBD	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA–PCPI
TBD	Heart Failure: Weight Measurement	AMA–PCPI
TBD	Heart Failure: Patient Education	AMA–PCPI
TBD	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	AMA–PCPI
TBD	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL–Cholesterol	AMA–PCPI
TBD	Hypertension: Blood Pressure Measurement	AMA–PCPI
TBD	Hypertension (HTN): Blood Pressure Control	CMS/NCQA
TBD	Hypertension (HTN): Plan of Care	AMA–PCPI

k. Public Reporting of PQRI Data

Section 1848(m)(5)(G) of the Act, as added by the MIPPA, requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers. In accordance with section 1848(m)(5)(G) of the Act, we stated in the CY 2010 PFS proposed rule (74 FR 33588 through 33589) our intent to make public the names of eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI on the Physician and Other Health Care Professionals Directory. In addition to posting the information required by section 1848(m)(5)(G) of the Act, for those group practices that are selected to participate in PQRI under the group practice reporting option, we also proposed to make the group practices' PQRI performance rates publicly available, for each of the measures. We solicited comments regarding our proposal to publicly report group practices' PQRI performance results.

The following is summary of the comments we received regarding the public reporting of PQRI data required under section 1848(m)(5)(G)(i) of the Act and our proposal to publicly report group practices' PQRI performance results.

Comment: We received some comments in support of public reporting of either the information required by section 1848(m)(5)(G)(i) of the Act or all PQRI measure results, including individual eligible professionals' performance results. One commenter stated that CMS needs to articulate a clear and aggressive path forward, with short-term benchmarks and a goal of having publicly available, actionable performance and cost information for all participating Medicare clinicians.

Response: We appreciate the commenters' support. As we have stated previously, we believe that public reporting of group practices' PQRI performance results represents an opportunity to make strides towards the goal of being able to make quality information about physicians and other healthcare professionals publicly available.

Comment: One commenter encouraged the use of composite measures to help increase the reliability of individual eligible professionals' performance data.

Response: At this time we have no plans to publicly release individual eligible professionals' performance data. Additional refinements to the PQRI are likely needed as the program matures.

Comment: One commenter recommended that CMS also publicly report the names of eligible professionals who choose not to participate in the PQRI. The commenter stated that the willingness (or lack thereof) of clinicians to participate in performance measurement and reporting should be publicly recognized.

Response: We disagree that such information would be useful to consumers since there are several valid reasons why an eligible professional may choose to not participate in a voluntary initiative, such as the PQRI. Consumers may potentially misinterpret the lack of participation to mean that an eligible professional is not interested in providing quality care.

Comment: Many commenters were opposed to releasing any other data on PQRI until issues with the Physician and Other Health Care Professional Directory are addressed and corrected.

Some of the issues cited by commenters include, the lack of accurate provider listings, poor and difficult to find disclaimer information regarding participation in PQRI, and poor user instructions. Many comments, in particular, requested that the disclaimer that was provided with the list of 2007 PQRI participants be updated and made more prominent.

Response: We appreciate the comments and plan to make improvements to the Directory with respect to reporting PQRI participation.

Comment: Many commenters were opposed to releasing any additional PQRI information, including the information required under section 1848(m)(5)(G)(i) of the Act, because of issues with the PQRI itself. Some of the concerns cited by commenters include the following:

- The errors identified with the 2007 PQRI have compromised the program's validity within the participant community;
- The program's plans to transition away from claims-based reporting may force eligible professionals who satisfactorily reported in the past to stop doing so;
- The potential for consumers to misunderstand the significance of the information being publicly reported since there are still many valid reasons why an eligible professional may not have participated or may have participated but was not considered a satisfactory reporter.

One commenter suggested that we consider alternative data sets for public reporting such as Board certification, CAHPS data, and/or a physician or other health care professional's participation in a registry. Other commenters requested that a formal evaluation of the 2007 and 2008 PQRI be conducted before releasing any participation, reporting, or performance rates.

Response: As required by section 1848(m)(5)(G)(i) of the Act, we must, at a minimum, make public the names of eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI on the Physician and Other Health Care Professionals Directory. We anticipate that the names of individual eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI will not be made available any earlier than in 2011 after the 2010 incentive payments are paid. In an attempt to address commenters' concerns, we will make information about the intended uses and/or limitations of the information being presented in the form of a disclaimer available on the Web site as well. To the extent that additional information derived from the PQRI, is made public we would also take such concerns into account.

Comment: Several commenters provided recommendations for CMS to consider with respect to publicly reporting PQRI information, including the information required by section 1848(m)(5)(G)(i) of the Act. These suggestions include the following:

- Establishing a process that allows for prior review and comment before data are made public and that allows for any comments received to be included with the publicly reported data;
- Establishing an appeals process with regard to any data that is to be publicly reported;
- Providing information outlining the data's potential uses and limitations;
- Providing information that clearly and specifically states that information about whether an eligible professional is a satisfactory reporter does not necessarily indicate that higher quality care was or will be provided by those eligible professionals (or group practices) who qualified to earn PQRI incentive payments;
- Providing better access to and more timely feedback;
- Avoiding characterization of the names of satisfactory reporters as comparative quality information; and
- Giving eligible professionals an opportunity to explain why they are not participating.

Response: We appreciate the commenters' valuable input. We believe that many of these suggestions have already been addressed. For example, eligible professionals have an opportunity to review their reporting and performance results via the feedback reports that are made available to all participating eligible professionals at the time that incentive payments are released for a particular program year. As discussed previously, we have also created an alternate process to make it easier for eligible professionals to obtain their feedback reports and created a dedicated Help Desk that is available to assist eligible professionals who have any concerns about the information contained in their feedback reports. All information that is publicly reported will also be accompanied by appropriate disclaimers that address the information's potential uses and limitations, including the fact that an eligible professional or group practice is listed as having satisfactorily reported PQRI quality measures does not necessarily indicate that he or she provides higher quality care than those who did not participate or those who participated but did not do so satisfactorily.

Comment: Several commenters provided recommendations for CMS to consider specifically with respect to our proposal to publicly report group practices' PQRI performance results. These suggestions include the following:

- Providing group practices the opportunity to suppress their data;
- Precisely defining what performance data CMS plans to post; and
- Conducting and publishing an evaluation of PQRI on its impact on quality of care before selecting measures for public reporting.

Response: As stated in the CY 2010 PFS proposed rule (74 FR 33589), we proposed to make the group practices' performance rates for each of the PQRI group practice reporting option measures public for each group selected to participate in PQRI group practice reporting option. We proposed to attribute the performance rates to the entire group and will not post any information with respect to the performance of individual eligible professionals other than, potentially, to identify the individual eligible professionals that were associated with the group during the reporting period.

As stated in section II.G.2.g.1. above, however, we have taken the commenters' concerns about publicly reporting the group practices' performance results in the first year of implementation of the PQRI group practice reporting option into consideration. We are not finalizing our proposal to require group practices that wish to utilize the group practice reporting option in 2010 to agree to have their PQRI performance results publicly reported. In addition, we will not report any 2010 group practice performance results publicly at all except as otherwise required by law and will limit public reporting of information on the PQRI group practice reporting to the information required by section 1848(m)(5)(G)(i) of the Act (that is, the names of group practices that satisfactorily submitted data on PQRI quality measures). Instead, we will consider implementing public reporting of group practices' performance results in the 2011 PQRI program year.

Comment: Many commenters were opposed to the public reporting of any PQRI information beyond what is specifically required by section 1848(m)(5)(G)(i) of the Act. These concerns include the following:

- CMS only has the specific authority to publicly report the information

required by section 1848(m)(5)(G)(i) of the Act;

- There continue to be substantial gaps in the PQRI quality measure set that may create a barrier to participation in PQRI;
- The value of PQRI data is questionable since there has been no formal evaluation of the PQRI to determine its impact on the quality of care, whether it allows for fair and meaningful comparisons of performance on eligible professionals, and whether it is valid; and
- PQRI is not available to all specialties.

Response: Other than the information required by section 1848(m)(5)(G)(i) of the Act, the only PQRI information that we contemplated making public is the PQRI performance results for group practices selected to participate in the PQRI group practice reporting option (that is, group practices that have agreed to have their PQRI performance results publicly reported as a condition of utilizing the group practice reporting option). As stated above, we have taken commenters' concerns into consideration and have decided to defer implementation of public reporting of group practices' performance results until the 2011 PQRI program year.

Comment: One commenter requested clarification of the term ''satisfactorily submitted.'' The commenter recommended that we exercise flexibility until there is a guarantee that we can accurately collect and analyze the submission of quality data codes.

Response: We do not believe we have the authority to flexibly define the term ''satisfactorily submitted.'' Section 1848(m) of the Act clearly considers any eligible professional or group practice who satisfies the criteria for satisfactory reporting, as defined in sections II.G.2.e. through II.G.2.g. of this final rule with comment period, to be an eligible professional or group practice who qualifies for an incentive payment. Furthermore, section 1848(m)(5)(G) of the Act clearly requires us to post the names of eligible professionals or group practices that satisfactorily submitted data on PQRI quality measures.

After considering the comments above, we intend to post the names of eligible professionals who: (1) Submit data on the 2010 PQRI quality measures through one of the reporting mechanisms available for the 2010 PQRI; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2010 PQRI; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act, on the Physician and Other Health Care Professionals Directory.

Similarly, for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act with respect to group practices, on the Physician and Other Health Care Professionals Directory, we intend to post the names of group practices that: (1) Submit data on the 2010 PQRI quality measures through the proposed group practice reporting option; (2) meet the proposed criteria for satisfactory reporting under the group practice reporting option; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period for group practices.

We do not intend to make performance rates for group practices participating in the 2010 PQRI group practice reporting option publicly available but anticipate publicly reporting group practices' performance results for the 2011 PQRI program year.

We anticipate that information with respect to quality data submitted for the 2010 PQRI (that is, the names of individual eligible professionals and group practices that satisfactorily report in 2010) will not be available until after the 2010 incentive payments are paid in 2011.

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

a. Statutory Authority

As required under section 1848(n) of the Act, as added by section 131(c) of the MIPPA, we established and implemented by January 1, 2009, the Physician Resource Use Measurement & Reporting Program for purposes of providing confidential reports to physicians that measure the resources involved in furnishing care Medicare beneficiaries. Section 1848(n) of the Act also authorizes CMS to include information on the quality of care furnished to Medicare beneficiaries by a physician or group of physicians.

b. Background

As stated in the CY 2009 PFS final rule with comment period (73 FR 69866), the Program would consist of multiple phases. We included a summary of the activities of phase I of the Program in the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869). In addition to discussing phase I of the Program, we also highlighted the activities of several other initiatives, including Medicare Value-Based Purchasing (VBP) programs and demonstrations and related activities undertaken by the MedPAC and the Government Accountability Office (GAO). We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a detailed discussion of these activities.

In the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869), we finalized, on an interim basis, the following parameters for phase I of the Program: (1) Use of both per capita and episode of care methodologies for resource use measurement; (2) cost of service category analysis (for example, imaging services or inpatient admissions); (3) use of 4 calendar years of claims data; (4) focus on high cost and/or high volume conditions; (5) reporting to physician specialties relevant to the selected focal conditions; (6) focus on physicians practicing in certain geographic areas, and (7) low, median, and high cost benchmarks.

In the CY 2010 PFS proposed rule (74 FR 33589 through 33591), we summarized the comments received from the CY 2009 PFS final rule with comment period and our responses. Further, we made the following proposals in the CY 2010 PFS proposed rule (74 FR 33591): (1) Reporting on quality measures in addition to resource use measures, and (2) reporting to groups of physicians in addition to individual physicians.

c. Phase I of the Program

As indicated above, the Program consists of multiple phases. Under this approach, each phase of the Program will inform future phases of the Program. We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a description of phase I Program activities. Using the parameters that were finalized on an interim basis, we have disseminated approximately 310 resource use reports (a sample report is available at *http://rurinfo.mathematica-mpr.com/*) to physicians in 13 geographic regions (74 FR 33590). In the proposed rule, we solicited public comments on the interim final Program parameters.

Commenters supported the Program parameters that were finalized on an interim basis in the CY 2009 PFS final rule (73 FR 69866 through 69869). Our summary of those comments and our responses are contained in the CY 2010 PFS proposed rule (74 FR 33589 through 33591). Accordingly, we are finalizing the interim final Program parameters.

In addition to the eight conditions finalized on an interim basis in the CY 2009 PFS final rule(74 FR 33590), we solicited public comment on adding diabetes as an episode of care.

Comment: Commenters supported including diabetes as one of the selected episodes of care for the Program.

Response: We are finalizing adding diabetes to the episode of care analysis in the Program.

In the CY 2010 PFS proposed rule (74 FR 33591), we referred readers to the following Web site to review a de-identified sample of the resource use reports disseminated to physicians: *http://rurinfo.mathematica-mpr.com/.* We solicited public comment on the resource use report used in phase I of the Program.

Comment: Commenters supported dissemination of feedback reports both in hard copy and electronically.

Response: We intend to offer both hard copy and electronic delivery of feedback reports in the Program.

Comment: Commenters supported electronic reports that allow user-driven data drilldown capability to the claim level.

Response: We intend to explore the feasibility of such drill-down capability.

Comment: A few commenters suggested that additional cost of service categories (described on pages 30 and 34–35 at *http://rurinfo.mathematica-mpr.com/*) should be included in the feedback reports. Additional categories mentioned included: prescribed drugs, costs due to infections, and specific information on diagnostic tests and services.

Response: We intend to explore the feasibility of these additional cost of service categories in the future.

Comment: A few commenters suggested capturing hospital readmissions as a measure in the feedback reports.

Response: We are committed to closely monitoring hospital readmissions in the Medicare program. We intend to explore the feasibility of capturing readmissions in the physician group feedback reports in the future.

Comment: A few commenters stated that some of the benchmarks used in the reports were too broad in order to make meaningful peer comparisons.

Response: We are committed to refining the benchmarks used in the Program to ensure meaningful peer comparisons. We note that there is a trade-off between statistical precision and narrow benchmarks. For additional discussion on this statistical topic, we refer readers to the CY 2010 PFS proposed rule (74 FR 33590 through 33591). Further, we note that the broad geographic benchmarks provide additional value to CMS by informing policymakers of measurement variation across geographic regions.

Comment: A few commenters mentioned that eligible professionals would appreciate knowing each beneficiary that was assigned to them. Further, physicians would appreciate knowing which other physicians were also providing care to the beneficiaries assigned to them.

Response: To the extent it is practicable, we are committed to providing physicians with information that targets specific performance areas. We intend to explore the feasibility of providing this detailed level of data.

Comment: One commenter requested that CMS pursue a robust evaluation of the risk adjustment methodology (pages 29 and 32 at *http://rurinfo.mathematica-mpr.com/*) used in the Program.

Response: We are committed to conducting further research to refine the risk adjustment rules currently being applied in the Program. Determining how to accurately adjust for patient risk factors is a priority for CMS.

Comment: One commenter suggested that we make the minimum thresholds for patients and episodes that are needed for statistical accuracy used in the Program publicly available.

Response: We are committed to making the methodologies used in the Program transparent. We are currently exploring the feasibility of publicly posting the minimum thresholds for patients and episodes used in the Program on our Web site.

Comment: A few commenters suggested that additional outreach and education is needed to help eligible professionals understand the reports. Further, commenters suggested including a task in the next Quality Improvement Organization (QIO) scope of work to assist physicians with interpreting their reports.

Response: We are committed to providing technical assistance to eligible professionals to aide in the understanding of the reports. We intend to explore the feasibility of including a task to provide technical assistance in understanding the reports in the QIO 10th scope of work.

Comment: One commenter questioned how E/M codes included in surgical bundle payments are used to inform CMS' designated attribution methodologies.

Response: We are committed to pursuing further research in order to refine the designated attribution rules currently being applied in the Program. Determining how to accurately attribute surgical bundles is a priority for CMS.

Comment: One commenter requested that CMS raise the minimum of 10 percent of E/M costs used to assign a patient or episode to a physician.

Response: In addition to setting the minimum threshold at 10 percent, we will test some higher minimum thresholds. We note that one of the goals of this Program is to provide confidential feedback reports to as many physicians as possible. One of the trade-offs to raising the minimum threshold is that fewer physicians may qualify to receive a feedback report.

Comment: Several commenters strongly supported CMS' use of the multiple proportional attribution rule (pages 26–27 and 33 at *http://rurinfo.mathematica-mpr.com/*).

Response: We will continue to examine the utility of this attribution rule and test others.

In the CY 2010 PFS proposed rule, we referred readers to two publicly available Web sites for commercial episode grouper vendors regarding transparency of their methodologies (74 FR 33591). We solicited public comment on the use of proprietary products to measure episodes of care in the Program.

Comment: Many commenters were in favor of CMS only using a Medicare-specific public domain episode grouper in the Program.

Response: To the greatest extent practicable, we are committed to ensuring all methodologies used in the Program are transparent. We intend to explore the feasibility of using a Medicare-specific public domain episode grouper in the Program. We refer readers to (74 FR 48979 through 48980) for an announcement regarding an upcoming public listening session that CMS is hosting to discuss this topic.

d. Phase II of the Program

For phase II, we proposed to expand the Program in ways that that targets specific performance areas for physicians. We proposed to add reporting to groups of physicians, recognizing that many physicians practice in arrangements other than solo practices. We noted that group level reporting will be more likely to resolve the sample size issues that arise when individual physicians have too few Medicare beneficiaries with specific conditions to generate statistically significant information. We solicited public comment on potential types of groups including the following: (1) Formally-established single or multi-specialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing

within facilities or larger systems of care.

Comment: Commenters supported reporting to groups of physicians, including all categories listed above, in addition to individual physicians. A few commenters questioned how CMS would define groups. Commenters did not offer a definition of group reporting, however. One commenter asked us to include accountable care organizations (ACOs) in the definition of the ''group.''

Response: We are finalizing our proposal to include group reporting. Since no explicit definition of group practice was suggested through public comment, for purposes of this Program, we are finalizing the following definition of group practice: more than one physician practicing medicine together. We choose this definition because we want to recognize groups of physicians as entities that are separate and distinct from individual physicians. We are defining a group as two or more physicians both to recognize groups as separate and distinct from individual physicians and to ensure that we have the broadest possible definition of a group so that all physicians could potentially be provided with resource use reports. If groups were to be defined more narrowly, it is possible that some physicians would not be subject to the resource use reporting because they are neither working in solo practice as an individual physician or part of a practice that meets our definition of a group.

This definition applies to the following groups: (1) Formally-established single or multi-specialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing within facilities or larger systems of care. With respect to ACOs, the term is not defined at this time in either the law or regulations but to the extent that the ACO includes more than one physician, the physicians in the ACO would constitute a group for resource use reporting. We are therefore, finalizing the definition for group practices and these three types of groups of physicians.

Phase I of the Program focused on providing confidential feedback on resource use measures. Section 1848(n)(1)(A) of the Act states that the Secretary may also include information on the quality of care furnished to Medicare beneficiaries by physicians (or groups of physicians) in the feedback reports. Providing physicians with feedback on both quality and cost of care better captures the value of the care provided. Including quality measures in the Program is consistent with the direction for other CMS VBP initiatives. We solicited public comments on the use of PQRI, GEM, and other aggregate quality measures to be used in the Physician Resource Use Measurement and Reporting Program.

Comment: Commenters were unanimously supportive of including quality measures, in addition to resource use measures in the Program.

Response: We are finalizing our proposal to include quality measures in the Program.

Comment: Commenters were in support of using both PQRI and GEM measures to capture quality of care. Some commenters cited the new nature of both PQRI and GEM measures as an area of concern and recommended caution in using these quality measures until the measures become more mature.

Response: Though we recognize that both the measures used in the PQRI and claims-based measures calculated without submission of quality data codes from physicians (such as GEM measures) will continue to mature over time, we intend to include them in the Program. Including these quality measures will allow us to gain more experience reporting performance metrics to eligible professionals on a confidential basis.

Comment: In addition to the use of PQRI and GEM measures, commenters also encouraged reporting of structure and outcome measures (outside of those currently included in the PQRI Program). Commenters stated that specialty societies and other measure developers should be encouraged to speed the development of these types of measures.

Response: We are committed to capturing all aspects of performance, including process, structure, and outcomes measures. As additional measures become available, we will examine the utility of such measures as an additional aspect of reporting in this Program.

Comment: A few commenters expressed that quality data should closely relate to the episodes of care that are targeted in the Program.

Response: We are committed to working collaboratively with measure developers on pairing quality measures with episodes of care.

Comment: A few commenters recommended that the time period represented by the quality and cost measures should overlap.

Response: To the greatest extent practicable, we are committed to recognizing overlapping measurement time periods between quality and cost measures in this Program.

Comment: A few commenters suggested capturing quality data from registries.

Response: We are committed to allowing the collection of quality measures from data contained within clinical registries. We refer readers to section II.G.2. of this final rule with comment period that discusses the PQRI for additional discussion on the use of registries to collect quality data.

e. General Comments

In addition to the areas where we specifically solicited comments, we also received several general comments.

Comment: Some commenters expressed concern about the use of the data contained within the feedback reports for purposes beyond confidential reporting. One commenter strongly encouraged CMS to publicly report the data contained within the feedback reports.

Response: Section 1848(n) of the Act currently provides the authority to use the information contained within the feedback reports on a confidential basis only.

Comment: One commenter suggested integrating the reporting of resource use measures into Maintenance of Certification programs.

Response: CMS is committed to working collaboratively with stakeholders on various mechanisms and programs to increase the value of care delivered to beneficiaries. We refer readers to section II.G.2. of this final rule with comment period that discusses the PQRI for additional discussion of this suggestion.

Comment: One commenter suggested that the feedback reports be used to provide information on geographic variations in the delivery of specific services.

Response: We are committed to monitoring and addressing geographic variations in the delivery of services. As mentioned above, we plan to explore group level reporting, which may include reporting to physicians within a specified geographic group.

Comment: One commenter strongly encouraged CMS to expand the number of reports delivered beyond the 310 delivered in Phase I of the Program.

Response: We are committed to providing feedback to as many physicians as our resources will allow. We intend to explore the feasibility of providing more reports in the Program.

4. Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners

a. Background

Value-based purchasing uses payment incentives and transparency to increase the value of care by rewarding providers for higher quality and more efficient services and for publicly reporting performance information. Section 131(d) of the MIPPA requires the Secretary to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for covered professional services made under, or based on, the PFS. Section 131(d) of the MIPPA also states that by May 1, 2010, the Secretary shall submit a report to the Congress, containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The Secretary, through the Physician and Other Health Professional VBP (PVBP) Workgroup, submitted a progress letter to Congress on January 8, 2009 detailing the progress made on the PVBP plan for physicians and other professionals.

Currently, Medicare health professional payments are based on quantity of services and procedures provided, without recognition of quality or efficiency. Under various authorities, we have pursued the implementation of building blocks to support the establishment of a VBP program for health professionals. These include initiatives in the following major topic areas: quality and efficiency measurement and reporting, approaches for aligning incentives with providing higher quality care instead of higher volume of care, care coordination, prevention, and health information technology (HIT). The following are examples of the initiatives specifically relevant to physicians and other health professionals:

- Pay for reporting of quality measurement data instituted under the Physician Quality Reporting Initiative (PQRI);
- Resource use reports comparing overall costs, as well as costs for treatment across episodes of care, as required by the Physician Resource Use Measurement and Reporting Program; and
- Demonstration projects including the Physician Group Practice demonstration of a shared savings model, gainsharing demonstrations, medical home and other care coordination and disease management demonstrations, and the Acute Care Episodes demonstration of a bundled payment model.

We are fully committed to implementing VBP incentives to drive quality improvement and greater efficiency for services furnished to Medicare beneficiaries.

b. Approach to Plan Development

We have created an internal cross-component team, the PVBP Steering Committee (formerly referred to as PVBP Workgroup), to lead development of the PVBP plan. Four Subgroups were established to address the major sections of the Plan: measures; incentives; data strategy and infrastructure; and public reporting. The PVBP Steering Committee was tasked with reviewing the state-of-the-art in performance-based payment for physicians, including relevant Medicare programs and demonstrations and private sector initiatives; preparing an Issues Paper to present program objectives and design principles; engaging stakeholders and obtaining input on program design; and developing the PVBP Plan and Report to Congress. A similar approach was used in the development of the CMS Hospital VBP Plan.

To guide the planning process, the PVBP Steering Committee adopted the following goal to improve Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services. In pursuit of this goal, the Workgroup has defined the following objectives:

- Promote evidence-based medicine through measurement, payment incentives, and transparency.
- Reduce fragmentation and duplication through accountability across settings, alignment of measures and incentives across settings, better care coordination for smoother transitions, and attention to episodes of care.
- Encourage effective management of chronic disease by improving early detection and prevention, focusing on preventable hospital readmissions, and emphasizing the importance of advanced care planning and appropriate end-of-life care.
- Accelerate the adoption of effective, interoperable HIT, including clinical registries, e-prescribing, and electronic health records.
- Empower beneficiaries to make value-based health care choices, and encourage health professionals to improve the value of care they provide by disseminating information designed to help them change their practice patterns to improve performance.

The goal and objectives were captured in an Issues Paper that was posted on the CMS Web site on November 24, 2008, in preparation for the December 9, 2008 Listening Session which was held at CMS headquarters. The Issues Paper included questions seeking public input on key design considerations. The Issues Paper is available on the CMS Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf*. Nearly 500 stakeholders participated in the day-long Listening Session. We received both verbal and written comments that are informing the design of the PVBP Plan. Stakeholder input from this Listening Session is summarized in the proposed rule (74 FR 33592 through 33593).

c. Next Steps in Plan Development

Building on input from the Listening Session on the Issues Paper topics, the PVBP Steering Committee has begun to develop potential recommendations for inclusion in the Report to Congress. The first step is to design various approaches for performance-based payment that will address the planning goal and objectives for different practice arrangements. This design process will include identifying appropriate measures and incentive structures, considering the necessary data infrastructure, and addressing public reporting options. Consideration will be given to approaches that:

(1) Overlay the current PFS, such as differential fee schedule payments based on measured performance;

(2) Address multiple levels of accountability, including individual health professionals, as well as larger care teams or organizations made up of a variety of health professionals and facilities; and

(3) Promote more integrated care through shared savings models and bundled payment arrangements.

In the proposed rule, we solicited public comment on the development of the PVBP plan and Report to Congress. We specifically requested for comments on two topics: (1) the appropriate level at which to hold practitioners accountable (for example, individuals or groups); and (2) appropriate data submission mechanisms. We received comments on these topics, as well as comments on other issues we should consider when developing the PVBP Report to Congress. The following is summary of the comments we received regarding section 131(d) of the MIPPA.

Comment: Regarding the appropriate level at which to hold practitioners accountable, commenters were supportive of our intention for the PVBP

plan to recognize multiple levels of accountability ranging from individual practitioners to larger organizations. Commenters recognized that a ''one size fits all'' approach would not be appropriate. One commenter suggested conducting a series of demonstrations and pilots to help further explore this issue. Commenters also urged us to design the program to allow participation by practitioners other than physicians.

Response: We plan to continue to explore ways to measure and incentivize practitioners for higher value care at multiple levels of accountability, including possible demonstrations and pilots to test and analyze the effectiveness of certain practice arrangements and payment systems. We recognize that the Congress intended the PVBP plan to be broader than physicians, and the PVBP Steering Committee is considering approaches that allow for participation by a wide variety of health care practitioners.

Comment: Regarding the appropriate methods for data submission, commenters overwhelmingly supported the adoption and use of interoperable electronic health records. Commenters suggested that the CMS PVBP Steering Committee coordinate with the Office of the National Coordinator for Health IT (ONC) to align PVBP incentives for electronic health records with the recently enacted HITECH incentives for health IT adoption. Commenters also recognized the role of registries in data submission. In addition, commenters urged us to carefully consider procedural protections for practitioners, such as allowing their review of their own data before submission to CMS.

Response: The CMS PVBP Steering Committee is exploring ways to encourage the use of interoperable health IT systems, including registries, as part of the PVBP plan. We have been actively engaged with ONC on how to align any PVBP incentives for health IT with the HITECH provisions and will continue to work closely with ONC. We recognize the importance of the accuracy and validity of electronically submitted data, and are exploring ways to incorporate data review processes for practitioners into the PVBP plan recommendations.

Comment: Several commenters were concerned with the relationship between the PVBP plan and the current Medicare payment system. Commenters stated that the current Medicare payment system is flawed in that it does not align incentives across providers and settings, and a PVBP plan that simply overlays the existing system will not be sufficient to re-align incentives to provide higher value care.

Response: In developing the PVBP plan, we are considering both short-term and long-term recommendations. Short-term recommendations may include changes within the current payment system. Such changes, though, would be interim steps toward implementing a more long-term approach for comprehensive payment reform.

Comment: Commenters urged us to not limit the Report to Congress to recommendations for only performance-based incentive payments. Commenters suggested the plan recommend a wide range of incentives for activities such as improving beneficiary health outcomes, patient experience of care, efficient performance of services, and use of electronic health IT such as registries or e-prescribing. Commenters also urged us to recommend using the PVBP plan to encourage high quality care by being actionable on the part of all practitioners.

Response: We are considering recommending a variety of different activities within the PVBP plan, taking into account what is more feasible in the short-term versus the long-term. We are also considering what program activities are likely to be the most meaningful and actionable for practitioners, both in the short-term and long-term.

Comment: Commenters urged CMS to gain experience with confidential feedback reporting of quality and resource use before using the information for either payment or public reporting. One commenter suggested that any public reporting under the PVBP plan should be geared toward consumer decision-making.

Response: We are considering a variety of program activities, including confidential feedback reports, public reporting, and incentive payments. The PVBP Steering Committee is carefully analyzing the options for each of these activities.

Comment: Several commenters mentioned that encouraging successful management of chronic disease is essential to any PVBP plan. Commenters mentioned medical home care models and the important role they can play in promoting integrated care and reducing costs.

Response: We recognize the importance of managing chronic disease, and are currently conducting a demonstration of the medical home concept. Findings from this demonstration may be used to inform plan development.

Comment: Commenters urged us to use the PVBP plan to increase efficiency and slow cost growth in the Medicare program. Commenters specifically mentioned shared savings models and encouraged us to further explore how to incorporate appropriate shared savings principles into the plan. There was no consensus among the comments regarding whether a PVBP plan should include shared savings or gainsharing. However, some commenters cautioned that a PVBP plan should not be viewed solely as a method to slow cost growth.

Response: We recognize the importance of both slowing cost growth and maintaining beneficiary access to high quality care. The PVBP plan will carefully explore program activities that accomplish both of these goals.

Comment: We received input on several issues related to the appropriate measurement of eligible professionals in a PVBP program. Commenters suggested we recommend only transparent evidence-based measures that are vetted by physician groups and endorsed by a national consensus-based organization. Commenters also suggested we recommend strategically selecting measures to address gaps in quality, or those related to high-cost and/or high-volume services. Measures used in the program should not be ''topped out,'' but still have significant room for improvement collectively across the Medicare program. In addition, commenters urged us to recommend the use of both quality and resource use information, and to report both domains of measures together in order to give a fuller picture of an eligible professional's performance. Commenters urged us to consider incorporating a broad range of quality measures into the PVBP program, including patient experience, clinical outcomes, disparities, care coordination, and structural measures such as the adoption of health IT.

Response: The PVBP Steering Committee is carefully considering what measures to recommend for which program activities (that is, incentive payment, confidential feedback, public reporting). We recognize the potential for the PVBP plan to address gaps in quality and high-cost and/or high volume services, and the importance of recommending the use of both quality and resource use information and the value to eligible professionals of providing this information together. We also recognize the importance of recommending the use of a broad array of measures. Many of the types of measures mentioned by commenters have not yet been fully developed. Therefore, short-term recommendations for the PVBP plan cannot include them, but long-term recommendations may encourage their development and use.

Comment: Commenters supported tying a portion of payment to an eligible professional's performance, and stated that participants should not be rewarded simply for reporting data to CMS. Commenters stated that the PVBP plan should reward both attainment of specified levels of performance, and improvement over time. Commenters also suggested that such incentive payments should be aimed toward breaking down the payment silos that currently exist between Medicare Parts A and B.

Response: Whether to reward eligible professionals for performance, and not merely participation is a key design option that the PVBP Steering Committee is considering for the PVBP plan. The Steering Committee will also carefully discuss whether to recommend paying incentives for attainment, improvement, or both.

Comment: Commenters stressed the importance of risk-adjustment, especially if performance data is used to make incentive payments.

Response: We recognize that risk-adjustment is essential and we are exploring methods for its incorporation into the PVBP plan.

Comment: Commenters commended CMS for involving stakeholders in PVBP plan development, and encouraged CMS to continue to involve stakeholders as plan development proceeds. Commenters urged CMS to ensure that any PVBP plan does not impede the evolution of medical practice, discourage innovation, or interfere with practitioner-patient decision-making.

Response: We appreciate the opportunity to hear from stakeholders regarding plan recommendations, and we value the input stakeholders have provided thus far. We are carefully considering options and taking an iterative approach to PVBP plan development to avoid the potential pitfalls mentioned by commenters.

We received other comments that were outside the scope of the proposed rule, and are therefore not discussed in this final rule with comment period.

5. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

a. Program Background and Statutory Authority

As described in the CY 2010 PFS proposed rule (74 FR 33593 through 33600), section 1848(m)(2) of the Act, as amended by section 132 of the MIPPA, promotes the use of electronic prescribing by authorizing incentive payments to eligible professionals or group practices who are ''successful electronic prescribers.'' This E-Prescribing Incentive Program is expected to encourage significant expansion of the use of electronic prescribing by authorizing a combination of financial incentives and payment adjustment and is separate from, and in addition to, any incentive payment that eligible professionals may earn through the PQRI program. Individual eligible professionals do not have to participate in PQRI in order to participate in the E-Prescribing Incentive Program (and vice versa).

For 2010, which is the second year of the E-Prescribing Incentive Program, the Secretary is authorized to provide successful electronic prescribers, as defined in section 1848(m)(3)(B) of the Act and further discussed below in this section, an incentive payment equal to 2.0 percent of the total estimated Medicare Part B PFS allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished during the 2010 reporting period. Covered professional services are defined under the statute to be services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional. The applicable electronic prescribing percent (2.0 percent) authorized for the 2010 E-Prescribing Incentive Program is the same as that authorized for the 2009 E-Prescribing Incentive Program.

We received several comments from the public on the CY 2010 PFS proposed rule related to the E-Prescribing Incentive Program. General comments about the E-Prescribing Incentive Program are addressed immediately below.

Comment: One commenter was opposed to making any changes to the E-Prescribing Incentive Program for 2010, but a majority of the comments voiced their support for the changes proposed for the 2010 E-Prescribing Incentive Program and discussed below.

Response: Although we understand the commenter's desire to keep the program the same in 2010, we believe that this would defeat our attempts to simplify the E-Prescribing Incentive Program and reduce the reporting burden for eligible professionals.

Comment: Some comments recommended that we conduct significant education and outreach activities, especially with respect to the changes for 2010, and that we promote the program by making participation information, as well as information about potential incentive payment amounts available.

Response: We value the input received from stakeholders and participants who have provided constructive feedback and have collaborated with us to disseminate educational materials about the E-Prescribing Incentive Program to eligible professionals in the health care community. We anticipate that ongoing education and outreach efforts will continue to evolve with the program. We will continue to work with national and regional stakeholder organizations to educate their members on program requirements for successful reporting, especially the changes that will be implemented for 2010, as discussed below. We also plan to continue to host monthly national provider calls in which we expect to provide guidance on specific topics, including having our E-Prescribing Incentive Program subject matter experts available to answer questions. Information about upcoming calls can be obtained from the CMS Sponsored Calls page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/04_CMSSponsoredCalls.asp#TopOfPage.* We will also continue to make educational materials and other resources available on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/erxincentive*. We encourage eligible professionals to visit this Web site and to review the frequently asked questions found on this Web site. Eligible professionals are also encouraged to join our physician listserv to obtain periodic updates about the E-Prescribing Incentive Program. Instructions for joining the listserv can be found at *https://list.nih.gov/archives/physicians-l.html.*

Comment: One commenter recommended that we promote the program by making participation information, as well as information about potential incentive payment amounts available.

Response: Once the 2009 program year is complete, we anticipate conducting an evaluation of the 2009 E-Prescribing Incentive Program reporting experience at an aggregate level and posting a national summary report similar to the ''PQRI 2007 Reporting Experience'' report found at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf.*

With respect to the suggestion to make information about potential incentive payment amounts available, we are concerned that doing so may be misleading since incentive payments will differ for each eligible professional based on his or her Medicare Part B PFS allowed charges for covered

professional services. We believe that information such as the mean incentive payment amount released in the ''PQRI 2007 Reporting Experience'' report could serve the same purpose.

Comment: Many commenters expressed a desire for the Drug Enforcement Agency (DEA) to permit electronic prescribing of controlled substances. Commenters noted that until electronic prescribing of controlled substances is permitted, eligible professionals may be reluctant to adopt electronic prescribing technology due to work flow issues and the need to utilize two processes (electronic and written) for generating prescriptions.

Response: We are aware of the current limitation for electronic prescribing of controlled substances. Actions taken or that may be taken by the DEA are beyond our purview. However, we have taken this limitation into consideration in establishing the 2010 criteria for determining a successful electronic prescriber.

Comment: Some commenters suggested that we obtain data on electronic prescribing from pharmacies rather than eligible professionals or that we should also be holding pharmacies or pharmacy networks accountable for ensuring accurate, timely, and consistent transmission of electronic prescribing data.

Response: As established by MIPPA, the E-Prescribing Incentive Program is an incentive program specifically for eligible professionals, as defined by section 1848(k)(3)(B) of the Act, based on information submitted by eligible professionals. Additionally, section 1848(m)(3)(B)(iv) of the Act authorizes the use of Part D data, which reflects information submitted by pharmacies to Part D plan sponsors. As we explained in the CY 2010 PFS proposed rule (74 FR 33595), however, the accuracy and completeness of the Part D data with respect to whether a prescription was submitted electronically is unknown since Part D plan sponsors will not be required to start submitting this information until 2010. Should we rely on Part D data in the future, we anticipate that we will no longer need eligible professionals to submit data on their electronic prescribing activities to us.

Comment: One commenter was concerned that the E-Prescribing Incentive Program will include a penalty, or payment adjustment, to begin in 2012 and requested that we, in consultation with stakeholders, define in a timely manner how we intend to use the case-by-case, significant hardship penalty exemption authority.

Response: We believe the commenter is referring to section 1848(a)(5)(B) of the Act, which permits the Secretary, on a case-by-case basis, to exempt an eligible professional from the application of the payment differential if the Secretary ''determines, subject to annual renewal that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.'' This hardship exemption is to be used at the discretion of the Secretary.

As we stated in the CY 2009 PFS proposed rule (74 FR 33549), we will discuss the application of the payment adjustment in future notice and comment rulemaking. We will address the circumstances under which the hardship exemption applies at that time.

Comment: One commenter recommended that we provide a participation option for eligible professionals who predominately practice in skilled nursing facilities. The commenter is concerned that many such professionals are currently unable to participate in the E-Prescribing Incentive Program because the facility's prescribing systems generate orders to an internal pharmacy and, for reasons unspecified by the commenter, do not meet the full definition of a qualified electronic prescribing system.

Response: Since the commenter did not describe what aspects of the definition of ''qualified'' electronic prescribing system a skilled nursing facility's electronic prescribing system fails to meet, it is not entirely clear how the fact that a facility's electronic prescribing system generates orders to an internal pharmacy alone would prevent the facility's system from meeting the definition of a ''qualified'' electronic prescribing system. In an attempt to provide eligible professionals who predominately practice in skilled nursing facilities with more opportunities to participate in the E-Prescribing Incentive Program, however, we are expanding the scope of the electronic prescribing measure's denominator codes to include professional services outside the professional office and outpatient setting. The expanded codes include professional services furnished in skilled nursing facilities and in the home care setting. To be considered a successful electronic prescriber, eligible professionals need only to report 25 separate electronic prescribing events during the reporting period. To qualify for the electronic prescribing incentive payment, a successful electronic prescriber must have 10 percent of their Medicare Part B PFS allowed charges for covered professional services be comprised of the codes in the denominator of the measure. The electronic prescribing system used for these 25 electronic prescribing events must have all of the functionalities listed in the measure's specifications and described in section II.G.5.c.3. below.

Comment: One commenter was concerned that the incentive payment favors prescribers who typically bill high-cost services since the incentive payment is based on Medicare Part B PFS allowed charges. The commenter suggested that the incentive payment should be a flat-rate bonus or a bonus payment that rewards medication management.

Response: We appreciate the comment; however, we do not have the authority to change the basis for the calculation of the incentive payment amount, which is defined in section 1848(m)(2)(A) of the Act.

b. The 2010 Reporting Period for the E-Prescribing Incentive Program

Section 1848(m)(6)(C)(i)(II) of the Act defines ''reporting period'' for the 2010 E-Prescribing Incentive Program to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. In the CY 2010 PFS proposed rule (74 FR 33594 through 33595), we proposed that the 2010 E-Prescribing Incentive Program reporting period would be the entire calendar year (January 1, 2010–December 31, 2010).

Comment: A majority of commenters supported the proposed reporting period. One commenter, however, recommended two 6-month reporting periods, because this would allow eligible professionals who are able to implement electronic prescribing in their practice by the middle of 2010 to still benefit from the incentive for 2010.

Response: We do not believe that adoption and implementation of an electronic prescribing system after the start of the 2010 reporting period would necessarily preclude an individual eligible professional from being able to qualify for the incentive payment. The 25 electronic prescribing events required to meet the criteria for successful electronic prescriber for 2010 (see section II.G.5.c. below) can be reported at any time during the 2010 reporting period.

After considering these comments, we are finalizing the entire calendar year as

the 2010 reporting period for the E-Prescribing Incentive Program. Successful electronic prescribers will be eligible to receive an incentive payment equal to 2.0 percent of the total estimated Medicare Part B PFS allowed charges (based on claims submitted by no later than February 28, 2011) for all covered professional services furnished January 1, 2010 through December 31, 2010.

c. Criteria for Determination of Successful Electronic Prescriber for Eligible Professionals

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

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

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

(1) Reporting the Electronic Prescribing Measure

For 2010, we proposed to make 3 reporting mechanisms available to individual eligible professionals to report the electronic prescribing measure. First, we proposed to retain the claims-based reporting mechanism that is used in the 2009 E-Prescribing Incentive Program. In addition, similar to the PQRI, for the E-Prescribing Incentive Program, we proposed to implement a registry-based reporting mechanism and, depending on whether we finalize the proposed EHR-based reporting mechanism for PQRI, we also proposed that an EHR-based reporting mechanism be available for the electronic prescribing measure.

We proposed that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI would be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2010 E-Prescribing Incentive Program. Similarly, we proposed that only EHR products ''qualified'' to potentially be able to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI would be considered ''qualified'' for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

We solicited comments on our proposal to provide alternatives to the claims-based reporting mechanism for reporting the electronic prescribing measure, as well as on our proposal to limit the registries and EHR products qualified to submit the electronic prescribing measure for the 2010 E-Prescribing Incentive Program to those that are qualified registries and EHR products, respectively, for the 2010 PQRI.

All commenters supported having alternatives to the claims-based reporting mechanism for reporting the electronic prescribing measure. All commenters were also in agreement that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI and EHR products ''qualified'' to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI be considered ''qualified'' for the purpose of an eligible professional being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program. Based on these comments, we are finalizing our proposal that for the 2010 E-Prescribing Incentive Program, eligible professionals will be able to choose whether to submit data on the electronic prescribing measure through claims, a qualified registry, or a qualified EHR product.

Only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI will be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2010 E-Prescribing Incentive Program. We will post a list of qualified registries for the 2010 E-Prescribing Incentive Program on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive* when we post the list of qualified registries for the 2010 PQRI on the PQRI section of the CMS Web site (see section II.G.2. of this final rule with comment period). Not all registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI will be qualified to submit quality measure results and numerator and denominator data on the electronic prescribing measure. That is to say that PQRI qualified registries may not wish to be qualified to submit all measures. The electronic prescribing measure is reportable by an eligible professional any time he or she bills for one of the procedure codes for Part B covered professional services included in the measure's denominator. Some registries that self-nominate to become a qualified registry for PQRI may not choose to self-nominate to become a qualified registry for submitting measures that require reporting at each eligible visit, such as the electronic prescribing measure. Therefore, we cannot guarantee that there will be a registry willing to submit the electronic prescribing measure on behalf of eligible professionals. Registries will need to indicate their desire to qualify to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing

Incentive Program at the time that they submit their self-nomination letter for the 2010 PQRI.

Similarly, only EHR products ''qualified'' to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI will be considered ''qualified'' for the purpose of an eligible professional being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program. As stated in section II.G.2.d.3. of this final rule with comment period, 2009 EHR Testing Program is underway. Therefore, we cannot guarantee that any of the EHR vendors that self-nominated to have one or more of their EHR products ''qualified'' for the PQRI will successfully complete the testing process and therefore, be eligible for participation as a qualified EHR vendor the E-Prescribing Incentive Program. An EHR vendor will need to indicate its intention to have one or more of their EHR products qualified for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program at the time that they are being vetted for the 2010 PQRI. We will post a list of qualified EHR vendors and products for the 2010 E-Prescribing Incentive Program on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive* when we post the list of qualified EHR vendors and products for the 2010 PQRI on the PQRI section of the CMS Web site (see section II.G.2. of this final rule with comment period). We anticipate completing the 2009 PQRI EHR Testing Program in early 2010.

(2) The Reporting Denominator for the Electronic Prescribing Measure

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

The denominator for the electronic prescribing measure consists of specific billing codes for covered professional services. The measure becomes reportable when any one of these procedure codes is billed by an eligible professional for Part B covered professional services. As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, we may modify the codes making up the denominator of the electronic prescribing measure. As such, we proposed to expand the scope of the denominator codes for 2010 to covered professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home care setting. We proposed to add the following CPT codes to the denominator of the electronic prescribing measure for 2010: 90862, 99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99341; 99342; 99343; 99344; 99345; 99347; 99348; 99349; and 99350. We solicited comments on the proposed changes to codes identified for the electronic prescribing measure denominator.

The following is a summary of the comments we received regarding the proposed denominator codes for the 2010 electronic prescribing measure.

Comment: Many commenters supported the proposed expansion of the electronic prescribing measure's denominator codes. However, some commenters noted that a subset of home care physicians will not be able to participate in the E-Prescribing Incentive Program without the addition of codes for domiciliary care visits in the measure's denominator.

Response: We appreciate the commenters' support of the proposed denominator codes. Based on comments indicating that some eligible professionals exclusively make domiciliary care visits, we are adding the following codes to the electronic prescribing measure's denominator for 2010: 99324 through 99328; 99334 through 99337; and 99346.

Comment: Other commenters suggested additional codes for inclusion in the measure's denominator, including an annual nursing facility assessment code (CPT code 99318) in lieu of CPT codes 99307 through 99310, inpatient evaluation and management (E/M) codes, codes for professional services furnished in renal dialysis facilities (CPT codes 90951 through 90970 for outpatient dialysis), and interactive psychotherapy codes (CPT codes 90810 through 90815).

Response: With respect to commenters' suggestions to add other denominator codes that were not proposed, we do not believe it is necessary to expand the denominator codes to include the suggested codes. As we stated previously, the electronic prescribing measure becomes reportable when any one of the procedure codes included in the measure's denominator is billed by an eligible professional for Part B covered professional services. Eligible professionals only need to have 10 percent of their Medicare Part B PFS allowed charges for covered professional services be comprised of the codes in the denominator of the measure and meet the criteria for determining a successful electronic prescriber to qualify to earn an electronic prescribing incentive payment. The incentive payment amount, however, will be calculated based on all of the eligible professional's total estimated Medicare Part B PFS allowed charges for covered professional services, including the services reflected in the suggested codes if such services are Medicare Part B PFS covered professional services.

Accordingly, we are finalizing the following denominator codes for the 2010 electronic prescribing measure: 90862; 99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99324; 99325; 99326; 99327; 99328; 99334; 99335; 99336; 99337; 99341; 99342; 99343; 99344; 99345; 99346; 99347; 99348; 99349; and 99350. There are no diagnosis codes in the measure's denominator and there are no age/gender requirements in order for a patient to be included in the measure's denominator (that is, reporting of the electronic prescribing measure is not further limited to certain ages or a specific gender). Eligible professionals are not required to report this measure in all cases in which the measure is reportable. Eligible professionals who do not bill for one of the procedure codes for Part B covered professional services included in the measure's denominator will have no occasion to report the electronic prescribing measure.

By December 31, 2009, we will post the final specifications of the measure on the ''E-Prescribing Measure'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive.*

(3) Qualified Electronic Prescribing System—Required Functionalities and Part D E-Prescribing Standards

To report the electronic prescribing measure in 2010, we proposed that the eligible professional must report one of the measure's numerator ''G'' codes (74 FR 33597). However, when reporting any of the G-codes for purposes of qualifying for the incentive payment for electronic prescribing in 2010, we proposed that the professional must have and regularly use a ''qualified'' electronic prescribing system, as defined in the electronic prescribing measure specifications.

Required Functionalities for a ''Qualified'' Electronic Prescriber System. We proposed (74 FR 33596 through 33597) that what constitutes a ''qualified'' electronic prescribing

system is based upon certain required functionalities that the system can perform (74 FR 33596 through 33597). As currently specified in the electronic prescribing measure for 2009, a ''qualified'' electronic prescribing system would be one that can:

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

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

(c) Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would suffice for this requirement for 2010 and until this function is more widely available in the marketplace.

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

Part D Electronic Prescribing Standards. Section 1848(m)(3)(B)(v) of the Act specifies that to the extent practicable, in determining whether an eligible professional is a successful electronic prescriber, ''the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e)'' of the Act. The Part D standards for electronic prescribing systems establish which electronic standards Part D sponsors, providers, and dispensers must use when they electronically transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. To be a qualified electronic prescribing system under the current E-Prescribing Incentive Program, electronic systems must convey the information listed above under (a) through (d) using the standards currently in effect for the Part D electronic prescribing program. Additional Part D electronic prescribing standards were implemented April 1, 2009. These latest Part D electronic prescribing standards, and those that had previously been adopted, can be found on the CMS Web site at *http://www.cms.hhs.gov/eprescribing.*

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

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

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

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

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

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

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

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

There are, however, Part D electronic prescribing standards that are in effect for functionalities that are not commonly utilized at this time. Such functionalities are not currently required for a ''qualified'' system under the E-Prescribing Incentive Program. One example is Rx Fill Notification, which is discussed in the Part D electronic prescribing final rule (73 FR 18918, 18926). For purposes of the 2010 Electronic Prescribing Program and incentive payments, we did not propose to require that an electronic prescribing system contain all functionalities for which there are available Part D electronic prescribing standards. For those required functionalities described above, we proposed that a ''qualified'' system must use the adopted Part D electronic prescribing standards for electronic messaging.

The following is a summary of the comments we received regarding the proposed required functionalities and Part D electronic prescribing standards for a qualified electronic prescribing system for 2010.

Comment: Many commenters supported the list of required functionalities for what constitutes a ''qualified'' system.

Response: We appreciate the commenters' positive feedback. We believe the list of required functionalities leverage many of the potential advantages to electronic prescribing, such as, but not limited to, improving patient safety and quality of care, improving formulary adherence, and providing access to patient's medication history.

Comment: One commenter requested clarification with respect to qualification (b) above, which requires that the functionality to allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts be enabled. The commenter recommended that we clarify in the final rule that '' 'printing prescriptions' from a qualified electronic prescribing system does *not* meet the criteria for 'creating' or 'generating' an e-prescription.''

Response: All functionalities required of a ''qualified'' electronic prescribing system must be enabled. As noted by the commenter, printed prescriptions, however, do not qualify as an electronic prescribing event. In order for a prescription to be considered an electronic prescribing event, the prescription must be transmitted electronically using the applicable standards and the prescriber's system must warn the prescriber of possible undesirable or unsafe situations.

Comment: One commenter recommended that we clearly articulate how we will align the definition of being a ''successful electronic

prescriber'' with the forthcoming ''meaningful use'' definition related to health information technology. Particularly, commenter recommended that the standards should come together in 2011 to promote the objective that for BOTH sets of incentives clinicians:

- Use computerized physician order entry (CPOE) for all orders;
- Implement drug/drug, drug/allergy, drug/formulary checks;
- Generate and transmit permissible prescriptions electronically;
- Maintain active medication lists; and
- Maintain active medication allergy lists.

The commenter is concerned that in the absence of greater alignment, the electronic prescribing standard will be inconsistent with the proposed meaningful use definition, and could undermine that definition and confuse clinicians.

Response: CMS is actively working internally and with external agencies, such as the Office of the National Coordinator (ONC) on meaningful use and its implications relative to our PQRI and E-prescribing Incentive Programs. Guidance on the definition of ''meaningful use'' is beyond the scope of this rule and will be provided in separate notice and comment rulemaking specifically addressing meaningful use.

Comment: One commenter recommended that CMS provide a list of qualified systems in order to assist eligible professionals with accurately selecting a system.

Response: We are unable to provide this information since we do not vet electronic prescribing systems to ensure that the systems have all of the required functionalities. Eligible professionals should be able to assess whether a system is qualified by going through the list of required functionalities and asking the system's vendor whether the system is capable of doing all of the required functionalities.

After considering the comments, we are finalizing as the required functionalities for a qualified electronic prescribing system for 2010 those outlined in the section above entitled ''Required Functionalities for a 'Qualified' Electronic Prescribing System.'' In addition, for each required functionality of a qualified system, the system must use the adopted Part D electronic prescribing standards for electronic messaging listed above in the section entitled ''Part D Electronic Prescribing Standards.''

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

We are aware that there are significant numbers of eligible professionals who are interested in earning the incentive payment, but currently do not have an electronic prescribing system. The electronic prescribing measure does not require the use of any particular system or transmission network; only that the system be a ''qualified'' system having the functionalities described above based on Part D electronic prescribing standards. If the professional does not have general access to an electronic prescribing system in the practice setting, there is nothing to report and the eligible professional would not be able to participate in the E-Prescribing Incentive Program.

(4) The Reporting Numerator for the Electronic Prescribing Measure

Currently, to report for an applicable case where 1 of the denominator codes is billed for Part B covered professional services, an eligible professional must report 1 of 3 G-codes specified in the electronic prescribing measure.

For 2010, we proposed to modify the first G-code (G8443) to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed (74 FR 33597). In addition, we proposed to eliminate the 2 remaining G-codes from the measure's numerator: G8445: Qualified E-prescribing System Available, but no Prescription(s) were Generated During the Encounter; and G8446: E-prescribing System Available, but not Used for One or More Prescriptions Due to Patient/System Reasons. We solicited comments on the proposed modifications to the electronic prescribing measure numerator.

The following is a summary of the comments we received regarding the proposed reporting numerator for the electronic prescribing measure for 2010.

Comment: A majority of commenters supported simplification of the measure's numerator to only 1 G-code. However, one commenter was opposed to the elimination of both the G8445 and G8446 codes, while other commenters were specifically opposed to the elimination of the G8446 code. The commenters believed that continued reporting is needed for cases in which an eligible professional would have electronically prescribed had electronic prescribing been possible, such as electronic prescribing of controlled substances.

Response: We are finalizing our proposal to modify the G-codes for the electronic prescribing measure. Since we are revising the criteria for determining that an eligible professional is a successful electronic prescriber to assess the actual number of electronic prescribing events (with the minimum threshold of 25 events) during the reporting period rather than assessing the percentage of eligible cases on which an eligible professional reported the measure, we believe it is no longer necessary to require eligible professionals to report the measure to us for cases where an eligible professional would have electronically prescribed but electronic prescribing was not possible or that no prescriptions were generated.

Comment: One commenter requested clarification on whether the revised G8443 code indicates at least one prescription ''generated'' by a qualified system or indicates at least one prescription ''sent electronically.''

Response: The new G-code for 2010 indicates that at least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.

Comment: Another commenter suggested that instead of modifying the G-code to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed, we should modify the G-code to indicate that ''at least 1 electronic prescription submitted for all qualified prescriptions for this visit.'' This would allow eligible professionals to report the G-code in all of the following circumstances: (1) All prescriptions were transmitted electronically; (2) some prescriptions were transmitted electronically; other prescriptions did not qualify for electronic transmittal; and (3) no prescriptions were submitted or qualified for electronic transmittal. The commenter was concerned that the proposed single G-code approach would not allow measure rates to be calculated as the numerator would not include visits for which no qualified prescriptions were submitted. The commenter further recommended that the measure rate calculations exclude instances where there were qualified

prescriptions, but no prescriptions were transmitted electronically.

Response: We appreciate the commenter's feedback. However, before eligible professionals can begin using electronic prescribing technology, they must first adopt the technology. Since, as we discussed in the CY 2010 PFS proposed rule (74 FR 33593), rates for the adoption and use of electronic prescribing technology by eligible professionals are still low and 2010 is only the second year of this incentive program, our goal for the 2010 E-Prescribing Incentive Program is to focus on increasing eligible professionals' adoption of electronic prescribing technology. We believe that this will be facilitated by administering the E-Prescribing Incentive Program in a way that does not create an unnecessarily large reporting burden on eligible professionals in order to qualify for the incentive.

The criteria for successful reporting we are finalizing for 2010 are designed to reward those eligible professionals who demonstrate that they have adopted a qualified electronic prescribing system and actually used the system in a substantial way to electronically prescribe. In this context, the reporting of information as to circumstances where a professional did not electronically prescribe is not pertinent. Additionally, although it may be of interest to measure the proportion of prescribing events that are electronic, we do not believe such detail at the individual or group practice level is of sufficient value to warrant the high burden of reporting such information. We do note that in the future the use of Part D claims data may allow this information to be collected without the necessity for professionals to specifically report such details.

Accordingly, for the 2010 electronic prescribing measure, we are finalizing the following numerator G-code: Gxxxx: At least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.

A new G-code will be assigned by CMS to the above code for 2010 and will be included in the measure's specifications, which we will post on the ''E-Prescribing Measure'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive.* We will post by no later than December 31, 2009, the final electronic prescribing measure specifications for 2010.

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

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

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

As discussed above, section 1848(m)(3)(B)(ii) of the Act specifies that an eligible professional shall be treated as a successful electronic prescriber for a reporting period based on the eligible professional's reporting of the electronic prescribing measure in at least 50 percent of applicable cases. For 2010, however, we proposed to exercise our authority under section 1848(m)(3)(D) of the Act to revise the criteria for submitting data on the electronic prescribing measure (74 FR 33598). For 2010, rather than requiring that the electronic prescribing measure be reported for a certain proportion of reportable cases, we proposed to make the determination of whether an eligible professional is a successful electronic prescriber based on a count of the number of times (minimum threshold of 25) an eligible professional reports that at least one prescription created during the encounter was generated using a qualified electronic prescribing system. We solicited comments on the proposed criteria for determination of successful electronic prescriber.

The following is a summary of the comments we received regarding the proposed criteria for determination of successful electronic prescriber for the 2010 E-Prescribing Incentive Program.

Comment: A majority of commenters supported the changes proposed for the criteria for the determination of successful electronic prescriber for 2010 and the proposed threshold for reporting the electronic prescribing measure at least 25 times during the reporting period. Some commenters, however, expressed concern that the proposed threshold may be insufficient to ensure that electronic prescribing is fully adopted into the prescriber's clinical practice and workflow since some eligible professionals may be able to meet this threshold in a matter of a few days or weeks.

Some commenters suggested that in lieu of a fixed threshold, we establish a percent threshold based upon the percent of eligible cases in 2009. Another commenter suggested that if an eligible professional has an electronic prescribing system, he or she should be using the system for all prescriptions. Other commenters suggested a threshold of 250–500 electronic prescribing events during the reporting period.

Response: We appreciate the commenters' feedback, and believe that lowering this requirement simplifies the reporting burden, which would encourage more eligible professionals to participate in this incentive program, and more importantly, to adopt an electronic prescribing system.

We agree with commenters that some eligible professionals may be able to meet the criteria for successful reporting in a matter of a few days or weeks. However, in establishing the threshold of 25 electronic prescribing events, we also took into account the many valid circumstances that would prevent eligible professionals who have adopted a qualified electronic prescribing system from having 25 electronic prescribing events during the calendar year and variations in practice characteristics. In addition to the patient-related, system-related, or legal reasons that were formerly addressed by reporting the G8446 code for the measure, some eligible professionals may have few opportunities to report the electronic prescribing measure since they generate a low volume of prescriptions, have few Medicare patients, infrequently provide the services included in the measure's denominator, or a combination of these factors.

Comment: Other commenters were concerned that the proposed changes to the criteria for determining a successful electronic prescriber, while lower than the 2009 criteria, would make it more difficult to qualify for the electronic prescribing incentive payment. The commenters were concerned that the impact on eligible professionals will vary depending on the percentage of Medicare patients in their practice and the volume of prescriptions generated by the practice. For some practices 25 electronic prescriptions could be achieved in a matter of days but for

other practices it may be difficult or impossible to achieve this threshold. One commenter suggested that lowering the reporting threshold from 25 to 15 may be enough to get an eligible professional to adopt and use an electronic prescribing system and to recognize its superiority. Other commenters suggested that we retain the criteria to report the electronic prescribing measure on 50 percent of applicable cases instead.

Response: As we stated previously, we have taken the commenters' concerns into consideration in establishing the proposed threshold of 25 electronic prescribing events. On average, we believe an eligible professional would need to have 2 to 3 electronic prescribing events per month to be considered a successful electronic prescriber. We believe that this is achievable by a majority of eligible professionals. However, we will monitor the 2010 E-Prescribing Incentive Program results and take the commenters' recommendation into consideration as we develop the criteria for future years.

Comment: Some commenters recommended that we allow for alternative reporting to accommodate those who may not be able to electronically prescribe at least 25 times due to state or federal laws and regulations that do not allow electronic prescribing for narcotics or other controlled substances.

Response: As stated previously, we have taken into account the many valid circumstances that would prevent eligible professionals who have adopted a qualified electronic prescribing system from having 25 electronic prescribing events during the calendar year, including state or federal laws and regulations that do not allow electronic prescribing for narcotics or other controlled substances, when we established the proposed threshold of 25 electronic prescribing events. Therefore, we do not believe that it is necessary to establish alternative reporting criteria for such eligible professionals.

Comment: One commenter recommended that, for eligible professionals who practice in a nursing facility and other institutional settings, the determination of successful electronic prescriber should be made by measuring the electronic management of prescription drugs instead of measuring adoption and use of a qualified electronic prescribing system. The commenter recommends that eligible professionals be required to submit, with each eligible CPT code, a HCPCS code verifying that all prescription medications for the patient were electronically reviewed prior to the submission of the claims. This would continue to incentivize eligible professionals, who are prescribing schedule drugs, or working in a facility which does not provide access to electronic prescribing or the internet, for electronically managing patients' drugs.

Response: We are unclear as to how incentivizing eligible professionals for electronically managing patients' drugs encourages the adoption and use of electronic prescribing technology. In contrast, the proposed criteria for determining a successful electronic prescriber encourage the adoption and use of electronic prescribing technology by requiring eligible professionals to report to us that they have used a qualified electronic prescribing system during the reporting period. Therefore, we are not adopting the commenter's recommendation.

Comment: One commenter recommended that we institute a ''floor'' or minimum number of prescriptions that must be prescribed in order to even be assessed for the electronic prescribing incentive. This would protect consultants or proceduralists who do not prescribe medications from being assessed a payment adjustment in future years.

Response: We believe that such a floor is already addressed by the limitation required under section 1848(m)(2)(B) of the Act. In order to avoid being subject to the limitation for 2010 and qualify to earn an electronic prescribing incentive payment, eligible professionals who meet the criteria for successful electronic prescriber must have at least 10 percent of their Medicare Part B PFS allowed charges for covered professional services comprised of the codes in the denominator of the electronic prescribing measure. In addition, we note that under section 1848(m)(2)(B) of the Act, eligible professionals who are subject to the limitation would not be subject to the payment adjustment.

Comment: One commenter recommended that we apply the proposed criteria for determining a successful electronic prescriber for 2010 to the 2009 E-Prescribing Incentive Program so that those eligible professionals who reported that they electronically prescribed at least 25 times in 2009 would also be eligible to receive a 2009 electronic prescribing incentive payment.

Response: We do not have the authority to change the criteria for determining a successful electronic prescriber for 2009. Section 1848(m)(3)(D) of the Act does not authorize us to revise the criteria for submitting data on electronic prescribing measures specified under subparagraph (B)(ii) until years after 2009. Additionally, even if we had the authority to modify the criteria for determining a successful electronic prescriber for 2009, we could not do so retrospectively.

Comment: Some commenters urged us to use our authority under section 1848(m)(3)(B)(iv) of the Act to utilize Part D claims to determine if eligible professionals are prescribing a sufficient number of prescriptions electronically. The commenters noted that this would be a more efficient means of capturing the information needed by us for determining whether an eligible professional is a successful electronic prescriber. One commenter stressed that it is necessary for us to overcome our concerns about the use of a certain number of Part D prescribing events as a basis for the incentive payment in time for implementation of the meaningful use criteria in 2011.

Response: We agree that using Part D claims to determine if eligible professionals are prescribing a sufficient number of prescriptions electronically could potentially be a more efficient means of capturing the information needed by us for determining whether an eligible professional is a successful electronic prescriber and we anticipate that we would do so as soon as it is practical to do so. As we stated in the CY 2010 PFS proposed rule (74 FR 33595), however, the accuracy and completeness of the Part D data with respect to whether a prescription was submitted electronically by an individual eligible professional is unknown since that information will not be collected on the Part D claims, until 2010. During 2010 we anticipate evaluating the adequacy of Part D data to determine the feasibility of its use for determining whether an eligible professional qualifies as a successful electronic prescriber. In the meantime, we are implementing alternative reporting mechanisms (that is, registry and EHR reporting) for reporting the electronic prescribing measure in 2010 in an effort to provide more flexibility to eligible professionals.

After considering the comments, for 2010, an eligible professional will be required to report the electronic prescribing measure at least 25 times during the reporting period for purposes of meeting the criteria for successful electronic prescriber and qualifying to earn the electronic prescribing incentive (subject to the limitation required under section 1848(m)(2)(B) of the Act). In other words, an eligible professional will be required to report that he or she

electronically prescribed at least 25 times during the reporting period for services indicated by one of the codes included in the measure's denominator.

As stated previously, by December 31, 2009, we will post the final specifications of the measure on the ''E-Prescribing Measure'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive*.

d. Determination of the 2010 Incentive Payment Amount for Individual Eligible Professionals Who Are Successful Electronic Prescribers

Section 1848(m)(2)(B) of the Act imposes a limitation on the electronic prescribing incentive payment. The Secretary is authorized to choose 1 of 2 possible criteria for determining whether or not the limitation applies to a successful electronic prescriber. The first criterion, under section 1848(m)(2)(B)(i) of the Act, is based upon whether the Medicare Part B allowed charges for covered professional services to which the electronic prescribing quality measure applies are less than 10 percent of the total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the reporting period. The second criterion, under section 1848(m)(2)(B)(ii) of the Act, is based on whether the eligible professional submits (both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can, again, be assessed using Part D drug claims data). If the Secretary decides to use the latter criterion, then, in accordance with section 1848(m)(2)(B) of the Act, the criterion based on the reporting on electronic prescribing measures would no longer apply. The statutory limitation also applies with regard to the future application of the payment adjustment.

Based on our proposal to make the determination of whether an eligible professional is a ''successful electronic prescriber'' based on submission of the electronic prescribing measure, we proposed to apply the criterion under section 1848(m)(2)(B)(i) of the Act for the limitation for the 2010 E-Prescribing Incentive Program.

The following is a summary of the comments we received regarding the proposed criterion for the limitation.

Comment: Although the commenters acknowledged that the limitation on the electronic prescribing incentive payment is required by law, a few commenters were opposed to the 10 percent threshold because certain types of eligible professionals would be unlikely to meet the 10 percent threshold.

Response: Unfortunately, we do not have the authority to change the 10 percent threshold, since the threshold is required by section 1848(m)(2)(B)(i) of the Act. In an effort to allow more eligible professionals to potentially qualify for the incentive payment, however, we have expanded the denominator of the electronic prescribing measure. Despite the requirement that 10 percent or more of an eligible professional's charges must be comprised of codes in the denominator, preliminary information from the 2009 E-Prescribing Incentive Program indicates that over 90 percent of eligible professionals who have prescribing privileges do not appear to be affected by the limitation. We believe that expanding the denominator of the measure will further reduce the percentage of eligible professionals who will be subject to the limitation.

Comment: One commenter requested that we make available to individual eligible professionals the percentage of their prior year's Medicare charges that resulted from the codes included in the electronic prescribing measure's denominator specifications since many eligible professionals may not have the time or analytic tools necessary to make the determination of whether they are likely to meet the 10 percent threshold prior to making the decision on whether to electronically prescribe.

Response: Unfortunately, we do not have the resources to calculate and provide feedback to eligible professionals regarding the composition of their charges. Most electronic billing systems, however, will have this functionality and should be able to provide eligible professionals who use such billing systems with this information.

Since, as discussed above, we are finalizing for 2010 our proposal to make the determination of whether an eligible professional is a ''successful electronic prescriber'' based on submission of the electronic prescribing measure, we also are finalizing our proposal to analyze the claims submitted by the eligible professional at the TIN/NPI level to determine whether the 10 percent threshold is met in determining the receipt of an electronic prescribing incentive payment for 2010 by an eligible professional. This calculation is expected to take place in the first quarter of 2011 and will be performed by dividing the eligible professional's total 2010 Medicare Part B PFS allowed charges for all such covered professional services submitted for the measure's denominator codes by the eligible professional's total Medicare Part B PFS allowed charges for all covered professional services (as assessed at the TIN/NPI level). If the result is 10 percent or more, then the statutory limitation will not apply and a successful electronic prescriber will qualify to earn the electronic prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the eligible professional will not earn an electronic prescribing incentive payment—even if he or she electronically prescribes and reports a G-code indicating that he or she generated and transmitted a prescription electronically at least 25 times for those eligible cases that occur during the 2010 reporting period. Although an individual eligible professional may decide to conduct his or her own assessment of how likely this statutory limitation is expected to apply to him or her before deciding whether or not to report the electronic prescribing measure, an individual eligible professional may report the electronic prescribing measure without regard to the statutory limitation for the incentive payment.

e. Reporting Option for Satisfactory Reporting of the Electronic Prescribing Measure by Group Practices

In the CY 2010 PFS proposed rule (74 FR 33599 through 33600), we discussed making incentive payments to group practices based on the determination that the group practice, as a whole (that is, the TIN), is a successful electronic prescriber for 2010, as required under section 1848(m)(3)(C)(i) of the Act. In addition, we noted that section 1848(m)(3)(C)(iii) of the Act requires that payments to a group practice by reason of the process established under section 1848(m)(3)(C)(i) of the Act shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for being a successful electronic prescriber.

(1) Definition of ''Group Practice''

Section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define ''group practice.'' For purposes of determining whether a group practice is a successful electronic prescriber, we proposed that a ''group practice'' would consist of a physician group practice, as defined by a TIN, with at least 200 or more individual eligible professionals (or, NPIs) who have reassigned their billing rights to the TIN (74 FR 33599). In addition, we proposed to limit the group practices eligible to participate in the 2010 E-Prescribing Incentive

Program through the group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option.

The following is a summary of the comments received regarding our proposed definition of ''group practice''.

Comment: Several commenters urged CMS to permit small and mid-sized group practices with fewer than 200 eligible professionals to participate in the group practice reporting option. One commenter requested that we reconsider the 200 individual eligible professional thresholds for the definition of a group practice or that we at least offer an alternative reporting option that uses a statistical sampling model for primary care oriented group practices.

Response: We recognize that the proposed required group practice size of 200 or more individual eligible professionals limits participation. As stated in the proposed rule (74 FR 33599), for 2010, we would like to limit the number of groups participating in the group practice reporting option until we get further experience with the group practice reporting option. Therefore, we are not adopting the commenters' suggestion to permit small and mid-sized group practices with fewer than 200 eligible professionals to participate in the group practice reporting option and are finalizing the definition of ''group practice'' for the electronic prescribing group practice reporting option as proposed.

In order for a group practice to participate in the electronic prescribing group practice reporting option for 2010, the group practice must be one that is selected to participate in the PQRI group practice reporting option, which requires that group practices have 200 or more eligible professionals. Group practices cannot solely participate in the electronic prescribing group practice reporting option. A group practice can choose to participate in: (1) both the PQRI group practice reporting option and the electronic prescribing group practice reporting option; (2) the PQRI group practice reporting option but participate in the E-Prescribing Incentive Program as individual eligible professionals; or (3) the PQRI group practice reporting option but not participate in the E-Prescribing Incentive Program at all.

We will use this initial implementation year to explore and refine the group practice reporting option and anticipate expanding this option to group practices with less than 200 individual eligible professionals in future program years.

Comment: A commenter urged us to keep PQRI and the E-Prescribing Incentive programs separate and distinct for group practices wishing to participate in the PQRI group practice reporting option.

Response: The PQRI and E-Prescribing Incentive Programs are separate and distinct incentive programs with different program requirements. However, in order for a group practice to participate in the electronic prescribing group practice reporting option, one of the participation requirements is that the group practice must be one that is selected to participate in the PQRI group practice reporting option. As stated previously, a group practice can choose to participate in: (1) Both the PQRI group practice reporting option and the electronic prescribing group practice reporting option; (2) the PQRI group practice reporting option but participate in the E-Prescribing Incentive Program as individual eligible professionals; or (3) the PQRI group practice reporting option but not participate in the E-Prescribing Incentive Program at all. Therefore, participation in the E-Prescribing Incentive Program, whether as a group practice or at the individual eligible professional level, is optional for those group practices selected to participate in the PQRI group practice reporting option.

For those group practices who choose to participate in both the PQRI and electronic prescribing group practice reporting option, it is important to note that the electronic prescribing measure is not reportable using the PQRI group practice reporting option data collection tool. The electronic prescribing measure is reportable via the same reporting mechanisms that are available to individual eligible professionals participating in the 2010 E-Prescribing Incentive Program (that is claims, a qualified registry, or a qualified EHR).

Comment: A commenter had concerns that some group practices will have difficulty ramping up for participation in both the PQRI and electronic prescribing group practice reporting options between now and January 1, 2010.

Response: As we stated previously, participation in the electronic prescribing group practice reporting option by group practices selected to participate in the PQRI group practice reporting option is optional. To the extent that a group practice chooses to participate in both programs' group practice reporting options, it does not need to be ready to begin the PQRI and electronic prescribing group practice reporting options between now and January 1, 2010. As stated in section II.G.2. of this final rule with comment period, we are requiring interested group practices that meet the criteria to self-nominate by January 31, 2010 and indicate to us whether the practice wishes to participate in just the PQRI group practice reporting option or both the PQRI and electronic prescribing group practice reporting option. The reporting periods for both programs are the same (that is, January 1, 2010 through December 31, 2010), the data submission timelines, however, are different.

In an attempt to ensure the group practices have sufficient time to become acclimated to the PQRI group practice reporting option, for the 2010 PQRI, the group practice will be notified of the selection decision to participate in the PQRI group practice reporting option no later than the second quarter of 2010. Training on the data collection tool is projected to be provided in the third quarter of 2010. The group practice will not be expected to complete and return the data collection tool until the end of the first quarter of 2011.

For the 2010 E-Prescribing Incentive Program, we proposed requiring that reporting of the electronic prescribing measure by group practices would occur under the same data submission timeline as reporting of the electronic prescribing measure by individual eligible professionals. The proposed reporting mechanisms for the electronic prescribing measure would be the same regardless of whether an eligible professional is participating individually or as a group practice. Furthermore, the electronic prescribing measure was not proposed to be reportable via the PQRI group practice reporting option data collection tool.

To summarize, based on these comments, for purposes of the 2010 E-Prescribing Incentive Program, we are finalizing a group practice reporting option that will consist of ''group practice'' being defined as a TIN with at least 200 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN and who are participating in the 2010 PQRI group practice reporting option. Therefore, unlike individual eligible professionals who are not required to participate in the PQRI, to be eligible to earn an electronic prescribing incentive in 2010, group practices that wish to participate in the electronic prescribing group practice reporting option will be required to participate in the PQRI group practice reporting option. Participation in the E-Prescribing Incentive Program, including participation in the electronic prescribing group practice reporting option is, however, optional for group

practices that are participating in PQRI under the group practice reporting option. If a group practice wishes to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option, it must indicate its desire to do so at the time that the group practice self-nominates to participate in the 2010 PQRI group practice reporting option. There is no need for group practices to indicate their intent to participate in the 2010 E-Prescribing Incentive Program as individual eligible professionals when the group practice self-nominates to participate in the 2010 PQRI group practice reporting option.

Group practices interested in participating in the 2010 PQRI through the group practice reporting option are required to submit a self-nomination letter to CMS, requesting to participate in the 2010 PQRI group practice reporting option. Instructions for submitting the self-nomination letter will be posted on the PQRI section of the CMS Web site by November 15, 2009. A group practice that wishes to participate in the E-Prescribing Incentive Program group practice reporting option will be notified of the selection decision to participate in the E-Prescribing Incentive Program at the same time that it is notified of the selection decision for the PQRI group practice reporting option.

In addition to meeting the eligibility requirements discussed in section II.G.5.e.1. of this final rule with comment period, a group practice that wishes to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option will also have to indicate how it intends to report the electronic prescribing measure. That is, the group practice will need to indicate in its self-nomination letter which reporting mechanism the group practice intends to use for purposes of participating in the 2010 E-Prescribing Incentive Program group practice reporting option.

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

For group practices selected to participate in the electronic prescribing group practice reporting option for 2010, we proposed the reporting period would be January 1, 2010 to December 31, 2010 (74 FR 33599 through 33600).

We proposed that physician groups selected to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option would be able to choose to report the electronic prescribing measure through the claims-based, the registry-based, or, contingent upon us finalizing this reporting mechanism for the 2010 PQRI, the EHR-based reporting mechanism.

In order for a group practice to be considered a successful electronic prescriber, we proposed that the group practice would have to report that at least 1 prescription during an encounter was generated using a qualified electronic prescribing system in at least 2,500 instances during the reporting period. We solicited comments on the proposed criteria for determining whether a group practice is a successful electronic prescriber. We also invited feedback on our underlying assumptions.

Section 1848(m)(2)(B) of the Act specifies that the limitation on the applicability of the electronic prescribing incentive applies to group practices as well as individual eligible professionals. Therefore, in determining whether a group practice will receive an electronic prescribing incentive payment for 2010 by meeting the proposed reporting criteria described above, we would determine whether the 10 percent threshold is met based on the claims submitted by the group practice.

The following is a summary of the comments we received regarding the proposed process for group practices to participate as group practices and criteria for successful reporting of the electronic prescribing measure by group practices.

Comment: One commenter agrees with CMS' assumptions and proposals for group reporting and believed it is reasonable to set criteria for successful electronic prescribing using the 2,500 threshold. Conversely, one commenter believed that 2,500 electronic prescribing events during the reporting period is too low a threshold for group practices and suggested that the threshold should be 25,000 to 50,000 electronic prescribing instances during the reporting period per group practice. One commenter believed that CMS should retain the 50 percent rule and thinks that establishing a numerical target of 2,500 electronic prescribing instances during the reporting period creates an unbalanced incentive depending on practice type, size, and percent Medicare patient mix. Another commenter stated that the electronic prescribing group practice reporting option should not be different for a group practice versus an individual eligible professional.

Response: By establishing a reporting threshold of 2,500 electronic prescribing events per reporting period per group practice, we desired to implement a threshold that is obtainable and demonstrates that the group practice has adopted and is using a qualified electronic prescribing system. Also, by establishing this threshold, we sought to reduce reporting burden. A numerical target of reporting 2,500 electronic prescribing events per reporting period will provide a tangible goal for the group practices to achieve. As stated previously, we are making every effort to promote the adoption of electronic prescribing by making participation both practical and operational so that group practices may achieve successful reporting. In establishing the threshold of 2,500 electronic prescribing events, we had to take into account not only all the circumstances that we discussed above with respect to the threshold for individual eligible professionals that could prevent a group practice who has adopted a qualified electronic prescribing system from having 2,500 electronic prescribing events during the calendar year but also the fact that the impact of these circumstances will vary depending on the types of specialties that are affiliated with each group practice.

Comment: A commenter expressed that the proposed method of calculating whether the limitation applies to a group practice will prevent most large multi-specialty group practices from being able to use the electronic prescribing group practice reporting option.

Response: We do not have the authority to change the basis for determining the applicability of the limitation. If we are making the determination of successful electronic prescriber based on reporting the electronic prescribing measure, section 1848(m)(2)(B) of the Act specifies that the limitation will apply if the Medicare Part B PFS allowed charges for all covered professional services furnished by the group practice for the codes to which the electronic prescribing quality measure applies are less than 10 percent of the total of the Medicare Part B PFS allowed charges for all covered professional services furnished by the group practice.

For the reasons mentioned above and after considering the comments, we are finalizing for the 2010 E-Prescribing Incentive Program the group practice reporting option discussed above. Specifically, group practices will be required to report the 2010 electronic prescribing measure at least 2,500 times during the reporting period in order for the group practice to be considered a successful electronic prescriber.

Group practices will be able to choose to report the electronic prescribing

measure through claims, a qualified registry, or qualified EHR product. As discussed for individual eligible professionals, only registries and EHR products qualified to participate in the 2010 PQRI will be qualified for purposes of the 2010 electronic prescribing group practice reporting option.

In addition, in determining whether a group practice will receive an electronic prescribing incentive payment for 2010 by meeting the reporting criteria described above, we will determine whether the 10 percent threshold is met based on our analysis of the claims submitted by the group practice during the reporting period. This calculation is expected to take place in the first quarter of 2011 and will be determined by dividing the group practice's total 2010 Medicare Part B PFS allowed charges for all covered professional services submitted for the measure's denominator codes by the group practice's total Medicare Part B PFS allowed charges for all covered professional services. If the result is 10 percent or more, then the statutory limitation will not apply and a group practice that is determined to be a successful electronic prescriber will qualify to earn the electronic prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the group practice will not qualify to earn the electronic prescribing incentive payment.

f. Public Reporting of Names of Successful Electronic Prescribers

Section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submit data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers. As required by section 1848(m)(5)(G) of the Act, we proposed to make public the names of eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program on the Physician and Other Health Care Professionals Directory.

The following is summary of the comments we received regarding requirements under section 1848(m)(5)(G) of the Act with respect to the E-Prescribing Incentive Program.

Comment: Some commenters supported public reporting of the names of successful electronic prescribers. One commenter, in particular, noted that public reporting of the names of successful electronic prescribers will assist health plans in identifying such entities for related requirements in Medicare Advantage and Part D and help private health plans identify those that may need to be encouraged or assisted with electronic prescribing.

Response: We are pleased to have commenters' support for our efforts to make information about eligible professionals' adoption and use of electronic prescribing technology publicly available. We agree that such information may be relevant and useful to a broad audience.

Comment: Many commenters urged us to post only the information required by section 1848(m)(5)(G) of the Act, that is, the names of individual eligible professionals and group practices who are successful electronic prescribers.

Response: As we stated in the CY 2010 PFS proposed rule (74 FR 33600), we proposed to make public only the names of eligible professionals and group practices who are successful electronic prescribers. We do not anticipate posting any other information with respect to the E-Prescribing Incentive Program at this time.

Comment: Other commenters recognized that we are statutorily required to carry out public reporting of the names of successful electronic prescribers but are, nevertheless, opposed to publicly releasing the names of successful electronic prescribers or urged us to delay releasing such information until the public has a better understanding of the details of the E-Prescribing Incentive Program. Some of the concerns specifically cited by commenters include the following:

- The E-Prescribing Incentive Program is voluntary and excludes many eligible professionals;
- A formal independent evaluation of the E-Prescribing Incentive Program's processes and an analysis and validation of the data gathered needs to be conducted prior to any information being publicly released;
- CMS needs to provide eligible professionals with better access and feedback to the quality data they report (especially feedback on why they failed to report successfully) before the release of any information;
- There is little to be gained from this effort since eligible professionals and patients do not fully understand the details of the program and are still learning about this program;
- Patients may not understand the purpose for posting this information since the program is still new; and
- The criteria for becoming a successful electronic prescriber are changing from 2009 to 2010.

Response: We are appreciative of the commenters' thoughtful and constructive feedback and will take these concerns into consideration as we further develop our plans for publicly reporting information from the E-Prescribing Incentive Program. While we understand the commenters' concerns, we note that section 1848(m)(5)(G) of the Act requires us to list the names of individual eligible professionals and group practices who are successful electronic prescribers in an easily understandable format on our Web site. As such, it is our intent to identify the eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program for posting in 2011. We note that we anticipate conducting an evaluation of the E-Prescribing Incentive Program and making the national evaluation results public through an experience report similar to the ''PQRI 2007 Reporting Experience'' report that we posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf*.

Comment: A few commenters stressed the importance of including appropriate and prominent disclaimers or other statements on our Web site that provides information about the E-Prescribing Incentive Program and specifically state that there are valid reasons why an eligible professional may not have been a successful electronic prescriber for 2010.

Response: We agree with the commenters on the importance of including disclaimers and other information on the Web site that explains the E-Prescribing Incentive Program and its goals and the limitations of the data being reported (such as the fact that there are valid reasons why an eligible professional may not have been a successful electronic prescriber). Thus, it is our intent to include such language and disclaimers on the Web site similar to what was displayed with the 2007 PQRI participation information that was publicly released on the Physician and Other Health Care Professionals Directory in December 2008. We also anticipate being able to update the Physician and Other Health Care Professionals Directory to display the relevant disclaimers more prominently.

Comment: Some commenters recommended that eligible professionals and group practices have an opportunity to review their electronic prescribing

results before those results are made public, including access to information about why they were not able to successfully report this data, and that we continue to work with eligible professionals on the sensitive issues that surround this concept.

Response: Eligible professionals and group practices will have an opportunity to review their electronic prescribing results via the detailed, confidential feedback reports that will be made available to all eligible professionals and group practices who participle in the E-Prescribing Incentive Program. Eligible professionals and group practices will have an opportunity to obtain their feedback reports prior to any information about their success being publicly released.

Eligible professionals who have concerns about their results or any other information included on their feedback reports are encouraged to contact the QualityNet Help Desk at (866) 288–8912 or *qnetsupport@sdps.org* for assistance.

Comment: One commenter recommended that we also publicly report the names of eligible professionals who choose to not participate in the E-Prescribing Incentive Program.

Response: We do not believe it will be meaningful to the public to know the names of those eligible professionals who choose not to participate in the E-Prescribing Incentive Program. As some commenters noted, the E-Prescribing Incentive Program is a voluntary incentive program and many eligible professionals who have adopted and use a qualified electronic system have valid reasons for not participating. For example, some eligible professionals may not provide the services included in the electronic prescribing measure's denominator and, therefore, would not have an opportunity to report the measure. Other professionals may know, based on the prior year's charges, that they are unlikely to meet the statutory limitation under section 1848(m)(2)(B) of the Act that would allow them to be eligible to qualify to earn the electronic prescribing incentive payment. Therefore, such eligible professionals would most likely opt to not participate in the E-Prescribing Incentive Program even if they are electronically prescribing.

After considering the comments, we will publicly report the names of eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program on the Physician and Other Health Care Professionals Directory. We anticipate that the names of individual eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program will be available in 2011 after the 2010 incentive payments are paid.

Although we stated in the CY 2009 PFS proposed rule (74 FR 33600) and the CY 2008 PFS final rule with comment period (73 FR 69852) that we intended to post the names of individual eligible professionals who meet the criteria for successful electronic prescriber and for whom the limitation does not apply (in other words, eligible professionals who qualify to earn an incentive payment), we would like to clarify that for purposes of publicly reporting the names of individual eligible professionals on the Physician and Other Health Care Professionals Directory, section 1848(m)(5)(G) of the Act requires only that the Secretary post the names of eligible professionals (or group practices) who are successful electronic prescribers. Therefore, with respect to the 2010 E-Prescribing Incentive Program we intend to post the names of individual eligible professionals who report the electronic prescribing measure at least 25 times during the 2010 reporting period for patient encounters included in the measure's denominator, without regard to whether the limitation applied to the eligible professional and without regard to whether the eligible professional actually qualified to earn an incentive payment. In addition, since the PQRI and the E-Prescribing Incentive Program are two separate incentive programs and individual eligible professionals are not required to participate in both programs to earn an incentive under either program, we point out that it is possible for an eligible professional who participates in both incentive programs to be listed both as an individual eligible professional who satisfactorily submits data on quality measures for the PQRI and is a successful electronic prescriber under the E-Prescribing Incentive Program. Likewise, an individual eligible professional may be listed as an individual eligible professional who satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber under the E-Prescribing Incentive Program (or vice versa) even if he or she participated in both incentive programs.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician and Other Health Care Professionals Directory, we intend to post the names of group practices who report the electronic prescribing measure at least 2,500 times during the 2010 reporting period for patient encounters included in the measure's denominator without regard to whether the limitation applied to the group practice or whether the group practice actually qualified to earn an incentive payment. Although any group practice participating in the E-Prescribing Incentive Program under the group practice reporting option would have had to also participate in the PQRI group practice reporting option, the criteria for satisfactory reporting of PQRI measures for group practices are different from the criteria for successful reporting of the electronic prescribing measure by group practices. Therefore, it is possible for a group practice to be listed as a group practice that satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber under the E-Prescribing Incentive Program, or vice versa.

6. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Section 1834(e) of the Act, as added by section 135(a) of the MIPPA, requires that beginning January 1, 2012, Medicare payment may only be made for the technical component (TC) of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act to a supplier who is accredited by an accreditation organization (AO) designated by the Secretary.

a. Accreditation Requirement

In the proposed rule, we proposed criteria for designating organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services as specified in section 1834(e) of the Act. In addition, we proposed the required procedures to ensure that the criteria used by an AO meets minimum standards for each imaging modality in § 414.68.

We did not propose any substantive standards that suppliers furnishing the TC of advanced imaging would have to meet. We have chosen to utilize clinical guidelines that are already accepted by the experienced accreditation organizations already performing accreditation. We believe that the suppliers should be able to assimilate these new accreditation requirements very easily into their medical practice.

We will be designating organizations based on, at minimum, their ability to meet the requirements set forth in the statute. In addition, in this rule we have

described the components that any organization must have in order to be considered for designated status.

As proposed, the CMS-designated AO would apply standards that set qualifications for medical personnel who are not physicians but who furnish the TC. The standards would describe the qualifications and responsibilities of medical directors and supervising physicians. including the following: recognizing whether a particular medical director or supervising physician received training in advanced imaging services in a residency program; and has attained, through experience, the necessary expertise to be a medical director or supervising physician; has completed any continuing medical education courses related to advanced imaging services; or has met such other standards as the Secretary determines appropriate.

In addition, the standards would require suppliers to: (1) Establish and maintain a quality control program to ensure the technical quality of diagnostic images produced by the supplier; (2) ensure the equipment used meets performance specifications; and (3) ensure safety of personnel. While the statute authorizes the Secretary to establish as criteria for accreditation any other standards or procedures the Secretary determines appropriate, we did not propose to establish other standards or procedures.

In the proposed rule, we also stated that we expect to publish a notice to solicit applications from entities for the purposes of becoming a designated AO the same day that this final rule with comment period is issued. We still expect to meet the January 1, 2010 statutory deadline in order to designate organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services by waiving the 60-day delay in the imaging accreditation provisions in the final rule.

We believe that we have furnished enough detail in the proposed rule, in addition to receiving extensive comments from prospective AOs, so that AOs will find that 30 days is sufficient time to respond to the solicitation.

b. Accreditation for Suppliers

Section 1834(e) of the Act requires the Secretary to designate and approve AOs to accredit suppliers of the TC of advanced diagnostic imaging services. To promote consistency in accrediting providers and suppliers throughout the Medicare program, we proposed to review existing procedures for the application, selection, and oversight of AOs detailed at 42 CFR part 488, subparts A and D, and apply them (with appropriate revisions) to organizations accrediting suppliers of the TC of advanced diagnostic imaging services. We proposed modifications to the existing part 488 requirements to meet the specialized needs of the advanced imaging industry. These modifications would require an independent AO applying for approval as a designated AO to include in their application:

- A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, specifically:

+ Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

+ Qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

+ Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished;

+ Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier.

- An agreement to conform accreditation requirements to any changes in Medicare statutory requirements in section 1834(e) of the Act.
- Information to demonstrate the AO's knowledge and experience in the advanced diagnostic imaging arena.
- The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation and any plans for reducing the burden and cost of accreditation to small and rural suppliers.
- Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

If, after review of an AO's submission of information, we determined that additional information was necessary to make a determination for approval or denial of the AO's application to be designated as an AO for suppliers of the TC of advanced diagnostic imaging services, the organization would be notified and afforded an opportunity to provide the additional information. We could visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff. The AO would receive a formal notice from CMS stating whether the request for designation was approved or denied. If approval was denied, the notice would include the basis for denial and outline the reconsideration procedures. We would make every effort to issue a final decision no more than 30 calendar days from the time the completed reapplication was received by CMS. An AO could withdraw its application for designation under section 1834(e) of the Act at any time before the formal notice of approval is received. An AO that was notified that its request for designation was denied could request reconsideration in accordance with § 488.201 through § 488.211 in Subpart D. Any AO whose request for designation was denied could resubmit its application if the organization (1) Revised its accreditation program to address the rationale for denial of its previous request; (2) provided reasonable assurance that its accredited companies meet applicable Medicare requirements; and (3) resubmitted the application in its entirety. If an AO requested a reconsideration of a denial, it could not submit a new application for the type of modality that is at issue in the reconsideration until the reconsideration was final.

A panel would evaluate all proposals from AOs seeking designation under section 1834(e) of the Act using existing CMS survey and certification processes, similar to those established at § 488.4.

c. Payment Rules for Suppliers of the TC of Advanced Diagnostic Imaging Services (§ 414.68)

We would implement at § 414.68 the statutory requirement of section 1834(e) of the Act that all suppliers of the TC of advanced diagnostic imaging services be accredited by a CMS-designated AO by January 1, 2012 for payments made under the fee schedule established under section 1848(b). In § 414.68(a), we proposed to define the following:

- ''Accredited supplier'' would mean a supplier that has been accredited by a CMS-approved AO.
- ''Advanced Diagnostic Imaging Services'' would mean diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography. We did not propose to include other diagnostic imaging services in this definition under section 1834(e)(1)(B)(ii) of the Act.
- ''CMS-approved accreditation organization'' would mean an independent AO designated by CMS to perform the accreditation function established in section 1834(e) of the Act.

d. Ongoing Responsibilities of CMS–Approved Accreditation Organizations

We proposed to require a CMS-approved AO to perform several activities on an ongoing basis. The organization would provide to CMS in written form and on an ongoing basis all of the following:

- Copies of all accreditation surveys of specific suppliers along with any survey-related information that we may require (including corrective action plans and summaries of CMS requirements that were not met).
- Notice of all accreditation decisions.
- Notice of all complaints related to suppliers of the TC of advanced diagnostic imaging service.
- Information about any suppliers of the TC of advanced diagnostic imaging service for which the accrediting organization has denied the supplier's accreditation status.
- Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implemented the changes before or without CMS approval, we could withdraw approval of the AO.
- Written notice of any deficiencies and adverse actions implemented by the CMS-approved AO against an accredited supplier of the TC of advanced diagnostic imaging within 2 days of identifying such deficiencies, if the deficiencies pose immediate jeopardy to a beneficiary or to the general public.
- Written notice of the withdrawal to all accredited suppliers within 10 days of CMS' notice to withdraw approval of the AO.
- Summary data specified by CMS related to the past year's accreditation activities and trends, on an annual basis.

In addition, the AO would permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

e. Continuing CMS Oversight of CMS–Approved Accreditation Organizations

We proposed to add § 414.68 to establish specific criteria and procedures for continuing oversight and for withdrawing approval of an approved AO.

(1) Validation Audits

We proposed to audit the accredited organizations in order to validate the survey accreditation process of approved AOs in the TC of advanced imaging. The audits would be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards. When conducted on a representative sample basis, we proposed that the audit would be comprehensive and address all of the standards or would focus on a specific standard in issue. When conducted in response to an allegation, we proposed to specify that the CMS team or our contractor would audit for any standard that we determined was related to the allegations. We also proposed to require a supplier selected for a validation audit to authorize the validation audit to occur and authorize the CMS team or our contractor to monitor the correction of any deficiencies found through the validation audit. If a supplier selected for a validation audit failed to comply with the requirements at § 414.68, the supplier would no longer meet the Medicare requirements and, under this proposal, the supplier's accreditation for the TC of the advanced medical imaging would be revoked.

We proposed that a CMS team or our contractor would conduct an audit of an accredited organization, examine the results of the AO's own survey procedure onsite, or observe the AO's survey, in order to validate the organization's accreditation process. At the conclusion of the review, we would identify any accreditation programs for which validation audit results indicated the following:

- A 10 percent or greater rate of disparity between findings by the AO and findings by CMS or our contractor on standards that did not constitute immediate jeopardy to patient health and safety if not met;
- Any disparity between findings by the AO and findings by CMS or our contractor on standards that constituted immediate jeopardy to patient health and safety if not met; or
- There were widespread or systemic problems in the organization's accreditation process such that the accreditation no longer provided assurance that suppliers met or exceeded the Medicare requirements, irrespective of the rate of disparity.

(2) Notice of Intent To Withdraw Approval for Designating Authority

As proposed, if a validation audit, onsite observation, or our concerns with the ethical conduct (that impacted the health and safety of the beneficiary) of an AO suggest that the AO was not meeting the requirements of § 414.68, we would provide the organization written notice of our intent to withdraw approval of the AO's designating authority.

(3) Withdrawal of Approval for Designating Authority

We proposed to withdraw approval of an AO at any time if we determined that:

- Accreditation by the organization no longer provided sufficient assurance that the suppliers of the TC of advanced imaging meet the requirements of section 1834(e) of the Act and the failure to meet those requirements could pose an immediate jeopardy to the health and safety of Medicare beneficiaries;
- Conditions at an imaging supplier accredited by an AO constituted a significant hazard to the public health; or
- The AO failed to meet its obligations for application and reapplication procedures.

(4) Reconsideration

We proposed to implement requirements similar to those set out under 42 CFR part 488 without substantive changes, as the requirements have been utilized for the health care providers covered under 42 CFR part 488 since 1992. We proposed that an AO dissatisfied with a determination that its accreditation requirements did not provide or do not continue to provide reasonable assurance that the suppliers accredited by the AO met the applicable standards would be entitled to a reconsideration. We also proposed to reconsider any determination to deny, remove, or not renew the approval of the designating authority to AOs if the AO filed a written request for reconsideration through its authorized officials or through its legal representative.

We proposed to require the AO to file the request for reconsideration within 30 calendar days after the issuance of CMS notice of an adverse determination or non-renewal. We proposed to require the request for reconsideration to specify the findings or issues with which the AO disagreed and the reasons for the disagreement. A requestor could withdraw its request for reconsideration at any time before the issuance of a reconsideration determination. In response to a request for reconsideration, we would provide the accrediting organization the opportunity for an informal hearing that would be conducted by a hearing officer appointed by the CMS Administrator and provide the accrediting organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew its designating authority.

As proposed, we would provide written notice of the time and place of the informal hearing at least 10 business days before the scheduled date. The informal reconsideration hearing would be open to CMS and the organization requesting the reconsideration, including authorized representatives, technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts), and legal counsel. The hearing would be conducted by the hearing officer, who would receive testimony and documents related to the proposed action. Testimony and other evidence could be accepted by the hearing officer. However, the normal evidentiary exclusions applicable in Federal courts would not apply to these hearings. The hearing officer would not have the authority to compel by subpoena the production of witnesses, papers, or other evidence. Within 45 calendar days of the close of the hearing, the hearing officer would present the findings and recommendations to the accrediting organization that requested the reconsideration. The written report of the hearing officer would include separate numbered findings of fact and the legal conclusions of the hearing officer. The hearing officer's decision would be final.

The following is a summary of the comments we received regarding our proposals for implementation of section 135 of MIPPA.

Comment: One commenter requested that we consider medical directors and supervising physicians to be equivalent positions, as they are frequently the same.

Response: We agree and have revised the regulation text accordingly at § 414.68(c)(1)(ii) to reflect that the clinical responsibilities of the medical director and/or supervising physician would be identical.

Comment: Some commenters stated that the physician should be qualified in the modality for which the supplier is applying. In order to ensure this compliance, one commenter suggested requiring billing under the NPI of that qualified physician and not another physician, which is commonly done to avoid self-referral provisions. Another commenter stated that we need to consider that any licensed physician, not just a radiologist who can respond to a patient's possible contrast reaction, be qualified as supervising medical directors and supervising physicians. The commenter also suggested that there be a degree of control over documented quarterly on-site interactions with nonphysician staff, creation and review of all imaging protocols along with developing quality performance guidelines as opposed to limiting the number of sites that the physician may serve as the medical director or supervising physician. The teleradiology area also needs to be included supervision performance criteria.

Response: We will develop billing policies connected to the provision of the TC of advanced subsequent to the issuance of this rule, and will take the commenters' concerns under advisement. With respect to performance measures for the Medical director and/or supervising physician, we expect that all AOs will consider performance measures in their credentialing and competency evaluations.

Comment: Some commenters stated that each designated AO should be required to evaluate the image quality produced as part of the AO's accreditation survey review process and that the accreditation personnel should have 5 years of specific documented experience and training in image acquisition and interpretation.

Response: We agree that experience in the advanced imaging area is important. For example, we are aware that some organizations require that accreditation personnel should have specific documented experience and training in image acquisition and interpretation for 5 years. CMS will review the standards for all potential accrediting organizations to determine whether it is necessary for CMS to impose a similar requirement. We intend to evaluate all accreditation organization applications based on documented evidence of having a level of experience in accrediting advanced imaging suppliers and the requirements for their surveyors who are completing these surveys.

Comment: One commenter requested that since the timeframe before the January 1, 2010 designation deadline was so near, the accompanying request for proposals should be on review prior to the display date of this final rule.

Response: Since the notice could have changed up to the display date of the final rule, we did not believe publishing a draft notice would have been helpful. We did, however, include all of the requirements in the proposed rule that we intended for the solicitation notice.

Comment: Some commenters believe that the proposed provision that exists for equipment review is not specific enough to guarantee a thorough evaluation of equipment performance and safety.

Response: We will revise our rule in § 414.68 to require that the equipment used by advanced imaging suppliers must meet the manufacturer's performance specifications.

Comment: Some commenters stated the quality of the supplier cannot adequately be assessed without a comprehensive evaluation of all aspects of the imaging service's operation, including personnel, image acquisition and quality, and the quality of the final report.

Response: We agree that all of these components are necessary in the evaluation of a TC supplier. We will be evaluating AOs' applications based on the performance standards that are used to make certain that these assessments are comprehensive.

Comment: One commenter requested clarification as to whether the proposed rules meant that advanced imaging standards could be lowered by CMS. If CMS changes its standards, the AO's experts should be given an opportunity to comment. The commenter also asked whether AOs could maintain or adopt standards that were more stringent than those required by CMS.

Response: Section 1834(e) of the Act, as added by section 135(a) of the MIPPA, requires that the Secretary consult with physician specialties and other stakeholders on provisions in this rule. We plan to do this, as required by the statute. Accreditation organizations may enforce the guidelines to be issued by CMS, or adopt standards that are more stringent than those Medicare requires.

Comment: Some commenters asked about the fee structure of the designated AOs. One commenter suggested that CMS assist small and rural suppliers, and that the fees be based on the number of imaging machines, number of testing modalities, and the number of testing sites. Another commenter stated the AOs should be allowed to use their differing methodologies for reducing accreditation costs for small and rural suppliers. The commenter believed that CMS was going to mandate the fee structure for the designated AO. One commenter suggested that we clarify the $5,000 cost per 3-year review cycle as an estimate of the cost per modality. One commenter stated that they were confused by what CMS intended the difference to be between small and specialty suppliers as compared to small and rural suppliers.

Response: We will be evaluating applications from all AOs that apply, and make certain that all have provisions for small and rural suppliers. Although we will not be prescribing the fee structure for the designated AO, we want to see that each application has a policy and procedure to determine cost and assistance that would take the

smallest supplier into consideration. As a clarification, note that this rule only applies to those specialty suppliers furnishing the TC of advance medical imaging.

Comment: Two commenters asked about unannounced site visits. There was concern that the site may either not have the appropriate staff for the modality, or in the case of a mobile unit, may not be present on the day the surveyor arrives. It was suggested that either the site visits were announced or that accrediting organizations utilize a combination of announced and unannounced surveys.

Response: We believe that a supplier who ''gets ready'' for the site survey is a supplier that is not providing quality care and services throughout the year. The supplier knows that a surveyor will be onsite every 3 years and thus would already be aware of an imminent survey.

Comment: Two commenters strongly encouraged that we include other diagnostic imaging services, such as ultrasound, to be eligible for accreditation.

Response: Section 1834(e)(1)(B)(ii) of the Act, as added by section 135(a) of MIPPA, specifically excludes X-ray, ultrasound, and fluoroscopy from those diagnostic imaging services subject to the accreditation requirement. Therefore, we cannot implement this change without Congressional action.

Comment: One comment discussed the transfer of individually identifiable health information and other information not intended for public disclosure. The commenter requested that we clarify under what circumstances such information would need to be transmitted and how that information would be safeguarded.

Response: Under normal circumstances, neither CMS or an AO would need to transfer individually-identifiable personal health information from one location to another. If, however, we need such information for investigational purposes it would either be transmitted via securely or de-identified prior to transmission.

Comment: One commenter requested clarification on the requirement that the AO notify Medicare of accreditation decisions to be intended for only those imaging suppliers that bill Medicare.

Response: We will provide that clarification. The requirement that the AO notify Medicare is only required for those suppliers billing Medicare.

Comment: Regarding the complaint reporting process, one suggested that the rule was not clear if the complaints that were to be reported were with respect to the AO or to the TC supplier being accredited. Another commenter suggested that we specify the frequency with which we expected accrediting organizations to report complaints about suppliers. The commenter also suggested that we specify the types of complaints about suppliers that would be subject to the reporting requirement. The commenter suggested that such conditions include: poor image quality, injury or harm from equipment, falsely claiming to be accredited, unqualified personnel, submission of false or misleading accreditation information. One commenter suggested that we change from 2 calendar days to 2 business days the proposed requirement that an AO notify CMS when it finds deficiencies in a TC supplier that pose an immediate jeopardy to the health and safety of patients receiving services from such supplier. One commenter also requested clarification of what was meant by ''appropriate licensing bodies,'' since there are specific State departments that control these entities.

Response: We agree with the commenter that we needed to clarify the applicability of the complaint reporting requirement. Therefore, we are clarifying in this final rule that the complaint process is applicable to any complaints that come from any source against an accredited supplier. We also agree that the reporting of complaints about conditions that pose immediate jeopardy to Medicare beneficiaries or the general public should be reported to CMS within 2 business days, because. Therefore, we are also amending § 414.68(c)(12)(iii)(G) to state that an approved AO will be required to notify CMS within 2 business days of such ''immediate jeopardy'' situations. Subsequent to the issuance of this rule, we will issue subregulatory guidance with respect to the frequency and types of other reporting that are necessary. In response to the commenter's inquiry, we are also noting that in the context of this final rule, ''Appropriate licensing body'' means any regulatory body, including State Radiation Control departments and the Nuclear Regulatory Commission.

Comment: Regarding circumstances in which CMS might withdraw its approval of an accrediting organization (thus requiring suppliers accredited by such organization to obtain new accreditation), two commenters suggested the final rule recognize that CMS and the remaining AOs would need to collaborate in order to distribute such affected suppliers among other accrediting organizations over a reasonable time period.

Response: We agree. It certainly is our expectation that any supplier transition process of this sort would be transparent, so that no disruption in patient care would occur.

Comment: One commenter stated that the proposal included hospitals in the summary data from the CMS' Services Tracking and Reporting System. Since the hospitals are not included in this proposal, the commenter requested reconfirmation that the provisions do not apply to hospitals.

Response: In § 414.68(a), in conformity with section 1834(e), we state that the imaging accreditation requirement applies only to suppliers of the TC of advanced diagnostic imaging services for which payment is made under the physician fee schedule. Since hospitals generally are not paid pursuant to such schedule, this accreditation rule is inapplicable. Hospitals, including their inpatient radiology departments, are accredited under 42 CFR part 488.

Comment: Two commenters suggested that instead of notifying CMS of all revisions to their accreditation requirements, standards and policies, as set out at proposed § 414.68(c)(12)(iii)(E) and § 414.68(d)(1)(v), accrediting organizations notify CMS only of major revisions to their respective accreditation standards or requirements or survey processes. In this context, ''major'' would be defined as ''changes having potential impact on the supplier's ability to maintain compliance with the standards or application process.''

Response: We agree; we will clarify our language to indicate that ''major changes'' mean only significant changes from what CMS approved in the AO's initial approved application.

Comment: Several commenters had questions about the proposed CMS audits of AOs. The commenters would like to have more information about the procedures that CMS surveyors would use. The commenters also stated that the meaning of the ''10 percent disparity rate'' was not clear. One commenter asked that we clarify who would bear the cost for a validation survey, what specific information would be collected in such surveys, and what percentage of sites would be surveyed.

Response: We will provide information on those specific procedures and criteria as they are developed. The 10 percent disparity rate is meant to be that of a single survey since it is important to CMS that each supplier is furnishing all of the standards as intended in a quality manner. CMS pays for these validation surveys.

Comment: One commenter requested clarification on how CMS would determine whether an AO was capable

of making ''timely reviews'' under proposed § 414.68(c)(6)(ii).

Response: We would consider an AO to be making timely reviews of suppliers' applications if the accrediting organization presented evidence that it could conduct such reviews in an orderly manner, and that all suppliers' applications would be judged uniformly and fairly, while still meeting the January 1, 2012 statutory deadline.

Comment: Two commenters asked about how AOs would prioritize suppliers in order to meet the January 1, 2012 deadline. The commenters believe that this practice would mean that some suppliers would have a preferential priority. The commenter believes that application processing order should instead be based upon the date the supplier submits its application to the accrediting organization. The commenters went on to state that CMS should inform suppliers of the application requirements so that all suppliers can be accredited by the January 1, 2012 deadline.

Response: While we agree with the commenters regarding education of all suppliers, we believe that the intent of the statute was that beneficiary services not be affected by any supplier not having the opportunity to meet all of the accreditation requirements. We will give guidance to the designated AOs so that there is a timely review of all existing suppliers.

Comment: Two commenters expressed concern over how new suppliers after January 1, 2012 would be able to bill for the TC of advanced imaging if they had not yet been accredited. One commenter wanted CMS to continue to allow those new suppliers the ability to bill up to nine months after January 1, 2012, as long as the new supplier was undergoing part of the accreditation process or received a provisional accreditation.

Response: We do not have the statutory authority to extend the billing privileges past the statutory deadline of January 1, 2012. We believe that there will not be any disruption to beneficiary services, as there are sufficient existing suppliers to furnish the TC of advanced diagnostic imaging services.

Comment: One commenter requested clarification regarding the treatment of suppliers accredited prior to January 1, 2012 as meeting the statutory requirements for accreditation. The commenter stated that the proposed rule could be interpreted to mean that any supplier accredited at any time prior to January 1, 2010 would be considered accredited regardless of their current status which could include their accreditation having previously expired, been revoked, or denied.

Response: Only those suppliers that have a current, unexpired accreditation as of January 1, 2012 will be deemed grandfathered with respect to the January 1, 2012 requirement.

Comment: One commenter requested that CMS require that AOs report not only revoked, withdrawn or revised accreditation decisions, but also include those accreditations that have expired, closed, or ceased providing that modality. The commenter suggested that this report be in an Excel file format and on a daily basis. The commenter also stated that if CMS reviewed copies of all survey materials and corrective action it would overwhelm the agency.

Response: We will require all accreditation decisions to be reported, including revocation and expiration of accreditation. We will require the accrediting organizations to include in their ongoing data the accreditation status of all of their suppliers, which includes the effective expiration dates and any changes to that accreditation status. We generally will not review individual suppliers' survey reports or corrective action plans unless there is a particular reason for us to do so. We will consider the most effective method of data collection.

Comment: One commenter suggested that CMS require a supplier to inform its AO if it ceases providing advanced diagnostic imaging services; to arrange transfer of each patient's medical record to a subsequent receiving supplier; to provide information to patients on how they can obtain their personal medical records; and to comply with any State or local requirements for such a record transfer.

Response: We agree with the commenter and are taking the suggestion. We will require a supplier to assist beneficiaries or their legal representative, in obtaining their records if requested, and notify the supplier's AO of any changes to the modalities being furnished at the time the accreditation decision is made.

Comment: One commenter requested that CMS clarify whether the orientation and in-service requirements in the proposed rule relate to the supplier or the AO. The commenter suggested that CMS should require AOs to direct the orientation and in-service programs toward image quality reviewers and on site surveyors.

Response: We will be reviewing all proposals to make certain that all approved AOs have robust orientation and in-service programs. Those programs should standardize the supplier review process and produce consistent quality surveys in both desk reviews and site surveys.

Comment: Regarding the annual summary data specified by CMS, one commenter suggested the data include the total number of sites and units applied and accredited; pass/fail rates by modality; results of any appeals by modality; number and reasons for any suspensions/revocations of accreditation overall and by modality; number and summary results of on-site surveys over and by category (random, scheduled, targeted and validation); surveyor resources available; any new surveyor training and summary of all complaints overall and by modality, including category and resolution.

Response: We will work with the designated AOs to develop annual reports that meet the needs of our stakeholders and the general public.

Comment: One commenter stated that CMS needs to develop a system for communicating the supplier's accreditation status to the Medicare contractors so that there are no claims denial errors. The commenter suggested the system to be updated on a daily basis. The commenter also suggested CMS institute a vigorous training program for local contractor staff.

Response: We will look into the necessity and feasibility of daily feeds to the contractor. Since CMS already has a comprehensive education program for our contractors, we will use the existing methods for educating all of our contractor staffs.

Comment: One commenter requested clarification regarding what format CMS is proposing to require when AOs provide information to CMS.

Response: We intend the written format to be via electronic submission in most cases. In those cases where Protected Health Information (PHI) needs to be transmitted by the AO, data files will be encrypted.

Comment: One commenter suggested that, instead of CMS instituting a formal re-application process for AOs, CMS could renew an AO's deeming authority on the basis of good standing. CMS could consider the AO's annual report, any validation survey findings, and other ongoing compliance instead of requiring a formal reapplication process. If CMS decided that a formal reapplication process were to be retained, the commenter suggested that CMS follow the precedent set by the Mammography Quality Standards Act (MQSA) for their approved accrediting bodies and set a seven year interval.

Response: We may consider such a suggestion. We do not believe that we would need to publish proposed

rulemaking in order to implement a formal re-application process.

Comment: One commenter asked CMS to clarify whether suppliers would still need to renew their accreditations under the timeframes of their designated AOs from January 1, 2010 to January 1, 2012.

Response: An accredited supplier would still need to renew its accreditation pursuant to the timeframe of its designated AO between January 1, 2010 and January 1, 2012. We believe it was the Congress' intent under section 1834(e)(5) of the Act that all suppliers accredited before January 1, 2010 by an accreditation organization designated on that date, be ''grandfathered'' with respect to the effectiveness of their accreditations. In other words, a supplier accredited by a designated AO as of January 1, 2010 would not need to be reaccredited subsequent to the AO's designation by CMS until the supplier's term of accreditation expired. However, this does not mean that a supplier can let its accreditation lapse between 2010 and 2012. Once a reaccreditation deadline has passed without reaccreditation, the supplier would no longer be considered accredited.

Comment: One commenter stated that CMS needs to consider the administrative time involved in obtaining precertification for Computerized Tomography (CT) of the head, ear, and maxilla facial area when determining the cost of these services. The technician's time involved in performing daily quality control testing to satisfy quality assurance requirements for accreditation and the physician time spent in quality assurance committee meetings to evaluate the images and reports has greatly increased the cost of providing in-office CT imaging. Another commenter stated that operating a certified imaging laboratory with methodology and protocols to the highest standards translates into increased costs for each study.

Response: Based on supplier interviews, maintaining the accreditation requirement has resulted in suppliers having opportunities to work more efficiently and effectively, thereby reducing the overall administrative costs per hour.

Comment: One commenter stated that the anticipated impact of implementation of accreditation standards for suppliers of the TC of advanced diagnostic imaging on family physicians would be minimal. The commenter supported the proposed accreditation requirements.

Response: We thank the commenters for the comment.

Comment: One commenter requested that CMS revise the supervision level requirement for certain CPT codes when these services are performed with assistance by the Registered Radiologist Assistant.

Response: We appreciate the information provided by the commenters as it will assist in understanding the role these individuals play in the provision of imaging services.

f. Other Issues for Consideration

In the proposed rule, we solicited information on the role of radiology assistants (RA) and radiology practitioner assistants (RPA), including the level of physician supervision that would be appropriate when RAs and RPAs are involved in the performance of the TC of advanced medical imaging, whether the role varies by State, and related information.

Comment: Commenters provided information concerning information on the role of radiology assistants and radiology practitioner assistants in the performance of the TC of advanced medical imaging in response to our request.

Response: We appreciate the information provided by the commenters as it will assist in understanding the role these individuals play in the provision of imaging services.

g. Provisions of the Final Rule

After reviewing the public comments, we are finalizing the accreditation provisions of the CY 2010 PFS proposed rule as follows:

- Clarifying that the—

++ Medical directors and supervising physicians are equivalent positions;

++ Equipment used by the supplier must performance specifications;

++ AOs may maintain or adopt standards that are more stringent than those of Medicare;

++ The AOs are required to notify Medicare of the accreditation decision of those suppliers billing Medicare

++ Accreditation requirement does not apply to hospitals; and

++ AO only needs to notify CMS for significant changes from what was approved on the AO's initial approved application.

- Including a requirement that a supplier must assist the beneficiary in obtaining his/her medical records if he/she requests.
- Including a requirement that the supplier must notify the AO of any subsequent changes to the modalities being offered since the accreditation decision was made.
- Clarifying that AOs must respond to complaints from any source with respect to an accredited supplier.
- Changing the regulations text to require that an AO notify CMS of any supplier deficiency putting Medicare beneficiaries in immediate jeopardy within 2 business days (previously 2 calendar days).
- Confirming that when a designated accrediting organization has its deeming authority withdrawn, CMS and the remaining AOs will work together in a collaborative effort to distribute suppliers affected by such withdrawal amongst other accreditations organizations within a reasonable time period.

7. Section 139: Improvements for Medicare Anesthesia Teaching Programs

Section 139 of the MIPPA establishes a special payment rule for teaching anesthesiologists and provides a directive to the Secretary regarding payments for the services of teaching certified registered nurse anesthetists (teaching CRNAs). It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the fee schedule amount (the regular fee schedule rate). These provisions are effective for services furnished on or after January 1, 2010.

a. Teaching Anesthesiologists: Special Payment Rule

The criteria for the payment of teaching anesthesiology services and the special rule for the teaching anesthesiologist are similar to the current criteria for payment of teaching surgeon services and the payment rule for the teaching surgeon involved in overlapping resident cases. Thus, there is a similarity in the payment rules for these physician specialties who work closely together.

(1) Payment for Anesthesia Services Furnished by a Physician

Currently, if the physician, usually an anesthesiologist, is involved in furnishing anesthesia services to a patient, the services can be furnished under one of three different scenarios. The anesthesiologist may—

- Personally perform the anesthesia services alone;
- Be involved in the case as a teaching anesthesiologist with an anesthesia resident; or
- Provide medical direction of the performance of anesthesia services for two, three or four concurrent cases involving a qualified individual (who may be a CRNA, an anesthesiologist

assistant (AA), an anesthesia resident, or a student nurse anesthetist under certain circumstances).

Under the statute and CMS policy, if the anesthesiologist personally performs the anesthesia service alone or is involved in the case as a teaching anesthesiologist with an anesthesia resident, payment for the anesthesiologist's service is made at the regular fee schedule rate.

If the anesthesiologist furnishes medical direction for two, three, or four concurrent anesthesia procedures, then payment for the anesthesiologist's service is made, in accordance with section 1848(a)(4)(B) of the Act, at 50 percent of the otherwise applicable fee schedule amount.

(2) Methodology for Payment of Anesthesia Services

Payment for anesthesia services furnished by a physician is made under the PFS under section 1848(b)(2)(B) of the Act. The methodology for the calculation of the allowable amount is unique to anesthesia services only. Payment is made on the basis of anesthesia base units and time units, calculated from the actual anesthesia time of the case, instead of on the basis of work, PE, and malpractice RVUs. The base unit reflects all activities other than anesthesia time and includes usual preoperative and postoperative visits, the administration of fluids, and blood incident to anesthesia care and monitoring services. Payment for anesthesia services is also based on the anesthesia CF instead of the general PFS CF.

(3) Section 139(a) of the MIPPA

Section 139(a) of the MIPPA adds a new paragraph at section 1848(a)(6) of the Act to establish a ''special payment rule for teaching anesthesiologists''. This provision allows payment to be made at the regular fee schedule rate for the teaching anesthesiologist's involvement in the training of residents in either a single anesthesia case or in two concurrent anesthesia cases furnished on or after January 1, 2010.

(4) Discussion

The Accreditation Council on Graduate Medical Education (ACGME) is a branch of the AMA, and it accredits allopathic residency programs. In order for a hospital to receive Medicare graduate medical education payments for its training programs, the residents must be in an ''approved medical residency program'' Under § 413.75(b), an approved medical residency program is one approved by one of the national organizations listed in § 415.152. One of the national organizations is the ACGME.

ACGME's policies and procedures require that each accredited residency program comply with the institutional requirements and the specialty program requirements. For approved anesthesia residency programs, ACGME requirements for faculty supervision and training of anesthesia residents specify that a faculty member not direct anesthesia at more than two anesthetizing locations in the clinical setting. (See the ACGME Web site at *http://www.acgme.org.*)

Consistent with this requirement, the American Society of Anesthesiologists (ASA) has advised us that, when providing services in two concurrent cases, a teaching anesthesiologist might be engaged in two concurrent anesthesia resident cases, or in two mixed concurrent cases, one a resident case and the other a CRNA or AA case.

The statute applies the special payment rule for teaching anesthesiologists to the single resident case or two concurrent cases involving anesthesia residents as long as the teaching anesthesiologist meets the requirements in sections 1848(6)((A) and 1848(6)(B) of the Act. However, the statute does not directly address a single resident case that is concurrent to another case involving a CRNA, AA, or other qualified individual who can be medically directed. The issue is whether the medical direction payment rules apply to each of these cases or whether an alternative payment policy may apply.

As an alternative to applying the medical direction payment rules to the concurrent mixed cases, we proposed to apply the payment rule for teaching anesthesiologists to the resident case that is concurrent to another case which is paid under the medical direction payment rules. While this represents a broader interpretation, it still limits the applicability of the special payment rule for teaching anesthesiologists to resident cases consistent with the terms of section 139 of the MIPPA. (See 74 FR 33603 for a more detailed discussion of this option.)

Accordingly, we proposed to delete the current regulatory language at § 414.46(e) (which is no longer relevant) and add new language to specify that the special payment rule for teaching anesthesiologists applies to resident cases under the following scenarios:

- The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case);
- The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case); or
- The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules.

Other than the application of the special payment rule for teaching anesthesiologists in the mixed concurrent case described above, we did not propose any other revisions to our medical direction payment policies.

Comment: Commenters supported our interpretation of section 139 of the MIPPA that allows the special payment rule for teaching anesthesiologist to apply if the teaching anesthesiologist is involved in one resident physician case that is concurrent to another case paid under the medical direction payment rules.

Response: We believe this interpretation is consistent with the statute and the ACGMS requirements that allow no more than two residents to be supervised concurrently. Our policy would allow the special teaching rule to apply in mixed concurrent cases, that is, the single resident case that is concurrent to another case not involving a resident that is paid under our medical direction payment rules. We are revising § 414.46 in this final rule with comment period as proposed.

Comment: Some commenters asked if there will be new claims service modifiers created for the teaching anesthesiologist or whether teaching anesthesiologists would continue to us the ''AA'' service modifier. They also asked if the ''GC'' modifier would continue to be used for physician supervision of resident cases.

Response: At this time, we are not creating a new claims service modifier for teaching anesthesiologists, but will inform teaching anesthesiologists to continue to use the ''AA'' modifier if they qualify as the teaching anesthesiologist under the three specific scenarios discussed above. The teaching anesthesiologist should also continue to use the ''GC'' certification modifier. (See Internet Only Manual (IOM) Medicare Claims Processing Manual Chapter 12, Section 50 K., titled Anesthesia Claims Modifiers. This can be found at www.cms.hhs.gov/manuals.)

b. Teaching Anesthesiologists: Criteria for Payment

(1) Criteria for Payment of Teaching Anesthesiologists

As part of the special payment rule established for teaching anesthesiologists, the statute requires that the teaching anesthesiologist is present during all key or critical

portions of the anesthesia procedure involved. In addition, the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.

In the proposed rule, we discussed two options for implement this provision. One option would allow different teaching anesthesiologists in the same anesthesia group practice to be considered the ''teaching physician'' for purposes of being present at the key or critical portions of the anesthesia procedure. This option would permit a teaching anesthesiologist to handoff a key or critical portion of the anesthesia procedure to another teaching anesthesiologist as long as the other anesthesiologist is a member of the same group. Another option presented was to require that only one teaching anesthesiologist must be present during all of the key or critical portions of the procedure, which would effectively permit no handoffs. We proposed to more narrowly interpret the law and require that only one individual teaching anesthesiologist be present during all of the key or critical portions of the anesthesia procedure.

Anesthesiologists, including the ASA, have advised us that it may be common for different members of a teaching anesthesia group to provide the anesthesia service instead of a single teaching anesthesiologist. In the proposed rule, we solicited comments on how continuity of care and the quality of anesthesia care are preserved during handoffs, whether there is an accepted maximum number of handoffs, any industry studies that have examined this issue, what factors contribute to handoffs, and whether there are anesthesia practices that do not use handoffs. A handoff refers to any transfer of care for any period or a terminal transfer between two anesthesia providers during a single anesthesia case.

Comment: The ASA and many of its members stated the reasons for handoffs and their presumed benefits. In general, the commenters remarked that handoffs can improve the efficiency of operating rooms, permit teaching anesthesiologists to use their specialized skills to teach anesthesia residents in certain cases, prevent physician fatigue and error, and improve quality and patient safety.

Several medical organizations objected to our proposal and recommended that we implement the alternative proposal in the proposed rule to permit different anesthesiologists in the same anesthesia group practice to be considered the teaching anesthesiologist for purposes of being present at the key or critical periods of the anesthesia case.

Some commenters discussed handoffs in general and did not specifically tie their comments regarding handoffs to a key or critical period of the teaching anesthesia service.

Some commenters cited a 1982 study in the *Journal of Anesthesiology* (*56:456–461*), titled ''Critical Incidents Associated with Intraoperative Exchanges of Anesthesia Personnel''. This article examined anesthesia practices from four hospitals in Boston, two of which were teaching hospitals. The study examined 1,089 reports of preventable errors and failures associated with anesthesia management. In 28 incidents, the relief anesthesia provider in the handoff discovered an error or cause of an error. Although 70 of the 1089 were associated with substantive negative outcomes, none of these incidents were caused by a relieving anesthetist related to a handoff.

The study noted that ''there is a strong implication that relief is beneficial more often than not even aside from the presumed beneficial effect on the vigilance of the primary anesthetists.'' The study further noted that from the descriptions of the causes and discoveries of errors in these relief-related incidents, guidance can be drawn for the safe and effective conduct of the intraoperative exchange of anesthesia personnel. This article referred to substitutions for short breaks during long surgical procedures. It did not specify whether any of these substitutions took place during key or critical periods of the teaching case.

Based on its study of relief-associated events, the authors suggested the adoption of specific handoff protocols and communication processes to reduce errors. This protocol would address such factors as familiarity with the status of the patient, progress of the surgical procedure, trends in the anesthetic course, significant medical history, anesthesia plan, and arrangement of equipment, apparatus, drugs, and fluids. This is the only study on handoffs that commenters presented.

In its comments, the ASA described the ''SBAR'' protocol, or a variation of it, as the handoff procedure most widely taught and used in anesthesia practices, both academic and private. The SBAR protocol gives physicians a format to follow when initiating handoffs. SBAR is an acronym used to describe four basic requirements for transfer of patient care:

S = Situations: State what is going on with the patient, the type of procedure and when it started

B = Background: Explain clinical background leading up to the situation, including medical history, medications, allergies, anesthetic management (including drugs, fluids, and blood loss, etc.)

A = Assessment: Provide an assessment of the current state of the patient and describe what problems, if any, you think exist.

R = Recommendation: Recommend what you think needs to be done.

According to the ASA, some anesthesia departments have defined written protocols that they follow for handoffs, but many do not because the fundamentals of the handoff process are part of the skill set that is believed to be taught and practiced by all teaching anesthesiologists.

The ASA simply expressed the opinion that the appropriate timing of a handoff is a decision best left to the physicians responsible for the care of the patient. The ASA also stated that to raise the issue of quality in anesthesia handoffs where no issue or evidence exists exceeds CMS's authority in implementing section 139 of the MIPPA. The ASA is supportive of an approach where its members use their judgment to decide when to use handoffs and the necessary information exchanged. The ASA recommended that we implement the payment provision only and leave any issues involving handoffs unexamined.

Response: Despite the existence of the SBAR protocol, it is unclear to what extent teaching hospitals have now developed standardized tools, checklists, clinical practice guidelines, or other techniques to ensure the appropriate exchange of information, including the appropriate type and content of anesthesia information, and the assurance that optimum care occurs during handoffs.

We identified two abstracts to be presented to the ASA later this year that present limited information on handoffs. One study, ''Transfer of Anesthesia Care: Are We Hiding Bad Outcomes?'' by Vilma A. Joseph, M.D., M.P.H., Charles E. Kamen, B.A., Rhonda D. Levine, M.D., Alla Krayman, M.S., and Robert S. Lagasse, M.D. This study showed that of 1740 anesthesia cases without a transfer of care, there were 12 recorded adverse outcomes, while there were zero adverse outcomes in the 132 cases where there was a transfer of care. The other study is: ''Evaluating Safety of Handoffs between Anesthesia Care Providers'' by Rhonda Leopold, M.D., Stuart Hart, M.D., Heather Scuderi

Porter, B.A., and Neil Giovanni, M.D.''. This study pointed out that there are not many tools available for anesthesia care providers to ensure that the transfer of care occurs without error. In 70 completed surveys involving the transfer of care, 34 percent of anesthesia care providers found the current handoff process to be inadequate. The majority did believe that standardization of the process would improve patient care.

There appears to be a limited amount of research on handoffs, and a lack of a detailed, industry-defined process on their use. Commenters did not report widespread use of written protocols by academic facilities.

As noted previously, we think the teaching anesthesiologist payment policy in section 139 of the MIPPA and the handoff issues are separate, but related issues. The handoff issue is a quality of care issue not directly addressed in section 139 of the MIPPA. Therefore, we are implementing the payment provision of section 139 but not finalizing a formal policy on handoffs in this final rule. For future rulemaking, we may consider working with the industry to develop guidelines on handoffs. These guidelines may, among other things, address the content and type of information exchanged during handoffs and whether there should be any limitations on the number of handoffs permitted.

In response to comments, we believe it is appropriate to implement this payment provision consistent with current teaching anesthesia practices and handoff arrangements. Thus, different anesthesiologists in the same anesthesia group practice can be considered the teaching physician for purposes of the statutory requirement that the teaching anesthesiologist be present at the key or critical portions of the anesthesia service. Of course, the criteria for the presence of the teaching physician would also be met if only one teaching anesthesiologist was present during the key or critical periods of the anesthesia service.

We are revising § 415.178 to incorporate our policy that allows either a single teaching anesthesiologist or different teaching anesthesiologists in the same anesthesia group practice to be considered the teaching physician for purposes of being present at the key or critical portions of the anesthesia service.

c. Teaching CRNAs

(1) Payment for Anesthesia Services Furnished by a CRNA

Currently, a CRNA who provides anesthesia services while under the medical direction of an anesthesiologist is paid at 50 percent of the regular fee schedule rate as specified in section 1833(l)(4)(B)(iii) of the Act. A CRNA who provides anesthesia services without the medical direction of a physician is paid the regular fee schedule rate as specified in section 1833(l)(4)(A) of the Act.

(2) Payment for Anesthesia Services Furnished by a Teaching CRNA With a Student Nurse Anesthetist

The legislation that initially directed CMS to establish the CRNA fee schedule (that is, section 9320 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509)) did not address payment for services furnished by teaching CRNAs involved in the training of student nurse anesthetists.

In the preamble to the CRNA fee schedule final rule published in the July 31, 1992 **Federal Register** (57 FR 33888), we stated that we would pay the teaching CRNA who is not medically directed by a physician at the regular fee schedule rate for his or her involvement in a single case with a student nurse anesthetist as long as he or she was present with the student throughout the anesthesia case. No payment would be made if the teaching CRNA divided his or her time between two concurrent cases involving student nurse anesthetists.

In August 2002, based on the recommendations of the American Association of Nurse Anesthetists (AANA), we modified our policy to allow the teaching CRNA not medically directed by a physician to be paid a portion of the regular fee schedule rate for each of two concurrent cases involving student nurse anesthetists. If the teaching CRNA is present with the student nurse anesthetist during the pre- and post-anesthesia care for each of the cases involving student nurse anesthetists, the teaching CRNA can bill the full base units (comprised of pre- and post-anesthesia services not included in the anesthesia time units) for each case and the actual amount of anesthesia time per case. The resulting payment for each of these anesthesia cases is greater than 50 percent, but less than 100 percent, of the regular fee schedule amount because the full base units plus the actual anesthesia time units spent by the teaching CRNA in each of the two cases yields a payment that is greater than 50 percent of the regular fee schedule amount.

(3) Comparison of Payment Policies for Teaching CRNAs and Teaching Anesthesiologists

For several years, the ASA requested that we revise our payment regulations to allow the teaching anesthesiologist to be paid the regular fee schedule amount for each of two concurrent resident cases. In the CY 2004 PFS final rule with comment period (68 FR 63224), we finalized a policy to permit the teaching anesthesiologist to be paid similarly to a teaching CRNA for each of two concurrent resident cases. This policy took effect for services furnished on or after January 1, 2005.

Thus, the payment policy is the same for a teaching CRNA for each of two concurrent student nurse anesthetist cases, and for a teaching anesthesiologist for each of two concurrent resident cases. The policy is that the anesthesia provider is paid the full base units plus time units, based on the actual anesthesia time, relating to each of two concurrent cases.

(4) Payment Policy for an Anesthesiologist, or an Anesthesiologist and CRNA jointly, With a Student Nurse Anesthetist

Currently, there are circumstances where an anesthesiologist may be involved in the training of student nurse anesthetists in two concurrent anesthesia cases. These anesthesia cases are not paid under the teaching anesthesiologist payment policy, but are paid under the usual medical direction payment policy. Payment can be made for the physician's medical direction (that is, 50 percent of the regular fee schedule amount) for each of two concurrent cases.

If an anesthesiologist is medically directing two concurrent cases involving student nurse anesthetists and a CRNA is also jointly involved with the two student nurse anesthetist cases, then the physician service, in each case, can be paid under the medical direction rules at 50 percent of the regular fee schedule. Payment for the CRNA services would also be made at the medically directed rate (that is, 50 percent of the regular fee schedule) for CRNA services, but the time units used to compute the anesthesia fee would be based on the actual time the CRNA is involved in each case.

(5) Section 139(b) of the MIPPA

Section 139(b) of the MIPPA instructs the Secretary to make appropriate adjustments to Medicare teaching CRNA payment policy so that it—

- Is consistent with the adjustments made by the special payment rule for teaching anesthesiologists under section 139(a) of the MIPPA; and
- Maintains the existing payment differences between teaching anesthesiologists and teaching CRNAs.

We proposed to implement the first directive (under section 139(b)(1) of the MIPPA) by establishing a new payment policy for teaching CRNAs that is similar to the special payment rule for teaching anesthesiologists, and to limit applicability of the rule to teaching CRNAs who are not medically directed. We proposed to add a new regulation at § 414.61 to explain the conditions under which the special payment rule will apply and the method for calculating the amount of payment for anesthesia services furnished on or after January 1, 2010, by teaching CRNAs involved in the training of student nurse anesthetists. As proposed, we would pay the teaching CRNA at the regular fee schedule rate for each of two concurrent student nurse anesthetist cases. Our medical direction payment policy would continue to apply if both an anesthesiologist and a CRNA are involved in a student nurse anesthetist case that is concurrent to another medically directed anesthesia case.

We believe the second directive in section 139(b)(2) of the MIPPA will be satisfied as a result of these proposals. Section 139(b)(1) of the MIPPA instructs CMS to make appropriate adjustments to implement a payment policy for teaching CRNAs that is consistent with the special payment rule for teaching anesthesiologists. Section 139(b)(2) of the MIPPA instructs CMS to maintain the existing payment differences between teaching anesthesiologists and teaching CRNAs. There currently are no substantive differences in payment between teaching anesthesiologists and teaching CRNAs, and there would continue to be no such differences under our proposed policies.

Payment for Teaching CRNAs Involved in Anesthesia Cases With Student Nurse Anesthetists

Under current policy, when a CRNA is involved in a single student nurse anesthetist case, the teaching CRNA can be paid at the regular fee schedule rate if the teaching CRNA is present with the student for the pre- and post anesthesia services included in the base units and is continuously present during the anesthesia time of the case. We did not propose any change to this policy.

When the teaching CRNA is involved in two concurrent student nurse anesthetist cases, payment is based on the amount of anesthesia time the teaching CRNA spends with the student in each case. For example, as noted in the proposed rule, if the teaching CRNA spends 40 percent of his or her time in concurrent case #1 and 60 percent of his or her time in concurrent case #2, and the total anesthesia time in both cases is 3 hours (or 180 minutes), then we would currently pay as follows:

- *Case #1:* (Base units + (0.4 × 180/15)) × Anesthesia CF
- *Case #2:* (Base units + (0.6 × 180/15)) × Anesthesia CF

(The base units are explained earlier in section on general anesthesiology payment methodology.)

The current payment policy has been predicated on paying the teaching CRNA for his or her actual time spent in the student nurse anesthetist case. In the CY 2010 PFS proposed rule, we proposed to pay the teaching CRNA at the regular fee schedule rate for his or her involvement in two concurrent cases. To bill the base units for each concurrent case, the teaching CRNA must be present with the student nurse anesthetist during the pre and post anesthesia services included in the anesthesia base units.

If our goal is to minimize the effect of this change on teaching CRNAs' practice arrangements and time devoted to cases, then, as proposed, the teaching CRNA would continue to devote his or her time to the two concurrent anesthesia cases and not be involved in other services. The teaching CRNA would decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status, and other factors.

We note that the Congress did not amend the statutory provisions relating to medical direction at section 1848(a)(4) of the Act. We do not believe the directives at section 139(b) of the MIPPA extend to other arrangements in which an anesthesiologist alone or both an anesthesiologist and CRNA together jointly supervise student nurse anesthetists during concurrent anesthesia cases. Therefore, we did not propose any changes to our current payment policies for anesthesia services furnished under other circumstances. We proposed that when an anesthesia provider (physician or CRNA) furnishes anesthesia services in concurrent cases under other circumstances, the current policies regarding medical direction will continue to apply.

The following is summary of the comments we received regarding section 139 of the MIPPA and teaching CRNAs.

Comment: Commenters supported the proposal to allow teaching CRNAs who are concurrently teaching two student nurse anesthetists to be able to bill the regular fee schedule rate for each anesthesia case involving the student nurse anesthetist. The commenters indicated this change is consistent with the adjustment made under section 139 of the MIPPA for teaching anesthesiologists involved in two concurrent resident cases.

Response: We are adopting our proposal that the teaching CRNA can be paid the full fee for his or her involvement in each of two concurrent cases involving student nurse anesthetists. While we are adopting this policy, we are concerned that it did not specifically address the availability of another anesthesia provider for the periods of concurrency for student nurse anesthetists. (In the case of teaching anesthesiologists and residents, section 139 specifically requires that the teaching anesthesiologist or another anesthesiologist with whom the teaching anesthesiologist has an arrangement is immediately available to furnish anesthesia services during the entire procedure.)

Subsequent to issuing the proposed rule and receiving comments, we learned more about the supervision requirements for student nurse anesthetists. According to the AANA, the standards of the Council on Accreditation of Nurse Anesthesia Programs address supervision of student nurse anesthetists in anesthesia cases. These standards require that in any case involving a student nurse anesthetist, including concurrent cases, a qualified anesthesia provider (CRNA or anesthesiologist) must be present and immediately available in the anesthetizing locations.

Furthermore, according to these standards, the qualified individual must be physically present in the area and immediately available for the student to summon for clinical assistance should it be required. As a result, if one teaching CRNA were temporarily occupied, another qualified anesthetist would respond.

Based on information received and in response to comments, we are requiring that the teaching CRNA be present during the case with the student nurse anesthetist. For periods of concurrency for two student nurse anesthetist cases, we are requiring that another anesthesia provider is available and can fulfill the requirements of the AANA standards.

Comment: Some commenters requested that we establish the same policy specified in section 139(a) of the MIPPA for teaching anesthesiologists

involved in two concurrent resident cases for situations where an anesthesiologist medically directs two concurrent student nurse anesthetists cases. The commenters stated that this would establish payment equity between teaching anesthesiologists and teaching CRNAs and not encourage anesthesiologists to select residents over student nurse anesthetists where the hospital has both types of anesthesia providers.

Response: We understand the commenters' concern and agree that their proposal would establish parity of payment in certain respects. However, in the proposed rule, we noted that the Congress did not amend the statutory provision relating to medical direction at section 1848(a)(4) of the Act. We do not believe the directives at section 139(b) of the MIPPA extend to arrangements in which anesthesiologists supervise two student nurse anesthetists during concurrent cases. While the anesthesiologist may engage in a teaching situation with a student nurse anesthetist, this does not constitute a teaching anesthesiologist relationship as conceived in the statute. The term ''teaching anesthesiologist'' as used in the Medicare statute refers to a teaching physician involved with a physician resident. Therefore, we will maintain our current policy that when an anesthesiologist is involved in two concurrent cases with student nurse anesthetists, the medical direction rules will apply.

Additionally, if we were to consider paying each student nurse anesthetist case at the regular fee schedule amount, it would be unclear what payment criteria would apply for the physician service. The teaching anesthesiologist criteria in section 139(a) of the MIPPA apply only to physician resident cases and not to student nurse anesthetist cases. It also does not seem appropriate to pay the regular fee schedule rate if the services fall within the terms of the statutory provision addressing medical direction under which the anesthesiologist is paid at 50 percent of the regular fee schedule rate. Therefore, we believe the most appropriate course is to maintain our current policy.

Comment: Commenters also requested that, in medical direction cases where there are two concurrent student nurse anesthetists directed by the anesthesiologist and one CRNA covering both student nurse anesthetist cases, that each medically directed CRNA service be paid at the usual medically directed rate or 50 percent of the anesthesia fee schedule.

Response: We make payment at 50 percent of the regular fee schedule amount for the physician who is medically directing the CRNA. We also make payment at 50 percent of the regular fee schedule amount for the service of the CRNA who is involved continuously with the patient in the administration of the anesthesia service. In the anesthesia scenario described in the comment, the student nurse anesthetist can be medically directed but payment cannot be made for the student nurse anesthetist service because he or she is not a qualified CRNA. If the CRNA is involved in two concurrent cases with the student nurse anesthetist, then we do not believe it would be reasonable to pay the usual medical direction fee for the CRNA service because the CRNA is not with the student throughout the case. We are finalizing the policy we proposed that the payment for the CRNA service would be made under the medical direction rules at 50 percent of the regular fee schedule amount, but that the time units used to compute the anesthesia fee would be based on the actual time the CRNA is involved in the case.

Comment: One commenter requested that CMS provide parallel rules for payment involving handoffs for all anesthesia providers, both teaching anesthesiologists and teaching CRNAs. Specifically, the commenter requested that CMS define anesthesia handoffs as the responsibility for care clearly transferred from one qualified anesthesia provider to the next; that handoffs are allowed for all portions of an anesthesia case; and that CRNAs be treated equitably as anesthesiologists.

Response: We addressed handoffs for teaching anesthesiologists in conjunction with our interpretation of the specific provision in section 139 of the MIPPA for coverage of teaching anesthesiologists with residents. We did not address handoff rules for teaching CRNAs. Because we made no proposal on this subject, we are not implementing the commenters' suggestion at this time.

Comment: A commenter requested that we establish a different payment modifier for teaching CRNAs to use for billing purposes when teaching student nurse anesthetists in single or concurrent cases. Currently, teaching CRNAs bill these services using the ''QZ'' modifier which is the same modifier they would use if they furnished the service alone. A new payment modifier would allow for differentiation in the claims processing system between the non-medically directed CRNA cases with student nurse anesthetists and those without the involvement of student nurse anesthetists.

Response: For the present, we will continue to use the existing claims modifier but will give consideration to whether a different modifier is needed to distinguish teaching CRNA cases from cases performed by a CRNA alone.

Comment: A commenter asked if the anesthesia teaching rules apply to an anesthesiologist assistant (AA). The services of AAs can be paid under the CRNA medical direction payment rules, but AAs must work under the supervision of an anesthesiologist.

Response: Our proposal applies only to teaching CRNAs who supervise student nurse anesthetists or to an anesthesiologist who provides medical direction for two concurrent cases involving student nurse anesthetists. It does not apply to AAs.

8. Section 144(a): Payment and Coverage Improvements for Patients with Chronic Obstructive Pulmonary Disease and Other Conditions—Cardiac Rehabilitation Services

Section 144(a) of the MIPPA amended Title XVIII of the Act, in pertinent part, to establish the benefit of cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) under Medicare Part B. The statute specifies certain conditions for these programs, with an effective date of January 1, 2010. The addition of the new CR and ICR programs is designed to improve the health care of Medicare beneficiaries with cardiovascular disease. This final rule with comment period implements these MIPPA provisions in order to ensure CR and ICR programs enhance the patient's clinical outcomes.

a. Background

Intensive cardiac rehabilitation (ICR) is a relatively new practice that is also commonly referred to as a ''lifestyle modification'' program. These programs typically involve the same elements as CR programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of CR and may be more rigorous.

b. Cardiac Rehabilitation Coverage Under Medicare

One mechanism we use to establish coverage for certain items and services is the national coverage determination (NCD) process. An NCD is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under Title XVIII.

Since 1982, Medicare has covered, under an NCD, cardiac rehabilitation for patients who experience stable angina, have had coronary artery bypass grafts, or have had an acute myocardial infarction within the past 12 months. The NCD is located in the Medicare NCD Manual (Pub. 100–03), section 20.10. Effective March 22, 2006, we modified the NCD language to cover comprehensive cardiac rehabilitation programs for patients who experience one of the following:

- A documented diagnosis of acute myocardial infarction within the preceding 12 months.
- A coronary bypass surgery.
- Stable angina pectoris.
- A heart valve repair/replacement.
- A percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.
- A heart or heart-lung transplant.

Comprehensive programs must include a medical evaluation, a program to modify cardiac risk factors, prescribed exercise, education, and counseling and may last for up to 36 sessions over 18 weeks or no more than 72 sessions over 36 weeks if determined appropriate by the local Medicare contractors. Facilities furnishing cardiac rehabilitation must have immediately available necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment and be staffed with personnel necessary to conduct the program safely and effectively who are trained in advanced life support techniques and exercise therapy for coronary disease. The program must also be under the direct supervision of a physician. Until section 144(a) of the MIPPA is effective on January 1, 2010. ICR programs are covered under this NCD and are subject to the same coverage requirements.

c. Statutory Authority

Section 144(a) of the MIPPA amended the Medicare Part B program by adding new sections 1861(s)(2)(CC) and 1861(s)(2)(DD) of the Act to include items and services furnished under a new benefit referred to as a ''cardiac rehabilitation program'' and an ''intensive cardiac rehabilitation program,'' respectively. A cardiac rehabilitation program is defined in new section 1861(eee)(1) of the Act and an intensive cardiac rehabilitation program is defined in new section 1861(eee)(4)(A) of the Act.

A cardiac rehabilitation program is a physician-supervised program that furnishes the following: physician-prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; outcomes assessment; and other items or services as determined by the Secretary under certain conditions. These items and services must be furnished in a physician's office, in a hospital on an outpatient basis, or in other settings as determined appropriate by the Secretary. A physician must be immediately available and accessible for medical consultation and emergencies at all times items and services are being furnished in a CR program except when provided in a hospital setting where such availability is presumed. The items and services furnished by a CR program are individualized and set forth in written treatment plans that describe the patient's individual diagnosis; the type, amount, frequency, and duration of items and services furnished under the plan; and the goals set for the individual under the plan. These written plans must be established, reviewed, and signed by a physician every 30 days.

An ICR program provides the same items and services under the same conditions as CR programs but must demonstrate, as shown in peer-reviewed published research, that they have accomplished one or more of the following: positively affected the progression of coronary heart disease, or reduced the need for coronary bypass surgery, or reduced the need for percutaneous coronary interventions (PCIs). The peer-reviewed published research must also show that the ICR program has resulted in a statistically significant reduction in 5 or more measures from their levels before ICR services to their levels after receipt of such services. These measures include low density lipoprotein; triglycerides; body mass index; systolic blood pressure; diastolic blood pressure; or the need for cholesterol, blood pressure, and diabetes medications. Beneficiaries eligible for ICR must have experienced the following: an acute myocardial infarction within the preceding 12 months; a coronary bypass surgery; current stable angina pectoris; a heart valve repair or replacement; a percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or a heart or heart-lung transplant. Section 1861(eee)(4)(C) of the Act, as added by section 144(a)(1)(B) of the MIPPA, states that an ICR program may be provided in a series of 72, 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

The statute authorizes the Secretary to establish standards for the physician supervising the ICR and/or CR programs to ensure that the physician has expertise in the management of individuals with cardiac pathophysiology and is licensed by the State in which the CR program (or ICR program) is offered. These standards ensure that the physician is responsible for the program and, in consultation with appropriate staff, is involved substantially in directing the progress of individuals in the program.

d. Provisions of the Proposed Regulation

We proposed to add § 410.49, ''Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage'' to our regulations.

Below is a summary of what we proposed for the new ICR and CR benefit in the proposed rule. (To read the proposed rule in its entirety, see the CY 2010 PFS proposed rule (74 FR 33606 through 33610, and 33675 through 33676.)

We proposed definitions with respect to the programs and services related to CR and ICR programs.

We listed the cardiac-related conditions for which CR and ICR items and services are eligible for coverage under this new benefit. We received several comments to add other conditions unrelated to cardiac conditions and will address those comments in section II.G.8.e. below.

We proposed that CR and ICR programs may only be provided in a physician's office or a hospital on an outpatient basis. Any additional settings will be added through future rulemaking.

We proposed that only a physician as defined in section 1861(r)(1) of the Act may establish the written individualized treatment plan, review the plan and update that plan. We received a few comments on this provision, specifically requesting that staff other than the physician should be able to update the plan. We address those comments in the section II.G.8.e. of this rule.

We proposed components of the CR and ICR program. All of the items and service related to the ICR and CR programs must be individualized to the beneficiary and delivered as part of the CR and ICR program. Any additional mandatory items and services will be added through future rulemaking.

We defined outcomes assessment as an evaluation of the patient's progress in the program using assessments from the commencement and conclusion of CR and ICR programs that are based upon patient centered outcomes. We also outlined the timing of when the patient centered outcomes must be measured—at the beginning of the CR and ICR program, prior to each 30-day review of

the individualized treatment plan, and at the end of the CR and ICR program.

Based on the outcomes assessment, the beneficiaries' plan of care should be updated as needed to ensure that the beneficiary continues to receive appropriate items and services based on his or her clinical needs.

We proposed the number of sessions that may be provided to a beneficiary participating in a CR program. The number of sessions that may be provided as part of an ICR program were specifically set forth in the statute and were included in the proposed rule as well.

We requested comments for specific physician standards that should be required to ensure that the physician is qualified to supervise the CR and ICR program. In addition to requesting comments for physician standards, we discussed two physician roles in the CR and ICR programs.

- Medical director: The physician who oversees or supervises the CR and ICR program at each site and who has expertise in the management of patients with cardiac pathophysiology. This person must be involved substantially in directing the progress of individuals in the program.
- Supervising physician: A physician that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished under the CR and ICR program. This physician must also have expertise in the management of individuals with cardiac pathophysiolgy.

We have added definitions for the medical director and supervising physician to the regulations text and discuss these additions in section II.G.8.f. of this final rule with comment period.

We noted in the proposed rule that physician supervision of the program is limited to a physician who is the program medical director or a program staff physician serving as the supervising physician. This person must be a physician as defined in section 1861(r)(1) of the Act and not another CR or ICR staff member.

We proposed that the statutorily-required ongoing physician availability for medical consultations and medical emergencies would be met through existing definitions for direct physician supervision in physicians' offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross references to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. We stated that direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because the physician must be present and immediately available where the services are being furnished. The physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For CR and ICR services provided in physicians' offices and other Part B settings paid under the PFS, we proposed that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service or procedure in accordance with the § 410.26(b)(5) as described in § 410.26(a)(2) of this subpart (defined through cross references to § 410.32(b)(3)(ii) of this subpart). This does not mean that the physician must be in the room when the service or procedure is performed.

For CR and ICR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We stated that we currently define and specify the requirement for direct supervision for services furnished in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is furnished. We also noted that if we were to propose future changes to the physician office or hospital outpatient policies for direct physician supervision, we would provide our assessment of the implications of those proposals for the supervision of cardiac rehabilitation services at that time. We note that in the CY 2010 OPPS/ASC proposed rule (74 FR 35362 through 35370), we proposed changes to the policy for direct physician supervision of hospital outpatient therapeutic services. We have addressed the application of the proposed and final hospital outpatient physician supervision policies in section II.G.8.e. below.

The MIPPA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption relating to direct physician supervision for hospital outpatient services means that direct physician supervision is the standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals, and we expect that hospitals are providing services in accordance with this standard.

We received the majority of the comments on the above supervising physician provision and have addressed those in section II.G.8.e. of this final rule.

In our proposal, we noted that the program medical director may fulfill both roles of medical director and supervising physician (of individual CR and ICR services furnished to patients) provided that the requirements for direct physician supervision as required in § 410.26 and § 410.27 are met when CR or ICR items and services are furnished, as discussed above.

In addition to the CR requirements, section 1861(eee)(4) of the Act requires ICR programs to meet several additional standards. To become qualified, an ICR program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following: (1) Positively affected the progression of coronary heart disease; (2) reduced the need for coronary bypass surgery; or (3) reduced the need for percutaneous coronary interventions (PCIs). A qualified ICR program must also demonstrate through peer-reviewed published research that the ICR program accomplished a statistically significant reduction for patients in 5 or more specific measures from the individual's levels before ICR services to their levels after receipt of such services. These measures include: (1) Low density lipoproteins; (2) triglycerides; (3) body mass index; (4) systolic blood pressure; (5) diastolic blood pressure; and (6) the need for cholesterol, blood pressure, and diabetes medications. To ensure that ICR programs meet these standards, we proposed that ICR programs apply to CMS to receive approval as a qualified ICR programs. Only approved programs would be eligible for Medicare coverage and would be required to undergo regular re-evaluation to maintain such status. We did not propose any specific approval process(es), but requested comments on what process should be adopted by CMS. No comments were received advocating for any specific process(es), but we did receive comments requesting that any process adopted must allow public input and be open and transparent. We have

addressed these comments and the ICR approval process in section II.G.8.e. of this final rule.

e. Analysis of and Response to Public Comments

We received over 100 public comments. Many were supportive of our proposals to establish CR and ICR rules. Most comments also addressed several of the proposed provisions in the rule. The following is a summary of the issues and our responses.

Comment: Regarding the application of the direct physician supervision requirement to hospital outpatient services, many commenters noted that the CY 2010 PFS proposed rule cited references to the current regulations in § 410.27(f), while the CY 2010 OPPS/ASC proposed rule proposed several new policies for the direct supervision of hospital outpatient therapeutic services. The commenters requested that CMS clarify that for hospital outpatient services, the proposed definitions and policies would apply.

Response: We understand the commenters' concerns and requests for clarification and have attempted to clarify the direct physician supervision requirement below. The proposed general policies for the direct supervision of hospital outpatient therapeutic services would apply to CR and ICR services furnished to hospital outpatients, with the exception of the required credentials of the supervising practitioner, as specifically discussed in the CY 2010 OPPS/ASC proposed rule for CR and ICR services. Consistent with section 1861(eee)(2)(B) of the Act, a physician must be the supervising practitioner for CR and ICR services in a hospital setting. The final policies for payment and direct physician supervision of CR and ICR services furnished to hospital outpatients are discussed in detail in section XII.B.3. through 4. of the CY 2010 OPPS/ASC final rule with comment period.

Comment: Several commenters requested that CMS allow NPPs to satisfy the physician supervision requirements for CR and ICR services. The commenters stated that the proposal in the CY 2010 OPPS/ASC proposed rule would allow certain NPPs (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse-midwives) to provide direct supervision of services which they may perform themselves within their State scope of practice and hospital-granted privileges and following all other requirements. The commenters concluded that CMS should not exclude CR and ICR services from this new policy.

Response: We understand the commenters' concern regarding allowing NPPs to satisfy the physician supervision requirement. We cannot adopt this request because the statutory language of the MIPPA defines both cardiac rehabilitation and intensive cardiac rehabilitation as ''physician-supervised'' programs. A physician is defined in section 1861(r)(1) of the Act. The MIPPA also specifically requires that ''a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program * * *;'' The text of the statute uses the word ''physician'' and does not include NPPs. We believe, based on the statutory language in MIPPA and the statutory definition of physician, that the statute does not provide us the flexibility to allow the supervising role to be filled by a non-physician practitioner. In other words, for the purposes of the CR and ICR programs, whether furnished in a physician's office, hospital outpatient setting or other Part B setting, the direct physician supervision definition applies only to a physician as defined in section 1861(r)(1) of the Act.

Comment: Several commenters requested that CMS remove the requirement from § 410.49(f) for patients to participate in a minimum of 2 CR sessions per week. The comments noted that such a requirement is not supported by specific published evidence and that many patients benefit from fewer than 2 sessions of CR per week. In addition, patients who have difficulty attending CR (due to long traveling distance, limited access to transportation, etc.) may not be able to attend 2 sessions per week and should not be prohibited from participating in CR because of transportation barriers.

Response: We understand and agree with these concerns and have removed from § 410.49(f) the requirement for patients to participate in a minimum of 2 CR sessions per week, as improved outcomes have been demonstrated in patients who participate in fewer than 2 CR sessions each week.

Comment: Many commenters also recommended that CMS revise the time period over which patients are eligible for CR services. The commenters suggested that we allow coverage for CR services for up to 36 sessions over 36 weeks. Additional commenters requested that we remove a provision that enabled Medicare contractors to extend coverage to up to 72 sessions.

Response: We agree with the comments requesting coverage for 36 sessions over 36 weeks. We have removed the requirement for CR patients to participate in a minimum of 2 CR sessions each week, and we have revised proposed § 410.49(f) to allow up to 36 sessions over 36 weeks. While the proposal to cover up to 36 CR sessions over up to 18 weeks was reasonable and consistent with the NCD, we agree that improved outcomes have been demonstrated in patients who participate in as little as one CR session per week.

We disagree with the suggestion that we remove contractor discretion under section 1862(a)(1)(A) of the Act to approve additional sessions of CR. As noted in the background, the statute required that CR programs be highly individualized and structured to meet an individual's needs. The programs are directed by physicians with expertise in cardiac pathophysiology. Our experience has been that not all patients require, and not all supervising physicians support, additional sessions for all beneficiaries. While some patients may continue to benefit from additional sessions, we believe that beneficiaries and the Medicare program will be best served if the 36 additional CR sessions are approved by local Medicare contractors based on each individual patient's specific circumstances. Therefore, we have changed the final rule to allow coverage of up to 36 CR sessions for up to 36 weeks and with the option for Medicare contractors to approve an additional 36 sessions over an extended period of time. The amount of additional time is determined by the Medicare contractor.

Comment: Various commenters requested that we use the term ''comprehensive cardiac rehabilitation'' rather than ''general cardiac rehabilitation'' when referring to CR programs (as opposed to ICR programs). Other commenters request that CMS not use the term ''intensive cardiac rehabilitation'' when referring to lifestyle modification programs as such a term implies that these programs are more effective than CR programs.

Response: We understand the confusion regarding the terminology used to describe CR and ICR, but do not agree with the public comments recommending that we use different terminology. We used the adjective ''general'' for ''cardiac rehabilitation'' in the preamble and some sections of the proposed rule to try to distinguish CR programs from ICR programs for the benefit of the reader. We accept the commenter's premise that a different adjective could have been used for that purpose. In the final regulation text in § 410.49(a), we removed the adjective ''general.'' We are not adopting the recommendation to change the adjective

to ''comprehensive'' cardiac rehabilitation. We believe that term may be even more confusing given the existence of the separate ''intensive cardiac rehabilitation'' definition in § 410.49(a). In order to avoid any confusion caused by an adjective, we will describe the benefit in section 1861(eee)(1) of the Act as ''cardiac rehabilitation.'' We will amend the regulation in § 410.49(f) to eliminate the adjective ''general.'' We disagree with commenters that suggested that the term ''intensive cardiac rehabilitation'' should not be used. Intensive cardiac rehabilitation was the term specifically used in the MIPPA and added in section 1861(eee)(4) of the Act. In addition to the regulatory text changes, the preamble of the final rule refers to ''cardiac rehabilitation'' and ''intensive cardiac rehabilitation.''

Comment: Some commenters expressed confusion or suggested the need for clarification regarding the process by which ICR programs become approved by CMS and how individual sites wishing to furnish ICR items and services are able to participate. Other commenters disagreed with our proposal. Some commenters stated that establishing a process for ICR program approval should include stakeholder involvement and should not result in significant administrative costs. These commenters also insisted that the process be clear and concise so that all stakeholders know how to become approved as an ICR program or site.

Response: We agree with many of the points offered by the commenters and are clarifying the process for the approval of ICR programs and the specific sites furnishing these new part B services. Based on the comments we received, we are using the NCD process to determine whether an ICR program meets the statutory requirements set forth in section 1861(eee)(4) of the Act. The NCD process, as authorized by section 1862(l) of the Act, is open, transparent, and provides an opportunity for public comments on a proposed national coverage determination (NCD). The NCD process is a well known process; therefore, stakeholders know what to expect when we open an NCD to review an ICR program. In addition to using the NCD process to determine whether ICR programs fall within the scope of the new Part B benefit, this final rule with comment period clarifies the distinct roles of an ICR approved program and the individual sites that would provide the ICR items and services. An ICR program is a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements. By statute, an ICR program must demonstrate by peer-reviewed published research that the program satisfies specific metrics. We typically consider and review peer-reviewed published literature through the NCD process. An ICR site, on the other hand, is a hospital outpatient setting or physician's office that is providing intensive cardiac rehabilitation utilizing an approved ICR program. For purposes of appealing an adverse determination, an ICR site is considered a supplier (or prospective supplier) as defined in § 498.2.

In this final rule with comment period, we are requiring that all ICR programs be approved through the NCD process. The NCD process will review each ICR program based on peer-reviewed published research, to ensure the program (or programs) under evaluation demonstrates that it satisfies the specific standards set forth in section 1861(eee)(4) of the Act. This process will involve at least one 30-day public comment period at which time the public may comment on the proposed decision. We believe this process allows for significant stakeholder involvement and is open and transparent, consistent with the commenters' request. Once we have approved an ICR program or programs through the NCD process, individual sites wishing to furnish ICR items and services via an approved ICR program may enroll with their local Medicare contractor to become an ICR program supplier as outlined in § 424.510.

We note that this enrollment process will ensure that specific sites meet the remaining statutory and regulatory requirements needed to furnish ICR services and provide a mechanism to appeal an adverse determination. With regards to billing and payment of CR and ICR services, physician office suppliers and hospital providers will continue to use their CMS Certification Number (supplier or provider number) and appeals related to the payment of claims will follow those separate processes.

Comment: Several commenters expressed opposition to the proposed requirement for all ICR programs to request and receive approval as a CMS approved ICR program based on peer-reviewed published research demonstrating that the program accomplishes specific outcomes.

Response: We do not agree with public commenters who oppose the provision requiring approval of all ICR programs. We believe that the statute requires ICR programs to be evaluated based on peer reviewed published research. The only way we are able to ensure that ICR programs are demonstrating these outcomes and that ICR sites are eligible for payment as required by the MIPPA is by reviewing the program using peer reviewed published research. We agree that the process adopted by CMS to review ICR programs must include public input and the NCD process will provide an opportunity for public participation. The NCD process may be internally generated by CMS or requested by an external party. ICR programs evaluated through an internally generated NCD are not required to submit peer-reviewed published research, as CMS identifies relevant research during the evidence review process. ICR programs that submit an NCD request, should submit the peer-reviewed published research upon which they are requesting approval. Specific information on the NCD process is available in the **Federal Register** notice (68 FR 55634).

Once ICR programs are approved through the NCD process, individual sites wishing to furnish ICR services must enroll with their local Medicare contractors. The ICR sites will be required to demonstrate that they meet the remaining regulatory and statutory requirements relating to state licensure, expertise in the management of individuals with cardiac pathophysiology, cardiopulmonary training, and certification in basic life support and advanced cardiac life support. By requiring enrollment via a local Medicare contractor as a supplier, a prospective ICR site would be entitled to appeal rights as outlined in 42 CFR part 498 if a site is not approved as meeting those standards. As noted above, this enrollment does not affect reporting and payment of CR and ICR services furnished by the hospital provider in the hospital outpatient setting. A hospital's enrollment as an ICR site ensures a separate appeal right related to the ICR site approval.

Comment: Several commenters recommended that we remove the requirement for ICR programs seeking approval to submit peer-reviewed published research in order to achieve approval. The commenters stated that most sites where ICR services are furnished do not publish their own data and should not have to collect voluminous data in order to become approved if the program is modeled after another program for which research has been published.

Response: We agree that individual sites furnishing ICR services are not required to submit data specific to the

site. It was not our intent to require each site where ICR items and services were being furnished to submit peer-reviewed published research specific to their site. Rather we intended, and have further clarified in this final rule with comment, that we will evaluate peer-reviewed published research to approve ICR programs through the NCD process. The peer-reviewed published research required for CMS approval as an ICR program is not a requirement of the individual ICR sites. Peer-reviewed published research submission is only a requirement of the ICR programs being reviewed for CMS approval via the NCD process. We are amending § 410.49(c)(3) to eliminate the need for reporting site specific outcome data.

Comment: Several commenters requested that we include additional indications for coverage of CR and ICR services. One commenter requested coverage for patients diagnosed with diabetes, breast cancer, prostate cancer, and metabolic syndrome. Another commenter requested coverage for patients with heart failure, peripheral artery disease, type 2 diabetes, high blood pressure, metabolic syndrome, post breast cancer treatment, and watchful waiting for prostate cancer.

Response: We do not agree that CR and ICR services should be covered for these non-cardiac patient populations. Extending ICR to other illnesses would appear to require additional legislation. We do not agree, based on currently available evidence, that coverage of CR should be expanded to include heart failure patients. If we determine based on supportive evidence that coverage for CR should be expanded to additional cardiac patient populations, such a decision will be made through an NCD.

Comment: Numerous commenters requested that CMS completely remove the requirement for the CR medical director to ''review and sign the plan prior to initiation of CR'' for all CR patients. The commenters state that such a requirement requires the medical director to review each patient's medical record to determine if the referring physician's treatment plan is appropriate and such a review is ''completely unrealistic, unnecessary, potentially costly and could prevent patients from receiving their therapy in a timely manner.''

Response: We do not agree with the public comments requesting that we remove the requirement for a physician to review and sign patients' treatment plans. We have clarified at § 410.49(b)(2)(v) that the treatment plan must be signed by a physician. We also note the importance of ensuring that the medical director and all CR and ICR staff are familiar with the treatment plan and any changes to the treatment plan. While the medical director is not required to scrutinize each patient's medical record, he or she should be aware of the patient's conditions and progress through the program. As the medical director is responsible for the program as a whole, he or she should at least be knowledgeable of each patient's progress through CR or ICR.

Comment: Several commenters requested that we establish clear, concise practice guidelines for practitioners to follow. We received numerous comments addressing qualifications for CR and ICR program medical directors, supervising physicians and support staff. Many commenters referred to the American Heart Association (AHA)/American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) description of medical director duties and levels of expertise as preferred guidelines and other comments stressed the importance of administration and management experience for the medical director. Guidelines released by the AHA/AACVPR were also cited with respect to standards for supervising physician(s) and support staff. Commenters suggested that CR and ICR staff be certified in Basic Life support (BLS) and meet performance measures identified by the AACVPR. Other commenters recommended that all staff maintain current cardiopulmonary resuscitation (CPR) certification and advanced cardiac life support (ACLS) certification and automated external defibrillator (AED) training. Commenters also requested that CMS stress the importance of incorporating a multidisciplinary staff in CR and ICR programs.

Response: We understand the commenters' requests and recommendations. In the proposed rule, we solicited comments on whether we should adopt practice guidelines and if so what guidelines should be adopted. We did not receive any comments on specific guidelines CMS should adopt besides the AHA/AACVPR guidelines discussed in the preamble of the proposed rule. While those guidelines are encouraged for CR and ICR programs and sites, we are not mandating that those guidelines be used in this final rule with comment period. Instead we have required in § 410.49(d) and (e) that in addition to the statutory required qualifications, the medical director and supervising physician(s) must have cardiopulmonary training in basic life support or advanced cardiac life support.

Comment: Commenters requested that we recognize registered dietitians and occupational therapists as part of the CR and ICR multidisciplinary team.

Response: We agree that these professionals may be part of the multidisciplinary team working with CR and ICR patients during CR and ICR sessions. While they may comprise part of the CR and ICR support staff, they may not supervise sessions or bill separately for services furnished during CR or ICR sessions. For more information on payment issues, see section II.G.8.g. of this final rule with comment period.

Comment: Some commenters requested that we remove the requirement for CR and ICR patients to participate in aerobic exercise during every CR or ICR session.

Response: We understand these commenters' concerns but believe these commenters misunderstood the aerobic exercise requirement. In the proposed rule, (§ 410.49(b)(2)(i)), we proposed to require patients to participate in aerobic exercise each day CR and ICR services are furnished. If patients participate in more than one CR or ICR session in a single day, then they are required to exercise aerobically in one, but not every, session.

Comment: Several commenters requested that we revise the language addressing outcomes assessments to recognize that some patient-centered outcomes will not demonstrate measurable changes within a 30-day period and should not be measured as frequently as every 30 days.

Response: We agree with these commenters that certain outcomes measures may not change significantly in a 30-day period and will allow CR and ICR programs flexibility with respect to what outcomes must be measured every 30 days. Measurement of outcomes that typically exhibit no or minute changes during a 30-day period is not required.

f. Provisions of the Final Regulation

This final rule maintains and refines coverage for CR for beneficiaries with the six conditions as originally established in Pub. 100–03, section 20.10 as this coverage was determined to be reasonable and necessary under section 1862(a)(1)(A) of the Act due to a high level of supporting clinical evidence. We may use the NCD process in the future if necessary to identify additional medical indications for cardiac patients who could obtain CR under Medicare Part B.

In § 410.49(a), we provide definitions of key terms used in this section. Most of the key terms received no comments

and our final rules are identical to the proposed definition terms for: (1) Cardiac rehabilitation; (2) individualized treatment plan; (3) outcomes assessment; (4) physician; (5) physician-prescribed exercise; and (6) psychosocial assessment. We have changed the term intensive cardiac rehabilitation to intensive cardiac rehabilitation program, but maintained the original definition, in order to delineate between ICR programs and ICR program sites in § 410.49(a).

We have added the following terms and definitions to § 410.49(a):

- Intensive cardiac rehabilitation program site which means a hospital outpatient setting or physician's office that is providing intensive cardiac rehabilitation utilizing an approved ICR program.
- Medical director which means a physician that oversees or supervises the cardiac rehabilitation or intensive cardiac rehabilitation program at a particular site.
- Supervising physician which means a physician that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished to individuals under cardiac rehabilitation and intensive cardiac rehabilitation programs.

In § 410.49(b), we set forth the general rules for covered beneficiary rehabilitation services and describe the required components of the program. The covered patient populations remain unchanged and include beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months.
- A coronary artery bypass surgery.
- Current stable angina pectoris.
- Heart valve repair or replacement.
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.
- A heart or heart-lung transplant.

We are changing the final indication to include ''cardiac'' when discussing other conditions that may be considered for coverage. The final indication states, for cardiac rehabilitation only, other cardiac conditions as specified through a national coverage determination.

The required components of cardiac rehabilitation programs remain unchanged, but we have clarified that the individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

In § 410.49(c), we establish the specific standards that ICR programs must meet. We have clarified how an ICR program will be evaluated through the NCD process, and how specific ICR sites will be evaluated to ensure those entities meet the regulatory requirements.

In order to utilize a clear and transparent process for approving ICR programs, the programs will be evaluated through the NCD process to determine if each program demonstrates through peer-reviewed published research that it has accomplished one or more of the following for its patients:

- Positively affected the progression of coronary heart disease.
- Reduced the need for coronary bypass surgery.
- Reduced the need for percutaneous coronary interventions.

ICR programs must also demonstrate through peer-reviewed published research a statistically significant reduction in 5 or more of the following measures for patients from their levels before CR services to after CR services:

- Low density lipoprotein.
- Triglycerides.
- Body mass index.
- Systolic blood pressure.
- Diastolic blood pressure.
- The need for cholesterol, blood pressure, and diabetes medications.

Individual sites wishing to furnish ICR items and services through an approved ICR program must enroll with their local Medicare contractor as an ICR program site. An ICR site will be considered a supplier or putative supplier for purposes of the appeals process in 42 CFR part 498 related to the approval of the ICR site.

In § 410.49(d), we list the specific standards that physicians must meet to be a medical director or supervising physician. All medical directors and supervising physicians must possess all of the following:

- Expertise in the management of individuals with cardiac pathophysiology.
- Cardiopulmonary training in basic life support or advanced cardiac life support.
- Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

In § 410.49(f), we list the specific limitations for the number of and time period over which CR and ICR sessions may be provided. The limitations for ICR coverage remain unchanged and allow for coverage of up to 72, 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks. We have changed the limitations for CR coverage to allow a maximum of 2, 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor under 1862(a)(1)(A) of the Act.

In addition to the provisions above, we have made the following revisions in the final rule:

- To clarify that the proposed and final policies for the direct supervision of hospital outpatient therapeutic services, as discussed in the CY 2010 OPPS/ASC final rule with comment period, do apply to CR and ICR services furnished to hospital outpatients. Due to specific language in the MIPPA pertaining to a physician being immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, a physician as defined in section 1861(r)(1) of the Act must supervise CR and ICR sessions, whether furnished in physicians' offices, hospital outpatient settings, or other Part B settings.
- To remove the term ''general cardiac rehabilitation'' and replace with ''cardiac rehabilitation.''
- To clarify CR and ICR medical director and supervising physician standards.
- To clarify that CR and ICR patients must exercise aerobically each day CR and/or ICR services are furnished and are not required to exercise aerobically during every CR or ICR session. If more than one session is furnished during 1 day, then patients are required to exercise aerobically during only one of the sessions.
- To allow flexibility in the 30-day patient centered outcomes measurements in order to allow outcomes that may not exhibit changes during a 30-day period of time to be measured less frequently, but no fewer times than at the beginning and end of patients' participation in a CR or ICR program.

g. Coding and Payment

(1) Cardiac Rehabilitation (CR) Payment

Currently, the following CPT codes are used for CR services described in section 144(a) of the MIPPA: CPT code 93797, *Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session*) and CPT code 93798, *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session).* We did not propose to revise these codes under the PFS because the CR program authorized by the existing National Coverage Determination (NCD) is essentially the same as what is included in the MIPPA.

(2) Intensive Cardiac Rehabilitation Payment

The statute requires that the hospital Outpatient Prospective Payment System

(OPPS) payment amount for CR services be substituted for ICR under the PFS, specifically the payment for CPT codes 93797 and 93798 or any succeeding HCPCS codes for CR. We proposed to create two new HCPCS codes for ICR services. These codes may only be billed by ICR programs that have been approved by CMS. The proposed codes are as follows:

- GXX28, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session.*
- GXX29, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session.*

These HCPCS codes will be recognized under the PFS and the OPPS. Under the OPPS, the existing CR HCPCS codes, CPT codes 93797 and 93798, are assigned to APC 0095 (Cardiac Rehabilitation) for CY 2009. Because the payment under the PFS for the two proposed ICR G-codes is required to be the same as the payment for CR services under OPPS, we proposed to pay the same amount as will be established through rulemaking for CY 2010 OPPS. We proposed that this amount will be adjusted for the appropriate locality by applying the GPCI under the PFS. The CY 2010 proposed APC assignments and payment rates for these two ICR G-codes were published in the CY 2010 OPPS/ASC proposed rule (74 FR 35361).

We note that when a CR/ICR service is furnished in a hospital outpatient department, a physician cannot bill the Medicare contractor for CR/ICR unless the physician personally performs the CR/ICR service. To personally perform the CR/ICR service, the physician would provide direct care to a single patient for the entire session of CR/ICR that is being reported. In this case, the hospital would report the CR/ICR service and be paid the OPPS payment amount for the facility services associated with the CR/ICR session and the physician would report and be paid the PFS amount for the CR/ICR service. A physician cannot bill under the PFS for CR/ICR services furnished in a hospital for which the physician furnishes only supervision or for services furnished in part by others. If the physician furnishes no direct CR/ICR services for a given session on a given day or provides direct CR/ICR services for less than the full session, then only the hospital would report the CR/ICR services and these services would be paid only under the OPPS.

The following is a summary of the comments we received regarding the payment of CR services under section 144(a) of the MIPPA.

Note: We received comments concerning the role of physical therapists, and occupational therapists in providing CR, ICR, and pulmonary rehabilitation (PR). Those comments are addressed in the PR section which follows this section.

Comment: One commenter stated that the physician work and staff resources required to perform the mandatory outcomes assessment are not valued in the physician work and PE RVUs established for CPT codes 93797 and 93798. The commenter recommends separate reporting and payment for the outcomes assessment.

Response: We note that an outcomes assessment is part of the CR benefit established by the Congress. While it may not have been described specifically in the CR program authorized by the existing NCD we believe an assessment of the patient's condition before initiating treatment and at periodic intervals to measure the patient's progress would be an expected part of treatment. In addition we note that the language at § 410.49 has been revised to allow more flexibility with regard to the outcomes that must be measured every 30 days. Section 410.49 requires that patient centered outcomes measurements must be taken no fewer times than at the beginning and end of a patient's participation in a CR or ICR program.

Comment: Some commenters requested an increase in the payment for traditional CR. One commenter also stated concerns about the way payment for ICR was established.

Response: The MIPPA made no substantive changes to the CR program authorized by the existing NCD and reported using CPT codes 93797 and 93798. Therefore, we proposed no changes to payment for these codes under the PFS. Under the statute, the payment for ICR under the PFS is based on the OPPS payment amount for CR services. Please see section XII.B.3 of the CY 2010 OPPS/ASC final rule for a discussion of how the payment amounts for CR and ICR were established under the OPPS.

Payment for CR

After consideration of the public comments we received, we are finalizing our CY 2010 proposal, without modification, to pay for CR using CPT codes 93797 and 93798.

Payment for ICR

We also are also finalizing our CY 2010 proposal to adopt the new 2010 PFS HCPCS G-codes for ICR with the following descriptors:

- G0422, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session);* and
- G0423, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session.*

As required by statute, payment under PFS for these services will be based on the OPPS payment amount for CR services. For more information on how the OPPS payment amount for ICR was established, see section XII.B.3 of the CY 2010 OPPS/ASC final rule. We have added the phrase ''per hour'' to the descriptors of these codes because we believe that CR services generally last one hour as documented by existing claims data for CR services. Section 1861(eee)(4)(C) of the Act provides for up to 72, 1-hour sessions of ICR and hence, adding ''per hour'' to the two new HCPCS code descriptors for ICR services implements the statutory definition of an ICR session as being 1 hour of service.

Moreover, we have established the payment for ICR services on the presumption that one session represents 1 hour of care. Therefore, we believe that it is appropriate to specify in the descriptors of the HCPCS codes for ICR services that one unit of the code represents 1 hour of care. As discussed previously, CR is covered for up to 36 1-hour sessions, with a minimum of 1 session per week and a maximum of 2 sessions per day, and Medicare contractors have authority to approve additional sessions, up to 72 sessions, over an additional period of time. Section 144(a)(1) of the MIPPA authorizes coverage of ICR programs in a series of 72, 1-hour sessions, up to 6 sessions per day, over a period of 18 weeks.

9. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Pulmonary Rehabilitation Services

Section 144 of the MIPPA amended Title XVIII of the Act to provide for coverage of pulmonary rehabilitation (PR) under Part B, under certain conditions, for services furnished on or after January 1, 2010. This final rule with comment period implements the new Medicare standards for a pulmonary rehabilitation program and establishes the requirements for furnishing such items and services to Medicare beneficiaries with chronic obstructive pulmonary disease (COPD).

COPD is one of the more common and severely debilitating chronic respiratory diseases, exemplified by chronic bronchitis and emphysema. Other conditions in this category include

persistent asthma, bronchiectasis, primary pulmonary hypertension, obesity-related respiratory disease, and ventilator dependency. This rule implements section 144(a) of the MIPPA to permit coverage and payment and to establish guidelines and standards as required by the statute.

a. Background

A PR program is typically a multidisciplinary program, individually tailored and designed to optimize physical and social performance and autonomy of care for patients with chronic respiratory impairment. The main goal is to empower and facilitate the individuals' ability to exercise independently. Exercise is combined with other training and support mechanisms to encourage long-term adherence to the treatment plan. The appropriate PR program will train and motivate the patient to attain his or her maximum potential in self-care and overall quality of life.

Prior to the MIPPA, some components of a pulmonary rehabilitation program were covered in office settings as individual services or as services incident to physician services.

b. Statutory Provisions of Section 144 of the MIPPA

In pertinent part, section 144 of the MIPPA amended section 1861(s)(2) of the Act to add a new subparagraph (CC) establishing coverage and payment of items and services furnished under a ''pulmonary rehabilitation program.'' A pulmonary rehabilitation program is defined in new subsection (fff)(1) to mean a ''physician supervised program'' that furnishes several specific items and services. Pulmonary rehabilitation consists of certain mandatory components including all of the following:

- Physician-prescribed exercise.
- Education or training (to the extent that the education and training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs).
- Psychosocial assessment.
- Outcomes assessment.
- Other items and services determined by the Secretary to be appropriate under certain conditions.

These mandatory components are to be provided in physicians' offices, hospital outpatient settings, and other settings determined appropriate by the Secretary.

A physician must at all times be immediately available and accessible for medical consultation and medical emergencies when PR items and services are being furnished under the program. The individual's treatment is furnished under a written treatment plan for each beneficiary participating in a PR program. The plan is developed by a physician in conjunction with the interdisciplinary team. A physician, who is involved in the patient's care and has knowledge of his or her condition, must establish and review the plan and it must be signed by a physician every 30 days. This plan must include the individual's diagnosis, the scope of services to be provided in terms of type, amount, frequency and duration, and the goals set for the individual. To be covered and receive payment from Medicare, the PR program must provide all of the specified mandatory items and services.

The statute authorizes the Secretary to establish standards for the physician supervising the PR program to ensure the physician has expertise in the management of individuals with respiratory pathophysiology and is licensed by the State in which the PR program is offered. These standards ensure that the physician is responsible for the program and, in consultation with appropriate staff, is involved substantially in directing the progress of individuals in the program.

c. Provisions of the Proposed Regulation

We proposed to add § 410.47, ''Pulmonary Rehabilitation Program: Conditions of Coverage'' to our regulations. The following is a summary of our proposals from the CY 2010 PFS proposed rule. For the full text, please see the CY 2010 PFS proposed rule (74 FR 33610 through 33614, and 33673 through 33674).

We proposed several definitions with respect to the services related to PR. These were for:

- Pulmonary rehabilitation.
- Individualized treatment plan.
- Outcomes Assessment.
- Physician.
- Physician-prescribed exercise.
- Psychosocial assessment.

We also proposed that Medicare would cover PR for beneficiaries with moderate (Stage II) to severe COPD (Stage III) when referred by the physician treating chronic respiratory diseases. Moderate and severe COPD was defined using the GOLD classification II and III.

We proposed that any additional covered clinical indications for the PR program would be added using the National Coverage Determination process.

We proposed that all PR programs must have the following components:

- Physician-prescribed exercise;
- Education or training;
- Psychosocial assessment;
- Outcomes assessment; and
- An individualized treatment plan.

The individualized treatment plan must be established, reviewed, and signed by a physician (as defined in section 1861(r)(1) of the Act) every 30 days.

The MIPPA provisions also authorized the Secretary to include other mandatory items and services within the scope of the PR program under certain conditions. We did not propose any other items or services. However, we stated that if we determine that the addition of any other items or services is appropriate, additions will made and implemented through future rulemaking.

We proposed that PR may be provided in a physician's office or in a hospital outpatient setting. If we determine that additional settings are appropriate, those settings will be added through future rulemaking. All settings should have all equipment and staff necessary to provide statutorily-mandated items and services.

We proposed that physicians furnishing PR items and services must have expertise in the management of individuals with respiratory pathophysiology and be licensed in the State in which the PR program is offered.

In the CY 2010 PFS proposed rule with comment period (74 FR 33613), we discussed that section 144 of the MIPPA includes requirements for immediate and ongoing physician availability and accessibility at all times for both medical consultations and medical emergencies when items and services are being furnished under the program. We proposed to define such availability in accordance with existing definitions for direct physician supervision services furnished in physician offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross reference to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. We stated that direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because a physician must be present and immediately available where and when the items and services are being furnished. A physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For PR services furnished in physicians' offices and other Part B settings paid under the PFS, we stated that this means that the physician must be present in the office suite and immediately available to furnish

assistance and direction throughout the performance of the service or procedure in accordance with § 410.26(a)(2) and (b)(5). It does not mean that the physician must be in the same room when the service or procedure is performed.

For PR services furnished in hospital outpatient settings, we stated that direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We currently define and specify the requirement for direct supervision for services provided in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is performed.

The MIPAA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption of direct physician supervision for hospital outpatient services means that direct physician supervision is the standard and we expect that hospitals are providing services in accordance with this standard.

We proposed that up to 36 sessions in the facility setting are appropriate, no more than one session per day. Patients should generally receive 2 to 3 1-hour sessions per week. We solicited comments regarding the proposed number of sessions. We addressed these comments in the response to public comment section of this final rule with comment.

d. Analysis and Response to Public Comments

We received many public comments on various provisions of our proposed rule. Comments were generally supportive of the new PR program but requested some changes related to the sessions and covered conditions. Commenters were in support of our definitions of pulmonary rehabilitation, individual treatment plan, psychosocial assessment, physician, and physician-prescribed exercise. The commenters also were supportive of the physician standards but asked for clarification of the direct supervision rules. The commenters suggested that we add language acknowledging the role and use of the PR staff/interdisciplinary team.

We also received comments related to NCDs but they were largely focused on the effect of the rule on current local coverage determinations (LCDs). Commenters did not request the addition of new items and services. We received a few comments regarding the addition of settings for PR, such as the CORF.

We received numerous comments noting that in the CY 2010 OPPS/ASC proposed rule with comment period (74 FR 35362 through 35370), we proposed that certain NPPs may supervise hospital outpatient therapeutic services that are within their State scope of practice and hospital granted privileges, provided that they also continue to meet all other requirements. Commenters requested that we allow the use of NPPs for PR services because NPPs may provide and supervise other therapeutic services in the HOPD. We received several significant comments and are providing our responses below.

Comment: We received comments requesting that we expand coverage to another level of COPD, very severe COPD (Stage IV). The commenters stated that very severe COPD should be included since the GOLD guidelines recommend PR for patients with Very Severe COPD (Stage IV). The commenters also cited the NETT trial in which they state that the very severe COPD patients had significant improvement as a result of the PR program.

Response: As a result of the comments, we are expanding the final policy and adding very severe COPD (Stage IV) as a covered condition. Based upon the evidence cited by the commenters and our own independent evidence review. We believe it is appropriate to allow coverage for COPD for the PR program. Commenters provided evidence from the National Emphysema Treatment Trial (NETT) which included patients with very severe COPD who were required to participate in pulmonary rehabilitation; trial results showed this sample of patients had significant improvement in exercise, dyspnea, and quality of life. Commenters also provided 2008 GOLD guideline evidence which supports the addition of very severe COPD. They cited GOLD guidelines which identify PR as the standard of care for patients with COPD stages II–IV and that all COPD stages benefit from an exercise program. Specifically, included in this patient population, the GOLD guidelines support PR for individuals with very severe COPD (Stage IV), while also suggesting consideration of surgical treatments. To the extent this patient group is able to engage in all of the mandatory components, including aerobic exercise, we believe patients would experience a clinical benefit. GOLD classification IV (Very Severe COPD) is defined as FEV1/FVC 70 percent and FEV1 <30 percent of predicted or FEV1 <50 percent predicted plus chronic respiratory failure.

Comment: We received numerous comments requesting that we expand coverage to a variety of other chronic respiratory conditions in addition to the proposed ones, (moderate to severe COPD). Most of the major respiratory care organizations submitted substantial comments pertaining to this issue. The conditions for which expansion was requested include cystic fibrosis, interstitial lung disease, restrictive chest wall disease, pulmonary hypertension, respiratory disorders associated with obesity, lung cancer, very severe COPD (stage IV), and bronchiectasis. The commenters requested that we add all of the requested conditions in the final rule, because the commenters allege substantial clinical benefit for all of them from a PR program.

Response: We proposed to use the national coverage determination process to consider expanding coverage of PR for other chronic respiratory diseases should adequate evidence support these additional uses. While the statute would permit expansion to other respiratory conditions, the data reviewed thus far did not substantiate the clinical benefit of PR for conditions beyond COPD. In making determinations for national coverage, the Medicare program is an evidence-based program. The chronic respiratory disease population is a highly clinically diverse patient population. As such, determining the appropriate conditions for coverage within the patient population requires a thorough review of existing evidence to meet the ''reasonable and necessary standard'' in accordance with section 1862(a)(1)(A) of the Act.

In this final rule with comment period, we announce that we will consider other conditions for which a PR program can be used through the NCD process. The number of various respiratory diseases is expansive and variance within the stages of each disease is broad. The need for, and benefit of, a PR program may relate to the specific respiratory function rather than a broad category of diseases. The NCD process will enable us to evaluate

the medical and scientific evidence to properly ascertain the specific conditions, and appropriate patients for whom a PR program is most beneficial. However, in the interim, until the NCD process is complete, the respiratory services previously allowed by local contractors for other medical conditions under other part B benefit categories remain in effect.

Comment: Some commenters requested that we add all of the requested conditions in the final rule because the commenters believe the proposed rule will supersede existing LCDs which currently allow some respiratory/pulmonary type services for a variety of other chronic respiratory lung diseases, including COPD.

Response: As explained above, we do not agree that the limitation of PR programs to one covered condition (moderate to very severe COPD) through the final rule will eliminate the ability of beneficiaries to obtain other respiratory services that are available under local coverage decisions based on other benefit categories. The individual respiratory services currently covered do not constitute a comprehensive PR program but individualized services that may also be components of a program. Accordingly, to the extent these existing individual respiratory services are reasonable and necessary, a local contractor may still cover them. If the patient has COPD that qualifies for coverage of pulmonary rehabilitation under this final rule with comment period, we would expect to see services furnished under the PR program and billed using the specific PR code. To the extent the provider is billing for the comprehensive PR code, the PR program implemented must meet all of the requirements outlined herein and be the only PR service billed. To the extent we add other conditions through the NCD process, some LCDs may become obsolete in the future.

Comment: We received a significant number of comments regarding the number of sessions for the PR program. Some commenters stated that our proposal of 36 sessions does not reflect the standard of care nationally. Commenters recommended that we allow between 60 and 72 sessions and allow more than one session per day, based in part on the experience of the Lung Volume Reduction Surgery patients in the NETT trial. Under that trial, certain patients were allowed a total of 30 sessions, each required to be minimally 2 hours in duration. Other commenters noted that the typical PR sessions may average 2 hours or more. The major professional organizations requested 72 hours of pulmonary rehabilitation, ''based on the individual's medical necessity and reaching a level of optimal care''.

Response: We agree with commenters that additional sessions may be appropriate in some circumstances. However, any PR program, due to the broad spectrum of patients, inherently necessitates a very individualized plan of treatment. Therefore, in this final rule with comment period, we are authorizing our contractors to approve up to an additional 36 sessions when medically necessary. This would provide qualifying beneficiaries access of up to 72 sessions of PR when appropriate.

Even within the population of patients with moderate to very severe COPD, an individual's ability to participate in additional sessions would require a specific review of evidence to determine whether an additional 36 sessions are warranted under section 1862(a)(1)(A) of the Act. This case-by-case expansion allows greatest flexibility for individual needs. It also takes into account the short term nature of the program based on lifestyle modification goals towards self management of the disease. Since the programs are highly individualized, we do not specify a duration by which sessions must be completed; this allows the possibility of sessions, if necessary, up to the maximum allowable of 72, over a longer period of time.

Comment: We received a number of comments regarding the number of sessions per day for the PR program. Some commented that our proposed sessions do not reflect the standard of care nationally. Commenters recommended that we allow more than one session per day.

Response: We agree with commenters that some patients may be capable of more than one PR session per day. The patient with very severe COPD may not be able to participate in a prolonged aerobic exercise session, and may benefit from 2 shorter periods of aerobic exercise within each session. Also, two sessions will facilitate greater logistical ease for those in rural areas who may want to do multiple sessions in a day, for example, morning and afternoon, and/or provide an opportunity for more compromised COPD patients to engage in two shorter aerobic sessions in a day. Therefore, we will allow up to two 1-hour sessions per day.

Comment: Some commenters asked that we include language in this regulation which minimally refers to the use of, and role of, the interdisciplinary team and/or PR staff.

Response: We agree that the disciplinary team/PR staff play an important role under the direction of the physician. These team members may include, but are not limited to, nurses, social workers, respiratory therapists, and dietitians. (See regulations text, ''Physician standards''.) We have revised § 410.47(e)(1) to emphasize this point.

Comment: Several commenters requested that we allow NPPs to provide the direct supervision, rather than requiring supervision by a physician in accordance with the definition in section 1861(r)(1) of the Act.

Response: The statutory language of the MIPPA defines pulmonary rehabilitation as a ''physician-supervised'' program. A physician is defined in section 1861(r)(1) of the Act. The MIPAA also specifically requires that ''a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that in the case of items and services furnished under such a program in a hospital, such availability shall be presumed.'' The text of the statute uses the word ''physician'' and does not include NPPs. We believe, based on the statutory language in MIPPA for pulmonary rehabilitation programs, that the statute does not provide us the flexibility to allow the supervising role to be filled by a non-physician practitioner. In other words, for the purposes of PR programs, whether furnished in a physician's office or hospital outpatient setting, the direct physician supervision definition applies only to a physician as defined in section 1861(r)(1) of the Act. As discussed previously, the supervision requirement is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26 and for hospital outpatient services at § 410.27. The final policies for payment and direct physician supervision of PR services furnished to hospital outpatients are discussed in detail in section XII.B.2 and B.4 of the CY 2010 OPPS/ASC final rule with comment period.

Comment: A few commenters requested that we provide a session which is ''no more than 1 hour''. The commenters believe that for some individuals, an hour would be the maximum time they could physically participate due to their compromised condition.

Response: We disagree. We believe that a maximum of 1 hour would not afford sufficient time for most patients to receive both the mandatory aerobic exercise and any other component services. Those in rural areas may want

to participate in longer sessions due to travel logistics.

Comment: One commenter proposed that we require at least 30 minutes of exercise.

Response: We disagree. Imposing a strict standard of minimal 30 minutes of exercise is not realistic; the programs are highly individualized. Many patients may not, at least initially, be able to participate in thirty minutes of aerobic exercise.

Comment: One commenter suggested we use the Silver Sneakers program at the YMCA for PR in the Medicare program. The commenter remarked it costs only $40 per month.

Response: While we generally encourage beneficiaries to exercise, we do not agree that this particular suggestion would be feasible. We do not expect that a typical YMCA would meet the statutory requirements related to physician standards and supervision, or perhaps the facility standards for safety and equipment. Further, YMCAs are not currently recognized as Medicare suppliers or providers.

Comment: A few commenters requested that we include a CORF as a PR setting.

Response: While the statute would allow the Secretary to cover PR in additional settings, we are not expanding the settings in this final rule. The CORF statutory definition, in section 1861(cc) of the Act, provides requirements for all services provided in that facility type. The CORF facility does not meet the supervision requirements imposed by the MIPPA. In accordance with section 1861(cc)(1) of the Act, the term ''CORF'' provides, in part, ''comprehensive rehabilitation facility means a facility which—(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative service to outpatients for the rehabilitation of *injured*, *disabled*, or sick persons.'' (Emphasis added)

''(B) provides at least the following comprehensive outpatient following rehabilitative (i) physicians' services (rendered by physicians, as defined in section 1861 (r) (1) who are available at the facility on a full or *part-time* basis;'' (Emphasis added). The definition of services and reference to the injured or disabled population is consistent with the mandate for rehabilitative services, which we maintain are not directed towards the chronically ill patients with respiratory disease such as COPD. The CORF statutory provisions allow a physician to be in the facility part-time. This conflicts with the MIPPA provisions for the physician supervision, that is, being immediately available and accessible at all times items services are being furnished under the program. However, the MIPPA PR program does not eliminate or affect the PT services provided in accordance with the CORF regulations at § 410.100. Initially, a COPD patient may be in need of PT services (in or outside of a CORF) in order to strengthen their muscles to prepare for the PR program. By clarifying the services in a CORF, which are mandated to include a majority of physical therapy, we sought to delineate these services from those provided in a PR program focused on the condition of COPD.

Comment: Commenters support the requirement that a physician must create an individualized plan of treatment for pulmonary rehabilitation. However, some commenters requested that we clarify whether we intend that physicians must personally create each plan of care or whether physicians may review and approve a plan of care created by pulmonary rehabilitation staff.

Response: A physician must establish the individualized treatment plan; however, there can be input from the pulmonary rehabilitation staff with respect to the plan.

The MIPPA provisions require that PR services be provided under written individualized treatment plans ''established, reviewed, and signed by a physician every 30 days.'' The individualized plan includes the individual's diagnosis, the types of services appropriate, the frequency and duration, and the treatment goals. This plan may initially be developed by the referring physician or the PR physician. If the plan is developed by the referring physician who is not the PR physician, the PR physician must also review and sign the plan prior to initiation of PR. The PR staff may make recommendations for modifications to the program, but the physician will still modify the plan as needed, and review and sign the plan every 30 days.

e. Provisions of the Final Rule

In the final rule we are adopting the provisions as set forth in the July 2009 proposed rule with the following revisions:

- Based on public comments and the GOLD guidelines we are expanding coverage to include individuals with very severe COPD (Stage IV) as a covered condition. We are modifying the final rule § 410.47 (b)(1) ''Beneficiaries who may be covered'', to state the addition. The GOLD standard evidence defines GOLD classification IV (Very Severe COPD) as FEV1/FVC 70 percent and FEV1 <30 percent of predicted or FEV1 <50 percent predicted plus chronic respiratory failure.
- We expanded section § 410.47(f) to include additional sessions by changing the total number of allowable sessions to 72 sessions; we did so by allowing an additional 36 at contractor discretion when medically necessary. We also expanded the daily number of the allowable sessions from one session to two sessions.
- We added definitions in § 410.47(a) for the ''Medical director'' and the ''Supervising physician''.

In addition, we are making the following clarifying and technical changes:

- We clarified in § 410.47(c)(5) that the physician establishing the treatment plan needs to be one who is involved in the patient's care and has knowledge of his or her condition.
- We added language in § 410.47(e)(1) to clarify the physician interaction with PR staff.
- We added the word ''medicine'' in § 410.47(e)(4) to conform the rule to the MIPPA statutory language.
- We added language in § 410.47(e)(3) for training requirements related to the use of emergency equipment; this correlates to the established requirements in the proposed rule for availability of this equipment.
- We added in § 410.47(f) the words ''up to'' to clarify the contractor is permitted to prescribe any additional amount lower than, and up to, 36 sessions based on medical necessity. We also added a reference to the pertinent statute.

f. Coding and Payment

We proposed to create one HCPCS code to describe and to bill for the services of a PR program as specified in section 144(a) of the MIPPA, GXX30 (now assigned code number G0424, *Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session, per day)*. This G-code is to be billed when the patient performs physician-prescribed aerobic exercises that are targeted to improve the patient's physical functioning and may also include the other aspects of pulmonary rehabilitation, such as education and training. Because the physician's role in the PR program is defined in a similar manner to that in the cardiac rehabilitation program, we stated that the physician work component should be analogous to that of CPT code 93797, *cardiac rehab without telemetry*. Therefore we proposed work RVUs of 0.18 RVUs for this new G-code. Using this same reference code, we proposed

that the malpractice RVUs would be 0.01 RVUs.

To establish the PE RVU payment for the proposed new PR G-code, we reviewed the PE inputs of similar services, particularly those of the respiratory therapy HCPCS codes, G0237 and G0238, as well as the cardiac rehabilitation codes, CPT codes 93797 and 93798 for non-facility settings. Given that various individuals, acting under the supervision of a physician, can make up the PR multidisciplinary team, we proposed that the clinical labor for the PR G-code could be best represented by the following labor types taken from the PE database: the nurse ''blend'' (RN/LPN/MTA), the respiratory therapist (RT), the social worker/psychologist and the medical/technical assistant—which we selected to represent various specialists involved in furnishing this service; these are valued at $0.37, $0.42, $0.45, and $0.26 per minute, respectively. Using an average of these values, $0.375 per minute, we proposed to use the nurse blend labor type found in the cardiac rehabilitation CPT codes, at $0.37 per minute, as the typical value for the PR clinical labor and assigning 28 minutes of clinical labor time for the new PR G-code based on the various components of the proposed PR program.

For the equipment PE inputs, we reviewed the direct PE inputs for similar existing codes and proposed a pulse oximeter (with printer), a 1-channel ECG, and a treadmill. Since no typical supplies were listed for similar existing codes in the PE database, we did not propose any specific supplies for this proposed new G-code.

The following is a summary of the comments we received regarding payment for pulmonary rehabilitation services under section 144(a) of the MIPPA.

Comment: Some commenters asked that we confirm that the services of physical therapists are not part of the PR, CR, or ICR benefits authorized by section 144(a)(1) of the MIPPA and are always paid under the physical therapy benefit and that, therefore, the therapy services do not require physician supervision when furnished as part of a PR, CR, or ICR program, including in the HOPD.

With regard to PR, some commenters stated that we have a longstanding history of recognizing the services of a therapist as an integral part of a PR program and requiring that these services be reported and paid as PT services. Specifically, the commenters indicated that in the CY 2002 PFS final rule (66 FR 55246) and in the current Medicare Claims Processing Manual (Pub. 100–04, Chapter 5, section 20.A), we specify that when physical therapists treat respiratory conditions, they should report CPT codes for PT in the 97000 series and should not report HCPCS codes G0237, *Therapeutic procedures to increase strength or endurance of respiratory muscles, one on one, face to face, per 15 minutes (includes monitoring);* G0238, *Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, one on one, face to face, per 15 minutes (includes monitoring);* or G0239, *Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring).* The commenters added that in the September 25, 2007 Decision Memo for Pulmonary Rehabilitation (CAG–00356N), CMS recognized the importance of PT to patients with pulmonary conditions and stated that these services should be billed and paid under the PT benefit. The commenters stated that a plan of care developed by a physical therapist to improve pulmonary function for a patient with chronic obstructive pulmonary disease (COPD), which meets the medical necessity criteria for PT services, is covered and paid under the PT benefit. The commenters explained that the therapy plan of care is separate from the benefits authorized by section 144(a)(1) of the MIPPA. The commenters believe it should continue to be reported under the CPT codes for PT services, and should be paid under the PT benefit.

In addition, with regard to CR/ICR, the commenters requested that CMS confirm that skilled PT services that are rendered in the CR setting by a qualified physical therapist should be conducted, reported, and paid as PT services, and that physician supervision is not necessary in the CR setting when the physical therapist is delivering treatment that clearly meets the criteria for a PT service. The commenters explained that we have recognized and codified that PT is a separate benefit and that physical therapists are qualified to perform certain services independent of direct physician supervision. Similar comments were received concerning occupational therapy services.

Response: Section 144(a)(1) of the MIPPA authorized a new comprehensive PR benefit, and also codified specific benefits for CR and ICR. Therefore, we believe that outpatient Part B providers and suppliers should furnish the full scope of the PR, CR, or ICR benefit as comprehensive programs to those patients who qualify for coverage. We would not expect the component services of PR, CR, and ICR programs to be unbundled and billed separately by different providers or practitioners under other benefit categories, such as the PT benefit.

In the outpatient physicians office setting, we expect that most patients participating in PR, CR, or ICR programs authorized by section 144(a)(1) of the MIPPA and covered by Medicare will be debilitated based on their underlying medical condition, age, or other factors. In order to develop a PR, CR, or ICR treatment plan, some debilitated patients may require evaluations by therapists on the multidisciplinary team, in addition to assessments by other team members. In order to participate successfully in the prescribed exercise component of the PR, CR, or ICR program, we also expect that these patients may receive individualized treatments by therapists on the multidisciplinary team and others to promote the increased functionality that is a principle goal of PR, CR, and ICR programs. As we stated in the CY 2010 PFS proposed rule, the items and services furnished by a CR or PR program are individualized and set forth in written treatment plans for each beneficiary (74 FR 33607 and 33611). We believe these evaluations and individualized treatments are a part of the PR, CR, or ICR program for those beneficiaries who need them. As such, we believe they should be conducted by one or more members of the multidisciplinary team of the PR, CR, or ICR program with the appropriate expertise.

While we have not defined PR, CR, or ICR services as always including therapists' services as part of the comprehensive benefit (74 FR 33608 and 33614), we have acknowledged in the CY 2010 PFS proposed rule that written treatment plans are highly individualized and that there should be flexibility in the type, amount, frequency, and duration of services provided in each session (74 FR 33607).

We expect that physical therapists could conduct assessments and individualized treatments as part of the PR, CR, or ICR program because physical therapists have the knowledge and skills to assist in addressing common problems that lead to physicians ordering PR, CR, or ICR services for their patients, including poor aerobic capacity, poor endurance, and shortness of breath, in the context of chronic pulmonary or cardiovascular disease. In the context of PR, while we also stated that individuals requiring PR services have a chronic respiratory

disease and are in need of supervised aerobic exercise, not PT, we acknowledged that patients require assessments to address individualized needs and the provision of a mix of services necessary to address those needs (74 FR 33613).

Patients in PR, CR, or ICR programs must receive the full complement of care as defined under these benefits as specified in section 144(a)(1) of the MIPPA, in accordance with their individualized treatment plan, including assessments and prescribed exercise. Additionally, the standard HCPCS coding guidance instructs practitioners and providers to report the code for the procedure or service that most accurately describes the service performed. As stated in Section 20.12.1.b. of Chapter 5 of the Medicare Contractor Beneficiary and Provider Communications Manual, in instances where several component services, which have different CPT/HCPCS codes, may be described in one more comprehensive code, only the single code most accurately describing the procedure performed or service rendered should be reported. Therefore, we would expect that when physical therapists provide evaluations and individualized treatment services under a PR, CR, or ICR treatment plan, these services would be billed as PR, CR, or ICR services under the PR, CR, or ICR CPT or Level II HCPCS G-codes that apply. When these programs are provided in a physician office setting and the physical therapist serves as a member of a multidisciplinary team, the services may not be separately billed as therapy services or as services incident to physician services and they need not follow the requirements of those policies. Services must be provided according to the policies for PR, CR, or ICR. For example, for therapy services in physician offices, qualifications of therapists, 90-day certification of plan of care, supervision by NPPs, treatment notes, and progress reports do not apply unless required by PR, CR, and ICR policies. As discussed in detail in sections II.G.8.e. and II.G.9.d. above in this final rule with comment period, for purposes of PR, CR, and ICR services, the required direct supervision must be provided by a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act for all services furnished under the plan. For services provided in physician's offices, direct supervision is defined in accordance with existing requirements and the existing definition of direct physician supervision for all therapeutic services furnished in physician offices at § 410.26.

We continue to believe that direct supervision, as defined in the regulations, is consistent with the language of the MIPAA because a physician must be present and immediately available where services are being furnished. A physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

We expect that most patients who meet the diagnosis requirements for coverage of PR, CR, or ICR would receive component services covered under the PR, CR, or ICR benefit as part of a comprehensive PR, CR, or ICR program, subject to the coverage and payment policies that we are finalizing in this final rule with comment period and the CY 2010 OPPS/ASC final rule with comment period. We understand that some component services of PR, CR, or ICR have previously been furnished to beneficiaries and paid by Medicare under other benefits, such as the outpatient PT benefit.

As stated above, since section 144(a)(1) of the MIPPA authorized a new comprehensive PR program and legislated the CR benefit to also recognize ICR services, we believe that outpatient Part B providers and suppliers should furnish the components of PR, CR, or ICR as comprehensive programs to those patients who qualify for coverage. We would not expect the component services of PR, CR, and ICR programs to be unbundled and billed separately by different providers or practitioners under other benefit categories, such as the PT benefit. Therefore, we expect that it would be uncommon for a patient receiving care under a PR, CR, or ICR treatment plan to also be receiving PT services under a separate PT plan of care.

There may be patients with therapy needs that are outside the treatment plan appropriate for PR, CR, or ICR and such patients should receive medically necessary PT services specific to those other needs under a PT plan of care and according to the policies for PT services. However, we would not expect it to be the norm that PT services and PR, CR, or ICR services are furnished to the same beneficiaries in the same day. Clearly, a single period of care can only be billed as one type of treatment service, so providers and suppliers could never bill both PT and PR, CR, or ICR services for the same time period for the same patient (for example, during an hour session from 10 to 11 a.m. on a single date of service).

We plan to monitor claims data for PR, CR, and ICR services as well as any additional claims for therapy services. If we detect patterns of care that are inconsistent with our stated expectations for PR, CR, or ICR services and therapy services, we may encourage Medicare contractors to review cases in which a provider or supplier reports both types of services for the same patient during the same span of time (for example, over a several month period) or we may propose changes to our payment methodologies for these services.

After considering the public comments received, we are clarifying that we would expect component services that are furnished under a PR, CR, or ICR treatment plan to beneficiaries who qualify for PR, CR, or ICR services to be furnished as PR, CR, or ICR services, regardless of whether they are furnished by a physical therapist or other healthcare practitioner, and that all of the coverage and payment requirements, including, but not limited to, the physician supervision requirements for services incident to a physician in the physician office setting, apply to those PR, CR, or ICR services. We expect that providers and suppliers of Part B services will furnish the comprehensive set of services that is described in the criteria for PR, CR, or ICR programs to beneficiaries who qualify for the benefit.

Similar comments were expressed concerning the inclusion of occupational therapy services in PR programs. The policies for occupational therapy services are the same as for physical therapy services.

Comment: Some commenters believed there were flaws in our method of determining the payment rate. The commenters did not agree that the physician work in pulmonary rehabilitation mirrors the physician work in cardiac rehabilitation without telemetry (CPT 93797). The commenters stated that CPT code 93797 has 11 minutes of physician time, but we applied a similar payment for a minimum of 60 minutes of PR service. Some commenters thought we should multiply the physician work RVUs of CPT code 93797 by 4 for a 60-minute session. Some commenters also stated that the respiratory therapy services paid by the G-codes currently are valued at about $15–20 for each 15 minutes of service and that we are proposing to pay $16 for a 1-hour session which is not enough to cover and pay for the services required.

Response: We do not agree that the physician work is substantially different in CR than in PR. We do not expect that the physician work for a 60-minute PR session equals 60 minutes. We believe the work is performed primarily by the multidisciplinary team, and not the physician. The current G-codes were valued for respiratory therapy services and not for a comprehensive pulmonary rehabilitation program.

Comment: Some commenters stated that our staffing and equipment assumptions were not valid. For example, some commenters stated that the list of individuals recommended by the guidelines for PR should be reflected by those included in the PE for PR. Commenters stated that PR includes review of data that is comparable to telemetry, such as EKG and oximetry. The commenters indicated that the equipment needed for PR should be included in the payment.

Response: We anticipate that a variety of team members will contribute to PR during a session, and we have blended the values of the types of staff that we believe would most commonly be used. In response to the comments, we have increased the variety of team members included in the mix. However, we have not included physical therapists or occupational therapists in the PE because we anticipate that beneficiaries who are eligible for the PR program will not typically require physical therapy as part of their PR program. If a therapist does participate as a member of the team, we believe that therapist typically would be furnishing PR services to meet PR goals that do not require the skills of a therapist. In addition, we have revised the PE to include more equipment as requested.

Comment: Several commenters requested that the pulmonary rehabilitation code exclude certain services that they would like to bill separately, especially the 6 minute walk test, outcomes assessments, 30 day reviews, physician E/M services, therapy codes, the current G0237–9 codes, and related services such as 94620, 94667, and 94667. The commenters stated that bundling the services of the PR program will result in reduced payment rates that could shut down PR programs.

Response: The pulmonary rehabilitation therapy G-codes were developed for a comprehensive pulmonary rehabilitation program as described in the statutory benefit. All of the services of the program are included in the payment. We would expect that an individual who is receiving PR services would receive the full complement of services within the PR program and that these services would be billed using the PR HCPCS code G0424. We recognize that an individual may require additional medically necessary services such as physician E/M or physical therapy, outside of the PR plan of care. However, as we noted above, we will monitor billing patterns to assess whether the full scope of services is being furnished to patients under PR treatment plans. If we detect patterns of care that are inconsistent with our expectations, we may encourage Medicare contractors to review cases in which a provider or supplier reports services for the same patient during the same span of time that might be considered part of a PR treatment plan, and as a result, we may propose changes to our payment methodologies for these services.

Comment: Some commenters requested that the current HCPCS G-codes for therapeutic procedures for respiratory function (G0237, G0238 and G0239) continue to be used to bill for pulmonary rehabilitation, E/M, and diagnostic services for pulmonary rehabilitation programs.

Response: The current HCPCS G-codes were developed for use in CORFs and other settings to describe the provision of respiratory therapy services. They continue to be appropriate for use in CORFs for this purpose. Outside of the CORF setting those codes are not appropriate for use in office settings to provide pulmonary rehabilitation services under the new pulmonary rehabilitation program as defined by the MIPAA. The pulmonary rehabilitation benefit was added by Congress for the purpose of covering services for patients with certain pulmonary conditions who require a coordinated program of treatment.

The existing HCPCS G-codes do not represent the full scope of services in a comprehensive PR program now authorized by the new PR benefit. We want to ensure that when a physician office bills and is paid for PR services that it attests to meeting all of the requirements of the comprehensive PR program by the reporting of a HCPCS G-code specific to a PR session. We would expect beneficiaries who could qualify for a PR program, where a program is available, to receive services related to those conditions in such a program rather than having services unbundled and provided separately outside a PR program. Therefore, specific codes have been developed to identify and make payment for services furnished as part of pulmonary rehabilitation programs. However, a beneficiary who was receiving treatment in a CORF and in need of respiratory therapy services could receive those services and the CORF could bill using the existing G-codes, as they would have prior to the MIPPA.

Comment: Many commenters expressed concern about the duration of the PR session which we proposed as a minimum of 1 hour. The commenters alleged the session is *capped* at 1 hour and requested longer sessions. The commenters maintained that the typical PR session is a minimum duration of 2 to 3 hours.

Response: We did not cap the length of the session at 1 hour, but proposed to require a minimum of 1 hour of treatment. Implied in these comments is justification for a higher payment rate, related to a longer duration for a session. In response to comments requesting longer treatments, we are adding the phrase ''per hour'' to the new HCPCS code G0424 descriptor to conform the descriptor of the code to the basis for the payment being made for one unit of the code and to enable suppliers to determine when one session of PR ends and the second session begins. The code descriptor is G0424, *Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session.*

In addition, we are modifying our final policy to cover up to 2 sessions of PR per day.

After reviewing the public comments, we will finalize our proposals with modifications. In summary, we will:

- Change the HCPCS code descriptor as follows: G0424, *Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per hour, per session.*
- As discussed above, we will also allow up to two sessions of PR per day.
- Modify PE inputs, as recommended by commenters, resulting in increased PE RVUs. However, we continue to believe the physician work for PR is comparable to CR and will make no changes to the work RVUs.

10. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment

a. Payment Rules for Oxygen and Oxygen Equipment

(i) Overview

The general Medicare payment rules for durable medical equipment (DME) are set forth in section 1834(a) of the Act and 42 CFR part 414, subpart D of our regulations. Section 1834(a)(1) of the Act and § 414.210(a) of our regulations establish the Medicare payment for a DME item as equal to 80 percent of either the lower of the actual charge or the fee schedule amount for the item. The beneficiary coinsurance is equal to

20 percent of either the lower of the actual charge or the fee schedule amount for the item once the deductible is met.

Specific rules regarding payment for oxygen and oxygen equipment are set forth in sections 1834(a)(5), (a)(9), (a)(14) and (a)(21) of the Act and § 414.226 of our regulations. Suppliers are paid a monthly payment amount for furnishing medically necessary stationary oxygen equipment under the class described in § 414.226(c)(1)(i) and oxygen contents (for both stationary and portable). Equipment in the stationary class includes stationary oxygen concentrators, which concentrate oxygen from room air; stationary liquid oxygen systems, which use oxygen stored as a very cold liquid in cylinders and tanks; and gaseous oxygen systems, which administer compressed oxygen directly from cylinders.

We also pay a monthly add-on payment to suppliers furnishing medically necessary portable oxygen equipment falling under one of two classes described in § 414.226(c)(1)(ii) and (iii). Equipment in these classes includes traditional portable equipment that includes portable liquid oxygen systems and portable gaseous oxygen systems and oxygen generating portable equipment (OGPE) that includes portable oxygen concentrators and oxygen transfilling equipment used to fill portable tanks or cylinders in the home. Both the liquid and gaseous oxygen systems (for stationary and portable) require on-going delivery of oxygen contents.

(ii) Provisions of the Deficit Reduction Act of 2005 (DRA)

Section 5101(b) of the DRA amended section 1834(a)(5) of the Act by limiting monthly rental payments to suppliers for oxygen equipment to 36 months of continuous use. At the end of this 36-month rental period, suppliers were required to transfer title of the oxygen equipment to the beneficiary. This requirement started for existing beneficiaries using oxygen on January 1, 2006 and new beneficiaries using oxygen on or after January 1, 2006. The provision also required payments for oxygen contents continue after title to the equipment has been transferred. In the November 9, 2006 **Federal Register**, we issued the ''Home Health Prospective Payment System Rate Update for CY 2007 and Deficit Reduction Act of 2005 Changes to Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment'' final rule (71 FR 65884) to implement these DRA changes. We amended § 414.226 to clarify that the monthly rental payments for items falling under the classes now described in § 414.226(c)(1)(i) thru (iii) are made for periods of continuous use not to exceed 36 months. We revised the rules regarding a period of continuous use for the rental of DME in § 414.230 of our regulations to clarify the continuous use determination. We also added § 414.226(f) requiring a supplier to transfer title to the oxygen equipment to the beneficiary on the first day after the 36th continuous month in which payment is made for the equipment. In addition, we revised § 414.226 to allow monthly payments to suppliers for furnishing gaseous or liquid oxygen contents for use with either beneficiary-owned stationary equipment or beneficiary-owned portable equipment.

Section 5101(b) of the DRA also authorized payments for maintenance and servicing of beneficiary-owned oxygen equipment if the Secretary determined such payments to be reasonable and necessary. We determined that paying for necessary repairs and periodic maintenance and servicing of beneficiary-owned oxygen equipment was reasonable and necessary to ensure that oxygen equipment owned by beneficiaries continued to function properly. Without these payments, we were concerned that there was little incentive for suppliers to maintain this equipment, because the equipment was no longer owned by the supplier.

In the November 9, 2006 final rule, we established other safeguards for beneficiaries receiving oxygen and oxygen equipment, which are set forth at § 414.210(e)(5) and § 414.226(g). Section 414.210(e)(5) requires suppliers—after transferring title of the oxygen equipment to the beneficiary—to furnish replacement equipment at no cost to the beneficiary or the Medicare program if the item furnished by the supplier does not last (that is, it breaks down and is irreparable) for the entire reasonable useful lifetime established for the equipment in accordance with § 414.210(f)(1). Per § 414.210(f), a beneficiary is allowed to elect to receive new oxygen equipment if the original equipment has been in continuous use by the beneficiary for the equipment's reasonable useful lifetime. Section 414.210(f)(1) states the reasonable useful lifetime for equipment is determined through program instructions. In the absence of program instructions, the carrier may determine the reasonable useful lifetime for equipment, but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the beneficiary elects to obtain new oxygen equipment after the reasonable useful lifetime, the payment is made in accordance with § 414.226(a). Section 414.226(g)(2) prohibits suppliers from replacing oxygen equipment prior to the expiration of the 36-month rental period unless a specific exception applies. This was intended to protect the beneficiary from the supplier changing the beneficiary's equipment in order to maximize Medicare payments. For example, the supplier may want to move a beneficiary from a portable oxygen concentrator to portable gaseous equipment for which Medicare makes additional payments after the 36-month rental period ends.

Section 414.226(g)(4) provides that, by no later than 2 months before the date on which the supplier must transfer title to oxygen equipment to the beneficiary, the supplier must disclose to the beneficiary: (1) whether, in the case of oxygen transfilling equipment and stationary or portable oxygen concentrators, it can maintain and service the equipment after the beneficiary acquires title to it; and (2) whether, in the case of stationary or portable gaseous or liquid oxygen systems, it can continue to deliver oxygen contents to the beneficiary after the beneficiary acquires title to the equipment.

(iii) Provisions of Medicare Improvements for Patients and Providers Act (MIPPA) Section 144(b)—Repeal of Transfer of Ownership of Oxygen Equipment

In the CY 2009 PFS final rule with comment period, we outlined the provisions of section 144(b) of the MIPPA (73 FR 69875 through 69876). Section 144(b) of the MIPPA repeals the requirement that the supplier transfer title to oxygen equipment to the beneficiary after the 36-month rental period. In its place, section 144(b) establishes a 36-month rental cap and amends section 1834(a)(5)(F) of the Act by adding three new payment rules and supplier requirements for furnishing oxygen and oxygen equipment after the 36-month rental period. Each of these provisions is discussed below.

(a) Furnishing Oxygen Equipment After the Rental Cap

Under this new provision, the supplier that furnishes oxygen equipment during the 36-month rental period must continue to furnish the oxygen equipment after the 36-month rental period. The supplier is required to continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful

lifetime of the equipment. Section 144(b) does not provide any exceptions to this requirement. For example, if the beneficiary relocates outside the supplier's normal service area at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment, the supplier must make arrangements for the beneficiary to continue receiving the equipment at his or her new place of residence. This responsibility is not transferred to another supplier. It is important to note that § 414.226(g)(1)(ii) does not apply this same requirement in situations where the beneficiary relocates during the 36-month rental period. We received comments from interested parties on whether this should be changed in light of the repeal of transfer of ownership of oxygen equipment and other recently enacted provisions of the MIPPA.

We revised § 414.226(f) to conform our regulations to this new requirement. We deleted the transfer of ownership requirement and added the new requirement that the supplier must continue furnishing the oxygen equipment after the 36-month rental period during any period of medical need for the remainder of the reasonable useful lifetime of the equipment.

In addition, we revised § 414.230 to specify that under no circumstance will a new period of continuous use begin following the 36-month rental period and before the end of the equipment's reasonable useful lifetime since the supplier is responsible for furnishing the equipment after the 36-month rental period for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Regardless of the length of any break in medical need that occurs following the 36-month rental period, once the break ends and medical need for the oxygen equipment resumes, the supplier is obligated to continue furnishing the item for no additional rental payments until the end of the equipment's reasonable useful lifetime. If the equipment's reasonable useful lifetime ends during the break in medical need, the supplier is under no obligation to continue furnishing the equipment. However, in accordance with § 414.210(f), the beneficiary may elect to obtain new equipment in these situations. If the beneficiary elects to obtain new equipment, a new 36-month rental period begins. It is important to note that, in accordance with section 5101(b)(2)(B) of the DRA, in the case of beneficiaries receiving oxygen equipment on December 31, 2005, the 36-month rental period begins on January 1, 2006. However, in accordance with § 414.210(f)(1), the reasonable useful lifetime of durable medical equipment, including oxygen equipment, begins on the date that the equipment is first delivered to the beneficiary. The reasonable useful lifetime of oxygen equipment furnished to beneficiaries on December 31, 2005, is not adjusted to begin anew on January 1, 2006, to correspond with the start of the 36-month rental period. Therefore, in these situations, the equipment's reasonable useful lifetime may end at any point during or after the 36-month rental period depending on the first day the equipment was delivered to the beneficiary. In these situations, a new period of continuous use and a new 36-month rental period would begin if the beneficiary elects to obtain new equipment.

We also revised § 414.210(e)(2), (e)(4) and (e)(5) to delete regulatory text which relates to beneficiary ownership of oxygen equipment. In addition, we deleted § 414.210(e)(3) because beneficiaries will no longer own oxygen tanks and cylinders. Because § 414.210(e)(3) was deleted, we redesignated § 414.210(e)(4) and § 414.210(e)(5) as § 414.210(e)(3) and § 414.210(e)(4), respectively.

We also revised § 414.226 to state that the protection against supplier replacement of oxygen equipment, unless an exception applies, continues to be in effect after the 36-month rental period ends. Specifically, we revised § 414.226(g)(2) to indicate that this prohibition applies until the expiration of the reasonable useful lifetime established for the equipment. As discussed in the November 9, 2006 final rule (71 FR 65894), we believe this is a necessary safeguard for the beneficiary against changes in equipment made by the supplier in order to maximize payments resulting from moving from one modality to another. Finally, we deleted § 414.226(g)(4) because the transfer of ownership of oxygen equipment provision has been repealed, rendering this provision inapplicable.

The following is a summary of the comments we received and our responses.

Comment: Numerous commenters requested a delay in the implementation of the 36-month rental cap on oxygen and oxygen equipment. Many commenters expressed concerns about the impact of the 36-month cap on suppliers. Some commenters stated the amendments of section 144(b) of the MIPPA are sparse and that more time is needed to consider options for implementing these amendments to the statute. Other commenters had concerns that the program has not issued adequate guidance to implement these provisions.

Response: While we recognize that the regulatory changes established new requirements for oxygen suppliers after the 36 month payment cap, the statutory mandate for implementing the 36-month oxygen payment cap does not provide any flexibility for a delay in the implementation of this provision. In accordance with section 1834(a)(5) of the Act, as amended by section 5101(b) of the DRA, we are required to limit monthly payments to suppliers for oxygen equipment to 36 months of continuous use, effective January 1, 2006. Since implementation of the 36-month rental cap is required by section 5101(b) of the DRA, it is outside the scope of this rulemaking effort, which addresses implementation of section 144(b) of the MIPPA. Section 144(b) of the MIPPA amendments to section 1834(a)(5)(F) of the Act, repealing the transfer of ownership of oxygen equipment after the 36-month payment rental cap, were effective January 1, 2009. CMS was committed to meeting this statutory mandate. We note that sub-regulatory guidance was issued which provided additional details on implementing the provisions of section 144(b) of the MIPPA.

Comment: Many commenters disagree that the 36-month rental cap on oxygen and oxygen equipment applies to all equipment, accessories, and supplies used in conjunction with the oxygen equipment (other than the oxygen contents). They believe that separate payment should be allowed after the cap for replacement supplies and accessories such as cannulas, tubing, and regulators.

Response: As discussed in the above response, implementation of the 36-month rental payment cap for oxygen equipment was mandated by section 5101(b) of the DRA. The cap applies to both the monthly payment amount for oxygen and oxygen equipment and the portable equipment add-on payments. Since 1989, suppliers have been paid, in accordance with the rules set forth in section 1834(a)(5) of the Act and § 414.226 of our regulations, a monthly payment amount that includes payment for all equipment, accessories, supplies, and stationary and portable oxygen contents. The November 9, 2006 final rule (71 FR 65885) to implement section 5101(b) of the DRA provides additional discussion on the implementation of the oxygen 36-month rental payment cap. Section 1834(a)(5)(F) of the Act only authorizes payment for oxygen contents following the 36-month cap. These rules mandate continued payments for furnishing oxygen contents for use with

gaseous or liquid oxygen equipment after the cap. The statute does not authorize payment after the cap for accessories and supplies used with the oxygen equipment.

Comment: Two commenters suggested that the Congress repealed the provisions of the DRA requiring transfer of title for oxygen equipment to the beneficiary because the Congress realized that oxygen recipients need frequent services from suppliers. These commenters believe that the new regulatory changes did not address the number of oxygen service visits thereby permitting reductions in service visits and quality of care.

Response: In accordance with section 1834(a)(5)(F) of the Act, we have revised § 414.226(f)(1) to require a supplier who furnished oxygen equipment to a beneficiary during the 36th month of continuous use to continue furnishing the equipment for any period of medical need until the end of the reasonable useful lifetime established for the equipment. Section 1834(a)(5)(F) of the Act authorizes payments following the 36-month cap for oxygen contents. The statute does not authorize payment after the cap for services related to furnishing oxygen equipment other than maintenance and servicing of the equipment, which is addressed in section II.G.10.c. below in this section.

Comment: A number of commenters noted that accreditation standards require oxygen suppliers to have on-call availability 24 hours a day to respond to patient respiratory issues. However, without additional program reimbursement after the 36-month cap, these commenters believe that suppliers may not adequately comply with the accreditation requirement unless accreditation is addressed separately at § 414.226.

Response: This comment is outside the scope of the rule. The accreditation standards are required by Section 1834(a)(20) of the Act, as amended by Section 302 of the Medicare Prescripton Drug, Improvement, and Modernization Act of 2003 (MMA). Section 424.57(c)(22) requires compliance with accreditation as part of the DMEPOS supplier standards. Also, if a supplier is found to not meet a mandatory supplier standard such as accreditation requirements, we may invoke administrative remedies. In accordance with § 424.57(d), failure to meet a mandatory supplier standard may be addressed by revoking a supplier's billing privileges.

Comment: Several commenters indicated that we did not amend our regulations to include beneficiary safeguards to prevent oxygen suppliers, who do not want to provide services after the 36 month cap, from forcing more complex and costly oxygen patients into skilled nursing facilities or forcing beneficiaries to pay out-of-pocket for certain services.

Response: We appreciate the commenter's interest in the prevention of abuse to oxygen beneficiaries. We believe beneficiary safeguards for prevention of abuse when furnishing of oxygen and oxygen equipment are encompassed in the DMEPOS supplier standards. The supplier standard at § 424.57(c)(1) requires the supplier to operate its business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements. Also, § 414.226(f) of our regulations requires that the supplier that furnishes oxygen equipment for the 36th continuous month during which payment is made must continue to furnish the equipment during any period of medical need for the remainder of the equipment's reasonable useful lifetime. The supplier may not charge the beneficiary or the program for services associated with meeting these requirements. Thus, if it is determined that the supplier is out of compliance with these requirements, CMS sanctions may apply.

As we discussed above, if a supplier is found to not meet a mandatory supplier standard, we may invoke administrative remedies. For example, in accordance with § 424.57(d), failure to meet a mandatory supplier standard may be addressed by revoking a supplier's billing privileges.

Comment: A number of commenters suggested amending our regulations to provide additional reimbursement after the 36-month cap when the oxygen supplier must assist beneficiaries due to power outages caused by natural disasters and other emergencies. Another commenter explained that an emergency could be defined as a beneficiary who is having trouble breathing after facing an unexpected environmental emergency situation.

Response: Section 1834(a)(5)(F) of the Act authorizes specific types of payments following the 36-month cap. The statute mandates continued payments for oxygen contents for use with gaseous or liquid oxygen equipment after the cap. Other than maintenance and servicing of the equipment, which is addressed in section II.G.10.c. below, the statute does not authorize other payment for services related to furnishing oxygen equipment. Thus, if a beneficiary's concentrator cannot function due to a power outage, the supplier may meet the beneficiary's oxygen needs by furnishing gaseous or liquid stationary equipment until the power resumes at the beneficiary's home. If oxygen equipment is lost or irreparably damaged due to an emergency situation such as a fire or flood, Medicare payment can be made for replacement of the oxygen equipment in accordance with § 414.210(f)(2).

Comment: Numerous commenters opposed the provisions in § 414.226(f)(1)(ii) and (f)(2)(ii) which requires the supplier to arrange to furnish oxygen equipment and oxygen if the beneficiary relocates to an area that is outside the normal service area of the supplier that initially furnished the equipment. Many commenters emphasized small and rural suppliers will have greater difficulty making arrangements outside their service area because these suppliers do not have expertise and resources to enter many arrangements outside their service area. Several commenters were concerned that supplier licensing and accreditation is not applicable outside their state or normal service area and this would present problems when supervising the furnishing of oxygen services for a beneficiary that relocates outside their service area. A few commenters noted that the costs associated with transferring a beneficiary to an out of area supplier were not discussed and thus a reasonable basis for the provisions at § 414.226(f)(1)(ii) and (f)(2)(ii) had not been established. One commenter contended that § 414.226(f)(2) is inconsistent with other regulations for the DME competitive bidding program.

Response: We understand there may be challenges with furnishing oxygen and oxygen equipment to traveling and relocating beneficiaries. However, in the CY 2009 PFS final rule with comment period (73 FR 69876), we explained that the provisions of section 144(b) of the MIPPA do not contain exceptions to the 36 month rental cap for situations when a beneficiary travels or permanently relocates to another area. In instances in which a beneficiary relocates outside of the normal service area of a supplier, the current supplier must make arrangements in the new service area with a Medicare-enrolled supplier who is required to be compliant with all applicable Federal and State licensure and regulatory requirements. Furthermore, we have worked with our contractors who issued subregulatory guidance on billing for situations when a beneficiary travels or permanently relocates because these situations necessitate attention to the date of service and location of the supplier. We

will continue to monitor this issue and if necessary, develop additional subregulatory instructions. Concerns related to the regulations for the DMEPOS competitive bidding program are not in the scope of these regulatory changes.

Comment: Some commenters noted that beneficiaries that have not reached the end of the 36-month cap may confront difficulties in securing a new supplier in an area that is outside the normal service area of the supplier that initially furnished the equipment since the new supplier will receive a reduced number of payments before the end of the 36-month rental period. Several commenters requested confirmation that § 414.226(g) does not require that the supplier furnish or make arrangements to furnish oxygen to a beneficiary outside of the service area during the 36-month rental period.

Response: Regulatory changes concerning the 36-month rental cap are outside the scope of this rule which is intended to implement the provisions of section 144(b) of the MIPPA. As a result, we are finalizing § 414.226(f)(1)(ii) and (f)(2)(ii) as proposed.

However, as discussed in our response above, we have worked with our contractors who issued subregulatory guidance on billing for situations when a beneficiary travels or permanently relocates because these situations necessitate attention to the date of service and location of the supplier. When a beneficiary travels or relocates during the 36-month rental period, the existing supplier can aid the beneficiary in locating a supplier in the new service area. In addition, ombudsman staff at 1–800–Medicare has been trained to assist beneficiaries in these situations to find a new supplier. We will continue to monitor this issue closely and will take appropriate actions to address these situations.

Comment: Several commenters requested clarification on how to apply the § 414.230 requirement of continuous use for durable medical equipment to the 36-month rental cap for oxygen equipment.

Response: In the CY 2009 PFS final rule with comment period (73 FR 69937), we added § 414.230(h) to our regulation on determining a period of continuous use to clarify that after the 36-month rental period, a new period of continuous use does not begin under any circumstance in the case of oxygen equipment furnished between the end of the 36-month rental cap and the end of the equipment's reasonable useful lifetime. The statute and regulation require a supplier to continue furnishing the oxygen equipment after the 36th continuous month for any period of medical need for the remainder of the equipment's reasonable useful lifetime. Additional details pertaining to the definition of continuous use of oxygen and oxygen equipment both before and after the 36-month rental cap have been issued through sub-regulatory guidance as part of the implementation of the 36-month rental cap mandated by the DRA. In addition to transmittal 421 (Change Request 6297), we provided program guidance on January 26, 2009 to contractors containing oxygen and oxygen equipment continuous use policies. These policies have been posted on the contractors' Web sites.

Comment: Several commenters requested clarification on supporting documentation for replacement oxygen equipment after the expiration of the 5-year useful lifetime.

Response: When oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime, a new Certificiate of Medical Necessity (CMN) is required to establish a new 36-month rental period and new reasonable useful lifetime. Suppliers must also furnish documentation in order to verify that the equipment being replaced has been in use for at least 5 years. Additional details pertaining to the documentation required to support the replacement of oxygen equipment after the expiration of the 5-year reasonable useful lifetime have been issued through Medicare contractor subregulatory guidance which has been posted on the contractor's Web sites.

Comment: Several commenters suggested that the requirements at § 414.226(f)(1)(i) and (f)(2)(i) for a supplier to continue furnishing oxygen and oxygen equipment after the cap prevent a beneficiary from changing suppliers if the supplier is performing poorly. This potentially results in the beneficiary being forced to utilize a low quality supplier for at least 5 years.

Response: Section 144(b) of the MIPPA requires that the supplier furnishing equipment in the 36th continuous month continue furnishing the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary. We believe the language of section 1834(a)(5)(F) of the Act, as amended by 144(b) of the MIPPA, is clear. Since oxygen contents are furnished as part of the continued furnishing of gaseous or liquid oxygen equipment, this requirement extends to oxygen contents furnished after the cap. This is explained in more detail in section II.G.10.b below. Regarding the quality of items and services provided by suppliers of oxygen and oxygen equipment, beneficiaries who encounter such problems should report them by contacting 1–800–Medicare. A beneficiary ombudsman will work to resolve the issue. Also, we note that program requirements are now in place and require suppliers of oxygen and oxygen equipment to have surety bonds and be accredited to meet mandated quality standards. Failures to remain in compliance with these quality standards will be reported to the supplier's accreditation organization.

Comment: Several commenters requested clarification on changing oxygen equipment systems during and after the oxygen rental period.

Response: During and after the 36-month rental period, if the beneficiary's physician orders a change in modality (oxygen equipment delivery system), the supplier must furnish that new modality without a restart of the 36-month rental period per the continuous use regulations at § 414.230. Section 414.226(g)(2) prohibits a supplier from changing a beneficiary's oxygen equipment/modality during the 36 month payment period without a physician's order, unless the equipment is lost, stolen, irreparably damaged, or in cases where the beneficiary elects to upgrade to newer technology equipment. Also, § 414.226(g)(1) requires that the supplier that furnished oxygen equipment for the first month during which payment is made must continue to furnish the equipment for the entire 36-month period unless certain specific exeptions apply.

After consideration of the public comments, we are finalizing these provisions without modification.

b. Payment for Oxygen Contents After the Rental Cap

Section 144(b)(1) of the MIPPA amends section 1834(a)(5)(F)(ii)(II) of the Act and requires us to continue to make payments to suppliers for furnishing oxygen contents after the 36-month rental cap for oxygen equipment ends. Under this provision, an oxygen supplier that furnished liquid or gaseous oxygen equipment during the 36-month rental period, and is required by section 1834(a)(5)(F)(ii)(I) of the Act to continue furnishing the equipment after the 36-month rental period ends, will receive payment for furnishing oxygen contents necessary for use with liquid or gaseous oxygen equipment after the 36-month rental period. Section 1834(a)(5)(F)(ii)(II) of the Act establishes the payment amount for the

oxygen contents as that set forth in section 1834(a)(9) of the Act.

We revised § 414.226(d) and (f) to specify that payment shall be made for oxygen contents for use with supplier-owned liquid or gaseous oxygen equipment furnished after the 36-month rental period. An oxygen supplier that furnishes liquid or gaseous oxygen equipment during the 36-month rental month must continue to furnish the oxygen contents for any period of medical need for the remainder of the reasonable useful lifetime of the liquid or gaseous oxygen equipment established in accordance with § 414.210(f)(1). This requirement is necessary because liquid and gaseous oxygen systems (stationary and portable) require on-going delivery of oxygen contents in tanks or cylinders to furnish oxygen to the patient. We believe that the MIPPA provisions when read together provide that the supplier that continues to furnish liquid or gaseous oxygen equipment in accordance with section 1834(a)(5)(F)(ii)(I) of the Act is also required to furnish the oxygen contents housed in those tanks. This is based on the nature of the benfit and the requirement in the statute that the supplier ''must continue to furnish'' the equipment during any period of medical need. Empty tanks furnished in accordance with section 1834(a)(5)(F)(ii)(I) of the Act would provide no benefit to the patient, since the patient would not be receiving oxygen through the equipment.

We revised § 414.226(f) to specify that the supplier must make arrangements for the beneficiary to continue receiving the equipment if the beneficiary relocates at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment. Likewise, we revised § 414.226(f) to specify that, in the case of liquid or gaseous equipment (stationary and portable) the supplier must make arrangements for the beneficiary to continue receiving oxygen contents if the beneficiary relocates at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the liquid or gaseous equipment (stationary and portable). The supplier must make arrangements for the beneficiary to continue receiving the oxygen contents and equipment at his or her new residence.

Comment: One commenter noted the rule does not specify if Medicare pays for the delivery of oxygen contents when the beneficiary elects to purchase their oxygen equipment.

Response: In accordance with § 414.226(d)(3)(i) and § 414.226(d)(4)(i), payment is made for the delivery of oxygen contents used with beneficiary-owned equipment as long as such contents are medically necessary.

Comment: Several commenters questioned the billing instructions for oxygen contents with regards to HCPCS codes, supporting documentation, and units of service.

Response: Since the publication of the CY 2009 PFS final rule with comment period, we have released subregulatory instructions on these issues for oxygen and oxygen equipment. The contents of these instructions have been posted on the contractors' Web sites.

Comment: Some commenters requested increased payments for higher contents usage. One commenter stated that after the 36 month cap, individual patient usage may increase due to a change in patient condition requiring more oxygen contents. The commenters suggested the supplier should be permitted to issue an Advanced Beneficiary Notice (ABN) and bill the beneficiary for nonassigned claims.

Response: Section 144(b)(1) of MIPPA, which amends section 1834(a)(5)(F)(ii) of the Act, does not provide for additional payments for volume adjustments on content payments after the 36-month rental cap. The monthly payments for oxygen contents include payment for oxygen contents needed for the entire month. The payment amount does not vary depending on the quantity (low or high) of oxygen needed. Use of an ABN is therefore not appropriate in these situations.

Comment: One commenter requested clarification on whether a nonparticipating DME supplier who has accepted assignment of claims for oxygen and oxygen equipment during the 36-month rental cap period has to continue to accept assignment of claims for oxygen contents furnished after the 36-month cap.

Response: Since nonparticipating suppliers can elect to accept assignment on a claim by claim basis, a non-participating supplier can decide to provide oxygen contents on an unassigned basis after the 36-month payment cap.

After consideration of the comments received, we are adopting these provisions as final without modifications.

c. Maintenance and Servicing of Supplier-Owned Oxygen Equipment After the Rental Cap

Section 1834(a)(5)(F)(ii)(III), as amended by section 144(b)(1) of the MIPPA, authorizes payment for maintenance and servicing of supplier-owned oxygen equipment furnished after the 36-month rental period if we determine such payments are reasonable and necessary.

In the CY 2009 PFS final rule with comment period, we determined that it is not reasonable and necessary to pay for servicing (repair) and non-routine maintenance of supplier-owned oxygen equipment. Given that the supplier owns the equipment, we believe the supplier should be responsible for maintaining its equipment in working order as it did during the 36-month rental period. In addition, warranties covering 5 years are generally available for the top selling brands of oxygen equipment and as discussed in the November 9, 2006 final rule (71 FR 65917) and the CY 2009 PFS final rule with comment period (73 FR 69878), we understand from manufacturers that such products are generally dependable. In a September 2006 report entitled ''Medicare Home Oxygen Equipment: Cost and Servicing,'' (OEI–09–04–00420), the Office of Inspector General (OIG) of the Department of Health and Human Services found that only 22 percent of beneficiaries who began renting oxygen equipment in 2001 rented the equipment for 36 months or longer. Recent claims data analysis indicates that more than 75 percent of Medicare beneficiaries do not rent oxygen equipment for longer than the 36 months (see Table 52 in section XIII. of this final rule with comment period.) Therefore, oxygen equipment is returned to suppliers before the end of the 36-month rental period in more than 75 percent of cases, and suppliers are then able to furnish the equipment to other beneficiaries, starting new 36-month periods of rental payments for the same equipment. Given that equipment that is less than 5 years old requires minimal maintenance and servicing, and in more than 75 percent of oxygen equipment rental episodes, suppliers receive more than 36 rental payments for the same piece of equipment, we concluded that suppliers should be responsible for maintaining their equipment in working order after the 36-month rental period as they did during the 36-month rental period.

Although we determined as part of the CY 2009 PFS final rule with comment period provisions that it is not reasonable and necessary to make payments for repair or non-routine maintenance of the supplier-owned oxygen equipment, we made an initial determination applicable to CY 2009 only that it is reasonable and necessary for the safety of the beneficiary to make

payments for periodic, in-home visits by suppliers to inspect oxygen concentrators and transfilling equipment and provide routine maintenance and servicing during these visits to ensure that the equipment is functioning properly. Therefore, we revised § 414.210(e)(2), to provide payment in 2009 for general maintenance and servicing of supplier-owned oxygen concentrators and transfilling equipment furnished after the 36-month rental period in accordance with section 1834(a)(5)(F)(ii)(I) of the Act consistent with our authority in section 1834(a)(5)(F)(ii)(III) of the Act. Payments are made in 2009 when the supplier performs routine maintenance and servicing as part of a visit to the beneficiary's home, 6 months after the 36-month rental period ends. Payments in 2009 for a maintenance and service visit may be made when the beneficiary is at home or at a temporary residence (for example, a vacation residence). For each visit, payment is equal to the Medicare allowed payment amount for 30 minutes of labor associated with repair of beneficiary-owned DME. As we indicated in the November 9, 2006 final rule for implementing section 5101(b) of the DRA (71 FR 65917), we believe that payment for 30 minutes of labor will adequately compensate suppliers for general maintenance and servicing visits based on findings by the OIG in their September 2006 report (OEI–09–04–00420) that many routine maintenance activities performed by suppliers on concentrators could be performed within that timeframe.

Separate payment is not made for parts replaced during the general maintenance and servicing visit, as the primary purpose of the periodic visit is to check the supplier-owned equipment to ensure that it is functioning properly. If parts need to be replaced in order to make the equipment serviceable, we concluded that the supplier should be responsible for replacing the parts on equipment from their inventory that they are furnishing to the beneficiary in order to meet the beneficiary's medical need for oxygen.

We solicited comments from interested parties on whether these payments should continue past CY 2009. The following is a summary of the comments we received and our responses.

Comment: Numerous commenters were in favor of continuing payment for maintenance and servicing visits past 2009. However, many commenters stated that a biannual maintenance and servicing payment is insufficient in frequency. Other commenters suggested that limiting maintenance and servicing payments to visits every 6 months will result in patients being hospitalized due to respiratory conditions. The commenters suggested that more frequent maintenance and servicing visits will prevent hospitalizations. Commenters also opposed basing the payment amount for maintenance and servicing on 30 minutes of labor. These commenters felt that the payment amount of two units of labor was inadequate to cover travel, labor (average 2 to 4 hours for travel and visit time), repairs, and supplies for a home visit. Several commenters requested clarification on the specific timeframe for when a maintenance and servicing visit may occur after the end of the 36-month rental period. Several commenters requested that we provide more specific data and the methodology used to compute the reimbursement for a maintenance and servicing visit.

A number of commenters suggested that the maintenance and servicing rules and payments for oxygen equipment should be similar to those described at § 414.229(e) for capped rental items furnished prior to January 1, 2006. Under these rules, the maintenance and servicing payment amounts are made every 6 months, beginning 6 months after the end of the rental cap period and cover all maintenance, servicing, and repair of the equipment that is needed after the rental cap. The payment amounts are limited to one month's rental payment for the item.

Response: We appreciate the comments received and agree that continuing maintenance and servicing payments for oxygen concentrators and transfilling equipment past 2009 is reasonable and necessary for the safety of the beneficiary. We are also clarifying that the supplier that furnishes the equipment during the 36th continuous month during which payment is made is responsible for continuing to furnish the equipment after the 36th continuous month (after the cap) and is responsible for furnishing equipment in good working order regardless of the implementation of section 1834(a)(5)(F)(ii)(III) of the Act. We would like to stress this point for commenters who suggest that beneficiaries will be harmed unless these payments are sufficient to cover specific costs incurred by the supplier for maintaining and servicing supplier-owned equipment.

Nevertheless, we agree with commenters that it is reasonable and necessary to increase the maintenance and servicing payment established for 2009 to further ensure the equipment is maintained and serviced by the supplier, thereby protecting beneficiaries who rely on oxygen equipment to deliver a sufficient concentration and quantity of oxygen on an uninterrupted basis. We also agree with commenters who believe that it is reasonable and necessary to establish rules for maintenance and servicing of certain oxygen equipment that are similar to the rules described at § 414.229(e) for capped rental items furnished to beneficiaries beginning on or before December 31, 2005.

These rules allow payment every 6 months, beginning 6 months after the end of the rental cap period, for all necessary maintenance and servicing. In accordance with § 414.229(e), a reasonable fee is established for maintenance and servicing not to exceed 10 percent of the purchase price of the item. Our experience and an OIG report from June 2002 entitled ''Medicare Maintenance Payments for Capped Rental Equipment'' (OEI–03–00–00410) indicates that such rules more than adequately reimbursed suppliers for maintenance and servicing of capped rental items. In addition, we believe it is necessary to continue requiring that suppliers make visits every 6 months to the beneficiary's home to inspect the oxygen equipment to ensure that all of the equipment maintenance and servicing needs are being addressed.

Regarding the fee for maintenance and servicing, in order to model the payment for maintenance and servicing of certain oxygen equipment after the capped rental maintenance and servicing provision at § 414.229(e), it is necessary to develop maintenance and servicing payments for oxygen equipment in a way that ensures that the amount does not exceed 10 percent of the purchase price of the equipment. The monthly payment amount for oxygen and oxygen equipment includes payment for oxygen contents in addition to equipment rental and is not established based on a percentage of the purchase price of the equipment, as is the case for capped rental items. In the September 2006 report on oxygen equipment, the OIG found that the average cost of an oxygen concentrator was $587. Increasing this amount to a 2010 price based on the percentage change in the Consumer Price Index for all Urban Consumers (CPI–U) from 2006 to 2010 yields a purchase price of $660. We note that the percentage change in the CPI–U from June 2008 to June 2009, the factor used to inflate prices from 2009 to 2010, is a negative 1.41 percent. Therefore, we use a factor of zero percent as the indicator for inflation for this year. Establishing the maintenance

and servicing fee based on 10 percent of this average price would result in a payment of $66 for CY 2010. For subsequent years, the payment amount will be adjusted based on the covered item update for DME as set forth in section 1834(a)(14) of the Act.

After careful consideration of comments on this issue, we are adding § 414.210(e)(5) to make ongoing maintenance and servicing payments for oxygen concentrators and transfilling equipment (or equipment other than stationary or portable gaseous or liquid oxygen equipment) furnished on or after July 1, 2010 based on a reasonable fee not to exceed 10 percent of the purchase price for a stationary oxygen concentrator. We are making these changes effective for items furnished on or after July 1, 2010, to allow time for necessary systems changes. We are revising § 414.210(e)(2) to continue the maintenance and servicing policy established for certain oxygen equipment for 2009, for items furnished from January 1, 2010 through June 30, 2010. For items furnished on or after July 1, 2010, the maintenance and servicing payments would be made following each subsequent 6-month period until either medical necessity ends or the beneficiary elects to obtain new equipment. Only one maintenance and servicing payment will be made during each 6-month period for any combination of concentrator and oxygen transfilling equipment used by the beneficiary in their home. The maintenance and servicing payment includes payment for all necessary maintenance and servicing of the beneficiary's oxygen concentrator (stationary or portable) and transfilling equipment and a minimum of one required visit to the beneficiary's home to inspect the equipment. Consistent with our existing policy, no payment is made for maintenance and servicing of gaseous or liquid oxygen equipment. Finally, in response to comments, we are revising § 414.210(e)(2), and adding (e)(2)(iii) and (e)(5)(iv) to clarify that the visit to the beneficiary's home must occur during the first month of the 6-month period. This will ensure that the visits occur in 6-month intervals so that maintenance and servicing necessary to keep the equipment in good working order for the next 6 months is performed for each subsequent 6-month period and avoids overlap of 6-month maintenance and servicing episodes.

Comment: One commenter asked for clarification as to whether suppliers can enter into a service contract with the beneficiary after the 36-month cap for additional maintenance and service visits along with any necessary on-call visits.

Response: In accordance with 1834(a)(5)(F)(ii)(I) of the Act and regulations at § 414.226(f)(1), the supplier is responsible for furnishing, or making arrangements to furnish, the oxygen equipment in good working order for any period of medical need after the 36-month cap for the remainder of the reasonable useful lifetime of the equipment. In addition, as indicated above, we are revising § 414.210(e)(2) and § 414.210(e)(5) to make payment for ongoing maintenance and servicing of equipment other than gaseous or liquid oxygen equipment after the cap. Therefore, we believe it would be inconsistent with these provisions for suppliers to require that beneficiaries enter into service contracts for maintenance and servicing of rented oxygen equipment at any time or to charge the beneficiary for maintenance and servicing of equipment beyond those allowed by regulations at § 414.210(e). As explained previously, the supplier is required to furnish gaseous or liquid oxygen equipment in good working order during the 36-month rental period and following the 36-month rental period when payments continue for delivery of oxygen contents. Therefore, it would be inconsistent with these provisions for the supplier to charge the beneficiary for maintenance and servicing of gaseous or liquid oxygen equipment.

After consideration of the comments received, we are adopting as final § 414.210 by revising § 414.210(e)(2) and adding § 414.210(e)(5).

d. Other Public Comments Received on the CY 2009 PFS Final Rule With Comment Period

Comment: Several commenters noted that CMS did not discuss the application of policies for Advanced Beneficiary Notices (ABN) on the period following the 36-month oxygen payment cap.

Response: Using an ABN in the post 36-month period is only applicable when upgrading to medically unnecessary equipment or equipment with features that are not medically necessary. As a result, we do not anticipate frequent application of an ABN during the post 36-month period and did not incorporate this issue in our regulations at § 414.226(f) and (g).

Comment: Several commenters explained that currently respiratory therapists are not separately reimbursed as licensed practitioners under the PFS. As a result, they receive payment for their professional services from suppliers receiving payment for furnishing oxygen equipment. Thus, reductions in payment for home oxygen equipment will adversely affect payments for respiratory therapists. The commenters requested that payment should be established for respiratory therapists under the PFS.

Response: This topic of Medicare coverage and payment for the professional services of licensed respiratory therapists is not a subject of the CY 2009 PFS final rule with comment period or this final rule with comment period for implementation of section 144(b) of MIPPA and therefore outside the scope of this rule.

Comment: Several commenters raised concern that our regulations do not address situations where an oxygen supplier discontinues its business or declares bankruptcy. The commenters believe a new supplier will refrain from accepting patients from a terminating supplier because the new supplier will receive fewer monthly rental payments and upon reaching the payment cap, the new supplier must continue furnishing the oxygen and oxygen equipment for the remainder of the reasonable useful lifetime of the equipment.

Response: We will evaluate current regulations to determine if oxygen equipment that is lost due to bankruptcy can be replaced. We are not addressing bankruptcy in this rulemaking which is intended to address the provisions of section 144(b) of the MIPPA.

Comment: Several commenters objected that our regulation at § 414.210(f)(1) establishes that the reasonable useful lifetime of DME cannot be less than 5 years and instead recommended that the regulation be revised for oxygen equipment to 3 years. One commenter stated most oxygen compressors expire after approximately 9,000 to 10,000 hours of use of the equipment. Additionally, one commenter requested clarification on whether the useful lifetime restarts if the oxygen equipment has been changed or replaced after the equipment was originally delivered to the patient but before the expiration of 5 years.

Response: The reasonable useful lifetime begins with the initial delivery date of the equipment. Equipment can be changed for another oxygen modality or replaced without affecting the duration of the reasonable useful lifetime as long as there is not a break in the medical necessity of oxygen (break in need) during the 36-month rental period, for at least 60 days plus the days remaining in the last paid rental month. It is important to note, however, that our regulations did not propose an amendment to § 414.210(f)(1) and as such, revisions to

the length of the reasonable period are outside the scope of this rulemaking effort.

11. Section 152(b): Coverage of Kidney Disease Patient Education Services

Section 152(b) of the MIPPA provides for coverage of kidney disease education (KDE) services for patients. The following is an outline of our final rule to implement the statutory amendments.

a. Statutory Authority

Section 152(b) of the MIPPA amended section 1861(s)(2) of the Act by adding a new subparagraph (EE) ''kidney disease education services'' as a Medicare-covered benefit under Part B. This new benefit is available for Medicare beneficiaries diagnosed with Stage IV CKD, who in accordance with accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. KDE services will be designed to provide comprehensive information regarding:

- The management of comorbidities, including delaying the need for dialysis;
- Prevention of uremic complications;
- Options for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and in-center, as well as vascular access options and transplantation);
- Ensuring that the beneficiary has the opportunity to actively participate in his or her choice of therapy; and
- Tailored to meet the needs of the beneficiary involved.

b. Public Meetings

Section 1861(ggg)(3), as added by section 152(b) of the MIPPA, requires that the Secretary set standards for the content of the KDE services after consulting with various stakeholders, who to the extent possible, had not received industry funding from a drug or biological manufacturer or dialysis facility. On November 6, 2008, and December 16, 2008, we held two feedback sessions to solicit stakeholder comments regarding the implementation of section 152(b) of the MIPPA. Both feedback sessions were open to the public. In addition to the feedback sessions, we conducted an internal review of the available medical evidence, literature, and currently available CKD patient education programs. Transcripts from both events are available on the CMS Web site at *http://www.cms.hhs.gov/CoverageGenInfo/08_CKD.asp#TopOfPage.* A summary of the feedback sessions is available in the proposed rule (74 FR 33615 through 33616).

c. Summary of Proposed Rule and Comments

We proposed, consistent with section 1861(ggg) of the Act, to amend 42 CFR part 410 to add new § 410.48 for KDE services as a Medicare Part B benefit. The following is a summary of the provisions of the proposed rule, and the comments we received on the proposed rule, and the changes we are making in this final rule regarding coverage of KDE under section 152(b) of the MIPPA. We received broad support from commenters regarding the addition of KDE services as a Medicare Part B covered benefit. Most were generally pleased with the proposed rule and commended us for our expeditious implementation of the MIPPA provisions. Commenters appreciated that CMS collected and incorporated broad stakeholder feedback in the development of the proposed rule.

(1) Definitions (§ 410.48(a))

As related to the implementation of section 1861(ggg) of the Act, we proposed the following definitions in § 410.48:

- Kidney Disease Patient Education Services: Consistent with section 1861(ggg)(1) of the Act, we defined Kidney Disease Patient Education Services as face-to-face educational services provided to patients with stage IV CKD. We specified that KDE services are provided in a face-to-face manner based on stakeholder feedback received during the consultation meetings and our general rulemaking authority. Face-to-face education is consistent with sections 1861(ggg)(C)(ii) and (iii) of the Act, which provide that the services should be designed to ensure that the beneficiary has the opportunity to actively participate in the choice of therapy and be tailored to meet the needs of the beneficiary involved.

Comment: One commenter agreed with our proposal to define KDE as face-to-face educational services provided to patients with Stage IV CKD. Several commenters asked us to consider allowing the services to be provided via telehealth and in Federally qualified health centers (FQHCs), since multiple education sessions may be difficult for some patients due to transportation issues and recommended that KDE services be added to the telehealth services at § 410.78. One commenter stated that we have recognized telehealth as a ''face-to-face'' encounter in the past.

Response: We appreciate the concerns raised by commenters regarding access to services in rural areas. In the proposed rule, we specified that KDE services be provided in a face-to-face manner based on stakeholder feedback received during the consultation meetings and our general rulemaking authority. Face-to-face education is consistent with sections 1861(ggg)(C)(ii) and (iii) of the Act, which provide that the services should be designed to ensure that the beneficiary has the opportunity to actively participate in the choice of therapy and be tailored to meet the needs of the beneficiary involved.

At this time, we believe that it would be more appropriate to consider the addition of KDE services for telehealth through full notice and comment procedures in the CY 2011 PFS proposed rule, based on the experience we gain observing the KDE programs over 1 year. We will accept requests for consideration to add KDE services to the list of approved telehealth services in the CY 2011 PFS proposed rule if received prior to December 31, 2009. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth/*.

Comment: One commenter stated that qualified persons should be precluded from using videos as a method for providing KDE services since patients need to ask questions and may fall asleep during a video due to their illness and anemia levels.

Response: We received similar feedback from stakeholders during the feedback sessions and understand the commenter's concerns about using videos as a method for providing KDE services. We agree that a video is not an appropriate modality for providing KDE services, which is why we specify that KDE services are services provided in a face-to-face manner.

We are retaining the definition of Kidney Disease Patient Education Services as proposed in this final rule.

- Physician: For purposes of KDE services, we proposed to define physician using the definition in section 1861(r)(1) of the Act; it defines ''physician'' as ''a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101(a)(7) [of the Act].'' We received no comments regarding our proposed definition of physician and are adopting this definition in this final rule.
- Qualified Person: Consistent with section 1861(ggg)(2)(A) of the Act, for purposes of KDE services, we proposed to define a ''qualified person'' as a

physician (as defined in section 1861(r)(1) of the Act); a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) (as defined in section 1861(aa)(5) of the Act, and implemented in § 410.74, § 410.75, and § 410.76 of this subpart). A provider of services located in a rural area is also included in the statute's definition of a qualified person. Section 1861(u) of the Act defines ''provider of services'' to be ''a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program or, for purposes of sections 1814(g)and section 1835(e) [of the Act], a fund''. We define a ''qualified person'' to include a provider of services located in a rural area and would include each of these healthcare entities except for a ''fund.''

In order for a provider of services to be a ''qualified person,'' the entity must be located in a rural area. We include in the definition of a ''qualified person'', only those hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospice programs that are located in a rural area under section 1886(d)(2)(D) of the Act (as defined in our regulations at § 412.64(b)(ii)(C)) and include hospitals and CAHs that are reclassified from urban to rural status pursuant to section 1886(d)(8)(E) of the Act, as defined in § 412.103. Specifically, § 412.64(b)(ii)(C) defines ''rural'' to mean any area outside an urban area, which § 412.64(b)(ii)(A) defines as a metropolitan statistical area (MSA) as defined by the President's Office of Management and Budget (OMB). Therefore, we believe that a hospital, CAH, SNF, CORF, HHA, or hospice program that is not physically located in an MSA should be considered ''rural'' for this benefit.

Section 1886(d)(8)(E) of the Act, implemented in § 412.103, requires us to treat hospitals that meet specified criteria as geographically rural under section 1886(d)(2)(D) of the Act even though they are physically located in an MSA. Because the statute identifies these hospitals as rural, we believe that it is appropriate to consider these hospitals as qualified persons for purposes of the KDE benefit.

Comment: Several commenters requested that we consider adding various other healthcare professionals to the definition of a qualified person including registered dietitians, renal dieticians, licensed dieticians, nutrition support clinicians (nutrition support physician, nurse, or pharmacist), medical nutrition therapists, nephrology social workers, registered nurses, nephrology nurses, and/or transplant coordinators as qualified persons or as members of a multi-disciplinary team headed by the qualified person to provide KDE services. One commenter was concerned that dietary advice provided by physicians, nurses, and NPs, while well meaning, is often overly restrictive, and could lead to malnutrition and lower quality of life. One commenter requested that at least one of the sessions be designated for the patient to meet with a registered dietitian. One commenter stated that a dietitian who is board certified in renal adds additional competency to his or her qualifications to provide KDE services.

Response: The Congress did not specifically authorize the Secretary to approve additional healthcare professionals within this defined term. Therefore, we are not accepting the comments to further expand the definition to include other healthcare professionals.

Comment: Regarding providers of services located in rural areas, one commenter recommended that we rely on facilities to schedule the appropriate staff to teach KDE services in these facilities and not to narrow the clinical practice activities beyond those permitted within each state's clinical scope of practice laws.

Response: Providers of services are responsible for providing proper staffing of KDE services. We encourage facilities to review the standards for content of KDE services when determining who will be providing such services, similar to how a facility would choose the appropriate staff for other facility functions.

Comment: One commenter disagreed with our proposed definition of a provider of services located in a rural area as a ''qualified person'' who may be paid for kidney disease education services. The commenter believes that the definition of a provider of services in a rural area should include rural hospital-based dialysis facilities. The commenter stated that these types of facilities are the only dialysis facilities that could be interpreted as a qualified person under section 1861(ggg)(2)(A)(i) of the Act and that renal dialysis facilities not located within a hospital are not providers of services under 1861(ggg)(2)(B). Furthermore, the commenter indicated that, as a practical matter, hospital-based dialysis facilities in rural areas are the only providers of services that would be capable of providing kidney disease education services as the Congress intended under the provisions of MIPAA.

Response: We disagree with the commenter's request to include dialysis facilities within the definition of a ''provider of services located in a rural area.'' Section 1861 (ggg)(2)(B) of the Act explicitly excludes renal dialysis facilities from being ''qualified persons'' for purposes of the kidney disease education benefit. The statute does not provide an exception for dialysis facilities located within hospitals. We do not consider dialysis facilities located in a hospital to be different from a freestanding dialysis facility for purposes of the statutory exclusion.

In addition, section 1861(u) of the Act defines a provider of services to be a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice. The provisions of MIPAA require that the provider of services must be located in a rural area in order to furnish KDE services. In implementing the KDE benefit, to exclude these providers of services located within a rural area would be contrary to the statutory definition of the term ''provider of services.''

Therefore, in this final rule with comment period and as specified in the statutory definition of a ''qualified person,'' we consider a qualified person to be either a physician (as defined in section 1861 (r)(1) of the Act) or a PA, NP, or CNS; or a provider of services located in a rural area, which includes a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice. A qualified person under this benefit does not include a renal dialysis facility, whether freestanding or hospital-based, regardless of whether the renal dialysis facility is located in a rural area or not. While the hospital-based renal dialysis facility located in a rural area is not a ''qualified person'' for purposes of payment for KDE services, we note that the hospital of which the hospital-based renal dialysis facility is a part would meet the definition of a ''qualified person'' because it is in a rural area.

- Renal Dialysis Facility: The Congress has provided in section 1861(ggg)(2)(B) of the Act that a ''renal dialysis facility'' may not be a ''qualified person.'' We proposed to define this term, consistent with § 405.2102 of this title, as ''a unit which is approved to furnish dialysis services(s) directly to ESRD patients.'' We received no comments on the definition and are adopting the proposed definition in this final rule.

• Stage IV Chronic Kidney Disease: Section 1861(ggg)(1)(A) of the Act states that KDE services shall be furnished to beneficiaries diagnosed with Stage IV CKD, who according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. Based on stakeholder feedback, we proposed to define Stage IV CKD as kidney damage with a severe decrease in GFR quantitatively defined by a GFR value of 15–29 ml/min/1.73 m^2, using the Modification of Diet in Renal Disease (MDRD) Study formula.[1] Because there are currently no agreed upon accepted clinical guidelines that describe the stage IV patients who would eventually require dialysis or a kidney transplant, we proposed to cover all stage IV patients. We received no comments regarding our proposed definition of Stage IV CKD or regarding clinical guidelines for identifying beneficiaries with stage IV CKD that will require dialysis or a kidney transplant. Therefore, we are adopting our proposed definition of Stage IV CKD in this final rule.

(2) Covered Beneficiaries (§ 410.48(b))

Consistent with section 1861(ggg)(1)(A) of the Act, we proposed that Medicare beneficiaries are eligible to receive KDE services if the beneficiaries are diagnosed with Stage IV CKD (as defined in new § 410.48(a)), and have been referred for such services by the physician managing the beneficiary's kidney condition.

Comment: Some commenters recommended that we modify the provisions regarding beneficiaries eligible to receive KDE services to indicate that the beneficiary be diagnosed with at least stage IV CKD. Several commenters held the opinion that the Congress envisioned that defining stage IV CKD would not be a precise process by requiring that CMS rely upon accepted clinical guidelines. Commenters were also of the opinion that the Congress recognized that some beneficiaries should qualify for the benefit because they were at a stage where RRT was imminent, but had not commenced. Commenters believed that the Congress added a limiting clause that precludes beneficiaries who are on dialysis or have received a transplant, which would prevent more than the targeted population from obtaining these services. Several commenters pointed out that the KDOQI guidelines acknowledge that the GFR ranges/measurements established in the guidelines should not be used as definitive cut-offs between stages because using such cut-offs is inherently arbitrary. Commenters requested that CMS not adopt a ridged approach, but rather recognize that beneficiaries with stage IV and those beneficiaries with stage V that have not yet started renal replacement therapy should be treated similarly for purposes of qualifying for the KDE services.

Response: We understand and appreciate that the staging criteria is a classification system and understand the commenters' desire for beneficiaries to have access to this important benefit. However, there is no statutory authority to expand eligibility for individuals beyond those noted in the proposed rule.

Comment: One commenter asked that we consider the needs of adolescent/young adult renal transplant patients between 18 and 24 years old that are transitioning from pediatric to adult nephrology care.

Response: We appreciate that adolescents and young adults with CKD have unique needs that need to be addressed as part of their overall plan of care. The standards for content allow for the KDE services to be tailored to the needs of the beneficiary involved. We note that an adolescent/young adult described by the commenter would need to be a Medicare beneficiary and meet the eligibility provisions of this rule in order to obtain services under this benefit.

Comment: One commenter requested that we use a standardized method to screen qualifying beneficiaries to participate in the KDE services.

Response: We are defining stage IV CKD as ''kidney damage with a severe decrease in glomerular filtration rate (GFR) quantitatively defined by a GFR value of 15–29 ml/min/1.73m^2, using the MDRD Study formula,'' and required that the beneficiary obtain a referral from the physician managing the beneficiary's kidney condition. These provisions provide a standardized method for determining if a beneficiary is eligible for KDE services.

Comment: Some commenters indicated that referrals for KDE services should not be limited to just those obtained from the physician managing the beneficiary's kidney condition. Commenters suggested that we allow referrals from those that meet the definition of a qualified person since many CKD patients are not under the care of a single physician managing the beneficiary's kidney condition. Commenters were concerned that a physician who diagnoses the beneficiary with CKD but has not been managing the kidney condition for a period of time, would be precluded from making a referral for KDE services. Commenters stated that beneficiaries may be diagnosed late in the progression of their CKD and may not have been managed by a physician up to that point. Commenters recommended that we clarify the language in this provision so that physicians or other healthcare professionals that diagnose the beneficiary's kidney condition be able to refer the beneficiary for KDE services.

Response: Beneficiary access to these new services is important and we recognize the commenters' concerns about whether a beneficiary's kidney disease is being managed by a physician. Section 1861(ggg)(1)(B) of the Act expressly requires that KDE services are ''(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person[…]'' We interpret the statute to mean that referrals are made by physicians and KDE services are furnished by qualified persons. Appropriate referral of a patient is left to the discretion of the physician as described above. If a physician diagnoses and discusses KDE services, we consider this to be sufficient to be considered the physician managing the beneficiary's kidney condition. Therefore, the physician, within his or her discretion, can make a referral for KDE services.

Comment: One commenter requested that the physician managing the beneficiary's kidney condition, as part of the KDE program, should initiate a referral for Medical Nutrition Therapy (MNT). Commenters also recommended that referrals for MNT be added to the KDE standards for content.

Response: We recognize that MNT can be an important benefit available to beneficiaries with chronic kidney disease. The MNT benefit (42 CFR 410 Subpart G) has distinct eligibility criteria, though it does overlap somewhat with the eligibility criteria for KDE services. A qualified person that provides KDE services and a physician managing a beneficiary's kidney condition may want to consider making patients aware that MNT is a Medicare covered benefit that provides beneficiaries with chronic kidney disease information about proper nutrition. We encourage physicians, healthcare professionals, and beneficiaries to discuss whether a referral for MNT services would be appropriate. Referral of a patient for MNT services is left to the discretion of the physician. Therefore, we do not believe it would be appropriate to

[1] Levey, A.S., Greene, T., Kusek, J, and Beck, G.A. J Am Soc Nephrol. 2000. 11: p. 155A.; Levey, A.S., Bosch, J.P., Lewis, J.B., Greene, T., Rogers, N., and Roth, D. Ann Intern Med. 1999 Mar 16; 130(6):461–70.

include a requirement for referral to MNT services as part of the referral process or the standards for content for KDE services.

Therefore, in this final rule, we are retaining our proposed provisions for covered beneficiaries.

(3) Standards for Qualified Persons and Exclusions (§ 410.48(c))

We proposed requiring that a qualified person be able to properly receive Medicare payment under 42 CFR part 424 (Conditions for Medicare Payment). Consistent with section 1861(ggg)(2)(B) of the Act, we proposed to specifically exclude a hospital, CAH, SNF, CORF, HHA, or hospice that is physically located outside of a rural area under § 412.64(b)(ii)(C), except for a hospital or CAH that is treated as being located in a rural area under § 412.103. In addition, consistent with section 1861(ggg)(2)(B) of the Act, a renal dialysis facility is not a qualified person.

While we did not propose specific education, experience, training, and/or certification requirements in the proposed rule, we solicited public comments on the appropriate level of education, experience, training, and/or certification appropriate for a qualified person to effectively provide KDE services. Factors to consider included specific education and expertise regarding the topic and the ability to explain these areas for the purpose of patient education.

Comment: Many commenters recommended that qualified persons either be board certified in nephrology or have at least 2 years experience working primarily with kidney disease patients. Commenters believed that the suggested qualifications supported our objective that the qualified person be able to explain the subjects enumerated in the proposed rule.

Response: The recommended qualifications were popular among commenters, but to our knowledge, the recommendations are not universally agreed upon standards for educators in existing education programs. Therefore, we are not adding specific education/experience qualifications for qualified persons to this final rule with comment period.

In this final rule with comment period, we are retaining the proposed standards for the ''Qualified Persons and Exclusions'' provisions.

(4) Standards for Content of Kidney Disease Patient Education Services (§ 410.48(d))

We believe that patient education needs vary by severity of the disease, the age of the patient, the patient's comorbid conditions and disabilities, the patient's primary language and culture, and desire to learn more about the disease and treatment options. Education services are more effective if the services are tailored to meet an individual beneficiary's needs. We proposed that KDE services include the content as specified in proposed new § 410.48(d).

Commenters were overwhelmingly supportive of the proposed standards for content and provided suggestions for improvement.

Comment: Some commenters requested that we provide more detailed regulatory guidance regarding the minimum core curriculum to maintain consistency and a balanced/comprehensive nature of the education sessions. Specifically, the commenters requested:

- Nature and treatment for co-morbidities that accompany CKD such as anemia, mineral and bone disorders, diabetes, and high blood pressure;
- Separate vascular access into its own topic heading and specify the benefits and risks of each option, the need to preserve vasculature for creation of fistulas, and care of vascular access to avoid infection and stenosis;
- Transplantation including preparation for transplantation, pre-emptive transplantation and differences between living donor and deceased donor transplantation, immunosuppression, allocation policies, and lifestyle post-transplant;
- Smoking cessation;
- Use of non-steroidal anti-inflammatory agents;
- Impact of blood transfusions on transplant candidacy;
- Nutrition, risk of malnutrition, impact of dietary interventions on the progression to kidney failure, and pre-dialysis and dialysis patient dietary prescriptions;
- Conservative management without renal replacement therapy and palliative care as a therapeutic option; and
- Advanced directives education.

Response: We appreciate the suggestions provided. The intent of the standards for content is that qualified persons provide a comprehensive set of information, but allow qualified persons flexibility in specific session design to meet the needs of the individual beneficiary(s) involved. Anemia, mineral and bone disorders, diabetes, and high blood pressure are addressed under § 410.48(d)(1), management of comorbidities including for the purpose of delaying the need for dialysis. Vascular access options, impact of blood transfusions on transplant candidacy, preparation for transplantation, pre-emptive transplantation, differences between living donor and deceased donor transplantation, immunosuppression, allocation policies, and lifestyle post-transplant are addressed under § 410.48(d)(3), therapeutic options, where we specify that qualified persons discuss the advantages and disadvantages of each therapeutic option. Regarding smoking cessation, conservative management without renal replacement therapy, palliative care as a therapeutic option, and advanced directives are addressed in § 410.48(d)(4), opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved. Nutrition, risk of malnutrition, impact of dietary interventions on the progression to kidney failure, and pre-dialysis and dialysis patient dietary prescriptions are addressed in § 410.48(d)(2), prevention of uremic complications, under diet and fluid restrictions; and medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision-making if the patient decides not to take a specific drug. The topics we list in § 410.48(d) do not constitute an all inclusive list. Specifically, we are stating with this final rule that the education provided to beneficiaries includes, but is not limited to the content standards topics listed in new § 410.48(d). We leave it to the discretion of the qualified person to tailor the services to individual needs.

Comment: One commenter requested that CMS include language stating that KDE services include, but are not limited to, the content as specified in § 410.48(d) and permit qualified providers to include additional reasonable and necessary content at their discretion.

Response: Under the standards for content, each content heading specifies that education sessions include, but are not limited to, the topics listed. We note that in the proposed rule § 410.48(d)(3), Therapeutic options, the ''not limited to'' language was inadvertently omitted. In this final rule, we are correcting this omission and clarifying that qualified persons discuss, but are not limited to, the topics listed under this content heading.

Comment: Some commenters requested standardized content. One commenter recommended the KDOQI guidelines as a source for standardization criteria.

Response: We understand and appreciate the suggestion that the KDE

services content should be standardized. The intent of the standards for content is consistent with the statutory provisions at section 1861(ggg)(1)(C)(iii) of the Act, which state that KDE services ''be tailored to meet the needs of the individual involved.'' The intent of the standards for content was to strike a balance between ensuring that beneficiaries are provided comprehensive information, but also that the services are tailored to individual needs. We outlined the major topics in the content standards that need to be addressed during KDE sessions, but also believe it is important to allow flexibility for qualified persons to tailor the education sessions to meet the needs of the beneficiaries involved, per the statutory requirements.

Comment: Commenters stated that the terminology ''vascular access'' does not encompass peritoneal dialysis access and recommended that we change the terminology to ''dialysis access for both hemodialysis and peritoneal dialysis.''

Response: We agree with the comments provided regarding vascular access and we are changing ''all vascular access options'' to ''all dialysis access options for hemodialysis and peritoneal dialysis.''

(5) Session Specifications (§ 410.48(e))

(a) Limitations on the number of sessions: Consistent with section 1861(ggg)(4) of the Act, we limit the number of KDE sessions to six (6). We did not receive any comments on the session limitations. Therefore, we are adopting the limits, as proposed, in this final rule.

(b) Session Length: In the proposed rule we defined the session length as 60 minutes.

Comment: One commenter concurred that 6 hours was sufficient to provide comprehensive KDE services, but recommended that we recognize a partial/fraction of a session. For example, one session could be billed in four 15-minute increments, to allow for variation in session length based on beneficiary needs.

Response: Consistent with section 1861(ggg)(4) of the Act, we limit the number of KDE sessions to six (6). As we discussed in the proposed rule, stakeholders provided a variety of recommendations regarding appropriate session length. In the absence of supporting evidence for session length, we are defining the session length in this final rule as one (1) hour, which coincides with the session length of some programs in existence and is the approximate average of stakeholder suggested session lengths.

(c) Individual and Group Session Format: Consistent with section 1861(ggg)(C)(iii) of the Act, we specify that the qualified person tailor the design of the education services to meet the needs of the beneficiary based on whether the beneficiary needs more individualized education, would benefit more from a group environment, or a combination; and consider any communication accessibility needs based on disability, language and health literacy.

Generally speaking, medical services are provided to beneficiaries on an individual basis. Beneficiaries can also benefit from the interaction in a group setting. We believe that the beneficiary, in consultation with the referring physician, will be able to best determine the education services modality that most effectively meets his or her needs.

Comment: One commenter recommended that we needed to build in flexibility of group versus the individual setting since some patients are more comfortable in the group setting. Other patients may be traumatized by the prospect of dialysis and need more individualized attention. One commenter suggested that the initial KDE education should be standardized and then later sessions be customized to meet patient specific needs. Another commenter requested that we mandate that at least 2 or more of each of the beneficiary's 6 KDE sessions be provided in a one-on-one format.

Response: We recognize that each individual, in consultation with the physician managing their kidney condition, are best able to determine the education services modality that most effectively meets his or her needs, whether that be group sessions, individual sessions, or a combination. The provisions of this rule allow for such flexibility.

Comment: One commenter requested an equal level of intensity for all sessions.

Response: In the final rule, we state that each KDE session is one (1) hour long, which addresses the commenter's concerns regarding session intensity.

Comment: One commenter requested that qualified persons should provide material that is specific to the patient, taking into account the patient's primary language, reading level, and comprehension level.

Response: We recognize the importance of providing beneficiaries with information in a format that is easy to comprehend. The provisions of the final rule allow that the KDE services be tailored to meet the needs of the individual beneficiary involved. We also address the commenter's concerns as part of the outcomes assessment process. This final rule with comment period states that the outcomes assessments will serve to assess KDE program effectiveness in meeting the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy.

Comment: One commenter recommended that we define a group session as consisting of between 2 and 20 participants.

Response: In § 410.48(e)(2) of this final rule, we specify that a session is one (1) hour long and may be provided individually or in group settings of 2 to 20 individuals who need not all be Medicare beneficiaries. We believe that this provision addresses the commenter's concerns about group size.

(6) Outcomes Assessment

The intent of the education services is for the beneficiary to take the information he or she has learned during the educational sessions in order to facilitate active participation by the beneficiary in the healthcare decision-making process with the physician managing his or her kidney condition. We believe that it is important that beneficiaries be assessed at the conclusion of the education sessions and that program assessments be used by the educators and CMS to assess the effectiveness of the education services, to help improve the programs for future participants, and better facilitate patient understanding of the material.

Based on stakeholder feedback and our general rulemaking authority, we proposed that qualified persons develop outcomes assessments and that each beneficiary be assessed during one of the education sessions. Section 410.48(d)(5) specifies that the outcomes assessment measures beneficiary knowledge about CKD and its treatment for the purpose of, and as a contributor to, the beneficiary's ability to make informed decisions regarding their healthcare and treatment options.

After completing the KDE services, the beneficiary should be able to take the information learned and use it to make informed choices about their healthcare during future consultations with the physician managing the beneficiary's kidney condition. It is important that the assessments be tailored to the beneficiary's reading level and language if the assessment is not administered by the qualified person that provided the education services, and be made available to CMS in a summarized format upon request. In the proposed rule, we specifically

solicited public comments regarding the development and administration of the outcomes assessments.

Comment: Commenters recommended both pre- and post-assessments and comparison studies of those beneficiaries that participated in KDE versus individuals that did not obtain the KDE services. Commenters recommended that the assessments cover topics specific to the content discussed during the KDE sessions, suggested that we work with stakeholders to develop standardized assessment tools, and provide a flexible implementation schedule that accounts for the time necessary for providers to adopt the new assessment instruments. Some commenters stressed the importance of long term post-assessment and follow-up by the physician managing the beneficiary's kidney condition, along with adoption of incentives to encourage providers to undertake such assessments. One commenter recommended that we re-evaluate the assessments over time to ensure that they address the most relevant topics and are administered effectively. One commenter requested standardized curriculum, evaluation, and monitoring tools.

Response: We are encouraged by the support from commenters about the development of outcomes assessments. After reviewing the feedback received during the stakeholders meetings and from commenters, there does not appear to be a standardized or agreed upon outcomes assessment mechanism. While we are not making any changes in this final rule from the proposed outcomes assessment provisions, we are considering working with organizations that are developing outcomes assessments as they work to develop a standardized assessment tool.

Comment: One commenter suggested that we develop an outcomes measure for ''physician referral for medical nutrition therapy'' as one of the monitoring tools.

Response: We appreciate the importance of proper nutritional counseling services. Since the outcomes assessment is part of the KDE services, it will not be paid separately and there is no need for a separate reporting tracking code.

Comment: One commenter requested clarification about whether pre- and/or post-assessments are included as part of the 6 sessions or in addition to the 6 sessions and whether there would be a separate reporting code and payment for the assessments.

Response: Outcomes assessments must be administered during a KDE session, meaning that the assessments are included as part of the sessions. Requests for separate reporting codes and payment for assessments would require a benefit category determination to determine if separate payment would fall within a Medicare benefit category.

Additional Issues

Comment: One commenter requested that we amend the ''Welcome to Medicare'' physical exam regulations to incorporate KDE as part of the preventive services checklist. Another commenter encouraged us to coordinate with Medicaid to examine whether stage IV education should be part of Medicaid case management services.

Response: We appreciate the attention being drawn to the importance of coordination with other benefits and programs such as the ''Welcome to Medicare'' physical exam and the Medicaid program. The commenter's requests do not fall within the scope of this rule. However, we plan to convey the commenter's suggestions to the appropriate components.

Comment: One commenter recommended that we promote the KDE program and the MNT benefit to beneficiaries and physicians.

Response: Medicare will release appropriate manual and transmittal instructions and information from our educational components for the medical community, including an MLN Matters article (Medicare Learning Network). The medical community can join this effort in educating physicians and beneficiaries by distributing their own communications, bulletins, or other publications. In addition, we have included information on the KDE benefit in the 2010 version of the Medicare and You Handbook. While we understand the importance of the MNT benefit, the commenter's request for promotion of the MNT benefit does not fall within the scope of this rule.

As a result of the comments received, we are making the following changes in this final rule with comment period:

- In the Standards for Content section, we are changing ''all vascular access options'' to ''all dialysis access options for hemodialysis and peritoneal dialysis.''
- In the standards for content section, we are clarifying that qualified persons discuss, but not be limited to, the topics listed under the 'therapeutic options' content standard heading.
- In the Limitations for Coverage of Kidney Disease Education Services section, we are changing the description of session length from ''60 minutes'' to ''one (1) hour.''

d. Payment for KDE Services

Section 152(b) of the MIPPA creates a new benefit category for KDE services. The MIPPA amends section 1848(j)(3) of the Act, which allows for payment of KDE services under the PFS. As we stated in the CY 2010 PFS proposed rule (74 FR 33619), KDE services are covered when they are furnished by a qualified person as defined in § 410.48(a) that meets the requirements of § 410.48(c) which means a physician, PA, NP, CNS, or a provider of services located in a rural area including a CAH, SNF, HHA, CORF, and hospice. We note that there is a possibility that a beneficiary may receive services from more than one ''qualified person''; however, payment should be made to only one qualified person on the same day for the same beneficiary.

In the proposed rule, we noted that the ''incident to'' requirements for physician services at section 1861(s)(2)(A) of the Act do not apply to KDE services. The MIPPA requirements are explicit, that the education services must be provided by a qualified person. We noted that rural health clinics (RHCs) do not meet the statutory definition of a provider of services (as defined in 1861(u) of the Act) and cannot be separately paid for furnishing KDE services.

In the proposed rule, we noted that the ''incident to'' provision does not apply to the implementation of a new service with a distinct benefit category under the PFS. We stated that the ''incident to'' requirements would not apply to KDE services.

Comment: Some commenters stated that CMS has the discretion and flexibility to allow KDE services to be provided ''incident to'' unless the statute explicitly precludes it. They also stated that section 152(b) of the MIPPA requires that KDE be furnished by a ''qualified person'', which includes physicians and specified nonphysician practitioners (NPPs) and that the statute does not prohibit KDE from being performed ''incident to'' the services of a ''qualified person''. Commenters also stated that CMS should allow a qualified person, as defined in section 152(b) of the MIPPA, to bill an E/M code on the same day as a KDE service.

Response: We do not agree that CMS has discretion to allow KDE services to be furnished incident to because the MIPPA specifically provides a benefit policy for KDE and that policy is different from incident to policy. In the December 31, 2002 final rule (67 FR 79994), we stated that ''Congress specifically provided for the many separate benefit categories of medical

and health services in the Act. We believe that the Congress intended for incident to services to be a catch-all category to allow payment for certain services and supplies commonly furnished in a physician's office and not having their own separate benefit category. The billing of services with their own separate and independent coverage benefit categories as incident to may circumvent the coverage and payment rules applicable to those other categories. Therefore, only services that do not have their own benefit category are appropriately billed as incident to a physician service.'' KDE has a benefit category with its own policies. For example, section 152(b) of the MIPPA requirements is explicit, that the education services must be provided by a qualified person, which is defined as a physician, NP, CNS or PA. A qualified person may include a provider of services located in a rural area. Therefore, the ''incident to'' requirements will not apply to KDE services. A qualified person can bill an E/M service on the same day they bill for a KDE service if the services being provided are not the same services which are included in KDE under our regulations at § 410.48.

Comment: A commenter stated that CMS has allowed separately and independently listed services to be provided under the ''incident to'' benefit. They also stated that CMS clarified in the CY 2002 PFS final rule that many services, even those that are separately and independently listed, can be furnished as ''incident to'' and need not meet the requirements of an ''incident to'' service.

Response: The commenter may be referring to policies prior to 2001. We have previously stated, ''In the November 2001 final rule (66 FR 5238), we revised regulations on services and supplies furnished incident to a physician's professional services. In the revised regulations at § 410.26(a)(7) we defined such services and supplies that may be provided as incident to as '* * * any services and supplies * * * that are included in section 1861(s)(2)(A) of the Act and are not specifically listed in the Act as a separate benefit included in the Medicare program.' '' (67 FR 79993) The commenter refers to one response to a comment in that rule that caused confusion. We repeated that comment at 67 FR 79994, column 1, and we clarified the intent of the response in column 2 of the same page. (See the previous response for the quotation that clarifies the intention of that response.) KDE has a benefit category with its own policies and, those policies are not the same as policies for services incident to physician services.

It is our policy that only services without a benefit category may be provided ''incident to'' the services of physicians or NPPs.

Comment: One commenter stated that while the patient's physician may know him or her, other members of the patient's multidisciplinary team may know them as well. The commenter also stated that the patient might receive better care if KDE services were provided by a team of persons such as nurses, dieticians, social workers and physicians, which could be done if we allow KDE to be provided incident to.

Response: The section 152(b) of the MIPPA requirements are explicit, in that the education services must be delivered by a qualified person, which is defined as a physician, NP, CNS, or PA, and also includes a provider of services located in a rural area.

Comment: A commenter stated that CMS has established subregulatory policy by which services furnished under the Medical Nutrition Therapy (MNT) and Diabetes Self Management Training (DSMT) benefits may not be provided ''incident to''. However, the commenter stated that there is no statutory or regulatory provision preventing those services from being performed ''incident to'' and that the services furnished under those benefits are not performed by physicians or NPPs. The commenter stated that the distinction is that the MNT and the DSMT benefits are furnished by practitioners who were previously not able to bill the Medicare program and who do not have an ''incident to'' benefit for their service. In contrast, the KDE benefit will be provided by practitioners who bill the Medicare program independently and who have an ''incident to'' benefit attached to their services.

Response: For separately and independently listed services, a physician and a NPP can bill using the ''incident to'' benefit. However, KDE is not defined as a separately and independently listed service, but as a separate and distinct benefit category and so the ''incident to'' benefit does not apply.

In summary we are finalizing our determination that the ''incident to'' benefit does not apply to KDE.

Section 1861(ggg)(4) of the Act limits the number of KDE services that a beneficiary may receive to up to six sessions in the NPRM. We proposed to create two HCPCS codes GXX26 now assigned as G0420 (individual) and GXX27 now assigned as G0421 (group), to describe and to bill for KDE services. The two G-codes consist of 1-hour face-to-face KDE sessions for an individual or group. We proposed to pay both G0420 and G0421 at the nonfacility rate. We also proposed that G0420 educational services related to the care of chronic kidney disease; individual per session will be crossed-walked to CPT code 97802; and that G0421, educational services related to the care of chronic kidney disease; group, per session will be crosswalked to CPT code 97804. We stated that the rationale for the proposed pricing of the G-codes is based on the similarity of this service to MNT in the individual (97802) and group (97804) setting.

In the CY 2010 OPPS/ASC proposed rule (74 FR 35358), we discussed our proposed payment for KDE to qualified persons located in rural areas who are hospitals, CAHs, SNFs, CORFs, HHAs, or hospices (74 FR 35358).

The following is a summary of the comments we received regarding our proposals related to the MPFS payment for kidney disease education under section 152(b) of the MIPPA.

Comment: One commenter suggested that CMS add the phrase ''furnished by a rural provider'' or similar language to the proposed Level II HCPCS G-code descriptors for KDE, to clarify that these services are intended for patients who solely meet the qualifications for coverage under the KDE benefit.

Response: We do not agree that the HCPCS G-code descriptors for KDE services should contain language that would limit their use to KDE services furnished by rural providers of services. The purpose of a HCPCS code is to describe a service furnished to a beneficiary. Generally code descriptors do not describe the provider who is furnishing these services. Adding a phrase to the G-code descriptors indicating that these services are furnished by a rural provider would exclude other qualified persons delineated in the Act from being able to bill and be paid for the KDE services they furnish. These qualified persons include a physician, PA, NP, or clinical nurse specialist, in addition to providers of services located in a rural area. Moreover, adding the language the commenter requests would not ensure that the service would be provided to patients who meet the criteria for coverage.

Comment: We received several comments stating that CMS accurately matched individual KDE to individual MNT and group KDE to group MNT. However, commenters stated that CMS did not take into account the relative time of the KDE and MNT sessions. The new KDE codes were cross-walked to

the MNT codes which are paid only for 15-minute individual sessions and 30-minute group sessions. We also received a comment concerning the inputs for supplies and equipment. In addition, commenters stating the proposed payment rates were too low to enable rural providers of services to furnish KDE.

Response: As a result of the comments we received and our own further analysis, we have adjusted the payment rates for G0420 and G0421 to reflect the 1-hour time limit for a session. We have multiplied the work RVUs for G0420 by four and the work RVUs for G0421 by two to account for the fact that we are crosswalking a 15 minute code to a 60 minute code (CPT code 97802 to G0420) and a 30 minute code to a 60 minute code (CPT code 97804 to G0421). We also adjusted the inputs for supplies. However, we did not do a straight multiplication of the actual inputs because we do not believe the required equipment and supplies would increase in direct proportion to the time for the codes. We did not increase the inputs for the body analysis machine and the printer and scale for use during the session. However, we did increase the inputs for equipment and supplies for the use of the table, computer, paper and other printed materials because regardless of how long the session is, it takes only 5 minutes to use the body/mass index item, 2 minutes to weigh the individual, and 2 minutes to use the printer (this time equals the number of pieces of paper).

Comment: A commenter stated that a significant portion of kidney education is about nutrition and diet and that the MNT benefit includes provisions of MNT to patients with kidney disease. Therefore, some kidney education is already being provided to Stage IV kidney patients through the MNT benefit and it would be inappropriate to pay four times more for nutrition education when it is provided under the MNT benefit than when the exact same education is provided under the kidney education benefit. The commenter also stated that MNT is provided by dieticians and KDE is provided by physicians and midlevel practitioners and the new G-codes should be cross-walked to the ''all physicians'' PE and not to the registered dieticians PE.

Response: As stated, we did adjust the inputs for supplies and equipment to eliminate any duplication. We also cross-walked the ''all physicians'' PE to HCPCS codes G0420 and G0421 at the mid-level office visit.

In summary, we are finalizing the proposed HCPCS codes G0420, *Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour,* and G0421, *Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour,* for KDE with the adjustments noted above. Refer to the Addendum B for the specific RVUs for G0420 and G0421.

12. Section 153: Renal Dialysis Provisions

Section 153 of the MIPPA requires changes to ESRD facilities for ESRD services effective January 1, 2010. The following is a summary of these changes.

Section 153(a)(1) of the MIPPA increases the current ESRD composite rate by 1.0 percent for services furnished on or after January 1, 2010. This also requires us to update the adjusted drug add-on. Since we compute the drug add-on adjustment as a percentage of the composite rate, the drug add-on percentage is decreased to account for the higher CY 2010 composite payment rate and results in a 15.0 percent drug add-on adjustment for CY 2010. As a result, the drug add-on amount of $20.33 per treatment remains the same for CY 2010, which results in a 15.0 percent increase to the base composite payment rate of $135.15 (see section II.I of this final rule with comment).

The composite rate paid to hospital-based facilities will be the same as the composite rate paid to independent renal dialysis facilities for services furnished on or after January 1, 2010, as required by section 153(a)(2) of the MIPPA. In addition, section 153(a)(2) of the MIPPA requires that in applying the geographic index to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.

These MIPPA provisions are self-implementing and require no substantive exercise of discretion on the part of the Secretary. A detailed discussion of the MIPPA provisions can be found in section III. of the CY 2009 PFS final rule with comment period (73 FR 69881).

The following is summary of the comments we received regarding section 153 of the MIPPA.

Comment: One commenter supports the composite payment rates for both independent and hospital-based facilities be site neutral, and urges CMS to ensure that pediatric facilities are not adversely impacted by this adjustment.

Response: Section 153(a)(2) of the MIPPA requires the composite payment rate for both independent and hospital-based facilities to be site neutral and does not negatively impact pediatric facilities because, in addition to the composite payment rate, all pediatric facilities including hospital-based facilities are paid the basic case-mix adjustment of 1.62 for pediatric patients.

13. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen

a. Background

(1) Process for Revising the List of Statutorily Named Compendia

Generally, compendia are ''pharmacopeia providing information on drugs, their effectiveness, safety, toxicity, and dosing and are frequently used to determine whether a medication has a role in the treatment of a particular disease; these roles include both therapeutic uses approved by the U.S. Food and Drug Administration (FDA) and off-label indications'' (Agency of Healthcare Research and Quality (AHRQ), *Potential Conflict of Interest in the Production of Drug Compendia* White Paper).[2] Compendia are published by various institutions and by traditional reference book publishing houses.

Compendia publishers, including internal editorial staff and external experts, review requests received for the inclusion of recommendations regarding off-label uses of drugs or biologicals in anticancer regimens. These requests may be internally generated by the publisher or may be received as requests from external parties. The publisher reviews evidence related to the request and reaches a disposition of the request.

Section 1861(t)(2)(B)(ii)(I) of the Act lists the following compendia as authoritative sources for use in the determination of a ''medically-accepted indication'' of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen: American Medical Association Drug Evaluations (AMA–DE); United States Pharmacopoeia-Drug Information (USP–DI) or its successor publication; American Hospital Formulary Service-Drug Information (AHFS–DI); and other authoritative compendia as identified by the Secretary. Due to changes in the pharmaceutical reference industry, AHFS–DI was the only statutorily

[2] Agency for Healthcare Research and Quality. White Paper: Potential Conflict of Interest in the Production of Drug Compendia. (2009, April 27). Available online at *http://www.cms.hhs.gov/mcd/viewtechassess.asp?from2=viewtechassess.asp&where=index&tid=64&*.

named compendium in current publication in CY 2008.

Section 1861(t)(2)(B) of the Act provides the Secretary the authority to revise the list of compendia in section 1861(t)(2)(B)(ii)(I) for determining medically-accepted indications for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Consequently, in § 414.930, we established an annual process to revise the list and a definition of ''compendium'' in the CY 2008 PFS final rule with comment period (72 FR 66222, 66303 through 66306, and 66404).

Currently, four compendia are recognized for purposes of section 1861(t)(2) of the Act: National Comprehensive Cancer Network Compendium, Gold Standard Clinical Pharmacology, Thompson Micromedex DrugDex, and AHFS–DI.

In addition to these compendia, the statute provides an alternative method for identifying medically-accepted off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Section 1861(t)(2)(B)(ii)(II) of the Act provides that local contractors may use ''supportive clinical evidence in peerreviewed medical literature'' to make such determinations. Thus these medically-accepted uses could be identified even if there were no compendia recognized for this purpose. We discussed this in our response to comments in the CY 2008 PFS final rule with comment period (72 FR 66305).

(2) Statutory Amendment

Section 182(b) of the MIPPA amended section 1861(t)(2)(B) of the Act (42 U.S.C. 1395x(t)(2)(B)) by adding the sentence, ''On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.''

As discussed in the proposed rule, we proposed revisions to the compendia standards to implement the MIPPA amendments. We note that the publishers of the four compendia that are currently recognized for purposes of section 1861(t)(2) of the Act have already adopted conflict of interest disclosure policies that are similar to our proposal. Though there are individual differences among the publishers, we note that these policies commonly include publication on the compendia publisher's Web site of the name of the individuals that participate in the compendia recommendation and the entity with which there is a significant relationship, the nature of the relationship (for example, salary, ownership, grant support), and the value of the relationship.

Additional information with respect to the conflict of interest policies of those compendia can be found on their Web sites.

In addition, there is a growing body of literature, including that from the Institute of Medicine (IOM),[3] that discusses the conflict of interest between research funding and research results. We believe that section 182(b) of the MIPPA is designed, in part, to address this issue in the compendia review process. For a detailed discussion of our proposals concerning conflict of interest, see the CY 2010 PFS proposed rule (74 FR 33620 through 33623).

b. Provisions of the Proposed Regulation

As discussed in the proposed rule, we believe that the implementation of this statutory provision that compendia have a ''publicly transparent process for evaluating therapies and for identifying potential conflicts of interests'' is best accomplished by amending the current definition of a compendium at § 414.930(a) to include the MIPPA requirements and by defining the key components of publicly transparent processes for evaluating therapies and for identifying potential conflicts of interests.

In order to implement the MIPPA requirements concerning a publicly transparent process for evaluating therapies, we proposed that a compendium could meet this standard by publishing materials used in its evaluation process on its Web site. This mode of publication provides broad contemporaneous public access to relevant materials. We believe that public access to such materials will increase transparency of the process used by compendia publishers for evaluating therapies and facilitate independent review of recommendations by interested parties. In addition, as discussed in the CY 2008 PFS final rule with comment period (72 FR 66305 through 66306), such disclosure may assist beneficiaries and their physicians in choosing among treatment options.

In the CY 2010 PFS proposed rule (74 FR 33620 through 33623), we proposed the following amendments to § 414.930(a):

- To revise the definition of ''compendium'' by adding an additional requirement that a compendium have a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.
- To add a definition of a ''publicly transparent process'' for evaluating therapies whereby a compendium publisher would publish on its Web site the complete application for inclusion of a therapy including criteria used to evaluate the request; disclosure of the evidence considered; the names of the individuals who have substantively participated in the development of the compendia recommendations; and transcripts of meetings and records of votes for disposition of the request. We requested comments on the requirement for publication of the transcript and the suitability of other alternatives such as minutes or other documents.
- To add a definition of a ''publicly transparent process for identifying potential conflicts of interests'' whereby a compendium publisher would disclose by publication on its Web site information regarding potential conflicts of interests associated with individuals who are responsible for the compendium's recommendations, as well as their immediate family members. We requested comments on the suitability of this process or whether the compendia should prescribe their own process. The specific details of the proposed process were outlined in the proposed rule (74 FR 33621 through 33623). We received the following comments on our proposed revisions.

c. Public Comment and Response

Comment: Commenters generally agreed with the principle that conflicts of interest pose a risk to the integrity of compendia and should be minimized.

Response: We appreciate the general support for the principle.

Comment: Some commenters were concerned with the technological burden of maintaining disclosable information publicly on the compendia Web sites for a 5-year period.

Response: Public interest in the review and disposition of a request pertaining to a drug or biological may in some cases arise only after a drug or biological has been in widespread use for several years, during which its risks or adverse effects become apparent. In order to balance the burden on the compendia publishers with the public's interest in timely access to this information, we are revising our proposal to require that the publicly transparent process provide for disclosures to remain available on the compendium's Web site for not less than 3 years. However, for the reasons discussed in the proposed rule (see 74

[3] Institute of Medicine. Conflict of Interest in Medical Research, Education, and Practice. Available online at *http://www.nap.edu/catalog.php?record_id=12598.*

FR 33622 through 33623), the compendia should retain custody of the relevant information, enabling public access to the material upon request for not less than 5 years.

Comment: Commenters suggested that the burden of disclosing conflict of interest information regarding individuals who participate substantively in the review and disposition of multiple requests could be lessened if there were no requirement to separately disclose this information for each and every request.

Response: We recognize that some individuals may participate substantively in the review and disposition of more than one request. However, we also recognize that a single relationship may present a significant conflict of interest in some cases but not others. Therefore, we are requiring compendia in establishing a publicly transparent process for identification of potential conflicts of interest, to list the names of those individuals who substantively participated in the review or disposition of each request.

Comment: Some commenters were concerned that the immediate removal of a compendium that fails to meet the statutorily-mandated January 1, 2010 implementation date as specified by section 182(b) of the MIPPA would adversely impact a patient being treated with an off-label anti-cancer chemotherapeutic regimen based on a recommendation from that compendium. One commenter suggested grandfathering patients that began an off-label anti-cancer chemotherapeutic regimen based the recommendation of a compendium that is removed from the list of statutorily recognized compendia based on noncompliance with section 182(b) of the MIPPA.

Response: The statute provides an alternative method for identifying medically-accepted off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen. In accordance with section 1861(t)(2)(B)(ii)(II) of the Act, local contractors have additional authority to make determinations regarding medically-accepted indications. We discussed this in our response to comments in the CY 2008 PFS final rule with comment period (72 FR 66305).

Comment: A few commenters were concerned that the proposed publicly transparent process for evaluating therapies might be interpreted to apply only to externally generated requests received by compendia.

Response: We appreciate this comment and have clarified this provision, because in some instances, a compendium's determination is internally generated. Therefore, we have added text to clarify that the requirements pertain to an internally or externally generated request.

Comment: Some of the commenters were concerned that requiring transcripts would inhibit discussion amongst compendia recommendation decision makers and would be too burdensome to compendia publishers because of the number or length of meetings, which may include discussion of topics beyond the request. The commenters suggested requiring minutes and voting records rather than transcripts. One commenter suggested that we delay the implementation of this requirement for up to 1 year.

Response: We agree that publication of minutes and voting records would be sufficient because it would provide public transparency regarding the evaluation of the therapy at issue. We also believe that this requirement can be implemented much more readily than the proposed requirement for transcripts.

Comment: A few commenters were concerned about the requirement for compendia to publicly transcribe all meetings pertaining to compendium recommendations. Specifically, some compendia publishers convene telephone conferences rather than meetings or have processes that isolate advisors from each others' recommendations.

Response: We have replaced the transcript requirement as noted above. However, this comment remains relevant as we have been made aware that some compendia publishers do not conduct actual meetings of individuals substantively involved in reviewing and reaching dispositions of requests and thus could not provide minutes of meetings. We believe that minutes of telephone conferences, to the extent that such conferences are used in the evaluation of the request, could also be used to demonstrate the evaluation process used by the compendia.

Comment: One commenter questioned the use of § 411.354 to define direct and indirect financial conflicts of interests.

Response: In the proposed rule, we stated that the process for identifying potential conflicts of interest should include disclosure of direct and indirect ''similar to those relationships identified in 42 CFR part 411.'' Compendia maintain discretion to develop their own definitions for direct and indirect financial conflicts of interests, however, the definitions included in 42 CFR part 411 are provided as a resource for compendia to use in the development of these definitions.

Comment: One commenter suggested that we establish a specific dollar value that would trigger disclosure of financial conflicts of interests that exceed some minimum amount.

Response: We are not requiring compendia to disclose a specific dollar amount. We have left it to the discretion of the compendia publisher as to whether a specific dollar value would be publicly disclosed.

Comment: Many commenters expressed support for the disclosure of the conflicts of interests of individuals who are responsible for the compendium's recommendations, as well as their *immediate family members*. There was concern from some commenters that the definition of immediate family member in § 411.351 (which includes, in part, relationships with a spouse, children, and grandparents) was too extensive.

Response: We agree with this comment and are amending the provision concerning the process for public disclosure of immediate family members to be less extensive and more consistent with the current FDA *Guidance for the Public, FDA Advisory Committee Members, and FDA Staff on Procedures for Determining Conflict of Interest and Eligibility for Participation in FDA Advisory Committees* released in August of 2008.

We have also amended the publicly transparent process for identifying potential conflicts to include a provision that requires compendia to have a process for collecting and maintaining conflict of interest information and disclosure, if requested by the public in lieu of publishing this information on their Web sites. We believe this strikes a reasonable balance between the individual's personal privacy and the public interest in transparency.

Comment: Some requestors asked if the regulatory requirements would apply to past requests that were received or under review by compendia publishers before January 1, 2010 that may have led to treatment recommendations that are published after that date.

Response: These provisions would not apply retroactively. However, the MIPPA provisions are effective on or after January 1, 2010. Thus, compendia are responsible for complying with these provisions with respect to requests received after the date.

d. Provisions of the Final Regulation

This final regulation amends § 414.930(a) to revise the definition of

compendium to add a requirement that a compendium have a publicly transparent process for evaluating therapies and for identifying conflicts of interests. We also define a publicly transparent process for evaluating therapies and for identifying conflicts of interests. The revised definitions read as follows:

• *Publicly transparent process for evaluating therapies* means that the process provides that the following information from an internal or external request for inclusion of a therapy in a compendium are available to the public for a period of not less than 5 years, which includes availability on the compendium's Web site for a period of not less than 3 years, coincident with the compendium's publication of the related recommendation:

(i) The internal or external request for listing of a therapy recommendation including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the request.

(iii) A listing of all individuals who have substantively participated in the review or disposition of the request.

(iv) Minutes and voting records of meetings for the review and disposition of the request.

• *Publicly transparent process for identifying potential conflicts of interests* means that the process provides that the following information is identified and made timely available in response to a public request for a period of not less than 5 years, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium. This publicly transparent process may include disclosure of, for example, compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals or the spouse or minor child of individuals who have substantively participated in the review and disposition of the request and the manufacturer or seller of the drug or biological being reviewed by the compendium.

(ii) Ownership or investment interests between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium.

H. Part B Drug Payment

1. Average Sales Price (ASP) Issues

a. Immunosuppressive Drugs Period of Eligibility

Before enactment of section 9335(c) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA '86), there was no specific Medicare benefit that provided for Medicare Part B coverage of prescription drugs used in immunosuppressive therapy. OBRA '86 added subparagraph (J) to section 1861(s)(2) of the Act to provide Medicare coverage for immunosuppressive drugs, furnished to an individual who receives an organ transplant for which Medicare payment is made, for a period not to exceed 1 year after the transplant procedure. Coverage of these drugs under Medicare Part B began January 1, 1987.

Section 13565 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66) amended section 1861(s)(2)(J) of the Act to allow eligible beneficiaries to receive additional Part B coverage within 18 months after the discharge date for immunosuppressive drugs furnished in 1995; within 24 months for immunosuppressive drugs furnished in 1996; within 30 months for immunosuppressive drugs furnished in 1997; and within 36 months for immunosuppressive drugs furnished after 1997. Beginning January 1, 2000, section 227 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (BBRA) extended coverage to eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expires during the calendar year, an additional 8 months beyond the 36-month period.

Section 113 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (BIPA 2000) revised section 1861(s)(2)(J) of the Act to eliminate the time limits for coverage of prescription drugs used in immunosuppressive therapy under the Medicare program. Effective with immunosuppressive drugs furnished on or after December 21, 2000, there is no longer any time limit for Medicare benefits. This policy applies to all Medicare entitled beneficiaries who meet all of the other program requirements for coverage under this benefit. Therefore, for example, entitled beneficiaries who had been receiving benefits for immunosuppressive drugs under section 1861(s)(2)(J) of the Act, but whose immunosuppressive drug benefit was terminated solely because of the time limit described above, resumed receiving that benefit for immunosuppressive drugs furnished on or after December 21, 2000.

According to section 226A(b)(2) of the Act, ''ESRD only'' beneficiaries continue to lose their general Medicare coverage and, by extension, Part B coverage for immunosuppressive drug therapy 36 months after discharge from a hospital following a covered transplant. Beneficiaries will have Part B coverage for immunosuppressive drug therapy for as long as they remain eligible for Medicare.

Our proposal to codify the immunosuppressive drug coverage does not cause a substantive programmatic change since the provisions in section 113 of the BIPA 2000 eliminating the time limit from section 1861(s)(2)(J) of the Act are self implementing for services on or after December 21, 2000. We included this topic in the proposed rule in order to make conforming changes to the regulatory text at § 410.30. We proposed to amend paragraph (b) to codify the changes to the immunosuppressive drug coverage time limit as required by section 113 of the BIPA 2000.

The following is a summary of the comments we received and our responses:

Comment: We received a few comments which supported our proposal. Commenters noted that this technical change will reduce the potential for confusion in the future about the scope of Medicare coverage of and payment for immunosuppressive drug therapy.

Response: We appreciate the supportive comments and agree that any steps which reduce confusion benefit Medicare and its stakeholders.

After reviewing the public comments, we are finalizing our proposed revisions to § 410.30.

b. WAMP/AMP Threshold

Section 1847A(d)(1) of the Act states that ''the Inspector General of HHS shall conduct studies, which may include surveys to determine the widely available market prices (WAMP) of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.'' Section 1847A(d)(2) of the Act states that, ''Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the ASP under this section for drugs and biologicals with—

• The widely available market price (WAMP) for these drugs and biologicals (if any); and

• The average manufacturer price (AMP) (as determined under section 1927(k)(1) of the Act for such drugs and biologicals).''

Section 1847A(d)(3)(A) of the Act states that, ''The Secretary may disregard the ASP for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).'' The applicable threshold is specified as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B) of the Act establishes that the applicable threshold is ''the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both.'' In CY 2006 through CY 2009, we specified an applicable threshold percentage of 5 percent for both the WAMP and AMP. We based this decision on the limited data available to support a change in the current threshold percentage.

For CY 2010, we proposed to specify an applicable threshold percentage of 5 percent for the WAMP and the AMP. At present, the OIG is continuing its comparisons of both the WAMP and the AMP. In April 2008, we implemented a change in the weighting methodology for calculating ASP. Information on how recent changes to the calculation of the ASP may affect the comparison of ASP to WAMP or AMP is limited at this time. In addition, due to the ongoing legal issues surrounding the availability of AMP, we believe it is prudent not to change the threshold at this time. Since we do not have sufficient data that suggest another level is more appropriate, we believe that continuing the 5 percent applicable threshold percentage for both the WAMP and AMP is appropriate for CY 2010.

As we noted in the CY 2009 PFS final rule with comment period (73 FR 69752), we understand that there are complicated operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP.

The following is a summary of the comments we received and our responses:

Comment: Most commenters supported maintaining the threshold at 5 percent. Other comments suggested that we exercise caution in the determination of price substitutions and that we develop a formal process and criteria to determine when substitutions are necessary. Comments also recommended that we provide adequate notice prior to making a price substitution. One commenter objected to the continuation of the 5 percent threshold but did not provide an alternative solution.

Response: We appreciate the comments supporting the continuation of the 5 percent threshold. As we noted in the CY 2009 PFS final rule with comment period (73 FR 69753), we understand there are complex operational issues associated with potential payment substitutions. As we continue to proceed in this area, we will provide stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions an opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP. As part of our approach we intend to develop a better understanding of the issues that may be related to certain drugs for which the WAMP and AMP may be lower than the ASP over time.

After reviewing the public comments, we are finalizing our proposal to continue the 5 percent WAMP/AMP threshold for CY 2010.

2. Competitive Acquisition Program (CAP) Issues

Section 303(d) of the MMA requires the implementation of a competitive acquisition program (CAP) for certain Medicare Part B drugs not paid on a cost or PPS basis. The provisions for acquiring and billing drugs under the CAP were described in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B proposed rule (March 4, 2005, 70 FR 10746) and the interim final rule (July 6, 2005, 70 FR 39022), and certain provisions were finalized in the CY 2006 PFS final rule with comment period (70 FR 70236). The CY 2007 PFS final rule with comment period (72 FR 66260) then finalized portions of the July 6, 2005 IFC that had not already been finalized.

The CAP is an alternative to the ASP (buy and bill) methodology of obtaining certain Part B drugs used incident to physicians' services. Physicians who choose to participate in the CAP obtain drugs from vendors selected through a competitive bidding process and approved by CMS. Under the CAP, participating physicians agree to obtain all of the drugs on the CAP drug list from an approved CAP vendor. The approved CAP vendor retains title to the drug until it is administered, bills Medicare for the drug, and bills the beneficiary for cost sharing amounts once the drug has been administered. The participating CAP physician bills Medicare only for administering the drug to the beneficiary. The initial implementation of the CAP operated with a single CAP drug category from July 1, 2006 to December 31, 2008.

After the CAP was implemented, section 108 of the MIEA–TRHCA made changes to the CAP payment methodology. Section 108(a)(2) of the MIEA–TRHCA requires the Secretary to establish (by program instruction or otherwise) a post payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological only if the drug or biological has been administered to a beneficiary. The Secretary is required to recoup, offset, or collect any overpayments. This statutory change took effect on April 1, 2007. Conforming changes were proposed in the CY 2008 PFS proposed rule (72 FR 38153) and finalized in the CY 2008 PFS final rule with comment period (72 FR 66260).

In the CY 2009 PFS proposed rule, we proposed several refinements to the CAP regarding the annual CAP payment amount update mechanism, the definition of a CAP physician, the restriction on physician transportation of CAP drugs, and the dispute resolution process (73 FR 38522). However, after the publication of the CY 2009 proposed rule, we announced the postponement of the CAP for 2009 due to contractual issues with the successful bidders. As a result, CAP physician election for participation in the CAP in 2009 was put on hold, and CAP drugs have not been available from an approved CAP vendor for dates of service after December 31, 2008. Physicians who participated in the CAP have transitioned back into the Average Sales Price (ASP) method of acquiring part B drugs for dates of service after December 31, 2008.

After the postponement was announced, we solicited public feedback on the CAP from participating physicians, potential vendors, and other interested parties. We solicited public comments on several issues, including, but not limited to the following: the categories of drugs provided under the CAP; the distribution of areas that are served by the CAP; and procedural changes that may increase the program's flexibility and appeal to potential vendors and participating physicians.

We also hosted a CAP Open Door Forum (ODF) on December 3, 2008, where participants had an opportunity to discuss the postponement and suggest changes to the program.

In the CY 2009 PFS final rule with comment period, we stated that we would review the public comments and consider implementing changes to the CAP before proceeding with another bid solicitation for approved CAP vendor contracts. Based on this information, we addressed items that were not finalized in the CY 2009 PFS final rule with comment period, and made additional proposals for the CAP. Our approach seeks to better define certain aspects of the program based on our experience. We also seek to continue to increase participation by minimizing the administrative burden for physicians and vendors who choose to participate. We appreciate the additional comments that we have received during the comment period.

a. Frequency of Drug Payment Amount Updates

As described in the July 6, 2005 IFC (70 FR 39070 through 39071) and § 414.906(c), payment amounts for drugs furnished under the CAP are set through a competitive bidding process, and as described in § 414.908(b), bids that exceed a composite bid threshold of 106 percent of the weighted ASP for the drugs in the CAP category are not accepted. The CAP payment amounts that are calculated from successful bids are updated from the time of the bidding period to the payment year. During the 2006 through 2008 CAP contract period, the initial update calculation used the change in the Producer Price Index (PPI) for prescription preparations to account for the time period between the bidding and the period in which the payment amounts were to be in effect, which was the middle of the first year of the three year CAP contract period (70 FR 39074). Finally, as specified in § 414.906(c), CAP payment amounts were updated again during the second and third year of the contract period based on the approved CAP vendor's reported reasonable net acquisition costs (RNAC). The annual updates are limited by payment amounts described in section 1847A of the Act and codified in § 414.906(c).

Section 1847B(c)(7) of the Act gives the Secretary the discretion to establish an appropriate schedule for the approved CAP vendor's disclosure of RNAC information to us, provided that disclosure is not required more frequently than quarterly. In the July 6, 2005 IFC (70 FR 39075 through 39076), we specified that each approved CAP vendor will disclose its RNAC for the drugs covered under the contract annually during the period of its contract and that we would calculate an annual payment adjustment based on this information. We specified an annual disclosure of RNAC because it imposes the minimal burden on approved CAP vendors. In 2005, some commenters suggested that more frequent updates would be desirable. Additional feedback about the CAP that was obtained after the program's postponement in 2008, as well as comments on previous rules, indicated that potential vendors would like the frequency of price adjustments to increase. In the past, various commenters have suggested a quarterly price adjustment in order to parallel the ASP process, to better match payment amounts with increases or decreases in drug costs, and to attract vendor interest. We believe that quarterly adjustments also would lower approved CAP vendors' financial risks because CAP payment amounts will be better able to keep up with unanticipated drug cost increases and would benefit the Medicare program by reacting to significant cost decreases more promptly.

Quarterly price updates also will eliminate the PPI-based increase that currently occurs between the time bids are submitted and the first day of CAP claims processing. The application of the PPI-based payment adjustment described in the July 6, 2005 IFC (70 FR 39074) has resulted in situations where the ASP+6 percent payment amount was exceeded during the first year of the 3-year approved CAP vendor contract. We do not believe that CAP payment amounts should exceed ASP+6 percent. In our discussion of bid ceilings in the July 6, 2005 IFC, we stated that the bid ceiling ''ensures that the CAP will be no more costly to the Medicare program than the alternative method of paying for drugs at 106 percent of ASP. This ceiling is thus consistent with the possibility of realizing savings to the Medicare program. It would also serve to maintain a level of parity between the two systems, preventing a situation in which significant payment differentials might skew incentives and choices (70 FR 39070).'' For this reason, and to remain consistent with current regulation text at § 414.906, we believe that all payment amounts calculated under the update process should be limited by the weighted payment amount established under section 1847A of the Act. We also believe that this approach will continue to provide for an ''appropriate price adjustment'' as required under section 1847B(c)(7) of the Act by improving responsiveness to unexpected price changes, and continuing a prudent limitation on the magnitude of payment amount adjustments.

Our approach for implementing quarterly updates is consistent with the ASP+6 percent limit on payment amounts and is based on composite bid price calculations, as described in the July 6, 2005 IFC (70 FR 39072 through 39073). Briefly stated, the ASP+6 percent limit would be applied by comparing the (weighted) composite update payment amount, calculated from participating approved CAP vendors' reasonable net acquisition cost data, to the most recent available weighted ASP prices for the same drugs. If the composite drug update payment amount exceeds the weighted ASP+6 percent payment limit, the composite payment amount for that group of drugs would be reduced to equal the ASP+6 percent limit by applying an equal percent reduction to each drug in the group. By way of example only, if a quarter's composite update payment was calculated as +2.3 percent, based on the median of all participating approved CAP vendors' data, but the calculated weighted ASP+6 percent limit for that group of drugs was +2.1 percent, the payment amounts for all HCPCS codes in the composite group would be increased by 2.1 percent in order to account for reported increases to the vendor's acquisition cost, but not to exceed the ASP+6 percent limit. This means that a 2.1 percent increase would be applied to CAP payment amounts for all HCPCS codes that are in the composite drug list and are being supplied under the CAP by one or more approved CAP vendors. For HCPCS codes that are priced separately, each code available through the CAP will be compared to the most recent ASP+6 percent limit for that code. CAP payment amounts for codes that exceed the ASP+6 percent limit will be reduced to ASP+6 percent. Each ''Not Otherwise Classified'' (NOC) drug described in § 414.906(f)(2)(iv), would also be updated on an individual (rather than composite) basis.

We proposed to discontinue annual CAP payment amount updates and to implement quarterly CAP payment amount updates at § 414.906(c). We also proposed to discontinue the special quarterly adjustments described at § 414.906(c)(2) (for the introduction of new drugs, expiration of drug patents or availability of generic drugs, material shortages, or withdrawal of a drug from the market) and instead to add details about the payment amount update

process described in section II.J.2.f. of this final rule with comment period (Annual CAP Payment Amount Update Mechanism). A quarterly RNAC reporting and payment adjustment process would begin as soon as we enter into contracts with the approved CAP vendor(s); that is, beginning with the first quarter during which CAP claims are submitted under the contract. Thus, we also proposed to eliminate the PPI-based adjustment for the time period between the time bids are submitted and the time claims processing begins under the contract, because that adjustment would no longer be necessary. We believe that using one payment update process will be easier to administer and will minimize the potential for CAP payment amounts to exceed ASP+6 percent for the first contract year. In order to provide sufficient time for the calculation of payment amount updates, we proposed that approved CAP vendors report quarterly RNAC data for drug purchased for use under the CAP during the previous quarter within 30 days of the close of that quarter. We made corresponding changes to regulation text at § 414.906(c) and asked for comments on these proposed changes.

The following is summary of the comments we received regarding the proposed revisions to the frequency of drug payment amount updates under the CAP.

Comment: All commenters agreed with the proposal to implement quarterly updates; however, some commenters were concerned that even quarterly updates would not cover losses that began prior to an update. The response to the ASP+6 percent limit was mixed. Several commenters supported the limit, but several commenters were concerned that payment at ASP+6 percent or less was a financial risk to vendors. Commenters suggested several approaches to further minimize vendors financial risks due to price increases, including a transaction fee to offset the financial risk associated with certain drugs, especially low cost items, the use of varying update percentages, including amounts greater that 6 percent, and product specific (NDC level) adjustments.

Response: We agree with comments that support the quarterly update process and agree that changing to a quarterly payment amount update frequency will benefit approved CAP vendors by reducing financial risk, even though the process is more burdensome than an annual process. The quarterly process will eliminate the need for a PPI based payment amount adjustment at the beginning of a contract period. We appreciate the discussion of risk presented by commenters, but we also believe that it is appropriate to maintain an ASP+6 percent limit for price increases for the reasons stated in our proposal and we note that the lag period between quarterly adjustments will apply to both price increases and price decreases, including situations where generic versions of a drug are introduced. As mentioned in the proposed rule and in previous rules, we continue to believe that the ASP+6 percent ceiling is consistent with our previous policies because it preserves the potential for savings to the program, while providing parity between the CAP and ASP payment systems.

We also believe that the elimination of many low cost items from the drug list, as discussed in the next section, will decrease financial risk and administrative burden for approved CAP vendors, and therefore, we do not believe that transaction fees are necessary or are consistent with the policy to maintain an ASP+6 percent ceiling. Finally, we remind readers that although payment amount updates for the core group of CAP drugs will be done as a group, payment amount updates for drugs added by approved CAP vendor request will continue to be calculated by individual HCPCS code, thereby further minimizing the financial risk associated with the addition of new drugs to the approved CAP vendor's CAP drug list.

Therefore, we are finalizing all of our proposals for this section without change. This includes the discontinuation of the annual payment amount adjustments, the discontinuation of PPI-based increases and the discontinuation of special quarterly payment amount increases described in § 414.906(c). We are also finalizing the implementation of quarterly payment amount increases that begin in the first quarter of the CAP claims contract period, the ASP+6 percent limit on payment amount increases, and all corresponding regulation text changes.

b. Changes to the CAP Drug List

(1) CAP Drug List

In the July 6, 2005 IFC, we responded to comments on our proposed approach for determining the CAP drug categories and how we select the specific drugs in the CAP drug list (70 FR 39026 through 39034). As stated in the CY 2006 PFS final rule with comment period (70 FR 70237), the CAP is intended to provide beneficiaries with access to Medicare Part B drugs and maintain physician flexibility when prescribing medications. Our approach incorporated drugs commonly administered by the range of physician specialties that bill for Part B drugs (70 FR 39030) and resulted in a list of about 180 drugs that were available through the CAP during the CY 2006 through CY 2008 contract period. We also developed a number of methods by which an approved CAP vendor's CAP drug list could be changed (see Table 26 at 70 FR 70242).

We believe that our general approach, to provide a wide variety of drugs to a variety of physicians over a large portion of the United States, is on target. Although we believe that the CAP is a means for physicians to minimize their drug inventory costs, we acknowledge that participation in the CAP cannot completely eliminate the need for participating CAP physicians to maintain at least a minimal drug inventory at the office. Many physicians who participate in Medicare also provide services to non-Medicare patients, and even physicians with a predominantly Medicare patient population may find it useful to keep a small stock of drugs on hand for unforeseen situations, such as emergencies and breakage.

During the CAP postponement, we became aware that both participating CAP physicians and potential vendors supported narrowing the CAP drug list. Both agreed that low cost drugs should be removed from the CAP. Although these items were initially included in the CAP so that an approved CAP vendor would be in a position to supply many of the Part B drugs that an office might administer, CAP physicians and the vendor community have stated that the inclusion of these items in the CAP creates an accounting, tracking, and claims submission burden for some participants. Based on these comments, we believe that low-cost, frequently utilized items, such as corticosteroid injections, could be removed from the list without significant impact on the CAP's utility to participating CAP physicians. Furthermore, it appears that physicians would be more interested in obtaining expensive products, such as biologicals, through the CAP. However, we are also mindful that narrowing the CAP drug list significantly also would decrease an approved CAP vendor's overall purchase volume, and we believe that this could limit the approved CAP vendor's ability to obtain volume-based discounts from the manufacturers or distributors from which it obtains drugs for use in the CAP. Creating a more tailored CAP drug category also could limit physician participation to one or several specialties, and may create a situation

where sudden supply interruptions and unexpected changes to distribution channels could affect a greater proportion of drugs in the program than would be the case with a broader CAP drug category.

We proposed to create a new CAP drug category for the next round of CAP contracting. Our approach is intended to address comments about the administrative burden of tracking and billing low cost/high volume items while maintaining access to a variety of high cost items. We proposed to identify the new CAP drug category using the existing CAP drug category as a starting point. The 2008 CAP drug list was compiled based on Part B drug claims data, the identification of specialties that frequently administer drugs under Part B, and public comment during rulemaking in 2005 (70 FR 39026 through 39033). We believe that using the 2008 CAP drug list as a starting point would maintain prescribing flexibility for a wide range of specialties and would also maintain access to a wide spectrum of drugs that have been utilized under the program previously. Furthermore, we do not believe it is necessary to develop a new approach because the 2008 CAP drug list was based on heavily utilized drugs in Medicare Part B physician practices; we believe that this approach is on target.

We proposed to amend our list based on CAP physician participation, claims data, and comments indicating that the list should be narrowed to higher cost items. First, we ''filtered'' the original CAP drug category (drugs furnished in 2006 through 2009) by the specialties that most frequently prescribe drugs under the CAP, and the highest dollar volume CAP drugs (top 20 percent of allowed charges) compiled from 2008 claims data. This filtered list is the starting point for the updated CAP drug category. However, we acknowledged that a filtering process based on frequency of claims from a subset of physicians who might participate in the CAP cannot fully capture all drugs that may be used by certain specialties. In other words, the filtering steps described above narrow the CAP drug list based on physician specialties and dollar volume and do not necessarily preserve groups of drugs that certain prescribers may utilize, especially the less frequently utilized items in such groups. Therefore, we also proposed to ''fill in'' groups of drugs with related items that do not appear on our list. We stated that we will consider ''filling in'' any drug or biological product that is physician-administered, has a reasonably high utilization in the Medicare population, is related to drugs already in the CAP (for example, because of similar clinical uses), and is otherwise appropriate for inclusion in the program. The concept of ''filling in'' drug groups is supported by feedback from former participating CAP physicians who suggested that certain categories of drugs, such as antibiotics, be more fully represented.

We solicited comments on specific drugs that should be added to the 29 item draft list presented in the proposed rule (Table 35 in the CY 2010 PFS proposed rule (74 FR 33627)), and we also sought comments on the method to assess whether a particular drug should be ''filled in'' so that it is included in the new, narrowed CAP drug category, especially drugs that did not pass the ''filtering'' step described above. We proposed an approach using the 180 item 2009 through 2011 CAP vendor bidding list (See the Downloads section at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/03a_vendorbackground.asp#TopOfPage*) that was used during the approved CAP vendor bidding for the 2009–11 contract. This list includes CMS approved items added to the original contract's bid list, as well as items approved for addition during the 2006–2008 contract period. This list's weighting is based on claims volume data by HCPCS code units rather than dollar volume and provides a different perspective than a dollar volume sorting. We proposed adding drugs from the 2009–2011 CAP Vendor bid list to the CAP drug category if the drug's weight is in the top 25 percent of the 2009–11 CAP vendor bidding list, indicating frequent claims submission, and if the drug's clinical uses are similar to a drug on the 29 item proposed list. This method results in the addition of 12 items, including several commonly used antibiotics, two antiemetics and several chemotherapeutic agents. Although this method helps ''fill in'' the proposed CAP drug list, we stated that this method still does not fully capture less frequently used drugs, or newly approved drugs, and we asked for comments on this method and alternative methods of filling this proposed list.

In order to provide additional flexibility for participating CAP physicians and approved CAP vendors, and to allow for participants to further tailor the program to meet their needs, we also proposed to add § 414.906(f)(2)(v) to allow approved CAP vendors to submit a request to CMS to add drugs (or biologicals) to the list of drugs furnished by the requesting vendor if there is sufficient demand and if the drug has therapeutic uses that are similar to other drugs already available through the CAP. The request and approval process would follow the existing regulations at § 414.906(f), and HCPCS code additions that are requested under this process would still be subject to CMS approval. This process adds to the process for adding newly issued HCPCS codes under § 414.906(f)(2)(iii) and newly approved drugs without HCPCS codes (NOC drugs) under § 414.906(f)(2)(iv). It is intended to facilitate more complete access to groups of drugs that may be used by certain specialties, and drugs used to treat certain disease states without having to rely on rigid definitions of classes of drugs that may not apply well to actual clinical practice across a large and diverse geographic area. We believe that this addition to the methods for changing an approved CAP vendor's drug list (see Table 26 in the CY 2007 PFS final rule with comment period (70 FR 70242)) will add to the flexibility of the program.

The following is summary of the comments we received regarding the proposed revisions the CAP drug list.

Comment: Narrowing the CAP drug list as proposed, particularly removing lower-cost items that are burdensome to track, was supported by numerous commenters, although one commenter pointed out that our revisions could affect participation by infectious disease physicians because of the limited number of antimicrobials. One comment specifically recommended using volume data to create the updated list. Also, commenters supported the concept of filling in drugs based on similar clinical uses. Several commenters requested that the following specific drugs or groups of drugs be added to the final list: Vectibix® (panitumumab); Nplate® (romiplostim); LHRH analogues-specifically leuprolide depot; orphan drugs; and more antibiotics. Several commenters recommended that plasma protein derived drugs and biologicals not be included in the CAP drug list. One commenter recommended that stakeholders other than vendors be allowed to request changes to the drug list.

Response: Based on overall support for a narrowed CAP drug list, we are specifying a 41 item bid list that appears in Table 29. This list includes both the list of drugs that we proposed to include as well as all of the potential additions that we discussed in the proposed rule and this list is the single drug category for the next bidding period. No plasma protein therapies described in comments appear on this list. Plasma protein therapies, including IVIG, clotting factors, and alpha-1 proteinase

inhibitors, have not been furnished under the CAP in the past and therefore would not have been included in the list from which we applied the ''filtering steps'' to develop this drug list. Also in the July 2005 interim final rule with comment (70 FR 39029) we stated that before adding clotting factors or IVIG to the CAP drug list, we would publish a proposed rule and seek public comment. At this time, we are not adding these items to the CAP drug list because we did not specifically propose to do so in the proposed rule.

Although we did not receive any comments that presented a specific and detailed method to further expand or fill in the drug list, the use of volume based filtering and the concept of filling in the drug list was supported by commenters. Thus, as noted above, we are including the potential additions specified in the proposed rule. Further, we are finalizing the proposed approach for approved CAP vendor-requested additions of drugs that have similar uses to drugs on the bid list.

We believe that selecting the larger base drug list and providing a process for approved CAP vendors to request to add drugs that can further ''fill in'' this list strikes a balance between specifying a minimum scope of drugs and biologicals that will be available under the CAP and providing flexibility for the approved CAP vendor to manage the risk associated with providing a broader array of drugs and biologicals. For this reason, we are not adding any other drugs or biologicals to the bid list or creating an addendum to the bid list at this time. We believe that vendors will be interested in expanding groups of drugs and biologicals available under the CAP in order to maximize physician participation and order volume, and that this will tend to increase the number of therapeutically similar items within the drug list.

We disagree with the commenter who requested that parties other than the approved CAP vendor, for example manufacturers, be permitted to request that CMS add drugs to the CAP category. First, we believe this rulemaking has provided an opportunity for the public to provide input on the CAP drug category, so an additional process is unnecessary. Second, we believe it would be imprudent to permit such a process during the CAP contracting period, because we believe it would be inappropriate to force an approved CAP vendor, mid-contract, to supply drugs that it did not initially consider in its bid and that may be financially risky, may require highly specialized handling, or may necessitate participation in specialized purchasing arrangements.

We believe that requiring approved CAP vendors to add products that they did not choose to bid on or subsequently provide may also limit bidders' interest and could limit the number of approved CAP vendors for physicians to choose from, thereby restricting all access to CAP drugs. We will continue with our policy that allows only approved CAP vendors to request changes to the CAP drug list; however, external stakeholders may approach approved CAP vendors to discuss the potential addition of products to an approved CAP vendor's drug list. As noted above, we believe approved CAP vendors would have an incentive to be responsive to such requests. The new mechanism for deleting drugs from the CAP drug list is discussed in the following section.

With respect to the specific drug and biological products mentioned in the comments, we believe that the addition of specific items mentioned in the comments appears to be best suited for addition to the CAP drug list through vendor requests. We have discussed issues pertaining to orphan drugs, leuprolide and drugs similar to leuprolide and in a previous rule (70 FR 70241 and 70 FR 70243, respectively). While we appreciate these suggestions, we are not compelled to add these drugs to the CAP drug list as required items based on these comments. For the reasons stated in our previous rules, we continue to believe it is prudent to continue to omit these drugs from the CAP. Further, because we are not certain of the potential market volume for these drugs in the CAP, we will not add them to the drug list at this time. We are aware that leuprolide and other gonadotropin releasing hormone agonists are commonly used to treat prostate cancer and are highly utilized items in Medicare; however CAP participation by providers that prescribe these drugs has been low. However, we note that triptorelin (J3315), a gonadotropin releasing hormone agonist used in the treatment of prostate cancer is on the CAP drug list, and therefore, the addition of other gonadotropin releasing hormone analogues though the approved CAP vendor process for adding drugs described above and in new regulation text at § 414.908 would be feasible.

Similarly, new drugs such as Vetibix® and some antibiotics, which were on the CAP drug list during the last contract period, but were filtered out during the development of the new drug list, appear to be good candidates for approved CAP vendor-requested additions because agents with similar therapeutic uses are on the drug list. We will not add these drugs to the drug list at this time because we are not certain that these drugs will have sufficient market volume in the CAP. We also note that one item, Nplate®, an orphan drug only available through a single specialty vendor, and with limited use potential in the Medicare population, also appears to be a candidate for addition upon approved CAP vendor request. As discussed above, we are seeking to balance physician access and approved CAP vendor risk related to the drug list. In light of the lack of widespread demand for such drugs to be included in the CAP drug list (and thus available from all approved CAP vendors), we believe that permitting approved CAP vendors to request to supply those drugs, but not requiring them to do so, strikes the appropriate balance.

BILLING CODE 4120–01–P

TABLE 29: Finalized CAP Single Drug Category List for the Next Contract Period

Code	Procedure Code Description
J0129	INJECTION, ABATACEPT, 10 MG
J0215	INJECTION, ALEFACEPT, 0.5 MG
J0585	BOTULINUM TOXIN TYPE A, PER UNIT
J0587	BOTULINUM TOXIN TYPE B, PER 100 UNITS
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG
J0878	DAPTOMYCIN INJECTION, 1 MG
J0881	INJECTION, DARBEPOETIN ALFA, 1 MCG (NON-ESRD USE)
J0885	INJECTION, EPOETIN ALPHA, (FOR NON ESRD USE), PER 1000 UNITS
J0894	INJECTION, DECITABINE, 1MG
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG
J1745	INJECTION INFLIXIMAB, 10 MG
J2323	INJECTION, NATALIZUMAB, 1 MG
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG
J2357	OMALIZUMAB INJECTION, 5 MG
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG
J2469	PALONOSETRON HCL, 25MCG
J2503	PEGAPTANIB, 0.3MG
J2505	INJECTION, PEGFILGRASTIM, 6 MG
J2778	INJECTION, RANIBIZUMAB, 0.1 MG
J2794	RISPERIDONE, LONG ACTING, 0.5MG
J3240	INJECTION, THYROTROPIN ALPHA, 0.9 MG, PROVIDED IN 1.1 MG VIAL
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG
J3396	INJECTION, VERTEPORFIN, 0.1 MG
J3487	INJECTION, ZOLEDRONIC ACID, 1 MG
J3488	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG
J7321	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, Per Dose
J7322	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J9010	ALEMTUZUMAB, 10 MG

Code	Procedure Code Description
J9035	BEVACIZUMAB INJECTION, 10MG
J9041	BORTEZOMIB INJECTION, 0.1MG
J9055	CETUXIMAB INJECTION, 10MG
J9170	DOCETAXEL, 20 MG
J9201	GEMCITABINE HCL, 200 MG
J9206	IRINOTECAN, 20 MG
J9263	INJECTION, OXALIPLATIN, 0.5 MG
J9305	PEMETREXED INJECTION, 10MG
J9310	RITUXIMAB, 100 MG
J9355	TRASTUZUMAB, 10 MG
J3370	INJECTION, VANCOMYCIN HCL, 500 MG
J9264	PACLITAXEL PROTEIN BOUND PARTICLES, 1MG
J0690	INJECTION, CEFAZOLIN SODIUM, 500 MG
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG
J0640	INJECTION, LEUCOVORIN CALCIUM, PER 50 MG
J9265	PACLITAXEL, 30 MG
J9190	FLUOROURACIL, 500 MG
J9045	CARBOPLATIN, 50 MG
J0290	INJECTION, AMPICILLIN SODIUM, 500 MG
J9214	INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS

BILLING CODE 4120–01–C

2. Removing Drugs From the CAP List

Although there are several methods under the CAP to add drugs to an approved CAP vendor's drug list, the current regulations do not specify a process for removing drugs from an approved CAP vendor's list. Our experience has shown that interruptions in availability can affect an approved CAP vendor's ability to supply CAP drugs during the course of a 3-year contract. For example, during the first contract period, we became aware of long-term and permanent drug unavailability, sometimes at the HCPCS level, due to removal of drugs from the market, or interruption of supply to an approved CAP vendor for reasons beyond the approved CAP vendor's control, such as changes to drug distribution methods, changes in agreements between manufacturers and distributors and/or pharmacies regarding who may purchase certain drugs, and direct distribution arrangements.

In order to better respond to sudden, long-term changes in drug supply that are beyond the control of the approved CAP vendor, we proposed to allow an approved CAP vendor to request the permanent removal from its CAP drug list of a HCPCS code for which no NDCs are available. Our proposal is intended to better manage situations where all NDCs from an entire HCPCS code unexpectedly become unavailable to an approved CAP vendor, and we would require the approved CAP vendor: (1) to document the situation in writing, including the unavailability of all NDC codes in a HCPCS code that is supplied under the CAP; (2) to describe the reason for the unavailability and its anticipated duration; and (3) to attest that the unavailability is beyond the approved CAP vendor's control. Approval of the deletion would apply only to the approved CAP vendor or vendors that requested the deletion. Our proposal was not intended to be used frequently, or to permit an approved CAP vendor to remove a HCPCS code from its CAP drug list simply because it has become unprofitable to provide it—we believe the payment amount adjustment proposals discussed in sections II.J.2.a. and f. of this final rule addresses that concern. Furthermore, our proposal was also not intended to be used for managing short-term unavailability, or unavailability of a finite duration—we believe the existing drug substitution policy described in § 414.906(f) already addresses those concerns. We proposed to add this process as § 414.906(g) because those regulations currently provide for additions and substitutions to the CAP drug list, and would therefore require a

written request to CMS, as well as CMS' approval.

Participating CAP physicians who are affected by the deletion of a HCPCS code from an approved CAP vendor's drug list would have the option of remaining with their selected approved CAP vendor and using the ASP (buy and bill) methodology for obtaining the drug that has been deleted, or selecting another approved CAP vendor under the exigent circumstances provision at § 414.908(a)(2). We believe that the deletion of an expensive and highly utilized CAP drug by one approved CAP vendor in the middle of a physician election period could cause hardship for a practice if it had to revert to the ASP methodology of acquiring and billing for that drug. Such a situation would constitute an exigent circumstance. Given CAP's goal of improving access to drugs, allowing the participating CAP physician to switch approved CAP vendors outside of a regular election period in this instance would be prudent.

The following is summary of the comments we received regarding the proposed method to remove items from an approved CAP vendor's drug list.

Comment: Comments supported a mechanism to delete unavailable drugs from vendors' lists and also supported allowing physicians affected by the deletion of a HCPCS to have an opportunity to obtain the drug through the ASP process or to select another vendor. One commenter asked for well-defined standards for removing a drug from the list.

Response: Based on support for our proposal in the comments, we are finalizing the proposed process where an approved CAP vendor may request the permanent removal from its CAP drug list of a HCPCS code for which no NDCs are available. Participating CAP physicians affected by such a deletion will be able to obtain the deleted drug under the ASP methodology, or will be able to switch approved CAP vendors outside of the regular physician election process under the exigent circumstance provision.

We believe that the preamble text provides sufficiently detailed guidance about the process. Specifically, we require the approved CAP vendor: (1) to document the situation in writing, including the unavailability of all NDC codes in a HCPCS code that is supplied under the CAP; (2) to describe the reason for the unavailability and its anticipated duration; and (3) to attest that the unavailability is beyond the approved CAP vendor's control. By way of example only, situations that create unavailability beyond the vendor's control could include: FDA action to remove a drug from the market, long-term unavailability of specialized raw materials or long-term manufacturing delays, and changes in distribution arrangements that prevent the approved CAP vendor from buying or supplying the drug within CAP requirements. CMS will assess the information provided by the vendor and approve such requests as described in regulation text at § 414.908(f)(3) and (4).

This process is intended to provide the approved CAP vendor with flexibility to respond to long-term drug supply issues, however, this process is not intended to be used frequently, or to permit an approved CAP vendor to remove a HCPCS code from its CAP drug list simply because it has become unprofitable to provide it, and this process is not intended to be used for managing short-term unavailability, or unavailability of a finite duration.

c. Geographic Area Served by the CAP

In the July 6, 2005 IFC (70 FR 39034 through 39036), we established a single, national competitive acquisition area for the initial stage of the CAP. This national distribution area included the 50 States, the District of Columbia, Puerto Rico, and U.S. territories. We recognized that designating a single national area might limit participation to those vendors that could compete to bid and supply drugs nationally, but we indicated this approach was a part of the phase-in plan for the CAP. We also discussed potential phase-in options for the future, stating that smaller areas might become a solution as the program expanded.

According to the vendor community, certain areas of the United States (especially Alaska, Hawaii, and the Territories) currently present logistical challenges and are associated with high drug shipping costs. Moreover, physician participation in these areas has been low; in 2008, physicians from Alaska, Hawaii, and the Territories represented less than 2 percent of total participating CAP physicians. Temporarily limiting the geographic areas served by the CAP could help limit costs and risks for approved CAP vendors associated with shipping drugs to distant parts of the country. However, we believe that the CAP is intended to provide services to all Medicare physicians (including those in distant parts of the country), and therefore, we do not believe that a limitation on the geographic area in which the CAP is available should be permanent.

Section 1847B(a)(1)(B) of the Act specifically requires the Secretary to phase-in the CAP with respect to the categories of drugs and biologicals in the program, in such a manner as the Secretary determines to be appropriate. We believe that this provision, particularly in conjunction with the statutory definition of a competitive acquisition area as ''an appropriate geographic region established by the Secretary'' provides broad authority for the Secretary to phase in the CAP with respect to the geographical areas in which the program would be implemented. As stated in the July 6, 2005 IFC, we considered several factors when defining geographic areas for the CAP, including aspects of vendors and their distribution systems, such as current geographic service areas, the density of distribution centers, the distances drugs and biologicals are typically shipped, and costs associated with shipping and handling (70 FR 39035). Taking these factors into consideration again, and considering entities who have bid on, or expressed interest in bidding on approved CAP vendor contracts, we believe that it is appropriate to use the authority granted under the Statute to temporarily narrow the area served by the CAP during the program's re-implementation. We appreciate the logistical issues associated with shipping drugs to remote areas and the uncertainties associated with transportation costs that have been described by the potential vendor community; however, we are reluctant to significantly reduce the area served by the CAP because at some point, the approved CAP vendor's volume would be affected and the likelihood of obtaining volume based discounts would decrease.

In the current proposed rule, we proposed to designate the CAP competitive acquisition area as the 48 contiguous States and the District of Columbia for the next round of CAP contracting. This change in the geographic area that is served by the CAP is meant as an interim measure under our phase-in authority and the statutory definition of a competitive acquisition area. We believe that omitting Alaska, Hawaii, and the Territories from the CAP competitive acquisition area at this time will balance the need to revise the CAP to attract more vendors with the need to offer the maximum number of physicians a meaningful opportunity to participate. We believe that the proposal will encourage potential vendors to participate in the CAP because it would temporarily omit areas associated with low physician participation, long shipping times, and high shipping costs. Furthermore, this measure is unlikely to

significantly decrease CAP drug order volume relative to historical physician participation in the CAP. However, we are aware that our proposal temporarily eliminates the CAP option for physicians in the areas not included in this CAP competitive acquisition area. Therefore, we did not propose this definition of the CAP geographical area as a permanent solution.

The following is summary of the comments we received regarding the proposed to revisions the geographic area serviced by the CAP.

Comment: Commenters supported the proposal; one commenter recommended a more limited approach using smaller areas and selected physician specialties.

Response: Based on comments supporting our proposal, we are finalizing the proposal to temporarily limit the CAP geographic area to the 48 contiguous States and the District of Columbia for the next bidding period. We do not believe that a smaller geographic area is desirable or necessary. Overnight shipping is available over much of the proposed area and we are concerned about further limiting access to the CAP.

As suggested in comments and discussed in the proposed rule, we will continue to assess the CAP and update plans for phase in activity in future rulemaking efforts, including determining the circumstances under which CAP participation will be offered to physicians in Alaska, Hawaii, and the Territories. We will also continue to consider modifying the definition of competitive acquisition area on the basis of regions, States, or some smaller geographic area, which might expand the number of vendors that could bid to participate in the program.

d. CAP Drug Stock at the Physician's Office

Our discussion about the CAP emergency restocking option in the July 6, 2005 IFC indicated that a participating CAP physician could not maintain a stock of an approved CAP vendor's drug in his or her inventory. This was done because we had reservations about potential program integrity and drug diversion issues (70 FR 39047).

Since that time, we have gained operational experience with the CAP and a better understanding of the ordering and drug delivery process. We have also received additional public feedback about the different ways that the program could be refined, and we have not received any negative feedback from the vendor community indicating a concern about storing CAP drugs in physicians' offices. Therefore, we believe at this time it is appropriate to consider allowing additional flexibility to encourage CAP participation.

Our experience with the CAP, and our increased understanding about the options approved CAP vendors might have for furnishing drugs to a participating CAP physician's office also support considering additional flexibility in this area. For example, we are aware of electronic inventory control and charge capture devices that could be utilized in ways that conform to CAP regulations and are compliant with applicable State and Federal laws. Such devices utilize an electronic transaction based on a physician's order to track the administration of drugs from inventory to a specific patient and to document appropriate charges for the drug. We believe that such systems could fit into the current CAP framework when transactions in such systems are based on a physician's order, because such systems can track inventory, and can be used to capture patient charge data.

For these reasons, we proposed to allow approved CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of approved CAP vendor-owned stock located at the physician's office in response to specific prescription orders and to capture charges related to such transactions. The proposal was also intended to clarify that entities with alternative approaches to supplying drugs that utilize an electronic transaction are welcome to participate in the CAP bidding process. We believe that this will allow for additional flexibility and efficiency in the ordering and delivery of drugs within the program because it allows for more efficient shipping of approved CAP vendor-owned stock and provides the option of CAP participation for physicians who use or may choose to use such drug inventory management platforms. The proposal did not change our position that a participating CAP physician shall not take title to or pay for CAP drugs, nor does it alter the requirements for information that must be submitted with a prescription order under § 414.908(a) or the application of HIPAA to such data.

Furthermore, the proposal does not affect the applicability of State licensing requirements for an approved CAP vendor. As stated in the July 6, 2005 IFC (70 FR 39066), either the approved CAP vendor, its subcontractor under the CAP, or both, must be licensed appropriately by each State to conduct its operations under the CAP. Therefore, if a State requires it, an approved CAP vendor would be required to be licensed as a pharmacy, as well as a distributor. We did not propose to revise the requirements at § 414.908(c) and § 414.914(f)(9), and we noted that sections 1847B(b)(6) and 1847B(b)(2)(B) of the Act continue to apply. In order to participate in the CAP successful bidders must continue to submit proof of pharmacy licensure, consistent with applicable State requirements.

Also, we stated that the proposal would not modify our definition of ''emergency delivery'' or its corresponding requirements at § 414.902. As we stated in our July 6, 2005 IFC, the intent of the 1-business-day timeframe for emergency deliveries is to address the participating CAP physician's need for more rapid delivery of drugs in certain clinical situations with the approved CAP vendor's ability to ship the drug and have it delivered promptly in a nationwide delivery area (70 FR 39045). The emergency delivery timeframe still applies in situations when CAP drugs are not available in the office for electronic delivery.

Moreover, the proposal did not seek to change the CAP inventory requirements. CAP drugs belong to the approved CAP vendor, and as indicated in the July 6, 2005 IFC (70 FR 39048), participating CAP physicians are required to maintain a separate electronic or paper inventory for each CAP drug obtained. CAP drugs must be tracked separately in some way (for example, an electronic spreadsheet). CAP drugs do not have to be stored separately from a physician's own stock; that is, co-mingling of CAP drug with drug from a participating CAP physician's own private stock is acceptable as long as a record of approved CAP vendor-owned drug is kept in a manner that is consistent with § 414.908(a)(3)(x) and the approved CAP vendor-owned drug can be accounted for, as needed.

Also, the proposal did not affect the CAP emergency restocking requirements. Section 1847B(b)(5) of the Act and § 414.906(e) provide criteria for the replacement of drugs taken from a participating CAP physician's inventory in the event of an emergency situation. When the emergency resupply criteria are met, a participating CAP physician can replace the drugs that were used from his or her own inventory by submitting a prescription order to the approved CAP vendor.

The proposal sought to clarify the potential approaches that a bidder may use (separately or in combination) to supply drugs under the CAP and did not seek to specify a particular approach that bidders must use in future responses to CAP bid solicitations or to strictly define the types of entities that

could bid on CAP vendor contracts; for example, whether bidders must be pharmacies, drug distributors, or a hybrid of the two; whether bidders must utilize just in time shipping, or electronic inventory transactions to supply CAP drugs. We stated that we will consider approving bidders' approaches that are consistent with the statutory framework, applicable laws, and regulations.

The following is a summary of the comments we received regarding CAP drug stock at the participating CAP physician's office.

Comment: Most commenters supported the concept of electronic transactions in the CAP drug supply process. However, a few commenters appear to have misunderstood our proposal as authorizing a CAP vendor to store unlimited amounts of stock in a physician's office. Some commenters also requested details about the types of systems we will accept, how these systems could work in smaller offices, and some commenters were concerned about how appropriate or ''nominal'' stock levels would be defined.

Response: The comments lead us to believe that we need to clarify our proposal. We proposed to allow approved CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of approved CAP vendor-owned stock located at the physician's office in response to specific prescription orders and to capture charges related to such transactions. This proposal is primarily intended to work with automated cabinets that provide controlled access to drugs and was intended to make clear that entities using electronic inventory devices were welcome to participate in the CAP. However, we are not requiring that these specific devices be used in conjunction with nominal amounts of vendor owned office stock or requiring any specific types of devices, hardware, or software.

Instead, we are providing a framework under which certain quantities of vendor-owned CAP drug stock may be located in a participating CAP physician's office and delivered in conjunction with electronic transactions and charge capture. An electronic transaction may be used to communicate the fact that participating CAP physician is submitting a prescription order for a CAP drug and, on the basis of that prescription order, the drug is being delivered to the participating CAP physician from the nominal amount of vendor-owned stock at the office for administration to a beneficiary. Once the approved CAP vendor receives the prescription order it may bill for the drug in accordance with existing rules. Corresponding documentation of drug administration in the medical record is still required for meeting post-payment review requirements to establish that the drug has been administered to a beneficiary and is thus eligible for payment under section 1847B(a)(3)(D) of the Act.

This process is intended to work with CAP inventory requirements in § 414.906(e) and § 414.908(a), and can also work with office stock models that utilize periodic shipment of stock to maintain predetermined levels. In such systems, periodic shipments of regularly used amounts of items are made, for example, weekly. The shipped amounts are based on average amounts used over the time period between shipments, but may be modified as necessary to accommodate for actual use.

We agree with commenters that we should provide further information about what we would consider to be a ''nominal'' level of vendor-owned stock. Therefore, we are clarifying that that ''nominal quantities of stock'' means quantities that do not exceed what is typically used by the participating CAP physician's office between the approved CAP vendor shipment periods. We are not specifying what the shipment periods must be, however, we would like to point out that we do not intend this process to mean that large quantities of CAP drug would be kept at a physician's office.

We also remind readers that CAP drug stock remains the property of the approved CAP vendor, and that participating CAP physicians do not take title to CAP drug stock or make any payment for drugs that furnished and administered under the CAP. CAP drugs must be stored in a manner that is consistent with applicable law and regulations, as well as product integrity and handling requirements.

Comment: One commenter understood the proposal to mean that physician-owned stock supplied by entities other than the approved CAP vendor may be used for the CAP. Another commenter encouraged a mechanism to reassign physician-owned stock for the CAP.

Response: CAP drugs remain the property of the approved CAP vendor until they are administered to a beneficiary, at which time billing for the drug by the approved CAP vendor may take place. Under our emergency restocking provisions (described in further detail below), drugs purchased by the participating CAP physician's office for its own drug inventory may be used instead of approved CAP vendor inventory in certain situations, and then the approved CAP vendor may supply a replacement.

However, we do not believe that the physician's office stock, that is, drugs bought by the physician's office, should be used as a primary source of drugs for the CAP because such a structure is inconsistent with the CAP program as set forth in section 1847B of the Act, which clearly contemplates that the approved CAP vendor supply CAP drugs to the participating CAP physician rather than merely just bill for drugs that the participating CAP physician already owns. Furthermore, the CAP is an alternative to the ASP or buy and bill process of obtaining drugs administered incident to a physicians' services, and under the CAP as we have implemented it, participating CAP physicians do not take title to or make any payment for drugs furnished under the CAP.

In situations where an approved CAP vendor maintains a certain nominal amount of drugs in a participating CAP physician's office, as discussed above, we anticipate that at certain times a prescription order for an unusual drug or an unexpectedly great demand may result in a situation where the approved CAP vendor's stock is not immediately available in the participating CAP physician's office. In such situations, the approved CAP vendor must ship the drug under the timeframe definitions at § 414.902.

In cases where the drug cannot be delivered in time to meet a clinical need, a participating CAP physician is permitted to use the practice's own inventory and obtain replacement inventory from the approved CAP vendor under § 414.906(e) if all of the following requirements are met: (1) The drugs are required immediately; (2) The participating CAP physician could not have anticipated the need for the drugs; and (3) The approved CAP vendor could not have delivered the drugs in a timely manner, as defined in § 414.902.

This provision is intended for clinical emergencies if a CAP drug is not available from the approved CAP vendor in time. Additional information about the emergency restocking provision appears in the July 6, 2005 interim final rule with comment (70 FR 39047). The physician will be expected to maintain documentation in the patient's medical record to verify that he or she complied with the criteria governing the resupply provision.

Comment: Commenters also suggested periodic inventory reconciliation between approved CAP vendors and participating CAP physicians to accurately track the actual amount of

vendor-owned drug in a physician's inventory.

Response: We believe that the method and the frequency with which an approved CAP vendor may want to account for nominal CAP drug stock at the physician's office will vary based on the cost and handling requirements of the drugs, quantities of drug at the offices, and the approved CAP vendor's experience with the practice. The role of special agreements between approved CAP vendors and participating CAP physicians was discussed in the July 2005 IFC (70 FR 39050).

We believe that details associated with inventory reconciliation, such as the frequency that the process is carried out, whether a vendor's representative would visit the location, etc., could be arranged under such an agreement. However, parties to such arrangements must ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission.

Comment: Commenters also requested clarification about whether CAP is a pharmacy- or distribution-based program and recommended that CMS specify one model in order to decrease vendor risk. One commenter recommended that the CAP be a distribution model in order to capture efficiencies.

Response: We appreciate the comments that suggested we consider our overall approach to the CAP. We have not specified whether the CAP must follow a distribution or a pharmacy model, or a combination, in previous rules. We believe that leaving the option open will maximize the number of bidders and will encourage a variety of approaches for supplying CAP drugs. Given the wide geographic area that the program covers and the diverse Medicare physician population, we also do not want to discourage bidders from developing novel or combined approaches to supplying CAP drugs. Although we acknowledge that vendor interest in the program has been limited, we believe that leaving these options open will benefit the program in the long run by allowing a variety of approaches to supplying drugs under the CAP. Choices between approved CAP vendors with different models will encourage physician interest and are more likely to serve a varied physician population, including large and small offices. We also do not want to unduly limit the types of subcontracting relationships that a bidding entity may develop to supply CAP drugs across a geographic area, particularly in light of the diversity of State laws and regulations, which may change over time.

Comment: One commenter asked whether the bidding documents would contain more detail about licensing requirements.

Response: We acknowledge the comment that suggested the licensing expectations be more clearly described at the time bids are announced. At this time, we will continue to require that an approved CAP vendor must be appropriately licensed in all States.

Comment: One commenter asked about a limited bid involving automation.

Response: This rule did not propose changes to the bidding process, and therefore, we are not making any changes to the bidding process at this time.

e. Exclusion of CAP Sales From ASP Calculations

In response to the March 4, 2005 proposed rule, many commenters requested clarification about whether the prices determined under the CAP will be taken into account in computing the ASP under section 1847A of the Act. In the July 6, 2005 IFC, we responded that prices offered under the CAP must be included in ASP calculations (70 FR 39077). This was done because we initially believed that we did not have the statutory authority to exclude prices determined under the CAP from the computation of ASP under section 1847A of the Act. Section 1847A(c)(2) of the Act contains a specific list of sales that are exempt from the ASP calculation, and sales to approved CAP vendors operating under CAP are not included on that list (70 FR 39077). Comments received in response to the July 6, 2005 IFC opposed this policy (70 FR 70479).

Ultimately, as stated in the November 21, 2005 IFC, we recognized commenters' concerns about the effect of including CAP prices in the calculation of ASP and agreed that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. In particular, we found compelling arguments from commenters about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other. Therefore, we excluded units of CAP drugs that are administered to beneficiaries by participating CAP physicians from the ASP calculation for the initial 3-year approved CAP vendor contract period (70 FR 70479). Accordingly, the definition of ''Unit'' at § 414.802 was also revised to reflect this exclusion.

In our August 18, 2006 interim final rule, we further addressed concerns pertaining to our definition of Unit. We published a PRA notice regarding a proposed modification of the OMB-approved ASP information collection requirements (CMS Form 10110 (OMB #0938–0921)) about the collection of the number of CAP units excluded from the ASP calculation. In response, a commenter expressed concern over manufacturers' reliance on approved CAP vendors for information about the number of units of CAP drugs that are administered to beneficiaries by participating CAP physicians (71 FR 48132). Since approved CAP vendors are the only entities with direct information on CAP units administered, the commenter believed that the requirement to exclude units of CAP drugs administered to beneficiaries by participating CAP physicians placed the manufacturer in the untenable position of reporting ASP and certifying reports of ASP based on second-hand information from approved CAP vendors. Further, the commenter noted that manufacturers may not have timely access to this information and that they could not independently confirm its accuracy (71 FR 48132). Additional feedback received as part of our ongoing work with manufacturers also indicated that they were concerned that they would have difficulty obtaining information from approved CAP vendors that would be necessary to accurately exclude administered CAP units from the ASP calculation (71 FR 48132).

Therefore, we further revised the definition of unit to clarify that for the initial 3-year contract period under the CAP units of CAP drugs sold to an approved CAP vendor for use under the CAP would be excluded from the calculation of ASP (70 FR 48132).

In the July 6, 2005 and August 18, 2006 IFCs, we stated that we would examine the effect of this exclusion and, if necessary, revisit our decision at the end of the initial 3-year period of the CAP (70 FR 70480 and 71 FR 48132, respectively).

Since then, operational experience has not indicated a reason for changing our policy of excluding CAP units sold to approved CAP vendors for use under the CAP from ASP calculations. Therefore, in the current proposed rule, we proposed to permanently exclude drugs supplied under the CAP from ASP calculations and make conforming

changes to the definition of unit at § 414.802. We stated that we believe that the proposal will continue to promote the separation and independence of the two drug payment models.

The following is a summary of the comments we received regarding the proposed revisions to the exclusion of CAP sales from ASP calculations.

Comment: All comments supported permanent exclusion of CAP Sales from ASP calculations.

Response: As a result of the comments, we are finalizing the proposal to permanently exclude CAP Sales from ASP calculations.

f. Annual CAP Payment Amount Update Mechanism

In the July 6, 2005 IFC (70 FR 39076), we described a two-step process to calculate RNAC-based price adjustment if there is a change in the RNAC reported by a particular approved CAP vendor. We stated that ''we would adjust the bid price that the vendor originally submitted by the percentage change indicated in the cost information that the vendor disclosed. Next, we would recompute the single price for the drug as the median of all of these adjusted bid prices.'' The two-step process contemplated that there would be more than one approved CAP vendor at the time prices were to be adjusted and that all successful bidders would participate in the CAP.

However, during the first round of CAP contracting, after offering more than one contract, we entered into a contract with only one successful bidder. Thus, during the 2008 price update calculation process, we developed an approach to account for the lack of RNAC data for bidders who chose not to participate in the CAP. In the CY 2009 PFS proposed rule, we stated that the approach we used to adjust prices for the 2008 contract year is consistent with § 414.906(c) and with the July 6, 2005 IFC because it retains a two-step calculation based on the approved CAP vendor's RNAC, as well as the calculation of a median of adjusted bid prices.

We also posted our approach on the Approved CAP Vendor page of the CMS CAP Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp.* The percent change in RNAC for 2008 was calculated based on data supplied by the approved CAP vendor. This percent change in RNAC was used as a proxy for the percent change in RNAC for successful bidders that chose not to become approved CAP vendors.

Then, in the CY 2009 PFS proposed rule (73 FR 38522 through 38523), we proposed to continue using this approach for future CAP payment amount updates where the number of approved CAP vendors is less than the number of successful bidders. We proposed that the average of the approved CAP vendor-supplied RNAC data would be used as a proxy for data from vendors who bid successfully but are not participating in the CAP. For example, if the payment amounts for the first year of a CAP contract are based on five successful bidders, but only four have signed contracts to supply drugs under the CAP (that is, there are four approved CAP vendors), only RNAC data collected from the four approved CAP vendors would be used to calculate the percent change in the RNAC. The average of the four approved CAP vendors' adjusted payment amounts would be used as a proxy for the RNAC of the successful bidder that is not participating in the CAP. The updated CAP payment amount would then be calculated as the median of the five data points (one data point for each approved CAP vendor's updated payment amount, and one data point calculated using the average of the approved CAP vendors' RNAC). Similarly, if there were five successful bidders but only three chose to become approved CAP vendors, the average of the three approved CAP vendors' RNAC would be the proxy for the RNAC of the two bidders who did not participate. The median of those five data points would become the updated CAP payment amount.

Our approach in the CY 2009 PFS proposed rule was intended to provide us with a flexible method for updating CAP prices, to be consistent with our original policy as stated in the July 6, 2005 IFC, and to account for bidders or approved CAP vendors who are not participating in the program at the time the price updates are calculated. However, our approach was limited in scope because it was made during a contract period and during bidding for an upcoming contract and we did not want to make any significant changes to the CAP program which could affect contractual obligations. Furthermore, we received a comment in response to the CY 2009 PFS proposed rule that suggested the elimination of the proxy procedure so that payments would be based on actual data from participating vendors and would better reflect experience within the program.

After additional consideration, we believe that it would be prudent to simplify and update our 2009 proposal in order to account for successful bidders who choose not to participate in the CAP, possible changes in the number of approved CAP vendors over the life of a 3-year CAP contract, and to allow for flexibility in setting the frequency of payment amount adjustments as described in section II.J.2.a. above. We believe that our updated proposal is easier for the vendor community to understand and for us to implement. Furthermore, our revised proposal is not constrained by concerns about the impact of changes on an active contract.

We proposed to clarify that the RNAC-based adjustment calculations are intended to apply only to approved CAP vendors (not all bidders), and that the most recent previous CAP payment amount (for example, the previous year's or the previous quarter's payment amount) will be the starting point for making the subsequent period's adjustment. Simply put, we proposed to eliminate the use of proxy data for bidders that are no longer participating in the program. Instead, we proposed to use RNAC data only from approved CAP vendors that are participating in the CAP at the time that an RNAC-based price update is being calculated. We also proposed to clarify that the starting point for the payment amount adjustment is the most recent payment amount. The percent change calculated from each participating approved CAP vendor's RNAC data will be applied to the most recent payment amount by recomputing the single price using the median of all participating vendors' adjusted prices.

For example, if quarterly adjustments beginning at the start of claims processing approved CAP vendor's contract as described in section a. above are implemented, and the post bid period's CAP payment amounts are calculated based on five successful bids, but only four approved CAP vendors are participating when CAP claims processing begins, the RNAC-based payment amount adjustment for the first quarter of CAP claims would be based on RNAC data provided by the four approved CAP vendors that will be furnishing drugs under the CAP. The four approved CAP vendors would be required to submit a quarter of RNAC data within thirty days of the close of the quarter to which the data applied, prior to the beginning of CAP claims processing for the new contract. We would apply the percentage change in RNAC reported by each of the four approved CAP vendors to the CAP payment amounts calculated from successful bids, and the adjusted payment amount would be the median of those four adjusted amounts. Assuming that these four vendors are

still furnishing drugs during the second quarter, calculations for the second quarter would apply the RNAC-based adjustment calculated from the four vendors' data to the first quarter's payment amount. That is, the payment amounts for the second quarter would be calculated from the first quarter's payment amounts, adjusted by RNAC data.

This process would apply to the composite bid drug list as amended by rulemaking, meaning that a single weighted percent change in RNAC is calculated for all drugs in the composite bid list (also referred to as the single drug category) and that single percent change is applied to all drugs in the list. For drugs that are bid as separate line items, such as drugs that were included in addendum B of the 2006 bidding period (see 70 FR 39072 and updated as addendum G in 70 FR 70238), or for drugs that are added during a contract period, each HCPCS code will be adjusted as a separate line item. Such codes will not be included in the composite, weighted drug list. Our process will continue to assign a single payment amount to all approved CAP vendors that supply a given HCPCS code; we do not intend to have more than one payment amount for any HCPCS code under the CAP or for individual ''NOC'' drugs described in § 414.906(f)(2)(iv).

This updated approach is flexible, and we believe it can accommodate a variety of scenarios, including a changing number of approved CAP vendors and changes to the frequency with which payment amount updates are made. It provides a straightforward and accurate clarification of the price adjustment mechanism described in regulation text. We believe that this proposal remains consistent with our original preamble language and with our CY 2009 PFS proposal, because it retains the two-step calculation using the percent change in RNAC. Finally, we believe that our approach will eliminate any perception that nonparticipating vendors can significantly affect CAP payment amount adjustments.

The following is summary of the comments we received regarding the proposed to revisions to the annual CAP payment amount update mechanism.

Comment: Comments about CAP price updates focused on the quarterly update frequency. We did not receive any comments that specifically discussed the proposed refinements to our approach, although one commenter recommended caution when using a single update percentage across a large group of drugs because this may increase vendors' financial risk, and suggested product level updates.

Response: We are finalizing the proposal to simplify the update calculation process. Although no comments directly mentioned this proposal, we believe that the updated approach will simplify the calculation process.

We appreciate the comment that suggested that price updates be done at the product or NDC level. However, bidding and payment for drugs furnished under the CAP is made at the HCPCS level. We believe that the smaller single drug category list finalized in section II.J.2.b will decrease the risk associated with applying a single percentage update over a group of drugs, and we also note that drugs added during the CAP contract period through a CMS approved vendor request and drugs that are separately bid will continue to be updated at the individual HCPCS level.

g. 2009 PFS Proposals

(1) Definition of a CAP Physician

In the July 6, 2005 IFC, we stated that section 1847B of the Act most closely describes a system for the provision of and the payment for drugs provided incident to a physician's service (70 FR 39026). In the November 21, 2005 IFC (70 FR 70258), we stated that for the purposes of the CAP, a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act. This definition includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry, as well as chiropractors. However, this definition does not include other health care professionals, such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and other professions such as physician assistants (PAs) who may be able to legally prescribe medications and enroll in Medicare.

In the CY 2009 PFS proposed rule (73 FR 38523), we proposed to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's service. While we believed that most practitioners described in section 1861(s)(2)(K) of the Act would bill under specific physician provider numbers, it was not our intent to exclude practitioners who are able to bill independently for drugs associated with services that are covered when provided by a physician and legally authorized to be performed.

In response to our CY 2009 proposed rule, only a few commenters were concerned about the inclusion of inadequately trained practitioners and risks to patient safety under this expanded definition. Another commenter stated that this definition goes beyond the scope of the provisions in the MMA and the strict definition of ''physician'' in the statute. However, the majority of comments supported this proposal.

We did not receive any feedback during the CAP postponement that would lead for us to reconsider this proposal. Therefore, we again proposed to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's services.

Our proposal was specific to the Part B Drug CAP and was not intended to affect the definition of physician in section 1861(r) of the Act, or the definition of ''Medical and Other Health Services'' described in section 1861(s) of the Act. The proposal also did not seek to expand the scope of the CAP beyond what has been described in previous rules, other than to clarify that a small number of providers who are enrolled in Medicare, and who legally prescribe drugs associated with services under section 1861(s) of the Act and can be paid by Medicare may elect to participate in the CAP if billing independently. In short, the CAP remains a program that provides Part B drugs furnished incident to a physician's services.

The following is summary of the comments we received regarding the updated definition of a CAP physician.

Comment: The majority of commenters supported our proposal to expand the definition of a physician for the purposes of the CAP. Commenters indicated that this proposal could increase patient access to drugs and treatment options, particularly in rural and underserved areas. It could also increase physician participation in the CAP and allow for greater program flexibility. However, some comments

expressed concerns about our approach. One commenter was concerned about the inclusion of inadequately trained health professionals and risks to patient safety under this expanded definition. This commenter also urged us to limit what types of CAP drugs could be handled by these additional health professionals included under our proposal. Another comment indicated that CMS more thoroughly refine its definition of ''physician'' through regulation since our proposed rule language seemingly implied that health practitioners included in this expanded definition who participate in the CAP could administer drugs regardless of any state-level prescription and administration laws. Another commenter indicated that we had exceeded our regulatory authority by expanding the definition of physician to include health professionals beyond those listed in section 1861(r) of the Act.

Response: We appreciate the comments that supported our proposal; however, we have further considered the comments on the 2009 PFS rule and the 2010 PFS proposed rule that cautioned us about potentially exceeding the statutory definition of a physician under section 1861(r) of the Act. Our proposal's intent was not to affect the definition of physician as specified in section 1861(r) of the Act. Upon further consideration in light of the comments, we agree that our proposal to expand the definition of a CAP physician is problematic, because it can be interpreted to be in conflict with section 1861(r) of the Act. Section 1847B of the Act specifically uses the term ''physician'' rather than a more general term, like provider, to describe who may select a CAP contractor to supply CAP drugs. Section 1861(r) of the Act specifies that the term physician includes, in some cases subject to certain limitations, the following types of practitioners: a doctor of medicine or osteopathy, a doctor of dental surgery or of dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.

Therefore, at this time, we will not be revising the definition of a CAP physician beyond what was previously stated in the November 21, 2005 IFC (70 FR 70258), that is for the purposes of the CAP, a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act. Based on CAP physician election data, we believe that the impact of not updating our definition at this time will have minimal impact on access to CAP drugs.

(2) Easing the Restriction on Physicians Transporting CAP Drugs

Although section 1847B(b)(4)(E) of the Act provides for the shipment of CAP drugs to settings other than a participating CAP physician's office under certain conditions, in initially implementing the CAP, we did not propose to implement the CAP in alternative settings. We implemented the CAP with a restriction that CAP drugs be shipped directly to the participating CAP physician, as stated in § 414.906(a)(4), and that participating CAP physicians may not transport CAP drugs from one location to another, as stated in § 414.908(a)(3)(xii). However, we were aware that physicians may desire to administer drugs in alternative settings. Therefore, in the July 6, 2005 IFC, we sought comment on how this could be accommodated under the CAP in a way that addresses the potential vendors' concerns about product integrity and damage to the approved CAP vendors' property (70 FR 39048). We discussed comments submitted in response to the July 6, 2005 IFC in the CY 2008 PFS proposed rule (72 FR 38158). We also requested comments in the CY 2008 PFS proposed rule (72 FR 38157) on the potential feasibility of easing the restriction on transporting CAP drugs where this is permitted by State law and other applicable laws and regulations. We responded to submitted comments in the CY 2008 PFS final rule with comment period (72 FR 66268).

In the CY 2009 PFS proposed rule (70 FR 38523), we proposed to permit the transportation of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. Because of the 2009 CAP postponement, we did not address this issue in the CY 2009 PFS final rule. However, we did receive the following comments in response to our proposed rule on easing transportation restrictions in the CAP:

- Many commenters indicated that this change would increase program flexibility and facilitate patient treatment.
- Some commenters were supportive, but also raised concerns about drug integrity and liability, and requested that appropriate safeguards be in place before transportation restrictions were eased.
- Generally, commenters wanted CMS to explicitly delineate standards about voluntary agreements that address concerns about product integrity, liability, transportation procedures, and documentation. One commenter indicated that such standards should be developed through a separate rulemaking period to allow for public comment.
- Several commenters cited State pedigree laws as possible impediments to physician transport of drugs.

We also requested and received feedback about the program during the 2009 postponement period. One member of the potential vendor community urged us to be mindful of increased legal liability for an approved CAP vendor if this policy were to be implemented, but also acknowledged that the proposal might substantially increase physician interest in the program.

We continue to be mindful of the concerns expressed by the commenters, and have evaluated both the advantages and disadvantages of easing the restriction on transportation of CAP drugs. Thus, we again proposed to permit transport of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. As indicated in our CY 2009 PFS proposed rule, we continued to propose that such agreements must comply with all applicable State and Federal laws and regulations and product liability requirements, and be documented in writing.

We would again like to reiterate the voluntary nature of these proposed agreements. Approved CAP vendors would not be required to offer and participating CAP physicians would not be required to accept such agreements when selecting an approved CAP vendor. An approved CAP vendor may not refuse to do business with a participating CAP physician because the participating CAP physician has declined to enter into such an agreement with the approved CAP vendor. Furthermore, we are not seeking to define which CAP drugs may be subject to the proposed voluntary agreements. In other words, each approved CAP vendor could specify which CAP drug(s) could be transported.

However, our proposal continues to contain certain limitations. In previous rulemaking, we have described requirements for voluntary agreements between approved CAP vendors and participating CAP physicians. In the July 6, 2005 IFC (70 FR 39050) and the CY 2006 PFS final rule (70 FR 70251 through 70252), we stated that we will not dictate the breadth of use or the specific obligations contained in voluntary arrangements between approved CAP vendors and

participating CAP physicians, other than to note that they must comply with applicable law and to prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements. Parties to such arrangements must also ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission. We proposed to apply these standards to any agreement for the transport of CAP drugs.

We remain concerned about opportunities for disruption in the drug's chain of custody and appropriate storage and handling conditions that may ultimately affect patient care or increase the risk of drug theft or diversion. Therefore, in order to maintain safety and drug integrity in the CAP and to protect against the fraudulent diversion of CAP drugs, we reproposed that any voluntary agreements between an approved CAP vendor and a participating CAP physician regarding the transportation of CAP drug must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported. We solicited comments on these issues, including the identification of who may transport the drugs, how documentation of transportation activities could be accomplished, and how the oversight of such agreements will be carried out.

In conclusion, we believe that the proposal to ease the restriction on transporting CAP drugs between a participating CAP physician's practice locations—when agreed upon by the participating CAP physician and the approved CAP vendor—will make the CAP more flexible and ultimately more appealing to participating CAP physicians. Additionally, we believe that this proposal will facilitate the participation of CAP physicians who have office locations in rural areas and/or have satellite offices with limited hours. Moreover, we believe that this proposal will promote beneficiary care, particularly for beneficiaries who live in rural locations. Since participating CAP physicians would be able to transport CAP drugs to another office location in accordance with a voluntary agreement with their approved CAP vendor, beneficiaries would have more flexibility in scheduling the location of their appointments. We solicited comments about this proposal.

The following is summary of the comments we received regarding the proposal to ease transport restrictions between participating CAP physicians' offices.

Comment: The comments represented a variety of perspectives and were very similar to the comments discussed in our previous proposal and outlined in the bullet points above. Many comments were supportive, but some also raised reservations pertaining to drug integrity and liability. The commenters requested that appropriate safeguards be in place before transportation restrictions were eased and that liability should be clearly defined in these voluntary agreements. One commenter supported our proposal, but indicated that concerns about drug integrity and liability would prevent approved CAP vendors from offering such voluntary agreements for transporting CAP drug. Another commenter indicated that the approved CAP vendor must be responsible for notifying physicians of handling or storage requirements for any drug. Two commenters indicated that licensed practitioners are able to take responsibility for transporting drugs because of their training and knowledge. A commenter requested that we develop specific transportation standards through a separate rulemaking period. Another comment indicated that the approved CAP vendor should develop and submit explicit drug transportation standards to CMS. One commenter suggested that CMS require physicians to document drug transfers via a standardized transport sheet.

A number of comments were supportive of our proposal and indicated that this change would increase program flexibility, make the program more desirable to physicians, and facilitate patient treatment. One commenter understood our proposal to mean that we would ''ship'' CAP drug directly to the site of service. Another commenter suggested that approved CAP vendors should be required to offer such agreements. Several commenters cited State pedigree laws as possible impediments to physician transport of drugs.

Response: Overall, there was support for our proposal and we agree that these agreements would provide flexibility for CAP providers. We agree with commenters who expressed concerns about product integrity and liability. However, we do not agree that additional CMS involvement such as developing detailed and specific agreements now, or through other means such as separate rulemaking, will contribute to the quality or appropriateness of these agreements. We believe that the details of these agreements can best be determined by the parties that participate in the agreement rather than CMS. Detailed knowledge about applicable State laws (including ''pedigree laws''), practice requirements and specialized knowledge about drug handling are beyond CMS' expertise. However, we believe that our proposal outlines a sufficient framework of safeguards and provisions to mitigate risks associated with damage to the product, drug diversion, and financial loss. We have stated that agreements must be made in writing and must comply with all applicable State and Federal laws and regulations and product liability requirements and must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported.

We are not seeking to define specific items in these agreements, such as which CAP drugs may be subject to the proposed voluntary agreements regarding drug transport because the parties involved in the agreement will have the greatest insight regarding such details and will better understand the variables and practical applications associated with these decisions. Drugs that may be furnished under the CAP are subject to a broad range of storage requirements—some drugs are especially temperature sensitive and some may be light sensitive.

Also, some CAP drugs are very expensive, and the loss of even a single dose could create significant financial impact for an approved CAP vendor. We believe that assessments and decisions about which drugs may be transported must be made by the approved CAP vendor at the drug level in order to allow the approved CAP vendor to better control the risk associated with transporting vendor-owned product and to apply its knowledge and expertise in product handling in order to either facilitate, or to choose not to allow the transportation of certain drugs that may require special handling, such as strict temperature control or limits to light exposure. So long as they are consistent with the standards we have set forth for these voluntary agreements, we also believe such agreements can address issues of financial liability for the drug, and we believe that the approved CAP vendor is in the best position to assess the financial risk associated with the transportation of specific drugs, and to make corresponding changes as new drugs are added to the CAP, or information about drugs already supplied under the CAP changes.

We are also concerned that additional CMS involvement regarding the details of these agreements could cause negative consequences by further delaying the implementation of this provision, or delays in responding to changes as new drugs become available under the CAP. Because the parties to the agreement have a better understanding of the specific information that must be used to assess each drug, CMS involvement could also result in the addition of requirements that may not be necessary, or the exclusion of requirements that may be beneficial. Providing a framework rather than specific requirements also provides an adaptable and scalable solution that can accommodate different drugs with different handling requirements, different participating CAP physician populations, and individual approved CAP vendors' financial risk assessments at the drug level.

We also note that shipment of drugs and biologicals often across significant distances is being done routinely by pharmacies, drug distributors, and home infusion providers. Therefore, we believe that significant practical experience associated with safely transporting drugs between various locations outside of standard shipping arrangements exists, and this experience could be applied to the transportation agreements. We encourage approved CAP vendors who enter into agreements with participating CAP physicians to permit transport of one or more CAP drugs between offices to assist with the dissemination of details and practical applications of specialized knowledge about drug handling and to either specify, or provide mechanisms to track, drugs that are being transported between offices.

We also agree with the comments that stated that participating CAP physicians and other CAP practitioners are able to follow the handling requirements associated with the drugs that they administer and we agree that they may be held responsible for adherence to those requirements. We believe that the participating CAP physicians will want to adhere to these requirements not only for the safety of the beneficiary who will receive the drug, but also for the financial well being of the approved CAP vendor—the entity that still owns the drug.

Based on the comments that we received, we are finalizing our proposal to ease the transportation restriction between a participating CAP physicians' offices as listed on the CAP physician election agreement using voluntary agreements between the approved CAP vendors and participating CAP physicians. The finalized proposal does not affect the current requirement that drugs be shipped from the approved CAP vendor only to a participating CAP physician.

We also remind readers that the change applies only to transportation of CAP drugs between the offices of a group to which the drug was shipped and does not include shipment to office locations not listed on the physician's election agreement, or transportation to sites other than the participating CAP physician's offices; these issues are outside the scope of what we had proposed.

We also remind readers that at a minimum, voluntary agreements that allow the transportation of CAP drugs between office locations must comply with all applicable State and Federal laws and regulations and product liability requirements, and be documented in writing and must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported. While we are not dictating the breadth of use or the specific obligations contained in voluntary arrangements between approved CAP vendors and participating CAP physicians, including the drugs covered by an agreement, the agreements must comply with applicable law and prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements. Parties to such arrangements must also ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission.

By way of example only, we believe that a voluntary agreement between the participating CAP physician and approved CAP vendor could also be used to address the following issues: assignment of financial liability associated with product loss or damage, tracking and stock reconciliation mechanisms, oversight and compliance mechanisms, who may transport the drug, and specific handling requirements for the each of the drugs that may be transported.

(3) Dispute Resolution Process

In the CY 2009 PFS proposed rule (73 FR 38524 through 38525), we discussed two changes to the CAP dispute resolution process. Section 1847B(b)(2)(A)(ii)(II) of the Act requires an approved CAP vendor to have a grievance and appeals process for the resolution of disputes. In the July 6, 2005 IFC (70 FR 39054 through 39058), we described the process for the resolution of participating CAP physicians' drug quality and service complaints and approved CAP vendors' complaints regarding noncompliant participating CAP physicians. We encouraged participating CAP physicians, beneficiaries, and vendors to use informal communication as a first step to resolve service-related administration issues. However, we recognized that certain disputes would require a more structured approach, and therefore, we established processes under § 414.916 and § 414.917.

(i) Approved CAP Vendor's Status During the Reconsideration Process

Section 414.917 outlines the dispute resolution process for participating CAP physicians. As discussed in the July 6, 2005 IFC (70 FR 39057 through 39058), if a participating CAP physician finds an approved CAP vendor's service or the quality of a CAP drug supplied by the approved CAP vendor to be unsatisfactory, then the physician may address the issues first through the approved CAP vendor's grievance process, and second through an alternative dispute resolution process administered by the designated carrier and CMS. In turn, the designated carrier would gather information about the issue as outlined in § 414.917(b)(2) and make a recommendation to CMS on whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. We would then review and act on that recommendation after gathering any necessary, additional information from the participating CAP physician and approved CAP vendor. If we suspend an approved CAP vendor's CAP contract for noncompliance or terminate the CAP contract in accordance with § 414.914(a), the approved CAP vendor may request a reconsideration in accordance with § 414.917(c).

In the July 6, 2005 IFC (70 FR 39058), we indicated that the approved CAP vendor's participation in the CAP would be suspended while the approved CAP vendor's appeal of our decision is pending. This suspended status is also implied in § 414.917(c)(9), which states that the ''approved CAP vendor may resume participation in CAP'' if the final reconsideration determination is favorable to the approved CAP vendor. In order to improve the clarity of our regulations, we proposed in the CY 2009 PFS proposed rule that the approved CAP vendor's contract will remain suspended during the reconsideration

period in § 414.917 (73 FR 38525). We believed that this proposed technical change is consistent with basic contracting concepts and with our current practices for the CAP. This proposal was not finalized due to the 2009 CAP postponement.

Comments submitted in response to our CY 2009 PFS proposed rule supported this proposed clarification and we did not receive additional feedback about this issue after the CAP was postponed. Based on this and our continued need to improve the clarity of our regulations, we reproposed that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917. We solicited additional comments on our proposal.

Comment: One commenter supported our proposal regarding the CAP's dispute resolution process.

Response: We are finalizing our proposal that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917. We believe that this technical change is consistent with basic contracting concepts and with our current practices for the CAP.

(ii) Termination of CAP Drug Shipments to Suspended CAP Physicians

Section 414.916 provides a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians. As stated at § 414.916(a), ''Cases of an approved CAP vendor's dissatisfaction with denied drug claims are resolved through a voluntary alternative dispute resolution process delivered by the designated carrier, and a reconsideration process provided by CMS.'' Once the decision is made to suspend a participating CAP physician's CAP election agreement, the participating CAP physician will be suspended from the CAP as described in § 414.916(b)(3).

Physicians whose participation in the CAP has been suspended are not eligible to receive CAP drugs. This is implied in § 414.906(a)(4), which speaks of approved CAP vendors providing CAP drugs directly to ''[a] participating CAP physician.'' However, we believe that the clarity of our dispute resolution regulations would be improved if this drug delivery issue were stated explicitly. Therefore, in the CY 2009 PFS proposed rule, we proposed to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. The proposal also applied to physicians engaged in the reconsideration process outlined in § 414.916(c) and included a conforming change at § 414.914(f)(12). We believed that these changes were in accord with the underlying intent of § 414.916, namely to provide a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians, and we believe that these changes will increase the clarity of our regulations. We also noted that the participating CAP physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked.

Comments submitted in response to the CY 2009 PFS proposed rule agreed with our proposal. Though we did not finalize this proposal due to the 2009 CAP postponement, we received no comments from the public in response to our request for feedback during the CAP 2009 postponement. Based on positive public feedback and our continued belief that the clarity of our dispute resolution regulations would be improved by being explicit about this issue, we reproposed to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. This suspension in drug shipment would also apply to physicians engaged in the reconsideration process outlined in § 414.916(c). We have also proposed a conforming change to § 414.914(f)(12). Physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked.

Comment: We received comments that both supported and opposed this proposal. One commenter supported this approach. Another commenter questioned the sufficiency of our procedures and indicated that the suspension of CAP drug shipments to a physician should not be implemented after an initial determination by CMS, but rather only after a final decision on reconsideration has been made.

Response: We disagree with the comment about the sufficiency of our dispute resolution procedures. We believe that in light of the very limited grounds for which a participating CAP physician may be suspended, the protections afforded under § 414.916(b)(3) prior to CMS's initial decision to suspend the physician from the CAP are sufficient. Indeed, a participating CAP physician may be suspended from the CAP only upon CMS approval after: information is collected and analyzed by the carrier on the issue of whether the participating CAP physician has been filing his or her CAP drug administration claims in accordance with the requirements of § 414.908(a)(3), the designated carrier provides numbered findings of fact to CMS, and CMS reviews the carrier's information and gathers relevant additional information from the participating CAP physician. These procedures allow a participating CAP physician to be actively involved in the dispute resolution process prior to CMS's decision to suspend the CAP election agreement. For these reasons, we believe that appropriate initial mechanisms are in place to protect the physician's access to drugs under the CAP.

Furthermore, physicians who are suspended from participation in the CAP and to whom the approved CAP vendor has ceased shipments of CAP drugs are able to obtain drugs and bill for them under the ASP payment system. Thus, these physicians will have continuous access to Part B drugs. Finally, because a participating CAP physician's failure to comply with regulations at § 414.908(a)(2) can negatively affect the approved CAP vendor's ability to receive payment for CAP drugs that it shipped to the physician, we believe that suspending shipment of CAP drugs upon CMS's initial determination of suspension of the CAP physician election agreement appropriately balances the needs of the participating CAP physician and those of the approved CAP vendor. For the foregoing reasons, at this time, we are finalizing our proposal that approved CAP vendors shall not ship CAP drugs to physicians whose participation in the CAP has been suspended after an initial determination by CMS.

I. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

In the CY 2010 PFS proposed rule (74 FR 33634 through 33639), we outlined the proposed updates to the case-mix adjusted composite rate payment system established under section 1881(b)(12) of the Act, as added by section 623 of the Medicare Modernization Act (MMA), which included updates to the drug add-on component of the composite rate system, as well as the wage index values used to adjust the labor component of

the composite rate. Specifically, as described in more detail below in this section, we proposed the following:

- A zero growth update to the proposed 15.0 add-on adjustment to the composite rates for 2010 required by section 1881(b)(12)(F) of the Act (resulting in a $20.33 per treatment drug add-on amount).
- An update to the wage index adjustment to reflect the latest available wage data, including a revised BN adjustment factor of 1.057888.
- A reduction to the ESRD wage index floor from 0.7000 to 0.6500.

We received few public comments on our proposals. The ESRD payment related comments are discussed in detail below in this section. In addition, as discussed in section II.G.12. of this rule, section 1881(b)(12)(G)(iv) of the Act, as added by section 153(a)(1) of the MIPPA, increases the composite rate by 1.0 percent for ESRD services furnished on or after January 1, 2010. Therefore, the 1.0 percent increases the current composite rate of $133.81 to $135.15 for services furnished on or after January 1, 2010.

1. Update to the Drug Add-on Adjustment to the Composite Rate

Section 1881(b)(12)(B)(ii) of the Act, as added by section 623(d) of the MMA, requires an add-on to the composite rate to account for changes in the drug payment methodology. Section 1881(b)(12)(C) of the Act provides that the drug add-on must reflect the difference in aggregate payments between the revised drug payment methodology for separately billable ESRD drugs and the Average Wholesale Price (AWP) payment methodology. In 2005, we generally paid for ESRD drugs based on average acquisition costs. Thus the difference from AWP pricing was calculated using acquisition costs. However, in 2006 when we moved to Average Sales Price (ASP) pricing for ESRD drugs, we recalculated the difference from AWP pricing using ASP prices.

In addition, section 1881(b)(12)(F) of the Act requires that, beginning in CY 2006, we establish an annual increase to the drug add-on to reflect estimated growth in expenditures for separately billable drugs and biologicals furnished by ESRD facilities. This growth update applies only to the drug add-on portion of the case-mix adjusted payment system. The CY 2009 drug add-on adjustment to the composite rate was 15.2 percent. The drug add-on adjustment for CY 2009 reflected a zero increase. This computation is explained in detail below and in the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757).

a. Estimating Growth in Expenditures for Drugs and Biologicals for CY 2010

Section 1881(b)(12)(F) of the Act specifies that the drug add-on increase must reflect ''the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable * * *'' By referring to ''expenditures'', we believe the statute contemplates that the update would account for both increases in drug prices, as well as increases in utilization of those drugs.

In the CY 2007 PFS final rule with comment period (71 FR 69682), we established an interim methodology for annually estimating the growth in ESRD drugs and biological expenditures that used the Producer Price Index (PPI) for pharmaceuticals as a proxy for pricing growth in conjunction with 2 years of ESRD drug data to estimate per patient utilization growth. We indicated that this interim methodology would be used to update the drug add-on to the composite rate until such time that we had sufficient ASP drug expenditure data to project the growth in ESRD drug expenditures.

However, for CY 2008, due to declining ASP prices, we no longer believed that using the PPI as a proxy for pricing growth was appropriate. Accordingly, for CY 2009, we revised the interim methodology for estimating the growth in ESRD drug expenditures by using ASP pricing to estimate the price component of the update calculation. Due to the declining trend in ASP pricing and utilization, we calculated a decrease in the drug add-on adjustment, and applied a zero update to the drug add-on adjustment (73 FR 69755 through 69757).

b. Estimating Growth in Expenditures for Drugs and Biologicals in CY 2010

Since we now have 3 years of drug expenditure data based on ASP pricing, we have reevaluated our methodology for estimating growth in drug expenditures. We believe that 3 years of drug expenditure data based on ASP pricing is sufficient to project drug expenditure growth based on trend analysis. Therefore, for CY 2010, we proposed to use trend analysis from ASP drug expenditure data to update the per treatment drug add-on adjustment (74 FR 33636).

In addition, we proposed to estimate per patient growth in drug expenditures by removing growth in ESRD enrollment from growth in total drug expenditures. To estimate drug expenditure growth using trend analysis, we looked at the average annual growth in total drug expenditures between 2006 and 2008. First we had to estimate the total drug expenditures for all ESRD facilities in CY 2008. For the CY 2010 PFS proposed rule, we used the final CY 2006, the final CY 2007 ESRD claims data, and the latest available CY 2008 ESRD facility claims, updated through December 31, 2008 (that is, claims with dates of service from January 1 through December 31, 2008, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2008). For the CY 2010 PFS proposed rule, we adjusted the December 2008 file to reflect our estimate of what total drug expenditures would be using the final June 30, 2009 bill file for CY 2008 (74 FR 33636). The net adjustment we applied to the CY 2008 claims data was an increase of 11.1 percent to the December 2008 claims file. In this final rule with comment period, we are using additional updated CY 2008 claims with dates of service for the same timeframe. This updated CY 2008 data file will include claims received, processed, paid, and passed to the National Claims History File as of June 30, 2009.

Using the full-year 2008 drug expenditure figure, we calculated the average annual change in drug expenditures from 2006 through 2008. This average annual change showed a decrease of 1.7 percent for this timeframe. We are using this 1.7 percent decrease to project drug expenditures for both 2009 and 2010.

c. Estimating per Patient Growth

Once we determined the projected growth in drug expenditures from 2009 to 2010, we then removed growth in enrollment for the same time period from the expenditure growth, so that the residual reflects per patient expenditure growth (which includes price and utilization combined). We believe that this approach is consistent with section 1881(b)(12)(F) of the Act, which requires us to annually update the drug add-on adjustment. To calculate the per patient growth in drug expenditures between CYs 2009 and 2010, we removed the enrollment component which represents the estimated growth in enrollment between CY 2009 and CY 2010. This was approximately 1.9 percent. To determine the growth in per patient expenditures, we divided the total drug expenditure decrease between 2009 and 2010 of 1.7 percent ($1.000 - 0.017 = 0.983$) by enrollment growth of 1.9 percent (1.019) for the same timeframe. The result is a per patient expenditure growth factor equal to 0.965 ($0.983/1.019 = 0.965$). Thus, we

are projecting a 3.5 percent decrease in per patient growth in drug expenditures between 2009 and 2010 (0.965 = 1.000–0.035).

d. Applying the Growth Update to the Drug Add-On Adjustment

In the CY 2006 PFS final rule (71 FR 69683), we applied the projected growth update percentage to the total amount of drug add-on dollars established for CY 2005 to establish a dollar amount for the CY 2006 growth update. In addition, we projected the growth in dialysis treatments for CY 2006 based on the projected growth in ESRD enrollment. We divided the projected total dollar amount of the CY 2006 growth by the projected growth in total dialysis treatments to develop the per treatment growth update amount. This growth update amount, combined with the CY 2005 per treatment drug add-on amount, resulted in an average drug add-on amount per treatment of $18.88 (or a 14.5 percent adjustment to the composite rate) for CY 2006.

In the CY 2007 PFS final rule with comment period (71 FR 69684), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2007, we applied the growth update factor of 4.03 percent to the $18.88 per treatment drug add-on amount for an updated amount of $19.64 per treatment.

In the CY 2008 PFS final rule with comment period (72 FR 66282), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2008, we applied the growth update factor of 3.5 percent to the $19.64 per treatment drug add-on amount for an updated amount of $20.33 per treatment.

In the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757), we applied a zero update to the per treatment drug add-on amount which left it at $20.33. As discussed in detail below, for CY 2010, we again will apply a zero update to the per treatment drug add-on amount of $20.33 established in CY 2008.

e. Update to the Drug Add-on Adjustment

As discussed previously in this section, we estimate a 1.7 percent decrease in total drug expenditures between CY 2009 and CY 2010. Growth in per patient drug expenditures is computed by dividing growth in total drug expenditures by growth in enrollment for the same time period. Therefore, to calculate growth in per patient drug expenditures, we remove the enrollment component, which is an estimated increase of 1.9 percent (1.019) from growth in total drug expenditures, which is an estimated decrease of 1.7 percent (1.000 − 1.017 = 0.983). As described above, the removal of the enrollment component from total drug expenditures is computed as follows: 0.983/1.019 = 0.965. Therefore, we are projecting a 3.5 percent decrease in per patient growth of drug expenditures between CY 2009 and CY 2010. However, similar to last year and as indicated above, we are finalizing a zero update to the drug add-on adjustment.

We believe this approach is consistent with the language under section 1881(b)(12)(F) of the Act which states in part that ''the Secretary shall annually increase'' the basic case-mix adjusted payment amounts by an amount determined by applying the estimated growth in expenditures for separately billed ESRD drugs for the drug add-on amount. Our understanding of the statute contemplates ''annually increase'' to mean a positive or zero update to the drug add-on. Therefore, we will apply a zero update to maintain the $20.33 per treatment drug add-on amount for CY 2010. The current $20.33 per treatment drug add-on reflected a 15.2 percent drug add-on adjustment to the composite rate in effect for CY 2009. However, given that the MIPPA mandates a 1 percent increase to the composite rate (effective January 1, 2010), this 1 percent increase results in a decrease in the CY 2009 drug add-on adjustment from 15.2 percent to 15.0 percent to keep the drug add-on amount at $20.33 per treatment.

Comment: Many commenters agreed with our decision to continue to use the ASP+6 percent methodology for separately billable drugs. The commenters indicated that the ASP+6 percent methodology is appropriate since the drugs will be reimbursed at the same amount as they would when furnished in a physician office.

Response: Although we did not propose any changes to reimbursement for separately billiable ESRD drugs and biologicals, we appreciate the commenters' support of our use of the ASP+6 percent methodology.

Comment: The commenters also agreed with our decision to continue with a zero update to the drug add-on adjustment. MedPAC stated that although it recognizes the elimination of the drug add-on payment will occur beginning January 1, 2011, MedPAC believes that the composite payment rate and the drug add-on should be combined because the add-on payment is complex and may not be the most appropriate way to pay for dialysis services

Response: We appreciate the commenter's support that we continue with a zero update to the drug add-on adjustment. As we explained above, we are finalizing our proposal to provide a zero update to the drug add-on adjustment for CY 2010. With regard to MedPAC's suggestions, under the proposed bundled ESRD prospective payment system (PPS) effective in CY 2011, the drug add-on adjustment will be eliminated for ESRD providers and facilities that opt to be paid under the proposed ESRD PPS system beginning in CY 2011 (and not go through the 4-year transition). However, we note that under the proposed ESRD PPS, we will continue to update the drug add-on adjustment during the transition period. For further details regarding the proposed ESRD PPS, please refer to the Medicare End-State Renal Disease Prospective Payment System Proposed Rule (74 FR 50003 to 50005).

f. Update to the Geographic Adjustments to the Composite Rate

Section 1881(b)(12)(D) of the Act, as amended by section 623(d) of the MMA, gives the Secretary the authority to revise the wage indexes previously applied to the ESRD composite rate. The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located. The wage indexes are calculated for each urban and rural area. In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. In addition, we generally have followed wage index policies related to these definitions used under the inpatient hospital prospective payment system (IPPS), but without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provisions that only apply to hospitals paid under the IPPS (70 FR 70167). For purposes of the ESRD wage index methodology, the hospital wage data we use is pre-classified, pre-floor hospital data and unadjusted for occupational mix.

g. Updates to Core-Based Statistical Area (CBSA) Definitions

In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB's CBSA-based geographic area

designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. The CBSA-based geographic area designations are described in OMB Bulletin 03–04, originally issued June 6, 2003, and is available online at *http://www.whitehouse.gov/omb/bulletins/b03-04.html.* In addition, OMB has published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. We wish to point out that this and all subsequent ESRD rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current ESRD wage index. The OMB bulletins may be accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

h. Updated Wage Index Values

In the CY 2007 PFS final rule with comment period (71 FR 69685), we stated that we intended to update the ESRD wage index values annually. The ESRD final wage index values for CY 2010 were developed from FY 2006 wage and employment data obtained from the Medicare hospital cost reports. As we indicated above, the ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix. We proposed to use the same methodology for CY 2010, using FY 2006 hospital data to develop the CY 2010 ESRD wage index values. For a detailed description of the development of the CY 2010 wage index values based on FY 2006 hospital data, see the FY 2010 IPPS final rule with comment period (74 FR 43834). Section III.G. of the preamble to the FY 2010 IPPS final rule with comment period, ''Method for Computing the Proposed FY 2010 Unadjusted Wage Index'', describes the cost report schedules, line items, data elements, adjustments, and wage index computations. The wage index data affecting the ESRD composite rate for each urban and rural locale may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage data are located in the section entitled, ''FY 2010 Final Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-reclassified Wage Index by CBSA.''

In the CY 2009 final rule with comment period (73 FR 69758 and 69759), we indicated that CY 2009 was the final year of the transition period and each ESRD facility's composite payment rate would be based entirely on its applicable CBSA-based wage index value.

i. Reduction to the ESRD Wage Index Floor

In the CY 2009 PFS final rule with comment period, we stated our intention to continue to reassess the need for a wage index floor (73 FR 63758). We also stated that a gradual reduction in the floor is needed to support continuing patient access to dialysis in areas that have low wage index values, especially in Puerto Rico where the wage index values are below the current wage index floor. For CY 2010, we proposed to reduce the wage index floor from 0.70 to 0.65. We also anticipate that we may reduce the floor gradually until full implementation of the ESRD PPS required by section 1881(b)(14) of the Act.

Comment: We received comments from commenters in both Puerto Rico and Wheeling, WV–OH CBSA expressing concern about the reduction to the wage index floor.

Response: The majority of facilities located in Puerto Rico have wage indices significantly below the 0.65 floor. The steady reduction in the proposed ESRD wage index floor of 0.65 still remains higher than the actual wage index values which range from 0.3348 to 0.4740 for facilities located in Puerto Rico. Although a reduction in the wage index floor may negatively impact these providers, these facilities still benefit from a 0.65 floor rather than their actual wage index value.

There are 2 facilities located in Wheeling, WV–OH CBSA, which have an actual wage index value of 0.6869 and is above the proposed 0.65 floor, but not significantly below the CY 2009 0.70 floor. We note that the CY 2010 wage index value of 0.6869 for the Wheeling, WV–OH CBSA is prior to application of the wage index BN factor. After application of the wage index BN factor of 1.057735, the wage index value for Wheeling, WV–OH CBSA is 0.7266.

Comment: One commenter noted that the ESRD facilities in the Wheeling WV–OH CBSA have a wage index value that is less than the wage index value for rural WV. The commenter requested that CMS apply the rural floor policy that is applicable under the Hospital IPPS.

Response: Under the ESRD basic case-mix adjusted composite payment system, currently there is no mechanism for allowing providers to seek geographic reclassification. We reviewed the MedPAC's wage index recommendations as discussed in MedPAC's June 2007 report entitled ''Report to Congress: Promoting Greater Efficiency in Medicare.'' We note that MedPAC's June 2007 Report to Congress recommends that the Congress ''repeal the existing hospital wage index statute, including reclassification and exceptions, and give the Secretary authority to establish new wage index systems.'' We believe that adopting the IPPS wage index policies (such as the rural floor) for the ESRD wage index would not be prudent at this time, because MedPAC suggests that the reclassification and exception policies in the IPPS wage index alters the wage index values for one-third of IPPS hospitals. In addition, MedPAC found that the exceptions may lead to anomalies in the wage index. By adopting the IPPS rural floor at this time, the ESRD basic case-mix adjusted composite payment system wage index could become vulnerable to problems similar to those that MedPAC identified in their June 2007 Report to Congress. We will continue to review and consider MedPAC's recommendations on a refined or alternative wage index methodology for the IPPS and how it could potentially apply to the ESRD basic case-mix adjusted composite rate system in future years.

We also note that section 106(b)(2) of the Medicare Improvements and Extension Act (MIEA) of 2006 (which is Division B of the Tax Relief and Health Care Act (TRCHA) of 2006, Pub. L. 109–432, collectively referred to as ''MIEA–TRHCA'') required the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. To assist CMS in meeting the requirements of section 106(b)(2) of MIEA–TRHCA, in February 2008, we awarded a Task Order under its Expedited Research and Demonstration Contract, to Acumen, LLC. Acumen, LLC conducted a study of both the current methodology used to construct the Medicare wage index and the recommendations reported to the Congress by MedPAC. Part One of Acumen's final report, which analyzes the strengths and weaknesses of the data sources used to construct the CMS and MedPAC indexes, is available online at *http://www.acumenllc.com/reports/cms.* MedPAC's recommendations are presented in the FY 2009 IPPS final rule (73 FR 48745). We plan to continue monitoring IPPS wage index research efforts and the impact or influence these

efforts may have for the ESRD basic case-mix adjusted composite payment rate system wage index.

Moreover, in light of all of the pending research and review of wage index issues in general, we believe that it would be premature at this time to adopt the IPPS rural floor policy to the ESRD wage index.

j. Wage Index Values for Areas With No Hospital Data

In CY 2006, while adopting the CBSA designations, we identified a small number of ESRD facilities in both urban and rural geographic areas where there are no hospital wage data from which to calculate ESRD wage index values. The affected areas were rural Puerto Rico, and the urban area of Hinesville, GA (CBSA 25980), and rural Massachusetts. For CY 2006, CY 2007, CY 2008, and CY 2009, we calculated the ESRD wage index values for those areas as follows:

- For the urban area of Hinesville, GA, we calculated the CY 2006 through CY 2009 wage index value based on the average wage index value for all urban areas within the State of Georgia.
- For rural Massachusetts, because we had not determined a reasonable wage proxy, we used the FY 2005 wage index value in CY 2006 and CY 2007. As discussed below, we adopted an alternative methodology for CYs 2008 and 2009.
- For rural Puerto Rico, because all geographic areas in Puerto Rico were subject to the wage index floor in CYs 2006 through 2009, we applied the ESRD wage index floor to rural Puerto Rico as well. We note that there are currently no ESRD facilities located in rural Puerto Rico.

For CY 2008, we adopted an alternative methodology for establishing a wage index value for rural Massachusetts and continued to apply this methodology in CY 2009. Because we used the same wage index value for 2 years with no update, we believed it was appropriate to establish a methodology which employed reasonable proxy data for rural areas (including rural Massachusetts) and also permitted annual updates to the wage index based on that proxy data. For rural areas without hospital wage data, we used the average wage index values from all contiguous CBSAs as a reasonable proxy for that rural area.

In determining the imputed rural wage index, we interpreted the term ''contiguous'' to mean sharing a border. In the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are contiguous with CBSA 12700, Barnstable Town, MA, and CBSA 39300, Providence-New Bedford-Fall River, RI–MA. We proposed to use the same methodology for CY 2010. Under this methodology, the CY 2010 final wage index values for CBSA 12700 (Barnstable Town, MA—1.2618) and CBSA 39300 (Providence-New Bedford-Fall River, RI–MA—1.0782) averages results in an imputed wage index value of 1.1700 for rural Massachusetts in CY 2010.

For rural Puerto Rico, for CY 2010, all areas in Puerto Rico that have a wage index are eligible for the proposed ESRD wage index floor of 0.65. Therefore, we proposed to apply the proposed ESRD wage index floor of 0.65 to facilities that are located in rural Puerto Rico.

For Hinesville-Fort Stewart, GA (CBSA 25980), which is an urban area without specific hospital wage data, we proposed to apply the same methodology used to impute a wage index value that we used in CY 2009. Specifically, we proposed to utilize the average wage index value for all urban areas within the State of Georgia. That would result in a CY 2010 final wage index value of 0.9028 for the Hinesville-Fort Stewart GA CBSA.

We received no comments on our proposals for wage areas with no hospital data. Therefore, we are finalizing our policies for wage areas with no hospital data as proposed.

In the CY 2009 PFS final rule with comment period (73 FR 69759 through 69760), we stated that we would continue to evaluate existing hospital wage data and possibly wage data from other sources such as the Bureau of Labor Statistics, to determine if other methodologies might be appropriate for imputing wage index values for areas without hospital wage data for CY 2010 and subsequent years. To date, no data from other sources, superior to that currently used in connection with the IPPS wage index has emerged. Therefore, for ESRD purposes, we continue to believe this is an appropriate policy.

k. Budget Neutrality Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d) of the MMA, required that any revisions to the ESRD composite rate payment system as a result of the MMA provision (including the geographic adjustment) be made in a budget neutral manner. Given our application of the ESRD wage index, this means that aggregate payments to ESRD facilities in CY 2010 would be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjusters. We note that this BN adjustment only addresses the impact of changes in the geographic adjustments. A separate BN adjustment was developed for the case-mix adjustments required by the MMA. As we did not propose any changes to the case-mix measures for CY 2010, the current case-mix BN adjustment of 0.9116 would remain in effect for CY 2010. As in CY 2009, for CY 2010, we proposed to apply the proposed wage-index BN adjustment factor of 1.057888 directly to the ESRD wage index values. Because the ESRD wage index is only applied to the labor-related portion of the composite rate, we computed the BN adjustment factor based on that proportion (53.711 percent).

To compute the proposed CY 2010 wage index BN adjustment factor (1.057888), we used the FY 2006 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2008 outpatient claims (paid and processed as of December 31, 2008), and geographic location information for each facility which may be found through Dialysis Facility Compare Web page on the CMS Web site at *http://www.cms.hhs.gov/DialysisFacilityCompare/*. The FY 2006 hospital wage index data for each urban and rural locale by CBSA may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp*. The wage index data are located in the section entitled, ''FY 2010 Final Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA.''

Using treatment counts from the 2008 claims and facility-specific CY 2009 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2009. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2010. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the ESRD wage index for CY 2010. The total of these payments became the new CY 2010 amount of wage-adjusted composite rate expenditures for all ESRD facilities. Section 153(a) of the MIPPA revised section 1881(b)(12)(G) of the Act to provide for an update of 1 percent to the composite rate component of the payment system effective January 1, 2010. We note that when computing the new CY 2010 amount, we did not include this 1 percent increase because the BN adjustment would negate the increase.

After comparing these two dollar amounts (target amount divided by the new CY 2010 amount), we calculated an

adjustment factor that, when multiplied by the applicable CY 2010 ESRD wage index value, would result in aggregate payments to ESRD facilities that would remain within the target amount of composite rate expenditures. When making this calculation, the final ESRD wage index floor value of 0.6500 is applied whenever appropriate. The final wage BN adjustment factor is 1.057735 for CY 2010.

To ensure BN, we also must apply the wage index BN adjustment factor to the wage index floor of 0.6500 which results in an adjusted wage index floor of 0.6875 (0.6500 x 1.057735) for CY 2010.

General Comments

Comment: One commenter supports our proposal to maintain the existing case-mix adjusters and believes it will be important to maintain consistency in the current composite rate by preserving the current case-mix adjustors, given the anticipated shift to a bundled payment system.

Response: As explained earlier in this section, we did not propose any changes to the current basic case-mix composite rate payment system. We have maintained the current basic case-mix adjusters for CY 2010. We have proposed a number of patient-level adjusters in the new bundled ESRD PPS system, which are explained in detail in the ESRD PPS proposed rule (74 FR 49925 and 49926).

l. ESRD Wage Index Tables

The CY 2010 ESRD wage index tables are located in Addenda F and G of this final rule with comment period.

J. Discussion of Chiropractic Services Demonstration

1. Background

Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) requires the Secretary to conduct a 2-year demonstration to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. Medicare coverage for chiropractic services is limited to manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Act. The demonstration expanded current Medicare coverage to include ''care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided'' and was conducted in four geographically diverse sites, two rural and two urban regions, with each type including a Health Professional Shortage Area (HPSA). The two urban sites were 26 counties in Illinois and Scott County, Iowa, and 17 counties in Virginia. The two rural sites were the States of Maine and New Mexico. The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of the MMA mandates the Secretary to ensure that ''the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.''

In the CY 2006, 2007, and 2008 PFS final rules with comment period (70 FR 70266, 71 FR 69707, 72 FR 66325, respectively), we included a discussion of the strategy that would be used to assess BN and the method for adjusting chiropractor fees in the event the demonstration results in costs higher than those that would occur in the absence of the demonstration. We stated BN would be assessed by determining the change in costs based on a pre-post comparison of Medicare costs for beneficiaries in the demonstration and their counterparts in the control groups and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites and control sites. We also stated that our analysis would not be limited to only review of chiropractor claims because the costs of the expanded chiropractor services may have an impact on other Medicare costs. If the demonstration was not budget neutral, we anticipated making reductions in the CY 2010 and CY 2011 physician fee schedules. We indicated that if we determined that the adjustment for BN was greater than 2 percent of spending for the chiropractor fee schedule codes, we would implement the adjustment over a 2-year period. However, if the adjustment was less than 2 percent of spending under the chiropractor fee schedule codes, we would implement the adjustment over a 1-year period.

2. Analysis of Demonstration

Brandeis University, the demonstration evaluator, used two approaches in examining BN. The ''All Neuromusculoskeletal Analysis (NMS)'' reflects an intent-to-treat approach whereby the utilization of all beneficiaries who received any Medicare covered services for neuromusculoskeletal conditions in the demonstration areas was examined. This method is potentially subject to large external forces because of its inclusion of all beneficiaries including those who did not use chiropractic services and who would not become users of chiropractic services, even with expanded coverage for them. Therefore, a second analysis, termed the ''Chiropractic User Analysis'' was conducted to examine only the subset of beneficiaries who used chiropractic services for the treatment of their neuromusculoskeletal conditions. Both approaches use hierarchical linear modeling of costs over 3 years—1 year prior to the demonstration and the 2 years of the demonstration. We posted a report describing these analyses on CMS Web site at *http://www.cms.hhs.gov/reports/downloads/MMA651_BudgetNeutrality.pdf.*

The results of both analyses indicate that the demonstration was not budget neutral. In the ''All NMS Analysis,'' which compared the Medicare costs associated with NMS conditions for *all* beneficiaries in the demonstration areas with those of beneficiaries with similar characteristics from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $114 million. In the ''Chiropractic User Analysis,'' which compared the Medicare costs associated with NMS conditions for beneficiaries who used expanded chiropractic services in the demonstration areas, with those of beneficiaries with similar characteristics who used chiropractic services as currently covered by Medicare to treat a neuromusculoskeletal condition from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $50 million.

Both approaches to assessing BN have strengths and limitations. The ''All NMS Analysis'' provides the broadest view of the Medicare population that would have been eligible for the demonstration's expanded coverage of chiropractic services. Its inclusion of all beneficiaries with neuromusculoskeletal conditions guards against validity threats of selection. However, this approach creates a large heterogeneous group which may only include a small proportion of chiropractic service users. Basing estimates of BN on such a large heterogeneous group increases the potential for changes in the use of services seldom affected by chiropractors to be falsely attributed to the demonstration, which could result in the costs of the demonstration to appear larger than actual.

Consistent with the CY 2010 PFS proposed rule (74 FR 33520, 33639 through 33640), for this final rule with comment period, we continue to believe

that the BN estimate should be based on the ''Chiropractic User Analysis'' because of its focus on users of chiropractic services rather than all Medicare beneficiaries with neuromusculoskeletal conditions, including those who did not use chiropractic services and who would not have become users of chiropractic services even with expanded coverage for them. Users of chiropractic services are most likely to have been affected by the expanded coverage provided by this demonstration. Cost increases and offsets, such as reductions in hospitalizations or other types of ambulatory care, are more likely to be observed in this group. Therefore, as proposed, we are adjusting the Medicare PFS for all chiropractors using the estimate provided in the ''Chiropractic User Analysis.''

The CMS Office of the Actuary (OACT) estimates chiropractic expenditures in CY 2010 to be approximately $487 million based on actual Medicare spending for chiropractic services for the most recent available year. Because the costs of this demonstration were higher than expected and we did not anticipate a reduction to the PFS of greater than 2 percent per year, we are finalizing our proposal (74 FR 33639 through 33640) to recoup the $50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period. As proposed, we are recouping $10 million each year through adjustments to the PFS for chiropractic codes in calendar years 2010 through 2014. This approach reflects a change from our BN discussion in the CY 2006, 2007, and 2008 PFS rules, which was described previously in this section. In those rules, we had proposed that if the adjustment for BN was greater than 2 percent of spending for the chiropractor fee schedule codes, the adjustment would be implemented over a 2-year period. Under this final rule, we are recouping costs by reducing payment under the PFS for chiropractic fee codes by $10 million each year starting CY 2010 through CY 2014. We note that in the proposed rule, we proposed a 2 percent reduction in the chiropractic fee codes in order to achieve the $10 million yearly recoupment. We note that 2 percent was an approximation. Because of rounding, the $10 million recoupment in each of CYs 2010 through 2014 will amount to approximately a 2 percent reduction since the reduction in the chiropractic fee codes may be slightly higher or lower than 2 percent, depending on OACT's estimate of chiropractic expenditures for that calendar year. In order to reflect this fact, we are refining the language in this final rule to indicate that the chiropractic fee codes will be reduced by approximately 2 percent for CYs 2010 through 2014. Additionally, we believe that spreading this adjustment over a longer period of time will minimize its potential negative impact on chiropractic practices.

3. Payment Adjustment

To implement the required BN adjustment, as was proposed (74 FR 33640), we are reducing the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942). As explained previously, we are finalizing our plans to recoup $10 million each year through adjustments to chiropractic CPT codes for calendar years 2010 through 2014. In order to achieve the $10 million recoupment during such years, payment under the PFS for these codes will be reduced by approximately 2 percent. As stated in prior PFS rules, application of the BN adjustment would be specific to these three codes which represent the ''chiropractic fee schedule'' because they are the only chiropractic codes recognized under the PFS. This methodology also appropriately impacts the chiropractic profession that is directly affected by the demonstration. Consistent with the proposed rule, for this final rule with comment period, we are reflecting this reduction only in the payment files used by the Medicare contractors to process Medicare claims rather than through adjusting the RVUs. Avoiding an adjustment to the RVUs would preserve the integrity of the PFS, particularly since many private payers also base payment on the RVUs. The RVUs published in Addendum B and posted on our Web site will not show this reduction but will be annotated to state that the reduction resulting from the chiropractic demonstration is not reflected in the RVUs.

We received the following comments regarding the methodology used to evaluate BN in the chiropractic services demonstration.

Comment: Instead of the application of an adjustment to the national chiropractor fee schedule, the commenter believes the Congressional intent was for CMS to make an adjustment to the totality of services payable under the Part B Trust Fund because of the language in section 651(f)(A) of the MMA, which directs the Secretary to ''provide for the transfer from the Federal Supplementary Insurance Trust Fund * * * of such funds as are necessary for the costs of carrying out the demonstration projects under this section.''

Response: We disagree that the intent of section 651 of the MMA requires the application of a BN adjustment to the totality of services payable under the Part B Trust Fund. Specifically, section 651(f)(1)(B) of the MMA requires the Secretary to ''ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.'' This statutory provision does not specify a particular methodology for ensuring BN, but leaves that decision to the Secretary. Additionally, section 651(f)(1)(A) of the MMA, in pertinent part, provides that ''the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund * * * of such funds as are necessary for the costs of carrying out the demonstration projects under this section.'' This provision merely indicates that payment for the demonstration is to be made from Part B Trust Fund dollars. Section 651(f)(1)(A) of the MMA does not specify in any manner the methodology by which the Secretary is to ensure BN. Consequently, we do not believe it is a mandate requiring the application of an adjustment to the totality of services payable under the Part B Trust Fund.

Comment: The commenter states that more information is necessary to fully understand the findings provided by the evaluator, Brandeis University. The commenter noted that the increase in costs from the demonstration was completely due to the Illinois site, and not the other sites, and that it is ''premature to use demonstration findings to estimate the cost of a national roll out * * * without further investigation of why the Chicago area is such an outlier.'' The commenter also asks how the increase in costs for all neuromusculoskeletal conditions could be causally related to the demonstration project.

Response: Regardless of the differences in the demonstration areas, the evaluation conducted by Brandeis University found that expanding coverage for chiropractic services under the demonstration resulted in increased Medicare expenditures, and the Secretary must recoup these costs in order to meet the BN requirement of the law. The decision to recoup funds is related to the results of the demonstration and the requirement in the law and not to the discussion in the

evaluation report of the costs of a national expansion of coverage.

With respect to the comment questioning how the increase in costs for all NMS conditions could be causally related to the demonstration, we are unsure of what the commenter is asking. If the commenter is asking if Medicare costs associated with all neuromusculoskeletal conditions were used in the evaluation, the response is no, only costs for specific NMS diagnoses that can be treated by chiropractors were included in the evaluation. If the commenter is asking for the rationale for the ''All NMS'' analysis, the response is that this analysis provides a broader view of all of the beneficiaries who would have been eligible for the expanded coverage under the demonstration. This analysis includes beneficiaries with the appropriate neuromusculoskeletal conditions who could have been treated by either a chiropractic physician or other medical physician. The intent-to-treat approach of the ''All NMS'' analysis guards against selection threats to validity. As mentioned previously in this section, we did not base the BN estimate on the ''All NMS'' analysis because it included Medicare beneficiaries who did not use chiropractic services and who would not have become users of chiropractic services even with expanded coverage for them.

K. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

A Comprehensive Outpatient Rehabilitation Facility (CORF) is a Medicare provider that furnishes respiratory therapy services among other services. In § 485.70, we set forth the personnel qualifications that must be satisfied by a CORF as a condition of participation under § 485.58 and as a condition of coverage of CORF services, including personnel qualifications for respiratory therapists providing CORF respiratory therapy services.

In the CY 2009 PFS proposed rule (73 FR 38502) and subsequent final rule with comment period (73 FR 69942), we revised the definition of a respiratory therapist under § 485.70(j). The change in the definition of respiratory therapist was intended to ensure accuracy in reference to persons who are qualified to perform respiratory therapy and to ensure that language regarding these professionals is consistent with current industry requirements for education, training, and practice.

Prior to its modification by the CY 2009 PFS final rule with comment period, § 485.70(j) reflected the qualifications for Certified Respiratory Therapists (CRTs)'' and ''Registered Respiratory Therapists (RRTs)'' as terms commonly used by the professional industry to identify persons furnishing respiratory therapy services.

Since publication of the CY 2009 PFS final rule with comment, we have been informed by the industry that the changes made in the definition of respiratory therapist exclude a category of professional that has completed the requirements of a CRT, has completed a nationally accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exam for respiratory therapists (RTs), and is eligible to sit for the national registry examination administered by the NBRC, but has not yet passed the examination. These persons are referred to in the industry as CRTs.

Because it is our policy that Medicare payment is available for respiratory services provided to Medicare beneficiaries in a CORF only if provided by a respiratory therapist meeting the qualifications set forth in § 485.70(j), payment is not available for respiratory services provided by CRTs in the CORF setting. We note that personnel qualifications for respiratory therapists previously set forth at § 485.70(j) prior to its modification by the CY 2009 PFS final rule with comment period did not exclude this category of personnel from the definition of respiratory therapist. We have also heard from CRTs and from CORFs that this change has limited the availability of respiratory therapy services to Medicare beneficiaries in certified CORFs, as many of these services are provided by CRTs. Thus, in modifying the definition of respiratory therapist in the CY 2009 PFS final rule with comment period, we may have inadvertently impacted access to respiratory therapy services for some Medicare beneficiaries.

Thus, we proposed to modify the definition of respiratory therapist and to clarify the terms that are used to identify those persons who furnish respiratory services in CORFs in § 485.70(j) to include CRTs, that is those individuals who have completed a nationally accredited educational program for respiratory therapists and are eligible to sit for the national registry examination administered by the National Board for Respiratory Care (NBRC), but who have not yet passed the examination. The change in the definition we proposed would permit CRTs to furnish respiratory therapy services to Medicare beneficiaries in the CORF setting.

As proposed, our intent was to assure that persons who were qualified to furnish respiratory therapy services to patients in CORFs prior to the finalization of CY 2009 PFS final rule with comment period (73 FR 69942), will continue to qualify to furnish RT services to CORF patients under this proposed rule.

We solicited public comment on the proposed change to § 485.70(j). We also solicited comments from the industry regarding the difference in services furnished by the different levels of professionals who provide RT services in CORFs.

The following is summary of the comments we received regarding the discussion of the proposed changes to § 485.70(j).

Comment: Commenters expressed strong support for the regulatory changes that we proposed, specifically the clarification of the professional qualifications for respiratory therapists (RTs) in the CORFs setting.

Response: We appreciate support for this regulatory change as we believe it is in the best interest of Medicare and Medicaid beneficiaries. As a result of the comments, we are finalizing these regulatory requirements as proposed.

L. Ambulance Fee Schedule: Technical Correction to the Rural Adjustment Factor Regulations (§ 414.610)

Section 1834(l)(9) of the Act provides that for ''ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which transportation originates in a rural area * * * or in a rural census tract of a metropolitan statistical area * * * the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.'' Thus, the statute authorized a rural mileage bonus for miles 18 through 50 for ground ambulance services furnished on or after July 1, 2001 and prior to January 1, 2004. This provision was implemented in § 414.610(c)(5)(i), but the regulation text does not currently specify the statutory time period during which this rural mileage bonus was effective. In the ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period (68 FR 67960, 67961), we acknowledged that we inadvertently omitted from the regulation text the time period during which this statutory adjustment was

applicable, and stated we were ''revising § 414.610(c) to reflect that this bonus payment applies only for services furnished during the statutory period.'' Thus, in the ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period, we revised the regulation to include the time period during which the adjustment is applicable (68 FR 67963). However, the revised language specifying the statutory time period was dropped inadvertently from the regulation text when § 414.610(c)(5) was later republished in the ''Medicare Program; Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004'' interim final rule (69 FR 40288, 40292).

In this final rule with comment period, we are finalizing our proposal to reinstate the language that was originally finalized in ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period (68 FR 67963), but then inadvertently omitted again when § 414.610(c)(5) was later republished, so that § 414.610(c)(5)(i) correctly sets forth the statutory time period during which this rural mileage bonus was applicable. This revision to the regulation is a technical correction to conform the regulation to the statute. For further information, see program instruction, Transmittal AB–03–110; Date August 1, 2003; Change Request 2767 which was issued to inform contractors to discontinue paying such bonuses effective January 1, 2004 in accordance with the statute.

M. Clinical Laboratory Fee Schedule: Signature on Requisition

In the March 10, 2000 **Federal Register**, we published the ''Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services'' proposed rule (65 FR 13082) announcing and soliciting comments on the results of our negotiated rulemaking committee tasked to establish national coverage and administrative policies for clinical diagnostic laboratory tests under Part B of Medicare. In our final rule published in the November 23, 2001 **Federal Register** (66 FR 58788), we explained our policy on ordering clinical diagnostic laboratory services and amended § 410.32 to make our policy more explicit. Our regulation at § 410.32(a) included the requirement that ''[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary.'' In the November 23, 2001 final rule, we added paragraph (d)(2) to § 410.32 to require that the physician or qualified nonphysician practitioner (NPP) (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners (NPs), and physician assistants (PAs)) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record (66 FR 58809). In the preamble discussions to the March 10, 2000 proposed rule and November 23, 2001 final rule (65 FR 13089 and 66 FR 58802, respectively), we noted that ''[w]hile the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered.'' In those preambles, we described the policy of not requiring physician signatures on requisitions for clinical diagnostic laboratory tests, but implicitly left in place the existing requirements for a written order to be signed by the ordering physician or NPP for clinical diagnostic laboratory tests, as well as other types of diagnostic tests. We further stated in the preambles of the proposed and final rules that we would publish an instruction to Medicare contractors clarifying that the signature of the ordering physician is not required for Medicare purposes on a requisition for a clinical diagnostic laboratory test (65 FR 13089 and 66 FR 58802).

On March 5, 2002, we published a program transmittal implementing the administrative policies set forth in the final rule, including the following instruction: ''Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record.'' (Transmittal AB–02–030, Change Request 1998, dated March 5, 2002).

On January 24, 2003, we published a program transmittal in order to manualize the March 5, 2002 Transmittal. (Transmittal 1787, Change Request 2410, dated January 24, 2003). The cover note to the transmittal states, ''Section 15021, Ordering Diagnostic Tests, manualizes Transmittal AB–02–030, dated March 5, 2002. In accordance with negotiated rulemaking for outpatient clinical diagnostic laboratory services, no signature is required for the ordering of such services or for physician pathology services.'' In the manual instructions in that transmittal in a note, we stated: ''No signature is required on orders for clinical diagnostic services paid on the basis of the physician fee schedule or for physician pathology services.'' The manual instructions did not explicitly reference clinical diagnostic laboratory tests as the cover note did. Rather, the transmittal seemed to extend the policy set forth in the **Federal Register** (that no signature is required on requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule) to also apply to clinical diagnostic tests paid on the basis of the PFS and physician pathology services. In addition, the manual instructions used the term ''order'' instead of ''requisition,'' which some members of the industry have asserted caused confusion.

When we transitioned from paper manuals to the current electronic Internet Only Manual system, these manual instructions were inadvertently omitted from the new Benefit Policy Manual (BPM).

In August 2008, we issued a program transmittal (Transmittal 94, Change Request 6100, dated August 29, 2008) to update the BPM to incorporate language that was previously contained in section 15021 of the Medicare Carriers Manual. The reissued language states, ''No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services.'' Based on further review, we have determined that there are no clinical diagnostic laboratory tests paid under the PFS. After Transmittal 94 was published, we received numerous inquiries from laboratory, diagnostic testing, and hospital representatives who had questions about whether the provision applied to all diagnostic services, including x-rays, MRIs, and other nonclinical laboratory fee schedule diagnostic services.

To resolve any existing confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we restated and solicited public comments on our policy in the CY 2010 PFS proposed rule (74 FR 33641). Our current policy is that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule (CLFS); however, it must be evident, in accordance with our regulations at § 410.32(d)(2) and (3), that the physician ordered the services. The policy that

signatures are not required on requisitions applies to requisitions for clinical diagnostic laboratory tests paid under the CLFS.

We note that we solicited and received comments on this signature requirement during the notice and comment period for the March 10, 2000 proposed rule in the context of our proposal to add paragraph (d)(2)(i) to § 410.32 to require that the practitioner who orders a diagnostic laboratory test must maintain documentation of medical necessity in the beneficiary's medical record. The majority of comments supported the adoption of a policy that the signature of the practitioner on a requisition for a clinical diagnostic laboratory test paid under the CLFS is not the only way of documenting that the test has been ordered and, thus, should not be required provided such documentation exists in an alternate form.

This policy regarding requisitions for clinical diagnostic laboratory tests does not supersede other applicable Medicare requirements (such as those related to hospital Conditions of Participation (CoPs)) which require the medical record to include an order signed by the physician who is treating the beneficiary. Nor do we believe that anything in our policy regarding signatures on requisitions for clinical diagnostic lab tests supersedes other requirements mandated by professional standards of practice or obligations regarding orders and medical records promulgated by Medicare, the Joint Commission, or State law; nor do we believe the policy would require providers to change their business practices.

We also restated and solicited public comment on our long-standing policy consistent with the principle in § 410.32(a) that a written order for diagnostic tests including those paid under the CLFS and those that are not paid under the CLFS (for example, that are paid under the PFS or under the OPPS), such as X-rays, MRIs, and the TC of physician pathology services, must be signed by the ordering physician or NPP. That is, the policy that signatures are not required on requisitions for clinical diagnostic laboratory tests paid based on the CLFS applies only to requisitions (as opposed to written orders) (74 FR 33642).

Additionally, we solicited public comments about the distinction between an order and a requisition (74 FR 33642). We note that an ''order'' as defined in our IOM, 100–02, Chapter 15, Section 80.6.1, is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (for example, if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility.
- A telephone call by the treating physician/practitioner or his or her office to the testing facility; or
- An electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility.

If the order is communicated via telephone, both the treating physician/practitioner, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

In the proposed rule (74 FR 33642), we defined a ''requisition'' as the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting labs with billing and handling of results, and serves as an administrative convenience to providers and patients. We believe that a written order, which may be part of the medical record, and the requisition are two different documents, although a requisition that is signed may serve as an order. We welcomed comments from the public about the distinction between requisitions and orders.

The following is summary of the comments we received regarding the discussion of the physician signature on requisitions issue.

Comment: We received several comments concerning the fact that a diagnostic test, such as an x-ray, continues to require the signature of the ordering physician or NPP on the written order whether or not the diagnostic test is paid under the CLFS.

Response: We are appreciative that the general public recognized a clear distinction in the proposed rule between clinical diagnostic laboratory tests paid under the CLFS and diagnostic tests that may also be paid under the PFS or OPPS. The discussion in the proposed and final rules this year concerns our current policy that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the CLFS. This policy was the result of Negotiated Rulemaking and was outlined in proposed and final rules published during 2000 and 2001, respectively (65 FR 13089 and 66 FR 58790, 58801, and 58802). This policy does not include diagnostic tests such as x-rays.

Comment: One commenter was supportive of both policies on which we solicited comments. Specifically, this commenter supported our policy that a written order for diagnostic tests (including those paid under the CLFS and those that are not paid under the CLFS) must be signed by the ordering physician or NPP. The commenter further stated that the request for a diagnostic test represents part of the physician's plan for the patient, which is part of the patient's medical record. As such, when the request is in writing, a physician signature would be appropriate and likely easily generated. The commenter also supported our policy that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the CLFS. The commenter stated that, to the extent a requisition is simply a paper mechanism for transmitting an order and more administrative in nature, it is less likely to be generated or handled by the physician. Thus, to require a physician's signature on a requisition for clinical diagnostic laboratory tests paid on the basis of the CLFS would be an added and unnecessary burden on physicians.

Response: We appreciate the commenter's support of our policies and the commenter's input on these issues.

Comment: Several commenters suggested that we should not require a physician's signature on a medical request, whether that request be an order or a requisition, for any type of test, paid under the CLFS or not, within or outside the hospital setting.

Response: To do as commenters suggest would be a departure from long-standing Medicare policy requiring the physician's signature on written orders in other settings. This procedure serves to document that the physician or NPP ordered the test and documented the medical necessity of the test. The exception of not requiring a physician's signature on the requisition for a clinical diagnostic laboratory test paid under the CLFS only is very narrow and does not include other types of tests paid in other types of settings.

Comment: Several commenters raised concerns about issues relating to electronic medical records. Specifically, commenters were concerned whether or not an electronic signature would be acceptable and had questions about what constitutes a medical record in a paperless environment. One commenter stated that, generally, electronic systems that are used to request laboratory testing can be used by physicians with authorized access only and that as a result, a physician's signature should not be expected or required.

Response: We appreciate the commenters' concerns about these issues. CMS is in the process of developing guidelines concerning electronic records and electronic signatures for use in CMS programs. These guidelines will be finalized at a later date. The general public will be kept apprised of our progress on this issue through future official issuances.

Comment: One commenter urged us to establish a ''rule of reason'' with regard to what is required to be in the medical record, while two other commenters provided detailed suggestions on how to improve our manual language in this regard. These commenters were concerned about the fact that physicians sometimes make shorthand notes or indicate that there was an office visit only without further details in the medical record concerning the specific laboratory tests that are ordered.

Response: We believe that, whenever a physician orders services, including laboratory tests, for a patient in order to assist in diagnosing or treating the patient's conditions, the ordering of those services should be documented in the patient's medical record. Nonetheless, we do appreciate the commenters' concerns about the scope of the medical record and efforts to make detailed suggestions about how to improve the direction provided in our manuals. We will carefully consider these issues and if we decide that further clarification is warranted, will issue such clarification.

Comment: Several commenters were concerned that, while documentation to support an unsigned requisition would be required to be maintained in the medical record, employees at the clinical diagnostic laboratory do not have access to the medical record to verify whether or not this documentation exists. Commenters stated that, once a laboratory receives an order or requisition, it is obligated to perform the test as quickly as possible because it is in the best interest of the Medicare beneficiary, regardless of whether or not a physician signature is present. Commenters also raised the issue of fragility of the specimen and that it is essential to complete testing as soon as possible before the specimen begins to degrade. Commenters were concerned about being obligated to ensure that orders maintained in the physician's office were signed prior to being able to perform the test in the laboratory. The commenters do not believe that this obligation is fair to them or the Medicare patient as access to essential information could be delayed or compromised. Conversely, another commenter recommended that, in addition to the affirmation by the physician in the medical record that the laboratory test had been ordered, the laboratory should be required to close the loop and provide documentation that the test had been performed for inclusion in the medical record as well.

Response: We recognize that, without the physician's signature on the requisition, some clinical diagnostic laboratories believe it is burdensome to verify that the request for services is valid. However, our regulations at § 410.32(d)(2)(iii) provide the entity submitting the claim (that is, the clinical diagnostic laboratory) with the option to request additional diagnostic and other medical information to document that the services it bills are reasonable and necessary.

Comment: Several commenters believe that the signature issue is burdensome because multiple physician services can be requested on the same form, and, in such cases, one service might require the physician's signature while another might not. For example, it is possible that both the Technical Component (TC) of physician pathology services and clinical laboratory services may appear on the same requisition and that it would be confusing to have one set of requirements for clinical diagnostic laboratory tests and a different set of requirements for physician pathology services. Physicians may not know whether a particular laboratory or pathology test is paid under the CLFS or the PFS. The commenters suggested that we further clarify our policy to address this particular issue. We received a number of comments specifically requesting that we develop a single policy for all outpatient laboratory services, without distinction for those paid under the CLFS or the PFS.

Response: We appreciate the commenters' concerns. We will examine options for creating a fair and consistent policy regarding signatures that will address situational needs.

Comment: Several commenters stated that we needed to draw a clearer distinction between a requisition and an order, as they did not understand the difference between them. Commenters also suggested that, as medical records move to an electronic format, this distinction becomes more difficult to describe.

Response: We agree with the commenters' interest in having clear and concise distinctions between ''requisition'' and ''order'' especially as we move toward electronic means of record keeping and communication. We asked for comments about how to define a requisition, and we did receive some helpful suggestions. At this time, we are not addressing the specific comments on the distinction between orders and requisitions. We will continue to develop clearer direction on this issue, taking into consideration the suggestions submitted by commenters.

Comment: One commenter was concerned that physicians are signing stacks of laboratory requisition forms in advance of their use, or using a pre-signed hand stamp to make a requisition form official. The commenter stated that we did not draw a distinction between requisitions signed in advance and requisitions signed at the point of service for a specific purpose in the presence of the patient.

Response: We appreciate that the commenter brought these real world procedures to our attention. We will review this issue and consider it in the future as we consider all the issues that were brought to our attention through the proposed rulemaking effort this year.

Comment: We received several comments concerning the date of service (DOS) rule in reference to performing clinical diagnostic laboratory tests on stored specimens which were collected from the patient during the time that he/she was an inpatient at a hospital.

Response: We thank the commenters for their concerns on this issue. However, since we have not proposed any changes to the DOS rule at this time, we will not be addressing this comment in this final rule as these comments are outside the scope of our proposals for CY 2010.

In light of the issues and concerns raised during the comment period, and our desire to create policy that will address the concerns in a meaningful, clear, and thoughtful way, we will continue to carefully consider the issues of physician signatures on requisitions and orders. We plan to revisit these issues in the future paying particular attention to the definition of order and requisition.

N. Physician Self-Referral

1. General Background

Section 1877 of the Act, also known as the physician self-referral law, prohibits the following: (1) a physician from making referrals for certain designated health services (''DHS'') payable by Medicare to an entity with which he or she (or an immediate family member) has a direct or indirect financial relationship (an ownership/investment interest or a compensation arrangement), unless an exception applies; and (2) the entity from presenting or causing a claim to be presented to Medicare (or billing another individual, entity, or third party payor) for those referred services. The statute establishes a number of exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse.

In the proposed rule, we proposed to clarify § 411.354(c)(3)(i) regarding the application of certain exceptions to arrangements in which a physician stands in the shoes of his or her physician organization. In section II.N.2. of this final rule with comment period, we respond to public comments on this proposal and finalize it without change.

In the FY 2009 IPPS final rule (73 FR 48721), we revised the definition of ''entity'' to include any person or entity that has ''performed services that are billed as DHS.'' In section II.N.3 of this final rule with comment period, we solicit comments regarding whether we should issue further guidance on what constitutes performing services billed as DHS and if so, the nature or content of such guidance.

2. Physician Stand in the Shoes

Determining whether an entity furnishing DHS and a physician have a direct or indirect compensation arrangement is a key step in applying the statute because it affects which compensation exceptions may apply to the arrangement. Section 411.354(c) governs when a physician ''stands in the shoes'' of his or her physician organization and may therefore, depending on the circumstances, have a direct, rather than an indirect, compensation arrangement with an entity furnishing DHS.

Our proposal (74 FR 33643) sought to clarify one aspect of the physician stand in the shoes provisions at § 411.354(c). Specifically, we proposed to clarify the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).''

Section 411.354(c)(3)(i) addresses the application of the general exceptions to the referral prohibition related to both ownership/investment and compensation (§ 411.355) and the exceptions to the referral prohibition related to compensation arrangements (§ 411.357), to arrangements in which a physician stands in the shoes of his or her physician organization. Many of these exceptions require the arrangement to be in writing and signed by the parties and prohibit the compensation from taking into account the volume or value of referrals or other business generated by the referring physician.

Under § 411.354(c)(3)(i), a physician who stands in the shoes of his or her physician organization is deemed to have the same compensation arrangements with the same parties and on the same terms as the physician organization. The second sentence of § 411.354(c)(3)(i) provides that ''[f]or purposes of applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the 'parties' to the arrangements are considered to be the entity furnishing DHS and the physician organization (including all members, employees, or independent contractor physicians).''

After the publication of Phase III, some members of the industry questioned whether the second sentence of § 411.354(c)(3)(i) defined the term ''parties'' everywhere it appears in the physician self-referral regulations, including the requirement in many exceptions that a compensation arrangement be in writing and ''signed by the parties.'' Consequently, these members believed it was necessary for everyone within a physician organization (that is, all members, employees, and independent contractor physicians) to sign a myriad of different arrangements with an entity furnishing DHS. This was not our intent. In January 2008, we posted a frequently asked question (FAQ) on our Web site to explain that ''we consider a physician who is standing in the shoes of his or her physician organization to have signed the written agreement when the authorized signatory of the physician organization has signed the agreement.'' After the FY 2009 IPPS final rule, under which only physician owners are deemed to stand in the shoes of their physician organizations, some industry representatives questioned whether physicians who did *not* stand in the shoes remained ''parties'' under § 411.354(c)(3)(i) and, would therefore, need to become signatories to any compensation arrangement that was required to be in writing and ''signed by the parties.''

We proposed to clarify the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).''

Our proposed change clarifies that we are not defining the term ''parties'' and should eliminate any possible public misconception that all physicians in a physician organization (whether or not they stand in the shoes of the physician organization) must sign the writing(s) memorializing a compensation arrangement between their physician organization and an entity furnishing DHS. Furthermore, we note that some members of the industry have erroneously applied the second sentence of § 411.354(c)(3)(i) by analyzing whether the compensation takes into account the referrals between the entity furnishing DHS and the physician who stands in the shoes of the physician organization *only,* not the referrals of all members, employees, and independent contractor physicians in the physician organization. The revised regulation reiterates that the relevant referrals and other business generated between the physician organization and the entity furnishing DHS are the referrals of all physicians in the physician organization (including all members, employees, and independent contractors), not simply the referrals made by each physician who stands in the shoes of the physician organization.

We solicited public comments regarding our proposal and alternative approaches to address this issue. We received five public comments that related to our proposal which supported our proposal. After consideration of the public comments received, we are adopting our proposal unchanged. We are revising the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician

stands in the shoes of his or her physician organization, the relevant referrals and other business generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).'' We believe the finalized language clarifies the regulation text and is consistent with our intent to minimize the potential for abuse without imposing undue burden on the provider community. We address below the specific comments that we received in response to our proposal in the CY 2010 proposed rule.

Comment: The commenters supported the clarification to the physician stand in the shoes provision. Several commenters appreciated that we clarified that not all physicians in a physician organization must sign documents memorializing a compensation arrangement between their organization and a DHS entity. One commenter stated that it is beneficial to consider a physician to have signed the written agreement if the agreement is signed by the organization's authorized signatory.

Response: The commenters' responses supported the approach we took in the proposed rule. Thus, as stated above, we are revising § 411.354(c)(3)(i) to state that when applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated ''between the parties'' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians). With regards to deeming a physician to have signed the written agreement, our revision of the regulation text to avoid the appearance of defining the word ''parties,'' eliminates the need to consider any particular physician to have signed an agreement that he or she did not actually sign.

3. Services Provided ''Under Arrangements'' (Services Performed by an Entity Other Than the Entity That Submits the Claim): Solicitation of Comments

Under section 1877(a)(1)(A) of the Act, if a physician (or an immediate family member) has a financial relationship with an ''entity,'' it may not make a referral to the entity for the ''furnishing'' of DHS, unless the financial relationship meets an exception. In the Phase I final rule, we defined the term ''entity'' at § 411.351 and specified that ''a person or entity is considered to be furnishing DHS if it is the person or entity to which [Medicare] makes payment.'' Thus, under the Phase I rule, only the person or entity that billed Medicare for the DHS was considered the DHS ''entity,'' and not the person or entity that actually performed the DHS (where that person or entity was not the person or entity billing for it) (66 FR 953). In the CY 2008 PFS proposed rule (72 FR 38186 through 38187, 38219, and 38224), we expressed concern that the Phase I definition of ''entity'' might permit certain abusive agreements for services provided under arrangements with hospitals and other providers. Based upon our concerns about overutilization, corruption of medical judgment and other abuse, we proposed to revise the definition of ''entity'' at § 411.351 to include ''the person or entity that has performed the DHS''.

In the FY 2009 IPPS final rule (73 FR 48434 and 48729), we stated our belief that, in some instances, hospitals would prefer to furnish services directly but have been concerned about losing referral streams if they compete with physician service providers. Very few comments submitted by hospitals objected to our proposed revision to the definition of entity, and, instead, two major hospital associations were generally supportive of it. Some physician commenters asserted that hospitals are risk averse to bringing services to communities. We questioned whether physicians are less risk averse because they can control the referral stream. We stated that hospitals may be more concerned about risk because they fear that referrals will go to their competitors if they do not enter into contractual arrangements with physician groups. Finally, we stated that ''our proposal as finalized will create a more level playing field between hospitals and physicians and also among hospital competitors.''

In that rule, we finalized the proposal by amending the definition of entity at § 411.351 to specify that an entity furnishing DHS includes the person or entity that has presented a claim to Medicare for the DHS as well as any person or entity that has ''performed services that are billed as DHS,'' notwithstanding that another person or entity actually billed the services as DHS.

Commenters to the proposed rule expressed concern regarding the potential ambiguity of the meaning of ''performs.'' We declined to provide a specific definition of ''performed services that are billed as DHS,'' but stated the following in response to one of the commenters:

> By way of example only, we consider a service to have been ''performed'' by a physician or physician organization if the physician or physician organization does the medical work for the service and could bill for the service, but the physician or physician organization has contracted with the hospital and the hospital bills for the service instead * * *. We do not consider an entity that leases or sells space or equipment used for the performance of the service, *or* furnishes supplies that are not separately billable but used in the performance of the medical service, *or* that provides management, billing services, *or* personnel to the entity performing the service, to perform DHS. (73 FR 48726, emphasis added).

We delayed the effective date of the amendment to the definition of ''entity'' until October 1, 2009, in order to afford parties an adequate time to restructure arrangements (73 FR 48723).

We assume that health care providers have restructured their arrangements to come into compliance with the new rule by the October 1, 2009 effective date. We have received numerous inquiries regarding whether we plan to issue additional guidance on the revised definition of entity, including the meaning of ''performed services that are billed as DHS.'' We continue to believe that the changes set forth in the FY 2009 IPPS final rule effectuated our intent to minimize overutilization and anti-competitive behavior and, as such, we decline to issue a specific proposal concerning the definition of entity at this time. In order to keep abreast of the views of industry stakeholders, we are soliciting comments to determine if further guidance is necessary and, if so, what clarification(s) may be beneficial to the industry in interpreting and applying the changes finalized in the FY 2009 IPPS final rule. Therefore, we are interested in receiving comments on the following:

- Whether we should define or clarify ''performed services that are billed as DHS,'' and, if so, how.
- Whether ''performed services that are billed as DHS'' should be analyzed in the same manner for inpatient and outpatient services provided under arrangements.
- Whether performance of a service billed as DHS should be determined based on how many of the following elements are provided: (1) Lease of space used for performance of the service; (2) lease of equipment used for the performance of the service; (3) supplies that are not separately billable but used in the performance of the service; (4) management services; (5) billing services, and (6) nonphysician services that are not separately billable.

If so, whether certain of these elements should be weighed more heavily than others in determining whether DHS are performed.

• Whether an interpretation of ''medical work'' was relied upon in restructuring arrangements and, if so, how.

• The degree to which the amount and nature of services provided by physician and nonphysician personnel (for example, technicians) should influence the determination of whether a person or organization has performed services billed as DHS.

• The degree to which the ability to bill separately for the service should influence the determination regarding whether a person or organization has ''performed services that are billed as DHS.''

• Whether there are other comments or alternative approaches or criteria that would address our policy concerns about overutilization and other abuse while minimizing the impact on legitimate non-abusive arrangements.

We welcome any information concerning how the industry interpreted and applied the definition of entity and how under arrangement agreements may have been restructured in order to comply with the new definition of entity at § 411.351.

O. Durable Medical Equipment-Related Issues

1. Damages to Suppliers Awarded a Contract Under the Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (Medicare DMEPOS Competitive Bidding Program) Caused by the Delay of the Program

Section 1847 of the Act, as amended by section 302(b)(1) of the MMA, requires the Secretary to establish and implement a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP). On July 15, 2008, the MIPPA was enacted. Section 154 of the MIPPA amended section 1847 of the Act to make certain limited changes to the competitive bidding program, including adding a new subsection (a)(1)(D) to section 1847 of the Act. Section 1847(a)(1)(D) terminates retroactively the competitive bidding contracts that were awarded to suppliers in 2008 for the Round 1 of competitive bidding and prohibits payment based on such contracts. Section 154 of the MIPPA effectively reinstated payment for competitively bid items and services to the Medicare fee schedule amounts, as set forth in section 1834 of the Act and 42 CFR part 414, subpart D of our regulations.

Section 1847(a)(1)(D)(i)(I) of the Act, as amended by the MIPPA, stipulates that to the extent any damages may be applicable as a result of the termination of contracts, payment is to be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Act. Section 1847(a)(1)(D) of the Act also states that nothing in section 1847(a)(1)(D)(i)(I) of the Act, which includes the reference to damages, shall be construed to provide an independent cause of action or right to administrative or judicial review with the regard to the termination of the Round 1 contracts.

For further discussion of the Competitive Bidding Program and the bid evaluation process, see the Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues final rule published in the April 10, 2007 **Federal Register** (72 FR 17992) and the Medicare Program; Changes to the Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) by Certain Provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) interim final rule with comment period (IFC) published on January 16, 2009 **Federal Register** (74 FR 2873).

We proposed to add new § 414.425 to establish a process to evaluate any claims for damages caused by the termination of contracts awarded in early 2008 under the DMEPOS CBP that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

We offered contracts in March 2008 to selected suppliers for the first round of the DMEPOS CBP. The contracts that were accepted were terminated by the MIPPA retroactive to June 30, 2008. We considered the terms of the contracts and other processes of the DMEPOS CBP as we developed this proposed process to determine, on a case-by-case basis, whether to award damages and, where applicable, the amount of damages to be awarded for the termination of these contracts.

When considering whether to submit a claim for damages, suppliers may consider the following factors:

• Each contract stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program.

• Each contract indicated CMS does not guarantee any amount of business or profits.

• Each contract stipulated that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized under the contract.

• Upon termination of the contracts by the MIPPA, payments reverted to the CY 2008 fee schedule amount, which was on average 26 percent higher than payment amounts under the DMEPOS CBP.

• We will review a supplier's estimated and historic capacity and any expansion plans that were submitted as part of a supplier's bid.

• We will review a supplier's action to meet its obligation to mitigate its damages.

• We listed the winning suppliers on the Medicare.gov Web site in the supplier locator tool; a supplier is allowed to keep any new customers they may have obtained because of being listed on the supplier locator tool.

• This list is not intended to suggest that there are not legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

The proposed provisions outline the information that suppliers would need to provide when submitting claims for damages and the process that we would follow to review these claims. The information we proposed to collect from suppliers is necessary for us to make a reasonable decision on whether damages are warranted and how much in damages should be awarded. We believe that the process is not overly burdensome to those suppliers choosing to participate in this review process and would ensure a thorough review of a supplier's claim for damages.

We proposed the following process to file a claim for damage claims:

a. Eligibility To File a Claim

Any aggrieved supplier that was awarded a contract in March 2008 for the Round 1 DMEPOS CBP and believes it has suffered damages is eligible to submit a claim. The supplier must be able to demonstrate how its company was damaged. These damages must be substantiated and be as a direct result of the termination by MIPPA of their Round 1 DMEPOS CBP contract. Only a contract supplier, and not a subcontractor of a contract supplier, is eligible to submit a claim for damages.

Comment: One commenter stated that although CMS has no direct obligation to subcontractors, CMS should allow contract suppliers to include in their claims the damages incurred by their subcontractors.

Response: We disagree with the commenter's statement that we should consider the damages incurred by

subcontractors because the contract is between CMS and the contract supplier. We believe the extent of our obligation should only consider damages realized by the contract supplier. However, should a contract supplier realize damages due to their arrangement with a subcontractor those damages may be included if they are directly attributable to the Round 1 terminations. We do not believe that the language of MIPPA extends beyond the original contract arrangements between CMS and contract suppliers, as required by the MMA.

After consideration of the public comments we received, we are not making any changes to the proposed process for awarding damages for contracts terminated under the MIPPA.

b. Timeframes for Filing a Claim

A completed claim, including all documentation described below in section II.O.1.c., must be filed within 90 days of January 1, 2010, which is the effective date of these damages provisions, unless the 90th day is a weekend or Federal holiday. In that case, the last date to file a claim will be the day following the weekend or Federal holiday. The date of filing is the actual date of receipt by the Competitive Bidding Implementation Contractor (CBIC) of a completed claim from the supplier that includes all of the information required by this rule. We strongly urge claimants to use a tracking method such as with the United States Postal Service or a carrier that requires a return receipt that indicates the date on which the claim was delivered.

We did not receive any comments on this section of the proposed process for awarding damages for contracts terminated under the MIPPA. Therefore, we are finalizing these provisions as proposed with a minor change by adding the effective date of these damages provisions.

c. Information That Must Be Included in a Claim

At a minimum, a claim should include all of the following:

- Supplier's name and bidding number.
- Supplier's current contact information (Name of authorized official, U.S. Post Office mailing address, phone number and e-mail address).
- A copy of the DMEPOS CBP Round 1 contract(s) the supplier signed with CMS.
- A detailed explanation of the damages incurred by the supplier. The explanation must document the supplier's damages through receipts and records that establish the claimant's damages directly related to meeting the terms of the DMEPOS CBP Round 1 contract.
- The supplier must also explain how it would be damaged if not reimbursed.
- A detailed explanation of the steps of all attempts to use for other purposes, return, or dispose of equipment or other assets purchased or rented for use in the Round 1 DMEPOS CBP contract performance.

Damages claimed must be specifically related to carrying out the terms of the contract, and may include, but are not limited to, the following:

- Items or equipment purchased or rented and dates of such rental or purchases.
- Additional employee costs.
- Additional inventory costs.
- Additional facility costs.

The supplier must include a separate justification for any of these items for which it is claiming damages and explain how they were necessary to meet the deadline of July 14, 2008 of the Round 1 DMEPOS CBP contract. This does not include expenses that would have occurred if the supplier had not been awarded a contract but only those expenses that were incurred for the Round 1 DMEPOS CBP contract performance. The claim must also detail steps taken by the supplier to mitigate damages that they may have incurred due to the contract termination.

In addition, we are not considering claims for expenses incurred prior to March 20, 2008, including the purchase or rental of items or equipment before that date, because a supplier would not have known that it was going to be offered a contract. We are not considering claims for most expenses incurred after July 14, 2008, including the purchase or rental of items or equipment, because this is the date on which MIPPA terminated all of the Round 1 contracts. The only exception to this requirement would be for expenses incurred to mitigate damages associated with the termination of the Round 1 contracts.

Comment: One commenter suggested that CMS should not exclude costs incurred prior to March 20, 2008 and after July 14, 2008.

Response: We disagree with the commenter. We first notified suppliers on March 20, 2008, that they were being offered a contract. We are not considering claims for expenses incurred prior to March 20, 2008, because a supplier would not have known that it was going to be offered a contract before that date. We are also not considering claims for most expenses incurred after July 14, 2008, including the purchase or rental of items or equipment, because this is the date on which MIPPA terminated all of the Round 1 contracts.

Comment: One commenter suggested that CMS should include costs incurred in preparing or submitting a claim for damages.

Response: We disagree with the commenter. Any damages awarded under this contract only include costs incurred in carrying out the terms of the contract. The cost of submitting a claim for damages is not a cost that is incurred in carrying out the terms of the contract. Suppliers must weigh the cost of filing a claim for damages against damages they believe they incurred.

Comment: One commenter suggested that CMS should include consulting and legal expenses required to submit a bid in the competitive bidding program.

Response: We disagree. Suppliers could have incurred these costs even if they were not awarded a contract. The MIPPA provision pertains to damages that were the result of the termination of the contract and not the cost of applying for the contract. This does not include expenses that would have occurred if the supplier had not been awarded a contract but only those expenses that were incurred for the Round 1 DMEPOS CBP contract performance. Damages claimed must be specifically related to carrying out the terms of the contract.

Comment: One commenter suggested that CMS should allow suppliers to amend a claim deemed incomplete by the CBIC.

Response: We disagree with the commenter. The proposed rule describes what constitutes, at a minimum, a complete claim. While all claims for damages will be considered, there is certain minimum information that has to be submitted with the claim in order for the claim to be processed. Without this information we will not be able to process the claim. We believe that 90 days is sufficient time for the supplier to submit a completed claim. This provides an equal amount of time for all suppliers filing a claim for damages to submit their claim.

Comment: One commenter suggested that CMS should not exclude from damages ''costs that the supplier has recouped by any means''.

Response: We disagree with the commenter. We believe that all parties to a contract are obligated to take action to mitigate any damages and to describe the steps they have taken to meet this obligation. For example, if a supplier purchases inventory to carry out the terms of the contract and later uses this inventory for other Medicare

beneficiaries, in effect the Medicare program would be charged twice for the same item, if it were to include these costs in an award for damages. Each supplier has an obligation to mitigate, as far as possible, damages associated with the termination of its Round 1 contract(s).

After consideration of the public comments we received, we are not making any changes to this section of the proposed process for awarding damages for contracts terminated under the MIPPA.

e. Filing a Claim

Suppliers should submit claims, with all supporting documentation, with the CMS CBIC at the following address: CBIC; Bldg 200, Suite 400; 2743 Perimeter Parkway; Augusta, Georgia 30909. The authorized official for the supplier must certify the accuracy of the information on the claim and all supporting documentation. The authorized official is appointed by the supplier and has the legal authority granted by the supplier to submit the claim for damages. This person may be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of the supplier organization, or must hold a position of similar status and authority within the supplier's organization. The CBIC will not accept electronic submissions of claims for damages.

Comment: Several commenters recommended that CMS allow suppliers who are dissatisfied with CMS' decision to obtain an independent administrative review of the determination for damages under this process.

Response: We disagree with the commenter. The statute does not provide for review of such determinations. Section 1847(a)(1)(D) of the Act, as amended by section 154(a)(1)of MIPPA does not provide for administrative or judicial review of the Determining Authority's decision. Section 1847(a)(1) of the Act, as revised by section 154(a) of the MIPPA, terminated the contracts that were awarded under the competitive acquisition program, and provided that such termination and award of damages should not be construed to provide an independent cause of action or right to administrative or judicial review. Therefore, the Determining Authority's final decision is not subject to administrative or judicial review.

Comment: One commenter recommended that CMS should identify who within CMS will be tasked with the reviews and the standards that will apply to requests for claims.

Response: We will utilize the necessary resources within the agency to make these decisions. We will be utilizing the expertise from various components within CMS, such as the Office of Acquisition and Grants Management, Office of Financial Management and the Office of the General Counsel in the Department of HHS as necessary. An Agency official who is a senior executive and who has responsibility for the competitive bidding program will be designated as the Determining Authority.

After consideration of the public comments, we are not making any changes to this section of the proposed process for awarding damages for contracts terminated under the MIPPA.

f. Review of Claim

(1) Role of the CBIC

The CBIC will conduct the first level of review and make recommendations to CMS, hereafter referred to as the Determining Authority regarding:

- Whether the claim is complete and was filed in a timely manner. The CBIC may seek further information from the claimant when making its recommendation. The CBIC may set a deadline for receipt of additional information.
- When the claim is incomplete or was not filed in a timely manner, the CBIC will make a recommendation to the Determining Authority not to process the claim further.
- Whether the government owes damages because of the MIPPA. The CBIC will include an explanation supporting its recommendation. The CBIC will recommend a reasonable amount of damages, if any, based on the claim submitted, including all accompanying documentation. The CBIC will consider the language of the contract, as well as both costs incurred and the contract supplier's attempts and actions to limit the damages.

(2) CMS' Role as the Determining Authority

CMS is the Determining Authority because we are responsible for the final review and final determination regarding claims for damages.

- The Determining Authority shall review the recommendation of the CBIC.
- The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.
- The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.
- If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the determination and the reasons for the final determination.
- If the Determining Authority nonconcurs with the CBIC recommendation, the Determining Authority may:

+ Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety; or direct the CBIC to write said determination for the Determining Authority's signature.

+ Return the claim to the CBIC with further instructions.

- The Determining Authority's determination is final and binding; it is not subject to administrative or judicial review under section 1847(a)(1)(D) of the Act, as amended by section 154(a)(1) of the MIPPA.

Comment: Several commenters suggested that an additional step be included to permit affected suppliers to cure technical and other deficiencies in their claim.

Response: We do not agree with the commenters. Claimants are required to submit a complete claim in a timely manner. CMS stated in the rule that either the CBIC or CMS as the Determining Authority may seek further information from the claimant concerning the claim. This does not mean that claimants will have an opportunity to provide additional information after the deadline for filing has ended, unless requested to do so by the CBIC or CMS.

After consideration of the public comments, we are not making any changes to this section of the proposed process for awarding damages for contracts terminated under the MIPPA.

g. Timeframe for Final Determinations

Every effort will be made to make a final determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later. In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

We did not receive any comments on this section of the proposed process for awarding damages for contracts terminated under the MIPPA. Therefore, we are finalizing the provisions as proposed.

h. Notification to Claimant of Damage Determination

The CBIC shall mail the final determination to the claimant by

certified mail return receipt requested. If CMS determines that money is due to a claimant, this notification will indicate when and how the money will be transmitted. If a monetary award is due, the supplier will be required to provide banking information for electronic deposit.

We did not receive any comments on this section of the proposed process for awarding damages for contracts terminated under the MIPPA. Therefore, we are finalizing these provisions as proposed.

We are finalizing the provisions concerning damages as proposed in the CY 2010 PFS proposed rule (74 FR 33644).

2. Notification to Beneficiaries for Suppliers Regarding Grandfathering

Section 1847(a)(4) of the Act requires that in the case of covered durable medical equipment (DME) items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary shall establish a ''grandfathering'' process under which rented DME items that were furnished prior to the start of the Competitive Bidding Program (CBP) may be continued to be rented to the beneficiary by a noncontract supplier. Agreements for those covered items and supplies that were rented by the supplier to the beneficiary before the start of a CBP may be continued, regardless of whether the existing supplier participates in the CBP.

In the April 10, 2007 final rule (72 FR 17992), in § 414.408(j), we established the grandfathering process described below for rented DME and oxygen and oxygen equipment when these items are included under the Medicare DMEPOS CBP. A supplier that is furnishing DME or is furnishing oxygen or oxygen equipment on a rental basis to a beneficiary prior to the implementation of a CBP in the competitive bidding area (CBA) where the beneficiary maintains a permanent residence may elect to continue furnishing the item as a grandfathered supplier. This process only applies to suppliers that began furnishing the competitive bid items described above before the start of the CBP to beneficiaries who maintain a permanent residence in a CBA.

In the case of the rented DME and oxygen and oxygen equipment identified in this section, we established in § 414.408(j)(4) that Medicare beneficiaries have the choice of deciding whether they would like to continue receiving the rented item from a grandfathered supplier or if they would like to receive the item from a contract supplier.

Suppliers that agree to be a grandfathered supplier for an item must agree to be a grandfathered supplier for all current beneficiaries who request to continue to rent that item from them. The beneficiary's decision to use a grandfathered supplier depends on the decision of the noncontract supplier that is currently renting the competitive bidding item to continue renting the item as a grandfathered supplier after the start of the CBP in accordance with the terms we have specified. The payment rules for grandfathered suppliers are specified in existing § 414.408(j)(2).

In addition, the beneficiary may elect, at any time, to transition from a noncontract supplier to a contract supplier. The contract supplier would be required to accept the beneficiary as a customer regardless of how many rental months had already been paid for the beneficiary to receive this item. If the grandfathered supplier is not willing to continue furnishing the item, a beneficiary must select a contract supplier to furnish the item in order to receive Medicare payment for that item. The grandfathered supplier is paid based on the payment rules outlined in the final rule on Competitive Bidding at § 414.408(j).

As a result of what we learned from Round 1 of the CBP, we proposed changes to the ''grandfathering'' rules by establishing notification requirements for noncontract suppliers that are furnishing rented DME competitive bid items at the time of implementation of the CBP in the CBA in which the beneficiary resides. We also proposed a new definition for a grandfathered item to include all rented item(s) in a competitive bidding product category that a supplier currently provides to its beneficiaries. Under the current regulation, suppliers may choose the items within a product category for which they want to become a grandfathered supplier.

As proposed, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the rented DME items within a product category that the supplier currently provides.

For further discussion of the CBP and the bid evaluation process, see the April 10, 2007 final rule and the January 16, 2009 interim final rule with comment period.

We proposed to revise the definition of ''grandfathered item'' in § 414.402 so that the term would refer to all rented items within a competitive bid product category that the supplier currently rents to beneficiaries. In addition, we proposed to redesignate the current § 414.408(j)(5) as § 414.408(j)(7) and add new § 414.408(j)(5) and (j)(6). The new § 414.408(j)(5) and (j)(6) will specify the notification requirements that apply to noncontract suppliers that are renting DME competitive bid items in a CBA at the time of implementation of the CBP.

a. Definition of a Grandfathered Item

We proposed to revise the definition of a ''grandfathered item'' in § 414.402 to avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier is willing or not willing to be a grandfathered supplier. Under the current regulations, a supplier may make separate choices regarding grandfathering for each individual HCPCS code. For example, a supplier may choose to be a grandfathered supplier for a particular type of walker within the product category instead of all of the walkers included in that product category that are furnished on rental basis.

Under the revised definition, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it would be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code. In addition, this proposed revision would prevent suppliers from choosing to be a grandfathered supplier for only the more profitable items, which could disadvantage certain beneficiaries.

Comment: One commenter stated that CMS should allow noncontract suppliers to furnish and bill for supplies, such as CPAP masks, for ''capped'' rental equipment, as well as, supplies for rental equipment that they have chosen to grandfather.

Response: Section 1847(a)(4) of the Act only refers to DME items for which payment is made on a rental basis under section 1834(a) of the Act. Therefore, grandfathering can only apply to those items and necessary accessories and supplies provided during the rental period. Once the rental period ends additional accessories and supplies must be provided by the contract supplier.

Comment: Several commenters suggested that CMS should expand the grandfathering provisions to all

products including diabetic testing supplies subject to the CBP.

Response: Section 1847(a)(4) of the Act only refers to DME items for which payment is made on a rental basis under section 1834(a) of the Act. Therefore, we cannot extend grandfathering provisions to items that are not DME or not paid on a rental basis.

After consideration of the public comments we received, we are not making any changes to this section of the proposed rule.

b. Notification of Beneficiaries and CMS by Suppliers That Choose To Become Grandfathered Suppliers

We proposed to add a new § 414.408(j)(5)to require suppliers furnishing items to be included in a CBP that are eligible for grandfathering to notify beneficiaries in the CBA and CMS regarding their decision whether to become grandfathered suppliers.

The notification requirements we proposed will prohibit certain inappropriate practices of noncontract suppliers. These inappropriate practices include: (1) suppliers attempting to receive additional monthly rental payments from Medicare by circumventing the grandfathering requirements; and (2) suppliers not formally notifying beneficiaries before picking up the rented item from the beneficiary's home. We also proposed to require a notification process to protect beneficiaries and to ensure less confusion during the transition period prior to implementation of the CBP. The proposed requirements will help ensure that beneficiaries are contacted and informed about the grandfathering process and what choices they have concerning their choice of supplier. Moreover, the notice will help to ensure that beneficiaries do not have medically necessary DME equipment taken from them unexpectedly by a noncontract supplier.

(1) Notification of Beneficiaries by Suppliers That Choose To Become Grandfathered Suppliers

We proposed to add § 414.408(j)(5)(i) which requires a noncontract supplier that elects to become a grandfathered supplier in a CBA to provide a written notification to each Medicare beneficiary in that CBA who is currently renting a grandfathered item from that supplier. The notification must state that the supplier is willing to continue to rent the grandfathered item(s) to the beneficiary as a grandfathered supplier. The notice must identify the DME grandfathered rented items for which the supplier will be a grandfathered supplier.

To ensure that beneficiaries are sufficiently informed and prepared for competitive bidding changes that affect rented DME, we proposed in § 414.408(j)(5) to require that the notification of the beneficiary must meet the following requirements. The notification must:

- Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the CBP in the CBA in which the beneficiary resides. The 30-day notice is necessary to give the beneficiary sufficient time before the start of the CBP to consider whether to continue to use their current supplier. Suppliers will be given sufficient time to meet the 30-day notification requirement.
- Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.
- Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.
- State that the supplier is offering to continue to furnish certain rented DME, oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the CBP) and is willing to continue to provide these items to the beneficiary for the remaining rental months.
- State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.
- Provide the supplier's telephone number and instruct the beneficiaries to call the supplier with questions regarding grandfathering and to notify the supplier of his or her election.
- State that the beneficiary can obtain information about the CBP by calling 1–800–MEDICARE or accessing *http://www.medicare.gov* on the internet.

In § 414.408(j)(i)(B), we proposed that the supplier should obtain an election from the beneficiary and maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. We also proposed that the supplier maintain a record of the beneficiary's choice, the date on which the choice was made, and how the beneficiary communicated his or her choice to the supplier. The 30-day notice to the beneficiary must be in writing to ensure that there is a record that the notification was made.

Comment: One commenter stated there may be difficulty contacting the beneficiary within the 30-business day requirement.

Response: We disagree. The suppliers should have an ongoing relationship with beneficiaries and be aware of how to contact them. In addition, suppliers are responsible for keeping themselves informed about the CBP and the notification requirements. When a supplier begins providing rented items to a beneficiary just prior to the start of the CBP and there are less than 30 days remaining before the start of the CBP, the supplier is required to provide the 30-day notification to the beneficiary at the time the supplier agrees to provide the items to the beneficiary. If the supplier decides not to be a grandfathered the supplier would still be required to provide the 10-day and 2-day notifications prior to picking up the equipment.

Comment: One commenter recommended that the supplier send out the initial notification letter to the beneficiary notifying them of the grandfathering option. The commenter also suggested that the beneficiary should not be required to take any additional steps if they would like to continue with their current supplier. The beneficiary would only be required to provide their current supplier with documentation if they wish to make a change to an alternate supplier.

Response: Beneficiaries are responsible for notifying their current supplier of their decision. We believe that this is the only way to ensure that the beneficiary has made an informed decision. The supplier must obtain an election from the beneficiary and document this in their records; however, this may be a verbal election.

Comment: Another commenter stated that CMS should limit the notification by noncontract supplier to a 30-day notice as to whether they will be a grandfathered supplier.

Response: We believe the notification process as outlined in the proposed rule is a necessary beneficiary protection to ensure that beneficiaries do not have medically necessary equipment taken from them unexpectedly by a noncontract supplier.

Comment: One commenter stated the notice should include information for the beneficiary on how to contact the supplier to notify them as to their decision.

Response: We agree. The proposed rule states it is a requirement to provide a 30-day written notification that should include the supplier's telephone number and instructions for the beneficiary to call the supplier to notify them of his or her election and provide the opportunity for them to ask any

questions they may have regarding grandfathering.

Comment: One commenter recommended that the two suppliers should then be required to coordinate the pickup and delivery of equipment.

Response: We agree. The proposed rule states when a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier, and the new contract supplier are responsible for making arrangements that are suitable to the beneficiary.

Comment: One commenter stated that multiple notification requirements impose a burden on suppliers who have lost competitive bids and will have little or no incentive to comply with these requirements.

Response: We disagree. The noncontract supplier has been paid for furnishing the equipment up to the first anniversary date after the start of the CBP. Therefore, they have already received compensation for this time period. In addition, the suppliers should have an ongoing relationship with the beneficiary, be aware of how to contact them, and know about any changes in their circumstances. We believe the notification process is necessary to protect the beneficiaries.

Comment: Another commenter believes that CMS has underestimated the paperwork burden requiring the beneficiary sign another document and for suppliers to track that documentation.

Response: There is no requirement for the beneficiary to sign an additional document. The supplier must obtain an election from the beneficiary; however, this may be a verbal election. We also believe suppliers should have an ongoing relationship with the beneficiaries for which they are providing items and services and billing Medicare. We do not believe this is an additional paperwork burden but rather good business practices.

After consideration of the public comments, we are finalizing this section of the proposed rule as proposed.

We proposed to add paragraphs § 414.408(j)(5)(i)(C)(*1*) through (*3*) which state if the beneficiary chooses not to continue to receive a grandfathered item(s) from the noncontract supplier, the supplier must provide the beneficiary with 2 additional notices prior to picking up its equipment. These notices are described below as the 10-Day Notification and the 2-Day Notification.

(i) 10-Day Notification

Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up and that this should occur on the first anniversary date after the start of the CBP or another date agreed to by the beneficiary. The noncontract supplier must bill and will be paid for the furnishing of the equipment up to the first anniversary date after the start of the CBP and the new supplier cannot bill for furnishing the equipment prior to this anniversary date. This requirement still applies if a date other than the anniversary date is chosen.

The beneficiary's anniversary date occurs every month on the date of the month on which the item was first delivered to the beneficiary by the current supplier. The anniversary date marks the date of every month on which a new monthly rental period begins. For example, using July 1 as the beginning date of the Medicare DMEPOS CBP:

- If a beneficiary's last anniversary date before the beginning of the CBP is June 29, the noncontract supplier must submit a claim for the rental month beginning June 29 and ending July 28. The noncontract supplier should not pick up the equipment prior to July 29. In this case, the noncontract supplier has been paid up to July 29 and therefore should pick up its equipment on July 29, and the contract supplier would deliver its equipment on July 29 and begin billing for the next month's rental as of that date.
- If a beneficiary's anniversary date is July 1, also the beginning date for the CBP, the noncontract supplier should not pick up the equipment before July 1 and should not submit a claim for the July rental period. The contract supplier should deliver the equipment to the beneficiary on July 1 and submit a claim for this month.

When a DME supplier submits a monthly bill for capped rental DME items, the date of delivery (''from'' date) on the first claim must be the ''from'' or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, etc.). In cases where the anniversary date falls at the end of the month (for example, January 31) and a subsequent month does not have a day with the same date (for example, February), the final date in the calendar month (for example, February 28) will be used.

Comment: One commenter stated that the burden of the coordination for the equipment pickup and replacement of an item should be placed upon the winning bidder and the losing bidder, in coordination with the beneficiary, rather than requiring the beneficiary to be in contact with both suppliers.

Response: We agree. In the proposed rule, we stated that when a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. We believe that such arrangements need to be coordinated between the noncontract and contract supplier to ensure that the beneficiary has continued access to medically necessary equipment.

Comment: One commenter stated that the beneficiary and the new contract supplier must assume the primary responsibility for the transition. Any other allocation of responsibility between contract and noncontract supplier is impractical.

Response: We disagree. The noncontract supplier has been paid for furnishing the equipment up to the first anniversary date after the start of the CBP. Therefore, they have already received compensation for this time period. The notification process is for beneficiary protection to ensure less confusion during the transition period. Therefore, we believe the noncontract supplier must play a role in this transition.

After consideration of the public comments we received, we are finalizing this section of the proposed rule as proposed.

(ii) 2-Day Notification

Two business days prior to picking up the item, the supplier must contact the beneficiary by phone to remind the beneficiary of the date the supplier will pick up the item. This supplier should not pick up the item before the beneficiary's first anniversary date that occurs after the start of the CBP.

There may be unusual circumstances that make it difficult to contact certain beneficiaries. However, we do not expect this to occur often because these suppliers have been submitting monthly rental claims for providing services to these beneficiaries. Therefore, the supplier should have an ongoing relationship with the beneficiary and be aware of how to contact them and any changes in their circumstances. However, under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that they are aware of the date on which the supplier is picking up the item and that arrangements have been made to have the item replaced on that date by a contract supplier. The pickup of the

noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date. The pick up by the noncontract supplier and the delivery by the contract supplier should occur on the first rental anniversary date of the equipment that occurs after the start of the CBP. When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, for the pickup and the delivery date but not in terms of billing. The new equipment cannot be billed for until the anniversary date and the old equipment cannot be taken from the beneficiary before the anniversary date.

Comment: One commenter stated that if a supplier decides it does not want to grandfather a product category, it should be sufficient if the supplier provides notice one time in writing and follows up by phone as the deadline for transitioning approaches.

Response: We agree. The initial 30-day notification must be in writing to ensure there is a record that the notification was made. The supplier must maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. The supplier must maintain a record of the beneficiary's choice, the date on which the choice was made, and how the beneficiary communicated his or her choice to the supplier. The 10 and 2-day notices can be done by phone. We proposed the 10 and 2-day notification process as a safeguard to protect Medicare beneficiaries and ensure that the beneficiary has continued access to medically necessary equipment. We do not believe this process is too burdensome because these suppliers have been submitting monthly rental claims for providing services to these beneficiaries and this notice can be satisfied by a phone call to the beneficiary.

After consideration of the public comments we received, we are not making any changes to this section of the proposed rule and finalizing it as proposed.

c. Notification to CMS for Suppliers That Choose To Become Grandfathered

We proposed to add § 414.408(j)(5)(ii) to state that suppliers that have chosen to become grandfathered suppliers must also notify CMS of their decision at least 30 business days before the start of the CBP. We believe that 30 business days is a reasonable period to allow CMS to compile a list of grandfathered suppliers and to answer questions about the availability of these suppliers. Unless the supplier notifies CMS consistent with this subsection, the supplier will not be considered a grandfathered supplier. Having a list of grandfathered suppliers is important to assist CMS in administering the grandfathering process. The list will be used to answer questions from beneficiaries concerning which suppliers have chosen the grandfathering option. The notification requirement will also help us to ensure that suppliers are not offering the grandfathering option to only a select number of beneficiaries. Also, having a list of suppliers that have chosen to be grandfathered suppliers will assist us in reviewing whether only noncontract suppliers that have elected to be grandfathered suppliers have received Medicare payment for rented competitive bid items in a CBA.

The notice that a noncontract supplier must provide to CMS if it elects to become a grandfathered supplier must meet the following requirements:

- State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the CBP) in a CBA and will continue to provide these grandfathered items to these beneficiaries for the remaining months of the rental period.
- Include all of the following: Name and address of the supplier; 6-digit NSC number of the supplier; and product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.
- Suppliers with multiple locations must submit one notification for the company rather than for each individual location.
- State that the supplier agrees to meet all the terms and conditions applicable to grandfathered suppliers.
- Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of a CBP.

d. Notifications of Beneficiaries by Suppliers That Choose Not To Become Grandfathered Suppliers

We propose to clarify under § 414.408(j)(6) that a noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notice to the beneficiary. A noncontract supplier that decides not to become a grandfathered supplier does not have the option of leaving its equipment in the beneficiary's home. The noncontract supplier is responsible for picking up the item from the beneficiary.

Proper notification by a supplier who chooses not to become a grandfathered supplier must include a 30-day, a 10-day, and a 2-day notice of its decision not to be a grandfathered supplier. These notifications must meet all of the requirements listed above for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, except for the following differences for the 30-day notice.

- The 30-day notice must indicate the items for which the supplier has decided not to become a grandfathered supplier and indicate the date upon which the equipment will be picked up.
- It must state that the supplier will only continue to rent these competitively bid item(s) up to the beneficiary's first anniversary date, as defined in § 414.408(j)(5), that occurs after the start of the Medicare DMEPOS CBP.
- It must also state that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

It must state that the beneficiary can obtain information about the CBP by calling 1–800–MEDICARE or accessing *http://www.medicare.gov* on the internet.

- It must also refer him or her to the supplier locator tool on *http://www.medicare.gov*.

The supplier must also provide the beneficiary with the 10-day and the 2-day notices prior to picking up their equipment.

When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, but the new equipment may not be billed by the contract supplier until the first anniversary date following the start of the CBP. Also, the old equipment may not be taken from the beneficiary before proper arrangements are made and the date of service cannot occur before the anniversary date.

As discussed above, under no circumstance should a supplier pick up the rented item prior to the supplier making an arrangement with the new contract supplier for the delivery of the new equipment at a time suitable to meet the beneficiary's medical needs. The noncontract supplier has been furnishing services to the beneficiary and receiving payments from the program. To ensure that the beneficiary has continued access to medically necessary equipment, the noncontract

supplier is expected to assist the beneficiary in locating a contract supplier. The noncontract supplier should communicate with the beneficiary the urgency of arranging to have the new equipment delivered as soon as possible.

e. Other Comments

Comment: Several commenters stated that the current accreditation and surety bond requirements were too burdensome.

Response: All comments concerning accreditation and surety bond requirements are considered beyond the scope of this rulemaking.

We are finalizing the provisions concerning grandfathering as proposed in the CY 2010 PFS proposed rule (74 FR 33644).

P. Five-Year Refinement of Relative Value Units

1. Background

Section 1848(c)(2)(C)(i) of the statute states that the Secretary shall determine a number of work RVUs for the service based on the relative resources incorporating physician time and intensity required in furnishing the service. Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less than every 5 years.

We initiated the first Five-Year Review of work RVUs in 1994 and refinements went into effect beginning in 1997 (59 FR 63410 and 61 FR 59490). The scope of the Five-Year Review was limited to work values, since at that time, the statute required that PE and malpractice RVUs be calculated based on 1991 allowed charges and PE and malpractice expense shares for the specialties performing the services.

The second Five-Year Review of physician work RVUs began in 1999 and refinements went into effect beginning in CY 2002 (64 FR 59380 and 66 FR 55246). The third Five-Year Review of the physician work RVUs began in CY 2004 with the resulting changes being effective beginning in 2007 (69 FR 66236 and 71 FR 69624).

While the statute requires the Secretary to review the relative values for services no less than every 5 years, the work RVUs for many services, have never been specifically reviewed since the inception of the PFS. Since we approach our review with the underlying assumption that services are appropriately valued, the focus of the Five-Year Reviews has been on potentially misvalued services that are identified by us or commenters.

2. Codes Reviewed Outside the Usual Five-Year Review Process

Although it was our practice for many years to wait for the next Five-Year Review to review and revise any potentially misvalued services, we remained concerned that it was inappropriate to wait 5 years (or until the next Five-Year Review of work RVUs) when we had some evidence that certain services were not valued correctly. MedPAC, the Congress, and other stakeholders have expressed similar concerns.

Subsequent to the completion of the third Five-Year Review, in collaboration with the AMA RUC, based on the additional concern that some services had not been reviewed since the inception of the PFS we have undertaken to review certain potentially misvalued codes. This effort is discussed elsewhere in this final rule with comment period (see section II.F.). The fourth Five–year Review will be conducted independently of the review of codes under the potentially misvalued code initiative.

3. Fourth Five-Year Review of Work RVUs

We are initiating the fourth Five-Year Review of work RVUs with the resulting changes being effective beginning in 2012. As with the previous Five-Year Reviews, we are soliciting comments only on services for which the currently assigned work RVUs may be inappropriate. To the extent that there are changes in physician time or in the number or level of post procedure visits as a result of the Five-Year Review of work, the PE inputs, and we could be impacted and we would them accordingly.

Under the Five-Year Review process, we solicit comments from the public on codes that are potentially misvalued. We then review the public comments and forward codes identified in those comments, as well as codes that we have identified as potentially misvalued, to the AMA RUC. The AMA RUC then follows a process, similar to that used for new CPT codes (see description below). The AMA RUC:

- Surveys its members to assess their level of interest in reviewing relative values for certain services (and to identify services for which the code descriptors may no longer be appropriate);
- Develops survey instruments for the specialty societies to use to assess the work or level of effort involved with the service;
- Asks specialty committees to conduct the surveys, review the results and prepare their recommendations for the AMA RUC; and
- Reviews the specialty committee recommendations and may either adopt them, refer them back to the specialty society or modify them prior to submitting its recommendations to CMS.

We then review the AMA RUC recommendations, decide whether we agree or disagree, and propose to accept or reject/revise the AMA RUC recommendations. Our responses to the AMA RUC recommendations are presented, and any changes in valuations are established through notice and comment rulemaking.

Consistent with the format for the previous Five-Year Reviews, in addition to the codes submitted by the commenters, we will also identify codes and submit them to the AMA RUC. Our focus will be on codes (especially high-volume codes across specialties) that:

- Are valued as being performed in the inpatient setting, but that are now predominantly performed on an outpatient basis, and
- Were not previously reviewed by the AMA RUC, (for example, Harvard-based codes).

In prior years, we solicited comments on codes for which there is a rank order anomaly within the family of codes, and accepted the possible existence of a rank order anomaly as a primary reason for specialty societies to submit codes for review. An anomalous relationship may exist between the code being valued and other codes. For example, code A describes a service that requires more work than codes B, C, and D, but code A is valued lower. For the fourth Five-Year Review of work RVUs, we will no longer consider the existence of a possible rank order anomaly to be the primary basis for undertaking the review of a code. However, rank order anomalies will continue to be used as a way to screen for potential problem areas.

In addition, when we submit codes to the RUC for review, we note that in order to maintain relativity, we may decide to submit the entire family of codes (including the base code) for review. The base code is the most important code to review because it is the basis for the valuation of other codes within the family and allows for all related codes to be reviewed at the same time. We believe that reviewing the entire family of codes can assist in ensuring relativity between services and consistent valuation of services.

We also note that codes that have been reviewed/revised under the potentially misvalued code initiative may also be considered for review under

the Five-Year Review of work RVUs. We believe this will allow for the most systematic review possible to ensure the appropriateness of values under the PFS.

The AMA RUC has developed detailed ''Compelling Evidence Standards'' which are used by the RUC as part of its process to determine if a recommendation to change the work RVU is warranted for a given code. We are including these standards in section II.P.4. of this final rule with comment period solely for informational purposes so that commenters are aware of the kind of information that has been used in the past to make a successful argument to the RUC for changing work RVUs.

We typically publish a proposed notice for the Five-Year Review separate from the annual notice of proposed rulemaking that is published for the PFS. Publishing the Five-Year Review notice separate from the annual PFS rule allows time for the potential establishment of refinement panels to address comments received on proposed work RVU changes resulting from the Five-Year Review.

The fourth Five-Year Review of Work RVUs will be addressed in a proposed notice that we intend to publish in the spring of 2011. In that proposed notice, we will discuss: the codes considered for review under this fourth Five-Year Review; the AMA RUC recommended work RVUs; and our proposed valuation of the services, including the rationale for the work valuation. We will solicit comments on our proposed valuation of the codes. We will then review and analyze the comments received in response to the proposed notice and publish our decisions as part of the CY 2012 PFS final rule with comment period. (As previously mentioned, in past years we have addressed comments on the proposed notice through the use of refinement panels, similar to those used to address comments received on interim values for new or revised codes.) The changes would be effective January 1, 2012.

In the last Five-Year Review of work RVUs, some specialty societies used methods other than the AMA RUC-developed survey instrument to arrive at recommended work RVUs. These methods included reliance on other data sources (for example, Department of Veteran Affairs (VA) National Surgical Quality Improvement Program (NSQIP) and the Society for Thoracic Surgeons (STS) databases).

- The NSQIP was initiated by the VA for quality improvement purposes in 1991 with 128 VA medical centers. It currently includes a large volume of surgical procedures from non-VA medical centers as well. The total number of cases for VA and non-VA medical centers is greater than one million. The NSQIP database contains pre-, intra-, and post-operative data, including intra-service times and length of stay data.
- The STS National database is a voluntary reporting system for the collection of outcomes data related to cardiothoracic surgical services. This database currently contains over two million patient records collected from more than 450 practices (from 1995 through 2004). Over 70 percent of the hospitals currently performing heart surgeries in the U.S. reportedly participate in this database.

As discussed earlier in this section, specialty societies usually rely on the AMA RUC survey process to arrive at work values for their services, often referencing the median work value (50th percentile) resulting from the survey as a recommendation for a proposed work RVU. However, for the last Five-Year Review, a few specialty societies used other data sources, such as those mentioned above, to establish recommended work values. We are concerned that reliance solely on these other data sources could result in an inconsistent assignment of work RVUs, eroding the relativity of the PFS.

We would like to emphasize that the most common approach used by the AMA RUC for valuation of the work of a service is the building block approach. In constructing the building blocks, a service is divided into pre-, intra-, and post-service components. For a surgical procedure, the pre-service component consists of all services furnished before the physician makes the skin incision (for example, pre-operative evaluation and scrubbing); the intra-service component consists of the ''skin-to-skin'' time (that is the operative time between surgical opening and closing); and the post-service component includes immediate post-surgery services and subsequent hospital and office visits. Each component (or building block) is then assigned work RVUs. Pre-service and intra-service work RVUs are based on time and the intensity of the activities. Post-service work is based on the specified E/M service for each post-operative visit. These three component work values are then summed to compute ''building-block'' work RVUs.

For purposes of the fourth Five-Year Review of work RVUs and in order to gain a better understanding of the distribution of data from surveys and other data sources submitted in support of work RVU refinements, we will require that the minimum/maximum values, the 5th, 25th, 50th (median), 75th, and 95th percentiles be reported. In addition, we will require reporting of the geometric mean. This is similar to information currently reported for the specialty surveys, with some additional percentiles and the geometric mean being included. However if the AMA RUC recommendation does not include the information discussed above we may reject the recommendation.

To the extent the PQRI databases may include information similar to that previously described in the physician surveys, these databases might serve as an additional source for establishing or validating work RVUs.

4. RUC Compelling Evidence Standards

The AMA RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The justification for a change must be substantial and meet the RUC's compelling evidence standards.

The argument in support of a change in work RVUs must be provided in a comment letter to us, and then later to the AMA RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a ''compelling argument'' that the published relative value units assigned for a service are inappropriate:

- Documentation in the peer reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
  - ++ Technique.
  - ++ Knowledge and technology.
  - ++ Patient population.
  - ++ Site-of-service.
  - ++ Length of hospital stay.
  - ++ Physician time.
- An anomalous relationship between the code being proposed for review and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being consideredand the codes to which it is compared. These reference services may be both inter- and intra-specialty. (**Note:** The AMA RUC may wish to continue to use this as part of its method for determination of compelling evidence. However, if it is

not used according to the parameters we have discussed earlier in this section we may reject the AMA RUC recommendation.)

• Evidence that technology has changed physician work, that is, diffusion of technology.

• Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

• Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

++ A misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation;

++ A flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and

++ A previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

5. Five-Year Review of Other PFS Components

a. Malpractice RVUs

From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Initial implementation of resource-based malpractice RVUs occurred in 2000. The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource based malpractice RVUs was addressed in the CY 2005 PFS final rule (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule (70 FR 70153). In this rule, we are implementing the second review and update of malpractice RVUs (see section II.C. of this final rule with comment period).

b. Practice Expense RVUs

The resource-based PE RVUs were effective January 1, 1999. To assist in the refinement of the direct PE inputs (developed by the specialty-specific Clinical Practice Expense Panels conducted in the late 1990s), the AMA RUC created the Practice Expense Advisory Committee (PEAC) in CY 1999. The PEAC refined the PE inputs for nearly all of the CPT codes in the PFS by the time it sunsetted 5 years later in March 2004. (The remainder of the codes, approximately 200, were refined at the September 2004 and February 2005 AMA RUC meetings.) These PEAC (and subsequent AMA RUC) refinements of the PE inputs were provided as recommendations to CMS.

A comprehensive review of PE was undertaken prior to the 4-year transition period for the PE methodology from the top-down to the bottom-up methodology which will be complete in 2010. In this final rule with comment period we are incorporating new Physician Practice Information Survey (PPIS) data. (These data are used to update the specialty-specific PE/HR data used to develop PE RVUs.)

The next Five-Year Review of PE RVUs will be addressed in CY 2014 and we are soliciting comments on approaches to take for this next Five-Year Review of PE RVUs. However, to the extent that there are changes in physician time or in the number or level of post procedure visits as a result of the fourth Five-Year Review of work, there will be a potential impact on the practice expense inputs, and we will revise the inputs accordingly.

In the interim, we will continue with our efforts as part of the misvalued code initiative to develop a process to ensure that prices for certain high cost supplies that are used to determine PE RVUs are accurate and reflect current information.

Q. Other Issues: 2010 Therapy Caps

Section 1833(g) of the Act applies an annual, per beneficiary combined cap on expenses incurred for outpatient physical therapy and speech-language pathology services under Medicare Part B. A similar separate cap for outpatient occupational therapy services under Medicare Part B also applies. (The caps do not apply to expenses incurred for therapy services furnished in an outpatient hospital setting.) The caps were in effect during 1999, from September 1, 2003 through December 7, 2003 and beginning January 1, 2006. Also beginning January 1, 2006, the Deficit Reduction Act (Pub. L. 109–171) (DRA) provided for an exception process to the therapy cap until December 31, 2006. Subsequent legislation (MIEA–TRHCA and the MMSEA) extended the exception process for therapy caps until December 31, 2007 and June 30, 2008, respectively. Section 141 of the MIPPA extended the exception process through December 31, 2009. Several therapy associations have requested that we announce the amount of the therapy cap for CY 2010 in the PFS final rule.

The annual, per beneficiary therapy cap for CY 2010 is computed by multiplying the cap amount for CY 2009, which is $1840, by the Medicare Economic Index, which is 1.2 percent, and rounding to the nearest $10. Therefore, each cap for CY 2010 will be $1860. The agency's authority to provide for exceptions to therapy caps will expire on December 31, 2009, unless the Congress acts to extend it. If the current exception process expires, the only exceptions to therapy caps will be for services billed by the outpatient hospitals.

III. Refinement of Relative Value Units for Calendar Year 2010 and Response to Public Comments on Interim Relative Value Units for 2009

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Sections III.B. and III.C. of this final rule with comment describe the methodology used to review the comments received on the RVUs for physician work and the process used to establish RVUs for new and revised CPT codes. Changes to the RVUs and billing status codes reflected in Addendum B are effective for services furnished beginning January 1, 2010.

B. Process for Establishing Work Relative Value Units for the Physician Fee Schedule

The CY 2009 PFS final rule with comment period (73 FR 69726) contained the work RVUs for Medicare payment for existing procedure codes under the PFS and interim RVUs for new and revised codes beginning January 1, 2009. We considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. In this section, we address comments on the interim work RVUs published in the CY 2009 PFS final rule with comment period, and our establishment of the work RVUs for new and revised codes for the CY 2010 PFS.

C. Work Relative Value Unit Refinements of Interim Relative Value Units

1. Methodology (Includes Table titled ''Work Relative Value Unit Refinements of the 2009 Interim and Related Relative Value Units'')

Although the RVUs in the CY 2009 PFS final rule with comment period were used to calculate 2009 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 substantive comments on approximately 12 CPT codes with interim work RVUs.

To evaluate these comments we used a process similar to the process used since 1997. (See the October 31, 1997 final rule (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multispecialty panel of physicians to assist us in the review of the comments. We invited representatives from the organizations from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- Two primary care clinicians nominated by the American Academy of Family Physicians and the American College of Physicians.
- Four carrier medical directors.
- Clinicians with practices in related specialties who were expected to have knowledge of the services under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the PFS. We assembled a set of 300 reference services and asked the panel members to compare the clinical aspects of the work of the service a commenter believed was 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 intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following the 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 interim 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 addition, 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 final rule. We did not modify the RVUs unless there was a 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 remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the 1993 PFS. The statistical tests were described in detail in the November 25, 1992 final rule (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.

The following table lists those interim codes reviewed under the refinement panel process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- 2009 Work RVU. The work RVUs that appeared in the November 2008 rule are shown for each reviewed code.
- Requested Work RVU. This column identifies the work RVUs requested by commenters.
- 2010 Work RVU. This column contains the final RVUs for physician work.

2009 Interim Work Relative Value Units For Codes Reviewed Under the Refinement Panel Process

CPT Code[1]	Mod	Descriptor	2009 Work RVU	Requested Work RVU	2010 Work RVU[2]
17106		Destruction Of Skin Lesions	3.61	4.55	3.69
17107		Destruction Of Skin Lesions	4.68	9.18	4.79
17108		Destruction Of Skin Lesions	6.37	13.52	7.49
61796		Srs, Cranial Lesion Simple	10.79	15.75	13.93
61798		Srs, Cranial Lesion Complex	10.79	19.75	19.85
63620		Srs, Spinal Lesion	10.79	18.00	15.60
93282	26	Icd Device Prog Eval, 1 Sngl	0.85	0.91	0.85
93283	26	Icd Device Progr Eval, Dual	1.05	1.20	1.15
93289	26	Icd Device Interrogate	0.78	1.03	0.92
93295		Icd Device Interrogat Remote	1.17	1.28	1.29
97802		Medical Nutrition, Indiv, In	0.53	0.75/0.65	0.53
97803		Med Nutrition, Indiv, Subseq	0.45	0.55/0.65	0.45

[1] All CPT codes and descriptions copyright 2009 American Medical Association. All rights reserved and applicable FARS/DFARS clauses apply.

[2] Work RVU values included in the summaries below may differ from the 2010 work RVU noted in this table due to work increases in 10 and 90 day global codes as a result of the elimination of the consultation codes.

D. Interim 2009 Codes

1. Destruction of Skin Lesions Codes

CPT codes 17106, *Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm, 17107, Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm,* and 17108, *Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm* were identified by the AMA RUC's Five-Year Review Identification Workgroup through the high intra-service work per unit of time (IWPUT) screen. The AMA RUC recommended 3.61 work RVUs for CPT code 17106, 4.68 work RVUs for

CPT code 17107, and 6.37 work RVUs for CPT code 17108, which we accepted in the CY 2009 PFS final rule with comment (73 FR 69884).

Comment: Commenters disagreed with the AMA RUC-recommended work values for these services, which we had accepted. The commenters expressed concerns about the AMA RUC's use of IWPUT to not only identify potentially misvalued services but also to revalue them. Commenters were also concerned that a ranking system (that is, IWPUT) not formally recognized by CMS had been used inappropriately to identify and value these services. Many commenters encouraged CMS to conduct a Refinement Panel Review of the valuation of these codes.

Response: Based on these concerns, we referred these codes to the Multi-Specialty Validation Panel for review. As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, we have assigned 3.61 work RVUs to CPT code 17106, 4.68 work RVUs to CPT code 17107, and 7.35 work RVUs to CPT code 17108.

2. Hemorrhoidectomy Code

For CPT code 46930, *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency),* the AMA RUC recommended 1.56 work RVUs and a global period assignment of 090 (major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount), which we accepted in the CY 2009 PFS final rule with comment (73 FR 69892).

Comment: We received comments from independent providers, one manufacturer, and specialty societies representing gastroenterologists who disagreed with the 90-day global period assignment and requested that we assign a 10-day (minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount) global period instead. The commenters believe this procedure is a minor procedure and a 10-day global period assignment would be appropriate. The commenters also believe that the work RVUs assigned to this procedure are more in line with a 10-day global period. We did not receive any comments from the colon and rectal surgeons and general surgeons who participated in the survey of this code and predominately perform this procedure.

Response: Prior to the creation of CPT code 46930, this procedure was performed using deleted CPT code 46934, *Destruction of hemorrhoids, any method; internal* which was assigned a 90-day global period. We believe the valuation and assignment of a 90-day global period is appropriate for this procedure. The post-operative care and potential clinical problems remain the same despite having a new technology to address this clinical condition. We will plan to review the clinical experience with this technology in the future to learn how patients fared who underwent destruction of hemorrhoids with this new technology. In the meantime, we will maintain a 90-day global period for this procedure.

3. Stereotactic Radiosurgery Codes

For CPT codes 61796, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion,* 61797, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple,* and 63620, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion* the AMA RUC recommended 15.50 work RVUs for CPT code 61796, 19.75 work RVUs for CPT code 61798, and 15.50 work RVUs for CPT code 63620. We disagreed with the AMA RUC recommendations and assigned 10.79 work RVUs to all three of these codes in the CY 2009 PFS final rule with comment (73 FR 69892). We believed the specialty societies and the AMA RUC, in general, used open surgical codes as comparators during the AMA RUC process instead of a more equivalent stereotactic radiation treatment code.

Comment: The commenters disagreed with the interim work RVUs assigned by CMS and urged CMS to accept the AMA RUC-recommended values for these codes. The commenters believed CMS erred in basing the interim values on the work RVUs of two radiation oncology services instead of surgical codes. The commenters expressed that sterotactic radiosurgey is much more intense than radiation therapy. Commenters were also confused as to why CMS valued CPT codes 61796, 61798, and 63620 identically since CPT code 61796 describes treatment of a ''simple'' cranial lesion and CPT code 61798 describes treatment of a ''complex'' cranial lesion. The commenters believed the work required to treat complex lesions is much greater than the work required to treat simple lesions. Based on these concerns, we referred these codes to the Multi-Specialty Validation Panel for review.

Response: As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, we have assigned 13.83 work RVUs to CPT code 61796, 19.75 work RVUs to CPT code 61798, and 15.50 work RVUs to CPT code 63620.

4. Cardiac Monitoring Codes

For CPT codes 92382, *Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter-defibrillator system,* 93283, *Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system,* 92389, *Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements,* and 93295, *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter-defibrillator system with interim physician analysis, review(s) and report(s),* the AMA RUC recommended 0.85 work RVUs for CPT code 93282, 1.18 work RVUs for CPT code 93283, 0.92 work RVUs for CPT code 93289, and 1.38 work RVUs for CPT code 93295. We agreed with the AMA RUC-recommended value for CPT code 93282, but disagreed with the AMA RUC-recommended value for CPT codes 93283, 93289, 93295 in the CY 2009 PFS final rule with comment (73 FR 69892). We questioned the recommended values for the increments between some codes within families and across families of pacemakers, implantable cardioverter defibrillators (ICDs), implantable loop recorders, and implantable cardiovascular monitoring systems and the methodology used to determine the AMA RUC recommended values. The AMA RUC primarily used a comparison methodology to determine the value of the pacemaker codes and the surveyed 25th percentile to determine the value of the implantable ICD codes. Even though different methodologies were utilized to develop the recommended values, we did not understand why the increments between various levels of the pacemaker programming codes were not also the appropriate increment between the various levels of ICD programming codes. Therefore, we did not accept the AMA RUC recommendations for CPT

codes 93283, 93289, and 93295. Instead, we established work RVUs that maintained the same incremental difference between levels of programming codes. We assigned 1.05 work RVUs to CPT code 93283, 0.78 work RVUs to CPT code 93289, and 1.17 work RVUs to CPT code 93295.

Comment: Commenters were disappointed that CMS did not accept the AMA RUC-recommended work RVUs and disagreed with CMS' assumption that there is a constant increment of work added to the programming evaluation of an ICD as it progresses from a single lead to dual lead device and from a dual lead to a multiple lead device. Commenters also disagreed with the comparison codes we used to value these codes. Although we agreed with the AMA RUC-recommended value for CPT code 93282, one commenter requested that we increase the work RVU. Based on these concerns, we referred these codes to the Multi-Specialty Validation Panel for review.

Response: As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, we have assigned 0.85 work RVUs to CPT code 93282, 1.15 work RVUs to CPT code 93283, 0.92 work RVUs to CPT code 93289, and 1.29 work RVUs to CPT code 93295.

6. Medical Nutrition Therapy

For CPT codes 97802, *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes* and 97803, *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes,* the AMA RUC-recommended 0.53 work RVUs for CPT code 97802 and 0.45 work RVUs for CPT Code 97803, to which we agreed in the CY 2009 PFS final rule with comment (73 FR 69890).

Comment: We received a comment from a provider who disagreed with CMS' acceptance of the AMA RUC-recommended work RVUs. The commenter believed the values were flawed as a result of a methodological error dating back to the 2000 Health Care Professional Advisory Committee (HCPAC) recommendations. The commenter requested that we establish accurate work RVUs (an RVU value of 0.65 for both codes) or that we ask the AMA RUC to revisit its recommendation. Based on these concerns, we referred these codes to the Multi-Specialty Validation Panel for review.

Response: As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, we have assigned 0.53 work RVUs to CPT code 97802 and 0.45 work RVUs to CPT code 97803.

In the CY 2009 PFS final rule with comment period we also responded to the RUC recommendations on the PE inputs for new and revised CPT codes for CY 2009. In addition to the PE comments discussed in section II.B.2. of this final rule with comment period we received the following comments concerning PE inputs.

- CPT Codes 46606, 46608, 46610, 46612, and 46930: CPT code 46930, *Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency),* was a new CPT code for 2009. In the CY 2009 PFS final rule (73 FR 69897), we asked for comments on whether a light guide is typical for this code and any of the other existing codes. Specifically, we did not accept the AMA RUC-recommended sheath to cover the light guide that the specialty proposed to add to the PE database for this service and 4 other procedures as we do not believe it to be typically used in furnishing these services. Because the light guide was not a component of the infrared coagulator item at the time we re-priced our entire equipment file for CY 2005, and because this same equipment item is used for 4 other endoscopy procedures, including CPT codes 46606, 46608, 46610, and 46612, we asked commenters to provide us with information and documentation as to whether the light guide is typical to any of these 5 procedures. Additionally, we invited comments about the typical use of the sheath in relationship to the light guide. In the interim, we assigned the new equipment price including the light guide to the new CPT code 46930 as well as the four other procedures that employ this infrared coagulator for CY 2009.

Comment: We received one comment stating that the sheath for the light guide is required for CPT code 46930 given the potential for contamination of the light guide if a sheath is not used, as well as the difficulty of cleaning the light guide if it is contaminated. Commenters also stated that the infrared equipment (EQ136) used with the sheath is not required for CPT codes 46606, *Anoscopy; with biopsy, single or multiple,* 46608, *Anoscopy; with removal of foreign body,* 46610, *Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery,* and 46612, *Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique,* as these procedures are typically performed using electrocautery for which PE inputs are already associated with these codes.

Response: We thank the commenters for their input. We are leaving the PE inputs as is while we conduct additional research on what is typical in furnishing these procedures.

- CPT Codes 93306, 93307, 93320, 93325, and 93351: In the CY 2009 PFS final rule (73 FR 69898), we discussed the AMA RUC PE recommendations for CPT codes 93306, *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography,* and 93351, *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision.*

For CPT code 93306, we stated that the AMA RUC did not recommend any changes to the PE direct inputs for the related echocardiography codes 93307, *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography,* 93320, *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete,* and 93325, *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography).* We asked the AMA RUC to review the PE inputs for CPT codes 93307, 93320, and 93325 to ensure that they are consistent with the recommended direct inputs for CPT code 93306.

For CPT code 93351, we stated that the AMA RUC-recommended PE inputs included three new equipment items. These items included an ultrasound machine, an echocardiography exam table, and a dual image viewing and reporting system. We did not accept the recommended ultrasound machine valued at $325,000 but used a model in a similar procedure priced at $248,000 in the PE database. We also did not accept the echocardiography exam table ($11,095) because we did not believe it was a typical equipment item found in the physician's office. Instead, we assigned the PE input typical for a similar service—a $1,915 stretcher. We

included the ''dual'' echocardiography image viewing and reporting system but we accepted the base unit price of $85,000 in place of the $173,000 price provided by the specialty.

We asked commenters to provide us with documentation as to the type and cost of equipment that is used in furnishing the procedure in the physician office along with a rationale for suggested changes from the existing inputs. We also asked commenters to provide us with the typical scenario as to whether one, two, or three ultrasound units will be connected to the third equipment item, the ''dual'' echocardiography image viewing, and reporting system. We asked for information as to the amount of time that the dual image management system is in use for this procedure.

Comment: Several commenters requested that CMS revise the PE inputs associated with CPT codes 93306 and 93351. Specifically, for CPT code 93306, commenters stated that there are increased equipment costs, that an echocardiography room should be included, and that the equipment times should be revised from 42 minutes to 63 minutes to reflect their intra-service use by the sonographer. For 93351, commenters requested that a higher priced echocardiography machine, an echocardiography table, and a cardiac ultrasound room be added to the equipment list. Commenters also requested that we update the price of the dual echocardiography image viewing and reporting system to reflect the more common purchase of this equipment with additional features compared to the base model.

Response: For CPT code 93306, we do not agree that use of an echocardiography room is typical, nor do we believe higher equipment costs are justified at this time. However, we do agree with commenters that equipment times should be increased to 63 minutes from 42 minutes to accurately reflect the use of this equipment during the procedure and have adjusted the PE database to reflect this. For CPT code 93351, the AMA RUC did not recommend these higher cost PE inputs and we agreed with them. We believe we valued the PE inputs for these CPT codes appropriately in the CY 2009 final rule. Therefore, we will assign the PE inputs from the PE database for similar services—$248,000 for the ultrasound machine and $1,915 for the stretcher—to these codes. We will also continue to use the accepted base unit price of $85,000 for the ''dual'' echocardiography image viewing and reporting system. In addition, we were advised by the AMA RUC that only one ultrasound unit is typically connected to this management system, which is used for 7 minutes during the procedure. We agree with the AMA RUC's advice.

- CPT Codes 93293 and 93296: In the CY 2009 final rule (73 FR 69897), we discussed CPT codes 93293, *Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days,* and 93296, *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results* (73 FR 69897). The AMA RUC recommended that a ''pacemaker interrogation system'' be used for the two CPT codes 93293 and 93296. However, the PE database does not contain an equipment item with this description. Because we noted a 100 percent crosswalk from existing CPT code 93733 that utilizes the pacemaker follow-up system to the new CPT code 93293, we assigned, on an interim basis, the pacemaker follow-up system to CPT codes 93293 and 93296 (a ''new'' service without a crosswalk). We asked commenters to provide documentation as to the type and cost of equipment that is used in furnishing these services in the physician office and other information to support any changes from the prior inputs.

Comment: Several commenters agreed with our use of the ''pacemaker interrogation system'' as well as its interim $123,250 price point for CPT codes 93293 and 93296. Only one commenter provided CMS with pricing information for a comparable ''pacemaker monitoring system'' based on three different price quotes, two of which were lower than the interim pricing information.

Response: Based on the information available, we will continue to assign the ''pacemaker interrogation system'' with a price of $123,250 to CPT codes 93293 and 93296. We will continue to review the price of the appropriate cardiac equipment used in both of these codes.

- CPT Codes 97802 and 97803: 97802, *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes;* and 97803, *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.*

The above codes were revalued in the CY 2009 PFS final rule with comment period as a result of the AMA RUC Recommendations for Potentially Misvalued Codes (73 FR 69890).

Comment: One commenter stated that inappropriate PE inputs were used for calculating the PE RVUs for Medical Nutrition Therapy codes (CPT codes 97802 and 97803), and requested a revision of the pre-, intra-, and post-service times listed in the PE database. The commenter believes that the pre-service and post-service times for these CPT codes should be increased to 3 minutes pre and 5 minutes post to accurately reflect the time spent.

Response: We agreed with the AMA RUC recommendations for CPT codes 97802 and 97803 in the CY 2009 final rule with comment period (73 FR 69890). We believe that the pre- and post-service times are accurate. If the commenter is concerned about the allocated times for these CPT codes, the commenter should request that the specialty society submit these codes to the AMA RUC for reconsideration.

E. Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2010 (Includes Table 30 Titled ''AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes'')

One aspect of establishing RVUs for 2009 was to assign interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 PFS (57 FR 55951) and in section III.B. of the CY 1997 PFS final rule (61 FR 59505), we established a process, based on recommendations received from the AMA RUC, for establishing interim work RVUs for new and revised codes.

We received work RVU recommendations for 161 new and revised CPT codes from the AMA RUC for 2010. We reviewed the AMA RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established. We also considered the relationships among the new and revised codes for which we received AMA RUC recommendations and agreed with the majority of the relative relationships reflected in the AMA RUC values. Table 30: AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes lists the new or revised CPT codes, and their associated work RVUs, that will be interim in CY 2010. Table 30 includes the following information:

• A ''#'' identifies a new code for CY 2010.

• CPT code. This is the CPT code for a service.

• Modifier. A ''26'' in this column indicates that the work RVUs are for the PC of the code.

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

• AMA RUC recommendations. This column identifies the work RVUs recommended by the AMA RUC.

• CMS decision. This column indicates whether we agreed or we disagreed with the AMA RUC recommendation. Codes for which we did not accept the AMA RUC recommendation are discussed in greater detail following this table.

• 2010 Work RVUs. This column establishes the interim 2010 work RVUs for physician work.

BILLING CODE 4120–01–P

TABLE 30: AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
#	14301			SKIN TISSUE REARRANGEMENT	12.47	Agree	12.65
#	14302	x		SKIN TISSUE REARRANGE ADD-ON	3.73	Agree	3.73
#	21011			EXC FACE LES SC < 2 CM	2.91	Agree	2.99
#	21012			EXC FACE LES SC = 2 CM	4.37	Agree	4.45
#	21013			EXC FACE TUM DEEP < 2 CM	5.34	Agree	5.42
#	21014			EXC FACE TUM DEEP = 2 CM	7.00	Agree	7.13
	21015			RESECT FACE TUM < 2 CM	9.71	Agree	9.89
#	21016			RESECT FACE TUM = 2 C	15.05	Agree	15.26
#	21552			EXC NECK LES SC = 3 CM	6.41	Agree	6.49
#	21554			EXC NECK TUM DEEP = 5 CM	11.00	Agree	11.13
	21555			EXC NECK LES SC < 3 CM	3.88	Agree	3.96
	21556			EXC NECK TUM DEEP < 5 CM	7.53	Agree	7.66
	21557			RESECT NECK TUM < 5 CM	14.57	Agree	14.75
#	21558			RESECT NECK TUM = 5 CM	21.37	Agree	21.58
	21930			EXC BACK LES SC < 3 CM	4.86	Agree	4.94
#	21931			EXC BACK LES SC = 3 CM	6.80	Agree	6.88
#	21932			EXC BACK TUM DEEP < 5 CM	9.71	Agree	9.82
#	21933			EXC BACK TUM DEEP = 5 CM	11.00	Agree	11.13
	21935			RESECT BACK TUM < 5 CM	15.54	Agree	15.72
#	21936			RESECT BACK TUM = 5 CM	22.34	Agree	22.55
	22900			EXC BACK TUM DEEP < 5 CM	8.21	Agree	8.32
#	22901			EXC BACK TUM DEEP = 5 CM	10.00	Agree	10.11
#	22902			EXC ABD LES SC < 3 CM	4.34	Agree	4.42
#	22903			EXC ABD LES SC > 3 CM	6.31	Agree	6.39
#	22904			RESECT ABD TUM < 5 CM	16.51	Agree	16.69
#	22905			RESECT ABD TUM > 5 CM	21.37	Agree	21.58
#	23071			EXC SHOULDER LES SC > 3 CM	5.83	Agree	5.91
#	23073			EXC SHOULDER TUM DEEP > 5 CM	10.00	Agree	10.13
	23075			EXC SHOULDER LES SC < 3 CM	4.13	Agree	4.21
	23076			EXC SHOULDER TUM DEEP < 5 CM	7.28	Agree	7.41
	23077			RESECT SHOULDER TUM < 5 CM	17.48	Agree	17.66
#	23078			RESECT SHOULDER TUM > 5 CM	22.34	Agree	22.55
	23200			RESECT CLAVICLE TUMOR	22.50	Agree	22.71
	23210			RESECT SCAPULA TUMOR	27.00	Agree	27.21
	23220			RESECT PROX HUMERUS TUMOR	30.00	Agree	30.21
#	24071			EXC ARM/ELBOW LES SC = 3 CM	5.62	Agree	5.70
#	24073			EX ARM/ELBOW TUM DEEP > 5 CM	10.00	Agree	10.13
	24075			EXC ARM/ELBOW LES SC < 3 CM	4.16	Agree	4.24

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
	24076			EX ARM/ELBOW TUM DEEP < 5 CM	7.28	Agree	7.41
	24077			RESECT ARM/ELBOW TUM < 5 CM	15.54	Agree	15.72
#	24079			RESECT ARM/ELBOW TUM > 5 CM	20.40	Agree	20.61
	24150			RESECT DISTAL HUMERUS TUMOR	23.25	Agree	23.46
	24152			RESECT RADIUS TUMOR	19.78	Agree	19.99
#	25071			EXC FOREARM LES SC > 3 CM	5.83	Agree	5.91
#	25073			EXC FOREARM TUM DEEP = 3 CM	7.00	Agree	7.13
	25075			EXC FOREARM LES SC < 3 CM	3.88	Agree	3.96
	25076			EXC FOREARM TUM DEEP < 3 CM	6.61	Agree	6.74
	25077			RESECT FOREARM/WRIST TUM<3CM	12.75	Agree	12.93
#	25078			RESECT FOREARM/WRIST TUM=3CM	17.48	Agree	17.69
	25170			RESECT RADIUS/ULNAR TUMOR	22.00	Agree	22.21
#	26111			EXC HAND LES SC > 1.5 CM	5.34	Agree	5.42
#	26113			EXC HAND TUM DEEP > 1.5 CM	7.00	Agree	7.13
	26115			EXC HAND LES SC < 1.5 CM	3.88	Agree	3.96
	26116			EXC HAND TUM DEEP < 1.5 CM	6.61	Agree	6.74
	26117			EXC HAND TUM RA < 3 CM	9.95	Agree	10.13
#	26118			EXC HAND TUM RA > 3 CM	14.57	Agree	14.81
	26250			EXTENSIVE HAND SURGERY	15.00	Agree	15.21
	26260			RESECT PROX FINGER TUMOR	11.00	Agree	11.16
	26262			RESECT DISTAL FINGER TUMOR	8.13	Agree	8.29
#	27043			EXC HIP PELVIS LES SC > 3 CM	6.80	Agree	6.88
#	27045			EXC HIP/PELV TUM DEEP > 5 CM	11.00	Agree	11.13
	27047			EXC HIP/PELVIS LES SC < 3 CM	4.86	Agree	4.94
	27048			EXC HIP/PELV TUM DEEP < 5 CM	8.74	Agree	8.85
	27049			RESECT HIP/PELV TUM < 5 CM	21.37	Agree	21.55
#	27059			RESECT HIP/PELV TUM > 5 CM	29.14	Agree	29.35
	27075			RESECT HIP TUMOR	32.50	Agree	32.71
	27076			RESECT HIP TUM INCL ACETABUL	40.00	Agree	40.21
	27077			RESECT HIP TUM W/INNOM BONE	45.00	Agree	45.21
	27078			RSECT HIP TUM INCL FEMUR	32.00	Agree	32.21
	27327			EXC THIGH/KNEE LES SC < 3 CM	3.88	Agree	3.96
	27328			EXC THIGH/KNEE TUM DEEP <5CM	8.74	Agree	8.85
	27329			RESECT THIGH/KNEE TUM < 5 CM	15.54	Agree	15.72
#	27337			EXC THIGH/KNEE LES SC > 3 CM	5.83	Agree	5.91
#	27339			EXC THIGH/KNEE TUM DEEP >5CM	11.00	Agree	11.13

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
#	27364			RESECT THIGH/KNEE TUM >5 CM	24.28	Agree	24.49
	27365			RESECT FEMUR/KNEE TUMOR	32.00	Agree	32.21
	27615			RESECT LEG/ANKLE TUM < 5 CM	15.54	Agree	15.72
#	27616			RESECT LEG/ANKLE TUM > 5 CM	19.42	Agree	19.63
	27618			EXC LEG/ANKLE TUM < 3 CM	3.88	Agree	3.96
	27619			EXC LEG/ANKLE TUM DEEP <5 CM	6.80	Agree	6.91
#	27632			EXC LEG/ANKLE LES SC > 3 CM	5.83	Agree	5.91
#	27634			EXC LEG/ANKLE TUM DEEP >5 CM	10.00	Agree	10.13
	27645			RESECT TIBIA TUMOR	27.00	Agree	27.21
	27646			RESECT FIBULA TUMOR	23.00	Agree	23.21
	27647			RESECT TALUS/CALCANEUS TUM	20.10	Agree	20.26
#	28039			EXC FOOT/TOE TUM SC > 1.5 CM	5.34	Agree	5.42
#	28041			EXC FOOT/TOE TUM DEEP >1.5CM	7.00	Agree	7.13
	28043			EXC FOOT/TOE TUM SC < 1.5 CM	3.88	Agree	3.96
	28045			EXC FOOT/TOE TUM DEEP <1.5CM	5.34	Agree	5.45
	28046			RESECT FOOT/TOE TUMOR < 3 CM	12.20	Agree	12.38
#	28047			RESECT FOOT/TOE TUMOR > 3 CM	17.24	Agree	17.45
	28171			RESECT TARSAL TUMOR	16.25	Agree	16.41
	28173			RESECT METATARSAL TUMOR	14.00	Agree	14.16
	28175			RESECT PHALANX OF TOE TUMOR	8.13	Agree	8.29
#	29581			APPLY MULTLAY COMPRS LWR LEG	0.60	Agree	0.60
#	31626	x		BRONCHOSCOPY W/MARKERS	4.16	Agree	4.16
#	31627	x		NAVIGATIONAL BRONCHOSCOPY	2.00	Agree	2.00
#	32552			REMOVE LUNG CATHETER	2.50	Agree	2.53
#	32553	x		INS MARK THOR FOR RT PERQ	3.80	Agree	3.80
	32560			TREAT PLEURODESIS W/AGENT	1.54	Agree	1.54
#	32561			LYSE CHEST FIBRIN INIT DAY	1.39	Agree	1.39
#	32562			LYSE CHEST FIBRIN SUBQ DA	1.24	Agree	1.24
#	33782			NIKAIDOH PROC	60.00	Agree	60.08
#	33783			NIKAIDOH PROC W/OSTIA IMPLT	65.00	Agree	65.08
#	33981			REPLACE VAD PUMP EXT	Contractor Priced	Agree	Contractor Priced
#	33982			REPLACE VAD INTRA W/O BP	Contractor Priced	Agree	Contractor Priced

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
#	33983			REPLACE VAD INTRA W/BP	Contractor Priced	Agree	Contractor Priced
#	36147			ACCESS AV DIAL GRFT FOR EVAL	3.72	Agree	3.72
#	36148			ACCESS AV DIAL GRFT FOR PROC	1.00	Agree	1.00
#	37761			LIGATE LEG VEINS OPEN	9.00	Agree	9.13
#	43281	x		LAP PARAESOPHAG HERN REPAIR	26.50	Agree	26.60
#	43282	x		LAP PARAESOPH HER RPR W/MESH	30.00	Agree	30.10
#	43775	x		LAP SLEEVE GASTRECTOMY	21.40	Agree	21.56
#	45171			EXC RECT TUM TRANSANAL PART	8.00	Agree	8.13
#	45172			EXC RECT TUM TRANSANAL FULL	12.00	Agree	12.13
#	46707	x		REPAIR ANORECTAL FIST W/PLUG	6.30	Disagree	6.39
#	49411	x		INS MARK ABD/PEL FOR RT PERQ	3.82	Agree	3.82
#	51727		26	CYSTOMETROGRAM W/UP	2.11	Agree	2.11
#	51728		26	CYSTOMETROGRAM W/VP	2.11	Agree	2.11
#	51729		26	CYSTOMETROGRAM W/VP&UP	2.51	Agree	2.11
#	53855	x		INSERT PROST URETHRAL STENT	1.64	Agree	1.64
#	57426	x		REVISE PROSTH VAG GRAFT LAP	14.15	Agree	14.30
#	63661			REMOVE SPINE ELTRD PERQ ARAY	5.03	Agree	5.08
#	63662			REMOVE SPINE ELTRD PLATE	10.87	Agree	11.00
#	63663			REVISE SPINE ELTRD PERQ ARAY	7.70	Agree	7.75
#	63664			REVISE SPINE ELTRD PLATE	11.39	Agree	11.52
#	64490			INJ PARAVERT F JNT C/T 1 LEV	1.82	Agree	1.82
#	64491			INJ PARAVERT F JNT C/T 2 LEV	1.16	Agree	1.16
#	64492			INJ PARAVERT F JNT C/T 3 LEV	1.16	Agree	1.16
#	64493			INJ PARAVERT F JNT L/S 1 LEV	1.52	Agree	1.52
#	64494			INJ PARAVERT F JNT L/S 2 LEV	1.00	Agree	1.00
#	64495			INJ PARAVERT F JNT L/S 3 LEV	1.00	Agree	1.00
#	74261	x		CT COLONOGRAPHY, W/O DYE	2.40	Disagree	2.28
#	74262	x		CT COLONOGRAPHY, W/DYE	2.50	Agree	2.50
#	74263	x		CT COLONOGRAPHY, SCREEN	2.28	Agree (a)	2.28
#	75565			CARD MRI VEL FLW MAP ADD-ON	0.25	Agree	0.25
#	75571	x		CT HRT W/O DYE W/CA TEST	0.58	Agree	0.58
#	75572	x		CT HRT W/3D IMAGE	1.75	Agree	1.75
#	75573	x		CT HRT W/3D IMAGE, CONGEN	2.55	Agree	2.55

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
#	75574	x		CT ANGIO HRT W/3D IMAGE	2.40	Agree	2.40
#	75791			AV DIALYSIS SHUNT IMAGING	1.71	Agree	1.71
#	77338			DESIGN MLC DEVICE FOR IMRT	4.29	Agree	4.29
#	78451		26	HT MUSCLE IMAGE SPECT, SING	1.40	Disagree	1.38
#	78452		26	HT MUSCLE IMAGE SPECT, MULT	1.75	Disagree	1.62
#	78453		26	HT MUSCLE IMAGE,PLANAR,SING	1.00	Agree	1.00
#	78454		26	HT MUSC IMAGE, PLANAR, MULT	1.34	Agree	1.34
#	88387	x	26	TISS EXAM MOLECULAR STUDY	0.62	Agree	0.62
#	88388	x	26	TISS EX MOLECUL STUDY ADD-ON	0.45	Agree	0.45
#	92540		26	BASIC VESTIBULAR EVALUATION	1.50	Agree	1.50
#	92550			TYMPANOMETRY & REFLEX THRESH	0.35	Agree	0.35
#	92570			ACOUSTIC IMMITTANCE TESTING	0.55	Agree	0.55
	93701			BIOIMPEDANCE, CV ANALYSIS	0.00	Agree	0.00
#	93750			INTERROGATION VAD, IN PERSON	0.92	Agree	0.92
#	94011	x	26	UP TO 2 YRS OLD, SPIROMETRY	2.00	Agree	2.00
#	94012	x	26	= 2 YRS, SPIROMTRY W/DILATOR	3.10	Agree	3.10
#	94013	x	26	= 2 YRS, LUNG VOLUMES	0.66	Agree	0.66
#	95905	x	26	MOTOR/SENS NRVE CONDUCT TEST	0.05	Agree	0.05
	96570			PHOTODYNMC TX, 30 MIN ADD-ON	1.10	Agree	1.10
	96571			PHOTODYNAMIC TX, ADDL 15 MIN	0.55	Agree	0.55
	99358			PROLONG SERVICE W/O CONTACT	2.10	Agree	2.10
	99359			PROLONG SERV W/O CONTACT ADD	1.00	Agree	1.00

New CPT Code

[1] All CPT codes copyright 2009 American Medical Association

[2] Work RVU values recommended by CMS may differ from the AMA RUC recommended value due to work increases in 10 and 90 day global codes as a result of the elimination of the consultation codes.

(a) AMA RUC-recommended work RVU accepted but coverage status of code is non-covered. See code discussion in section F. Discussion of Codes and AMA RUC Recommendations.

BILLING CODE 4120–01–C

F. Discussion of Codes and AMA RUC Recommendations

The following is an explanation of our rationale for not accepting particular AMA RUC-recommended work RVUs. It is arranged by type of service in CPT order and refers only to work RVUs.

1. Excision of Soft Tissue and Bone Excision of Soft Tissue and Bone Tumors

In February 2009, the CPT Editorial Panel approved the coding proposal submitted by the Soft Tissue Tumor and Bone Workgroup, which revised and expanded the soft tissue tumor and bone tumor section codes to more accurately describe the services being provided and to address the concerns raised by the AMA RUC during the Third Five-Year Review. For CY 2010, the CPT Editorial Panel split 31 codes into 62 codes differentiated by the size of the excised lesion, 18 codes were revised, and 12 additional codes were created. These codes were created to fill in anatomic gaps in the coding convention for excision of soft tissue tumors.

The survey results for these codes reflected that the majority of these services, while previously performed as outpatient services (based on 2007 Medicare claims data), had now been valued as inpatient services by the AMA RUC. We believe the Medicare claims data are accurate and do not agree with the inclusion of inpatient services in these codes, particularly, the smaller sized tumors. We have concerns about the additional minutes added to the pre-service time for positioning of the patient. We believe the additional minutes are excessive and request that the AMA RUC re-examine the minutes allocated for positioning of the patient. We also have concerns about the projected utilization for these codes. We understand that the specialty society had difficulty in estimating the frequency split for current codes and frequency estimates for new codes and for the majority of the codes, estimated that the smaller sized tumors would be reported 90 percent of the time, while the larger tumors would be reported only 10 percent of the time. The AMA RUC recommended that these services should be re-reviewed to determine the accuracy of these utilization assumptions once 2 years of frequency data from Medicare have been obtained. We agree with the AMA RUC and plan to monitor the frequency data for these codes and may propose further changes to the work RVUs in the future based upon this data.

Although we have serious concerns with the valuation of these codes for 2010, and due to the comments received on the site of service anomaly codes, we have agreed to accept the AMA RUC-recommended values for these codes on an interim basis. However, we will work with the AMA RUC to address our concerns about the valuation of these codes and will consider whether it would be appropriate to propose further changes in future rulemaking.

We note that the CPT 2010 instructions regarding the use of the excision and resection of soft tissue and bone tumor codes advise that a complex repair may be separately reported. Longstanding Medicare policy generally includes payment for all simple, intermediate, and complex repairs of procedural incisions. Therefore, Medicare will not separately pay for complex repairs for these codes.

2. Fistula Plug

For CY 2010, the AMA RUC-recommended 6.30 work RVUs for CPT code 46707, *Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]).* We disagree with the AMA RUC-recommended value and believe it should be valued the same as the reference code, CPT code 46280, *Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton,* which is assigned 6.28 work RVUs. Although CPT code 46707 has 2 minutes less pre-service time and 5 minutes less intra- and post-service time than the reference code, we believe these two codes are similar and should be valued the same. While the AMA RUC noted that the intra-service time intensity is greater in CPT code 46707 than in the reference code, we do not believe this rationale justifies a higher recommended work RVU for CPT code 46707. Therefore, we have assigned 6.28 work RVUs to CPT code 46707.

3. Computed Tomography Colongraphy

For CY 2010 the AMA RUC recommended 2.40 work RVUs for CPT code 74261, *Computed tomographic (CT), colonography, diagnostic, including image postprocessing; without contrast material.* We disagree with the AMA RUC-recommended value and believe this code is comparable to CPT code 74263, *Computed tomographic (CT) colonography, screening, including image postprocessing,* which virtually has the same description of work, pre-, intra-, and post-service time for which the AMA RUC recommended 2.28 work RVUs. Therefore we have assigned 2.28 work RVUs to CPT code 74261.

CPT code 74263 was previously reported using Category III code 0066T, *Computed tomographic (CT) colonography (ie, virtual colonoscopy); screening,* which has been deleted and was a non-covered code. Based on the descriptors, these CPT codes describe services that include screening services. In general, screening services under Medicare are considered to be those services provided to beneficiaries in the absence of signs or symptoms of illness or injury; therefore, to the extent that the services described by CPT code 74263 have a screening element, the screening component would not meet the statutory requirements for coverage under section 1862(a)(1)(A) of the Act. Screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Accordingly, we will not recognize this CPT codes that incorporates screening for payment under the PFS.

Although we have accepted the AMA RUC recommendation for this service, we have assigned a status indicator of ''N'' (Non-covered) to CPT code 74263 since the code descriptor describe services that include screening services.

4. Myocardial Perfusion Imaging

For CY 2010 the AMA RUC recommended 1.40 work RVUs for CPT code 78451, *Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* and 1.75 work RVUs for CPT code 78452, *Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection.*

For CPT code 78451, it was unclear what methodology the AMA RUC used to calculate the recommended RVU and, therefore, we disagree with the AMA RUC-recommended value. We believe the work RVU for the 25th percentile is more appropriate and have assigned 1.38 work RVUs to CPT code 78451.

For CPT code 78452, we disagree with the reference code used, CPT code 70496, *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing,* which is assigned 1.75. We believe CPT code 78452 is comparable to CPT code 73219,

Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint; with contrast material(s), which is assigned 1.62 work RVUs and the same pre-, intra-, and post-service time. Therefore, we have assigned 1.62 work RVUs to CPT code 78452.

5. Comments Received on New CPT Codes for CY 2010

We received comments on new CPT codes for CY 2010. Since these are new codes for CY 2010, they are subject to comment as part of this final rule. To the extent that commenters have additional concerns, we would encourage them to submit comments in response to this rule.

6. Other AMA RUC Recommendations Received: H1N1 Immunization Administration

The CPT Editorial Panel created CPT code 90470, *Immunization administration (intramuscular, intranasal), including counseling when performed to assist the public health effort to vaccinate for H1N1.* The AMA RUC reviewed this service and recommended 0.20 work RVUs. However, for Medicare payment purposes, we will not recognize this code since we created a specific HCPCS code *(G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family))* for this service that was effective September 1, 2009. We have assigned a status indicator of ''N'' (Non-covered) to this service and will publish the AMA RUC-recommended value in accordance with our practice for non-covered CPT codes.

G. Additional Coding Issues

1. Reduction in the Technical Component (TC) Payment for Imaging Services Paid Under the PFS to the Outpatient Department (OPD) Amount

Effective January 1, 2007, section 5102(b)(1) of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) capped the TC of most imaging services paid under the PFS at the amount paid under the Outpatient Prospective Payment System (OPPS) (71 FR 69659).

The list of codes subject to the OPPS cap has been revised to reflect new and deleted CPT codes for 2010. The complete list of codes subject to the OPPS cap is in Addendum H.

H. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2010

We have developed a process for establishing interim PE RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the AMA RUC recommends the PE direct inputs (the staff time, supplies and equipment) associated with each new code. CMS reviews the recommendations in a manner similar to our evaluation of the RUC-recommended work RVUs. The AMA RUC recommendations on the PE inputs for the new and revised CY 2010 codes were submitted to CMS as interim recommendations.

We have accepted, in the interim, the PE recommendations submitted by the RUC for the codes listed in Table 30: AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes.

IV. Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS Codes

A. General

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

Section 1877(h)(6) of the Act and § 411.351 of our regulations specify that the following services are DHS:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

B. Annual Update to the Code List

1. Background

In § 411.351, we specify that the entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS publications. The DHS categories defined and updated in this manner are:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.

The Code List also identifies those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- EPO and other dialysis-related drugs furnished in or by an ESRD facility (§ 411.355(g)).
- Preventive screening tests, immunizations, or vaccines (§ 411.355(h)).

The Code List was last updated in the CY 2009 PFS final rule with comment period (73 FR 69726) and in a subsequent correction notice (73 FR 80302).

2. Response to Comments

We received one public comment relating to the Code List that became effective January 1, 2009. The comment involved CPT code 0019T, *Extracorporeal shock wave involving musculosketal system, not otherwise specified, low energy.*

Comment: A commenter wrote concerning the classification of CPT code 0019T as ''physical therapy.'' The commenter stated that the use of extracorporeal shock wave generators is restricted by Federal law to sale by or on the order of a physician. The commenter stated that ''the practice of extracorporeal shock wave therapy by *non qualified providers* poses a considerable risk to the safety of the patient and a likely reduction in the effectiveness in the treatment * * *'' (emphasis added by commenter).

Response: The commenter seemed to be objecting to the classification of CPT code 0019T as physical therapy, not only for the purpose of the physician self-referral Code List, but also for broader Medicare payment purposes. We believe that the commenter also has concerns about physical therapists ordering extracorporeal shock wave therapy even though a physician must sign the plan of care. While we appreciate the commenter's concerns,

the concerns encompass issues that are outside the scope of this rule and cannot be addressed here. The purpose of our update is to announce changes to the Code List to account for changes in the most recent CPT and HCPCS publications or Medicare policies. We added CPT 0019T to the physician self-referral Code List effective January 1, 2006 (see 70 FR 70297 and 70472) under the category of ''Physical Therapy, Occupational Therapy, and Speech-language Pathology'' because it was added to the CY 2006 PFS for payment purposes, was included as a ''therapy'' code in Medicare Transmittal 805, ''Annual Update to the Therapy Code List'' that was effective January 1, 2006, and meets the definition of physical therapy services that is set forth in § 411.351. Thus, we believe the code is properly included as a physical therapy service on our Code List.

3. Revisions Effective for 2010

The updated, comprehensive Code List effective January 1, 2010 appears as Addendum I in this final rule with comment period and is available on our Web site at *http://www.cms.hhs.gov/PhysicianSelfReferral/11_List_of_Codes.asp#TopOfPage.* Additions and deletions to the Code List conform the Code List to the most recent publications of CPT and HCPCS and to changes in Medicare coverage policy and payment status.

Tables 31 and 32 identify the additions and deletions, respectively, to the comprehensive Code List that was published in Addendum J of the CY 2009 PFS final rule (73 FR 70214 through 70237) and revised in a subsequent correction notice (73 FR 80302). Tables 31 and 32 also identify the additions and deletions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and in § 411.355(h) (regarding preventive screening tests, immunizations, and vaccines).

In Table 31, we specify additions that generally reflect new CPT and HCPCS codes that become effective January 1, 2010, or that became effective since our last update. We also are adding HCPCS codes G0416 through G0419 that represent pathology codes for prostate needle saturation biopsy sampling to the ''Clinical Laboratory Services'' category of the Code List. These codes became effective January 1, 2009, and were discussed in the preamble of the CY 2009 PFS final rule (73 FR 69751). We inadvertently failed to add them to the Code List update that was published in that rule.

Table 32 reflects the deletions necessary to conform the Code List to the most recent publications of the CPT and HCPCS. In addition, we are making other deletions based on changes in Medicare coverage and payment status. We are deleting CPT code 0085T, representing a breath test for heart transplant rejection, since this code is no longer payable by Medicare. We also are deleting CPT code 95992, a code for canalith repositioning procedures, as it will be designated as ''invalid'' for Medicare purposes as discussed in section II.E.1 of this preamble.

We will consider comments regarding the codes listed in Tables 31 and 32. Comments will be considered if we receive them by the date specified in the ''DATES'' section of this final rule with comment period. We will not consider any comment that advocates a substantive change to any of the DHS defined in § 411.351.

BILLING CODE 4120–01–P

TABLE 31: Additions to the Physician Self-Referral List of CPT[1]/HCPCS Codes

CLINICAL LABORATORY SERVICES	
G0416	Sat biopsy prostate 1-20 spc
G0417	Sat biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60
G0419	Sat biopsy prostate: >60
G0430	Drug screen multi class
G0431	Drug screen single class
G9143	Warfarin respon genetic test
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
[no additions]	
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
75565	Card mri vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
RADIATION THERAPY SERVICES AND SUPPLIES	
32553	Ins mark thor for rt perq
49411	Ins mark abd/pel for rt perq
77338	Design mlc device for imrt
A9604	Sm 153 lexidronam
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
Q0139	Ferumoxytol, esrd use
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[no additions]	

[1]CPT codes and descriptions only are copyright 2009 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 32: Deletions to the Physician Self-Referral List of CPT[1]/HCPCS Codes

CLINICAL LABORATORY SERVICES	
0064T	Spectroscop eval expired gas
0085T	Breath test heart reject
0087T	Sperm eval hyaluronan
0194T	Procalcitonin (PCT)
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
95992	Canalith repositioning proc
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
0067T	Ct colonography; dx
0144T	Ct heart wo dye; qual calc
0145T	Ct heart w/wo dye funct
0146T	Ccta w/wo dye
0147T	Ccta w/wo, quan calcium
0148T	Ccta w/wo, strxr
0149T	Ccta w/wo, strxr quan calc
0150T	Ccta w/wo, disease strxr
0151T	Ct heart funct add-on
78460	Heart muscle blood, single
78461	Heart muscle blood, multiple
78464	Heart image (3d), single
78465	Heart image (3d), multiple
78478	Heart wall motion add-on
78480	Heart function add-on
RADIATION THERAPY SERVICES AND SUPPLIES	
A9605	Sm 153 lexidronm
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
[no deletions]	
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[no deletions]	

[1] CPT codes and descriptions only are copyright 2009 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

BILLING CODE 4120–01–C

V. Physician Fee Schedule Update for CY 2010

A. Physician Fee Schedule Update

The PFS update is determined using a formula specified in section 1848(d)(4) of the Act. Section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 conversion factor (CF) and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the 6-month increase that was applicable to the CF for the first half of CY 2008 to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

If section 101 of the MIEA–TRHCA had not been enacted, the CY 2007 CF update would have been −5.0 percent (0.94953), as published in the CY 2007 PFS final rule with comment period (71 FR 69760). If section 101 of the MMSEA had not been enacted, the CY 2008 CF update would have been −10.1 percent (0.89896), as published in the CY 2008 PFS final rule with comment period (72 FR 66383).

If section 131 of the MIPPA had not been enacted, the CY 2009 CF update would have been −15.1 percent (0.84941), as discussed in the CY 2009 PFS final rule with comment period (73 FR 69900).

For CY 2010, the Medicare Economic Index (MEI) is equal to 1.2 percent (1.012). The update adjustment factor (UAF) is −7.0 percent. Our calculations of these figures are explained below in this section.

In order to determine the 2010 PFS CF update, the CFs for 2007, 2008, and 2009 must be calculated as if the various legislative changes to the CFs for those years had not occurred. Consistent with the formula specified by the statute, the CY 2010 CF update is −21.2 percent (0.78760). Our calculations are explained below in this section.

B. The Percentage Change in the Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) is authorized by section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that the higher level is justified by year-to-year economic changes.

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 multifactor productivity. This index, which has CY 2000 base year weights, is comprised of two broad categories: (1) physician's own time; and (2) physician's practice expense (PE).

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: (1) wages and salaries; and (2) fringe benefits.

The physician's PE category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's PE component also includes the following categories of nonlabor inputs: office expense; medical materials and supplies; professional liability insurance; medical equipment; prescription drugs; and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of productivity in the private nonfarm business sector.

Table 33 presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2010 update. For CY 2010, the increase in the MEI is 1.2 percent, which includes a 1.3 percent productivity offset based on the 10-year moving average of multifactor productivity. This is the result of a 3.2 percent increase in physician's own time and a 1.8 percent increase in physician's PE. Within the physician's PE, the largest increase occurred in prescription drugs, which increased 7.1 percent.

BILLING CODE 4120–01–P

BILLING CODE 4120-01-C

TABLE 33: Increase in the Medicare Economic Index Update for CY 2010[1]

Cost Categories and Price Measures	CY 2000 Weights[2]	CY 2010 Percent Changes
Medicare Economic Index Total, productivity adjusted[3]	N/A	1.2
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector[3]	N/A	1.3
Medicare Economic Index Total, without productivity adjustment	100.000	2.5
1. Physician's Own Time[4]	52.466	3.2
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	3.5
b. Fringe Benefits: Employment Cost Index, benefits, private Nonfarm[4]	9.735	1.8
2. Physician's Practice Expense[4]	47.534	1.8
a. Nonphysician Employee Compensation	18.653	2.6
(1) Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	2.7
(2) Fringe Benefits: Employment Cost Index, fringe benefits, weighted by occupation	4.845	2.4
b. Office Expense: Consumer Price Index for Urban Areas (CPI-U), housing	12.209	2.2
c. Drugs and Medical Materials and Supplies	4.319	4.7
(1) Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI-U, medical equipment and supplies (equally weighted)	2.011	1.1
(2) Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	7.1
d. Professional Liability Insurance: Professional liability insurance Premiums[5]	3.865	-3.6
e. Medical Equipment: PPI, medical instruments and equipment	2.055	0.8
f. Other Expenses	6.433	2.0

1. The rates of historical change are estimated for the 12-month period ending June 30, 2009, which is the period used for computing the CY 2010 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 5, 2009.
2. The weights shown for the MEI components are the 2000 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 CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 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. These numbers may not sum due to rounding and the multiplicative nature of their relationship.
4. The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and CPIs can be found on the BLS Web site at http://stats.bls.gov .
5. Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2009).

C. The Update Adjustment Factor (UAF)

Section 1848(d) of the Act provides that the PFS update is equal to the product of the MEI and the UAF. The UAF is applied to make actual and target expenditures (referred to in the statute as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

1. Calculation under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with CY 2001 is equal to the sum of the following—

• *Prior Year Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

+ Dividing that difference by the amount of the actual expenditures for those services for that year; and

+ Multiplying that quotient by 0.75.

• *Cumulative Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

+ Dividing that difference by actual expenditures for those services for the prior year as increased by the SGR for the year for which the UAF is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (CY 2010 in this case), the current CY (that is, CY 2009) and the preceding CY (that is, CY 2008) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures for a year generally are estimated initially and subsequently revised twice. The second revision occurs after the CY has ended (that is, we are making the second revision to 2008 allowed expenditures in this final rule with comment).

In the CY 2010 PFS proposed rule (74 FR 33650), we noted that section 1848(f)(4)(A) of the Act provides the Secretary with clear discretion to determine what items and services should be included in the definition of ''physicians' services'' for purposes of determining allowed expenditures and the SGR. As the statute affords the Secretary clear discretion to revise the definition of ''physicians' services'', we proposed to remove physician-administered drugs from the definition of ''physicians' services'' in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years. Furthermore, given the past effect of spending growth for physician-administered drugs on future PFS updates, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of ''physicians' services'', we also indicated that we believed it was reasonable to remove drugs from the calculation of allowed and actual expenditures for all prior years.

In the proposed rule (74 FR 33651), we noted that the term ''actual expenditures'' is not defined in the statute, nor are there any statutory limitations on the Secretary's ability to recompute actual expenditures to reflect changes in the amount of actual expenditures. On several occasions, we have made revisions to the amount of actual expenditures to reflect new information regarding spending on physicians' services. In order to eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates, we proposed to remove drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996/1997 base year. Further, we proposed to remove drugs from the calculation of the SGR beginning with 2010.

Comment: Commenters strongly supported our proposal to remove drugs from the calculation of allowed and actual expenditures retrospectively to the 1996/1997 base year and our proposal to remove drugs from the calculation of the SGR beginning with 2010. Many noted that they have been requesting this change for years. However, all commenters expressed concerns about the estimated negative update for CY 2010 of approximately −21 percent, followed by multiple years of negative physician updates of approximately −5 percent. Commenters described how they believe the SGR and update formulas are flawed, and they stated their belief that the magnitude of the 1-year reduction, followed by multiple years of continued reductions, will impair beneficiary access to quality care. Many commenters urged us to work with Congress to revise or replace the physician update and SGR formulas. Some of these commenters suggested alternative methodologies for updating physician payments, and a number of them specifically expressed their support for the SGR-related provisions of H.R. 3200. A few commenters suggested using our administrative authority to implement additional changes that would further lessen the negative impact. The AMA requested that we publish in our final rule estimates of the annual updates for 2011 through 2014.

Response: As discussed in the proposed rule (74 FR 33650), the magnitude of the estimated 1-year reduction led us to reexamine administrative actions that the Secretary could take to lessen the potential for repeated further reductions in the PFS update. We explored the breadth of options available under current authority including an assessment of whether the cost of physician-administered drugs should continue to be included in actual expenditures, allowed expenditures and the SGR. As the statute affords the Secretary clear discretion to define ''physicians' services'' for purposes of determining allowed expenditures and the SGR (section 1848(f)(4)(A) of the Act), we proposed to remove physician-administered drugs from the definition of ''physicians' services'' in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and the levels of allowed expenditures and actual expenditures in all future years. Moreover, given the past effect of spending growth for physician-administered drugs on future PFS updates, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of physicians' services in section 1848(f)(4)(A) of the Act, we proposed to remove drugs from the calculation of allowed and actual expenditures under section 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996 base year in order to eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates. (See 74 FR 33651 for a more detailed

explanation of our legal authority for this proposal). We received no public comments that disagreed with these proposals.

Accordingly, we are removing physician-administered drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act for CY 2010 and retrospectively to the 1996/1997 base year in this final rule. We are also finalizing our proposal to remove drugs from the calculation of the SGR beginning with 2010.

With respect to the many suggestions we received in the public comments asking the Secretary and the Congress to do more to avert the reduction in PFS payments for 2010 and future years, all other options suggested in the comments would require a change to the statute. We also received a comment requesting that we include estimates of the updates from 2010 through 2014 in this final rule. We are providing the 2010 update in the final rule, but are not providing estimates of the updates for later years as future updates will vary depending on the baseline used and will also change as additional information becomes available.

Our decision to remove drugs from the allowed and actual expenditures and the SGR will have no effect on the 2010 PFS update of −21.3 percent because removing drugs from allowed and actual expenditures retroactively to the base year changes the UAF for CY 2010 from −30.9 percent to −8.8 percent. As the statute limits the UAF for a year to −7.0 percentage points, the UAF would be −7.0 percent irrespective of whether drugs are included or excluded from allowed and actual expenditures retroactive to the base year. Although the magnitude of future updates remains uncertain, as the following analysis demonstrates, it is clear that our proposal to remove drugs from allowed expenditures, actual expenditures, and the SGR will make a positive PFS update far more likely. Removing drugs from allowed and actual expenditures for all years and from future SGRs reduces the difference between cumulative allowed and actual expenditures from $71.8 billion to $19.4 billion or by over $50 billion. Future PFS updates will only have to be reduced by $19.4 billion rather than $71.8 billion to equate actual and allowed expenditures. The UAF for 2010 changes from −30.9 percent to −8.8 percent, but is limited to −7.0 percent under either scenario. If physician-administered drugs were to remain included in allowed and actual expenditures, the UAF would be expected to be at the maximum reduction of −7.0 percent for several years beyond 2010. By excluding these drugs, far fewer negative UAFs are expected in future years.

Table 34 shows annual and cumulative allowed and actual expenditures for physicians' services from April 1, 1996, through the end of the current CY, including the short periods in 1999 when we transitioned to a CY system. As discussed in the CY 2010 PFS proposed rule (74 FR 33651), once the Secretary has revised the level of allowed expenditures during the base year (as is authorized under the statute), it is reasonable to carry this revision through into all subsequent years. Thus, Table 34 also reflects recomputed allowed and actual expenditures from the base year and subsequent years to remove the costs associated with physician-administered drugs.

Table 34 also shows the SGR corresponding with each period. The calculation of the SGR is discussed in detail below in this section.

BILLING CODE 4120–01–P

TABLE 34: Annual and Cumulative Allowed and Actual Expenditures for Physicians' Services from April 1, 1996 through the End of the Current Calendar Year

Period	Annual Allowed Expenditures ($ in billions)	Annual Actual Expenditures ($ in billions)	Cumulative Allowed Expenditures ($ in billions)	Cumulative Actual Expenditures ($ in billions)	FY/CY SGR
4/1/96-3/31/97	$46.8[1]	$46.8	$46.8	$46.8	N/A
4/1/97-3/31/98	$48.3	$47.0	$95.2	$93.9	FY 1998=3.2%
4/1/98-3/31/99	$50.4	$47.8	$145.6	$141.7	FY 1999=4.2%
1/1/99-3/31/99	$12.7	$12.4	[2]	$141.7	FY 1999=4.2%
4/1/99-12/31/99	$40.3	$37.0	[3]	$178.8	FY 2000=6.9%
1/1/99-12/31/99	$53.0	$49.5	$185.8	$178.8	FY 1999/2000
1/1/00-12/31/00	$56.8	$54.1	$242.7	$232.9	CY 2000=7.3%
1/1/01-12/31/01	$59.4	$61.2	$302.1	$294.2	CY 2001=4.5%
1/1/02-12/31/02	$64.3	$64.6	$366.4	$358.7	CY 2002=8.3%
1/1/03-12/31/03	$69.0	$70.2	$435.4	$429.0	CY 2003=7.3%
1/1/04-12/31/04	$73.6	$78.3	$509.0	$507.2	CY 2004=6.6%
1/1/05-12/31/05	$76.7	$83.5	$585.7	$590.7	CY 2005=4.2%
1/1/06-12/31/06	$77.8	$84.6	$663.5	$675.3	CY 2006=1.5%
1/1/07-12/31/07	$80.5	$84.5	$744.0	$759.8	CY 2007=3.5%
1/1/08-12/31/08	$84.2	$86.7	$828.2	$846.4	CY 2008=4.5%
1/1/09-12/31/09	$89.3	$90.5	$917.5	$936.9	CY 2009=6.1%
1/1/10-12/31/10	$81.4	NA	$998.9	NA	CY 2010=-8.8%

[1] Allowed expenditures in the first year (April 1, 1996-March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site at the following address: http://www.cms.hhs.gov/SustainableGRatesConFact/. We expect to update the web site with the most current information later this month.

[2] Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.

[3] Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

BILLING CODE 4120–01–C

Consistent with section 1848(d)(4)(E) of the Act, Table 34 includes our second revision of allowed expenditures for CY 2008, a recalculation of allowed expenditures for CY 2009, and our initial estimate of allowed expenditures for CY 2010. To determine the UAF for CY 2010, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2009 and the CY 2010 SGR. Consistent with section 1848(d)(4)(E) of the Act, we will be making revisions to the CY 2009 and CY 2010 SGRs and CY 2009 and CY 2010 allowed expenditures. Because we have incomplete actual expenditure data for CY 2009, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the UAF for future years. In addition, as discussed above, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of ''physicians' services,'' we are removing drugs from the calculation of allowed expenditures for CY 2010, CY 2009, CY 2008, and all prior years.

We are using figures from Table 34 in the following statutory formula:

$$UAF_{10} = \frac{Target_{09} - Actual_{09}}{Actual_{09}} \times 0.75 + \frac{Target_{4/96–12/09} - Actual_{4/96–12/09}}{Actual_{09} \times SGR_{10}} \times 0.33$$

UAF_{10} = Update Adjustment Factor for CY 2010 = −8.8 percent

$Target_{09}$ = Allowed Expenditures for CY 2009 = $89.3 billion

$Actual_{09}$ = Estimated Actual Expenditures for CY 2009 = $90.5 billion

$Target_{4/96–12/09}$ = Allowed Expenditures from 4/1/1996–12/31/2009 = $917.5 billion

$Actual_{4/96–12/09}$ = Estimated Actual Expenditures from 4/1/1996—12/31/2009 = $936.9 billion

SGR_{10} = −8.8 percent (0.912)

$$\frac{\$89.3 - \$90.5}{\$90.5} \times 0.75 + \frac{\$917.5 - \$936.9}{\$90.5 \times 0.912} \times 0.33 = -8.8\%$$

If we had not removed the costs associated with physician-administered drugs from the calculation of allowed and actual expenditures retrospectively to the 1996/1997 base year and from the calculation of the SGR beginning with 2010 SGR, the UAF determined using the statutory formula would have been −30.9 percent.

$$\frac{\$93.2 - \$100.8}{\$100.8} \times 0.75 + \frac{\$958.0 - \$1,029.8}{\$100.8 \times 0.930} \times 0.33 = -30.9\%$$

The increase in the UAF reflects the reduced discrepancy between actual and target expenditures resulting from removing the costs of physician-administered drugs from our calculations.

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.07 or greater than 0.03. Since −0.088 is less than −0.07, the UAF for CY 2010 will be −0.07. Moreover, because −0.088 and −0.309 are both less than −0.07, removing the costs of physician-administered drugs from our calculations did not change the effective UAF for CY 2010.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1.0 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1.0 to −0.07 makes the UAF equal to 0.93.

Section 1848(d) of the Act provides that the PFS update is equal to the product of the MEI and the UAF. Because the effective UAF for CY 2010 is −0.07 whether or not the costs of physician-administered drugs are included in the levels of allowed and actual expenditures, removing these costs from our calculation did not change the physician payment update for services furnished on or after January 1, 2010.

VI. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the PFS update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with CY 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services;

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries;

(3) The estimated projected growth in real GDP per capita; and

(4) The estimated change in expenditures due to changes in statute or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (The Act also provides for adjustments to be made to the SGRs for FY 1998 and FY 1999. See the February 28, 2003 **Federal Register** (68 FR 9567)

for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule with comment, we are making our preliminary estimate of the CY 2010 SGR, a revision to the CY 2009 SGR, and our final revision to the CY 2008 SGR. Although we are removing drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996/1997 base year, we determined that we are only authorized to remove drugs from the calculation of the SGR beginning with 2010. Therefore, we will not be removing drugs from previous years' SGR calculations, and the revisions to our estimates of the CY 2009 and CY 2008 SGRs will be limited to revisions to reflect later data available as of September 1, 2009, that were not available when we published our previous estimates.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that ''the term physicians' services includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.''

We published a definition of physicians' services for use in the SGR in the November 1, 2001 **Federal Register** (66 FR 55316). We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. As discussed in section VII.C. of this final rule with comment period, the statute provides the Secretary with clear discretion to decide whether physician-administered drugs should be included or excluded from the definition of ''physicians' services.'' Accordingly, we are finalizing our proposal to remove physician-administered drugs from the definition of ''physicians' services'' in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and the levels of allowed expenditures and actual expenditures CY 2010 and all future years. Furthermore, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of ''physicians' services,'' we are removing physician-administered drugs from the calculation of allowed and actual expenditures for all prior years.

Thus, for purposes of determining allowed expenditures, actual expenditures for all years, and SGRs for CY 2010 and subsequent years, we are specifying that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified) or the equivalent services processed by the Medicare Administrative Contractors:

- Physicians' services.
- Services and supplies furnished incident to physicians' services, except for the expenditures for drugs and biologicals which are not usually self-administered by the patient.
- Outpatient physical therapy services and outpatient occupational therapy services.
- Services of PAs, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, NPs, and certified nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training (DSMT) services.
- MNT services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.
- An initial preventive physical exam.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Telehealth services.
- Physician work and resources to establish and document the need for a power mobility device.

C. Preliminary Estimate of the SGR for 2010

Our preliminary estimate of the CY 2010 SGR is −8.8 percent. We first estimated the CY 2010 SGR in March 2009, and we made the estimate available to the MedPAC and on our Web site. Table 35 shows the March 2009 estimate and our current estimates of the factors included in the CY 2010 SGR.

TABLE 35—2010 SGR CALCULATION

Statutory factors	March estimate	Current estimate
Fees	1.2 percent (1.012)	0.9 percent (1.009)
Enrollment	−0.3 percent (0.997)	1.2 percent (1.012)
Real Per Capita GDP	0.8 percent (1.008)	0.7 percent (1.007)
Law and Regulation	−9.7 percent (0.903)	−11.3 percent (0.887)
Total	−8.2 percent (0.918)	−8.8 percent (0.912)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.009 × 1.012 × 1.007 × 0.887 = 0.912). A more detailed explanation of each figure is provided in section VIII.F.1 of this preamble.

D. Revised Sustainable Growth Rate for 2009

Our current estimate of the CY 2009 SGR is 6.1 percent. Table 36 shows our preliminary estimate of the CY 2009 SGR that was published in the CY 2009 PFS final rule with comment period (73 FR 69904) and our current estimate.

TABLE 36—2009 SGR CALCULATION

Statutory factors	Estimate from CY 2009 final rule	Current estimate
Fees	2.1 percent (1.021)	1.8 percent (1.018)
Enrollment	−0.2 percent (0.998)	−0.8 percent (0.992)
Real Per Capita GDP	1.2 percent (1.012)	0.9 percent (1.009)
Law and Regulation	4.2 percent (1.042)	4.1 percent (1.041)
Total	7.4 percent (1.074)	6.1 percent (1.061)

A more detailed explanation of each figure is provided in section VIII.F.2 of this preamble.

E. Final Sustainable Growth Rate for 2008

The SGR for 2008 is 4.5 percent. Table 37 shows our preliminary estimate of the 2008 SGR from the CY 2008 PFS final rule with comment period (72 FR 66379), our revised estimate from the CY 2009 PFS final rule with comment period (73 FR 69904) and the final figures determined using the best available data as of September 1, 2009.

TABLE 37—2008 SGR CALCULATION

Statutory factors	Estimate from CY 2008 final rule	Estimate from CY 2009 final rule	Final
Fees	1.9 percent (1.019)	1.4 percent (1.014)	1.4 percent (1.014).
Enrollment	−0.7 percent (0.993)	−3.2 percent (0.968)	−2.0 percent (0.980).
Real Per Capita GDP	1.7 percent (1.017)	1.6 percent (1.016)	1.6 percent (1.016).
Law and Regulation	−2.9 percent (0.971)	3.5 percent (1.035)	3.5 percent (1.035).
Total	−0.1 percent (0.999)	3.2 percent (1.032)	4.5 percent (1.045).

A more detailed explanation of each figure is provided in section VIII.F.3. of this final rule.

F. Calculation of 2010, 2009, and 2008 Sustainable Growth Rates

1. Detail on the CY 2010 SGR

All of the figures used to determine the CY 2010 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent PFS updates.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2010*

This factor is calculated as a weighted-average of the CY 2010 changes in fees for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the PFS are estimated to account for approximately 90.8 percent of total allowed charges included in the SGR in CY 2010 and are updated using the MEI. The MEI for CY 2010 is 1.2 percent. Diagnostic laboratory tests are estimated to represent approximately 9.2 percent of Medicare allowed charges included in the SGR for CY 2010. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U), which is −1.4 percent for CY 2010. However, section 145 of the MIPPA reduces the update applied to clinical laboratory tests by 0.5 percent for CY 2009 through CY 2013. Therefore, for CY 2010, diagnostic laboratory tests will receive an update of −1.9 percent. As noted in Section VII.C. of this final rule with comment period, we are finalizing our proposal to remove physician-administered drugs from the allowed charges included in the SGR in CY 2010 and in all future years. Therefore, drugs represent 0.0 percent of Medicare allowed charges included in the SGR in CY 2010.

Table 38 shows the weighted-average of the MEI and laboratory price changes for CY 2010.

TABLE 38—WEIGHTED-AVERAGE OF THE MEI AND LABORATORY PRICE CHANGES FOR CY 2010

	Weight	Update
Physician	0.908	1.2
Laboratory	0.092	−1.9
Weighted-average	1.000	0.9

We estimate that the weighted-average increase in fees for physicians' services in CY 2010 under the SGR (before applying any legislative adjustments) will be 0.9 percent.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees from CY 2009 to CY 2010*

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from CY 2009 to CY 2010. Services provided to Medicare Advantage (MA) plan enrollees are outside the scope of the SGR and are excluded from this estimate. We estimate that the average number of Medicare Part B fee-for-service enrollees will increase by 1.2 percent from CY 2009 to CY 2010. Table 39 illustrates how this figure was determined.

TABLE 39—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2009 TO CY 2010

[Excluding beneficiaries enrolled in MA plans]

	2009	2010
Overall	42.431 million	43.164 million.
Medicare Advantage (MA)	10.926 million	11.271 million.
Net	31.506 million	31.893 million.

TABLE 39—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2009 TO CY 2010—Continued

[Excluding beneficiaries enrolled in MA plans]

	2009	2010
Percent Increase		1.2 percent.

An important factor affecting fee-for-service enrollment is beneficiary enrollment in MA plans. Because it is difficult to estimate the size of the MA enrollee population before the start of a CY, at this time we do not know how actual enrollment in MA plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for CY 2010 becomes known.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2010*

We estimate that the growth in real GDP per capita from CY 2009 to CY 2010 will be 0.7 percent (based on the 10-year average GDP over the 10 years of 2001 through 2010). Our past experience indicates that there have also been changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is possible that this figure will change as actual information on economic performance becomes available to us in 2010.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2010 Compared With CY 2009*

The statutory and regulatory provisions that will affect expenditures in CY 2010 relative to CY 2009 are estimated to have an impact on expenditures of −11.3 percent. These include the MIPPA provisions regarding the physician update, e-prescribing bonuses, the expiration of the work GPCI floor, and the expiration of payment provisions related to certain pathology services.

2. Detail on the 2009 SGR

A more detailed discussion of our revised estimates of the four elements of the 2009 SGR follows.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2009*

This factor was calculated as a weighted-average of the 2009 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR in 2009.

We estimate that services paid using the PFS account for approximately 82.4 percent of total allowed charges included in the SGR in CY 2009. These services were updated using the CY 2009 MEI of 1.6 percent. We estimate that diagnostic laboratory tests represent approximately 8.0 percent of total allowed charges included in the SGR in CY 2009. Medicare payments for these tests are updated by the CPI–U, which is 5.0 percent for CY 2009. However, section 145 of the MIPPA reduces the update applied to clinical laboratory tests by 0.5 percent for CY 2009 through CY 2013. Therefore, for CY 2009, diagnostic laboratory tests will receive an update of 4.5 percent. We estimate that drugs represent 9.7 percent of Medicare-allowed charges included in the SGR in CY 2009. We estimate a weighted-average change in fees for drugs included in the SGR (using the ASP+6 percent pricing method) of 1.6 percent for CY 2009.

Table 40 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2009.

TABLE 40—WEIGHTED-AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2009

	Weight	Update
Physician	0.824	1.6
Laboratory	0.080	4.5
Drugs	0.097	1.6
Weighted-average	1.000	1.8

After considering the elements described in Table 40, we estimate that the weighted-average increase in fees for physicians' services in 2009 under the SGR (before applying any legislative adjustments) will be 1.8 percent. Our estimate of this factor in the CY 2009 PFS final rule with comment period was 2.1 percent (73 FR 69905). The decrease in the estimate is due to the availability of some actual data.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees from CY 2008 to CY 2009*

We estimate that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in Medicare Advantage plans) decreased by 0.8 percent in CY 2009. Table 41 illustrates how we determined this figure.

TABLE 41—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2008 TO CY 2009

[Excluding beneficiaries enrolled in MA plans]

	2008	2009
Overall	41.747 million	42.431 million.
Medicare Advantage (MA)	9.999 million	10.926 million.
Net	31.748 million	31.506 million.
Percent Increase		− 0.8 percent.

Our estimate of the − 0.8 percent change in the number of fee-for-service enrollees, net of Medicare Advantage enrollment for CY 2009 compared to CY 2008, is a larger change than our original estimate of − 0.2 percent in the CY 2009 PFS final rule with comment period (73 FR 69905). While our current projection based on data from 8 months of 2009 differs from our original estimate of − 0.2 percent when we had no actual data, it is still possible that our final estimate of this figure will be different once we have complete information on CY 2009 fee-for-service enrollment.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in CY 2009*

We estimate that the growth in real GDP per capita will be 0.9 percent for

CY 2009 (based on the 10-year average GDP over the 10 years of CY 2000 through CY 2009). Our past experience indicates that there have also been differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is possible that this figure will change further as complete actual information on CY 2009 economic performance becomes available to us in 2010.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2009 Compared With CY 2008*

The statutory and regulatory provisions that will affect expenditures in CY 2009 relative to CY 2008 are estimated to have an impact on expenditures of 4.1 percent. These include the DRA provision reducing payments for imaging services, the MMSEA provision regarding the PQRI bonuses payable in 2009, and the MIPPA provisions regarding the change in cost sharing for mental health services, the physician update, and the change in application of BN to the CF.

3. Detail on the CY 2008 SGR

A more detailed discussion of our final revised estimates of the four elements of the CY 2008 SGR follows.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2008*

This factor was calculated as a weighted-average of the CY 2008 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR in 2008.

Services paid using the PFS accounted for approximately 82.7 percent of total Medicare-allowed charges included in the SGR for CY 2008 and are updated using the MEI. The MEI for CY 2008 was 1.8 percent. Diagnostic laboratory tests represented approximately 7.7 percent of total CY 2008 Medicare allowed charges included in the SGR and are updated by the CPI–U. However, section 628 of the MMA specifies that diagnostic laboratory tests will receive an update of 0.0 percent from CY 2004 through CY 2008. Drugs represented approximately 9.7 percent of total Medicare-allowed charges included in the SGR for CY 2008. We estimate a weighted-average change in fees for drugs included in the SGR of − 0.7 percent for 2007. Table 42 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2008.

TABLE 42—WEIGHTED-AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2008

	Weight	Update
Physician	0.827	1.8
Laboratory	0.077	0.0
Drugs	0.097	− 0.7
Weighted-average	1.000	1.4

After considering the elements described in Table 42, we estimate that the weighted-average increase in fees for physicians' services in CY 2008 under the SGR (before applying any legislative adjustments) was 1.4 percent. This figure is a final one based on complete data for CY 2008.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees from CY 2008 to CY 2007*

We estimate the decrease in the number of fee-for-service enrollees (excluding beneficiaries enrolled in MA plans) from CY 2007 to CY 2008 was − 2.0 percent. Our calculation of this factor is based on complete data from CY 2008. Table 43 illustrates the calculation of this factor.

TABLE 43—AVERAGE NUMBER OF MEDICARE PART B FROM CY 2007 TO CY 2008

[Excluding beneficiaries enrolled in MA plans]

	2007	2008
Overall	41.055 million	41.747 million.
Medicare Advantage (MA)	8.661 million	9.999 million.
Net	32.394 million	31.748 million.
Percent Increase		− 2.0 percent.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2008*

We estimate that the growth in real per capita GDP was 1.6 percent in 2008 (based on the 10-year average GDP over the 10 years of CY 1999 through CY 2008). This figure is a final one based on complete data for CY 2008.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2008 Compared With CY 2007*

Our final estimate for the net impact on expenditures from the statutory and regulatory provisions that affect expenditures in CY 2008 relative to CY 2007 is 3.5 percent. These include the DRA provision reducing payments for imaging services, the MIEA TRHCA provisions regarding the 2007 PQRI reporting bonuses payable in 2008, and the MIPPA provisions regarding the physician update and bonus payments for mental health services.

VII. Anesthesia and Physician Fee Schedule Conversion Factors for CY 2010

The CY 2010 PFS CF is $28.4061. The CY 2010 national average anesthesia CF is $16.6191.

A. Physician Fee Schedule Conversion Factor

The PFS CF for a year is calculated in accordance with section 1848(d)(1)(A) of the Act by multiplying the previous year's CF by the PFS update. The formula for calculating the PFS update is set forth in section 1848(d)(4)(A) of the Act. In general, the PFS update is determined by multiplying the CF for the previous year by the percentage increase in the MEI times the UAF, which is calculated as specified under section 1848(d)(4)(B) of the Act. However, Section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2008 CF that applied during the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for

CYs 2007, 2008, and 2009 had never applied.

In order to determine the 2010 PFS CF update, the CFs for 2007, 2008, and 2009 must be calculated as if the various legislative changes to the CFs for those years had not occurred.

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ more than $20 million from what would have been in the absence of these changes. If this threshold is exceeded, we must make adjustments to preserve BN. We estimate that CY 2010 RVU changes would result in a decrease in Medicare physician expenditures of more than $20 million. Therefore, we are increasing the CF by 1.00103 to offset this estimated decrease in Medicare physician expenditures due to the CY 2010 RVU changes.

We illustrate the calculation of the CY 2010 PFS CF in Table 44.

TABLE 44: Calculation of the CY 2010 PFS CF

CY 2006 Conversion Factor		$37.8975
CY 2007 Pre-legislation Conversion Factor Update	-5.0 percent (0.94953)	
CY 2007 Pre-legislation Conversion Factor		$35.9848
CY 2008 Pre-legislation Conversion Factor Update	-5.3 percent (0.94674)	
CY 2008 Pre-legislation Conversion Factor		$34.0682
CY 2009 Pre-legislation total, including budget neutrality adjustments totaling -6.3 percent	-11.5 percent (0.88502)	
CY 2009 Pre-legislation Conversion Factor		$30.1510
CY 2010 Medicare Economic Index	1.2 percent (1.012)	
CY 2010 Update Adjustment Factor	-7.0 percent (0.930)	
CY 2010 CF Budget Neutrality Adjustment	0.103 percent (1.00103)	
CY 2010 Conversion Factor		**$28.4061**

Payment for services under the PFS will be calculated as follows:

Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU malpractice × GPCI malpractice)] × CF.

B. Anesthesia Conversion Factor

We calculate the anesthesia CF as indicated in Table 45. Anesthesia services do not have RVUs like other PFS services. Therefore, we account for any necessay RVU adjustments through an adjustment tothe anesthesia CF to simulate changes to RVUs. More specifically, if there is an adjustment to thework, PE, or malpractice RVUs, these adjustments are applied to the respective shares of the anesthesia CF as these shares are proxies for the work, PE, and malpractice RVUs for anesthesia services.

As explained above, section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2008 CF from the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

In order to determine the 2010 PFS CF update, the CFs for 2007, 2008, and 2009 must be calculated as if the various legislative changes to the CFs for those years had not occurred. Also, section 133(b) of the MIPPA provided for the application of the 2007–2008 5-Year work review BN adjuster to the CF for years beginning with 2009. To make this change for the anesthesia CF, we recalculated the adjustments to the anesthesia CF for CY 2007 and CY 2008 by removing the BN adjuster for work which had been applied to calculate the CF for each of these years. (See the CY 2009 PFS final rule with comment period (73 FR 69909) for more information on this calculation.) Table 45 also includes the CY 2010 adjustment to the anesthesia CF due to changes in CY 2010 payment polices for PE and malpractice RVUs.

TABLE 45: Calculation of the CY 2010 Anesthesia Conversion Factor

CY 2006 Anesthesia Conversion Factor		$17.7663
CY 2007 Pre-legislation Conversion Factor Update	-5.0 percent (0.94953)	
CY 2007 Adjustment without BN adjuster	.9874	
CY 2007 Pre-legislation Conversion Factor		$16.6571
CY 2008 Pre-legislation Conversion Factor Update	-5.3 percent (0.94674)	
CY 2008 Adjustment without BN adjuster	1.2528	
CY 2008 Pre-legislation Conversion Factor		$19.7566
CY 2009 Pre-legislation total, including budget neutrality adjustments totaling -6.3 percent	-11.5 percent (0.88502)	
CY 2009 Pre-legislation Conversion Factor		$17.4849
CY 2010 Medicare Economic Index	1.2 percent (1.012)	
CY 2010 Update Adjustment Factor	-7.0 percent (0.930)	
CY 2010 Anesthesia Adjustment	0.99 percent (1.0099)	
CY 2010 Anesthesia Conversion Factor		**$16.6191**

VIII. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2010 is 1.2 percent.

Therefore, for CY 2010, the payment amount for HCPCS code Q3014, Telehealth originating site facility fee, is 80 percent of the lesser of the actual charge or $24.00. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 46.

TABLE 46: The Medicare Telehealth Originating Site Facility Fee and MEI Increase by the Applicable Time Period

Facility Fee	MEI Increase	Period
$20.00	N/A	10/01/2001 – 12/31/2002
$20.60	3.0%	01/01/2003 – 12/31/2003
$21.20	2.9%	01/01/2004 – 12/31/2004
$21.86	3.1%	01/01/2005 – 12/31/2005
$22.47	2.8%	01/01/2006 – 12/31/2006
$22.94	2.1%	01/01/2007 – 12/31/2007
$23.35	1.8%	01/01/2008 – 12/31/2008
$23.72	1.6%	01/01/2009 – 12/31/2009
$24.00	1.2%	01/01/2010 – 12/31/2010

IX. Provisions of the Final Rule

The provisions of this final rule with comment period restate the provisions of the CY 2010 PFS proposed rule, except as noted elsewhere in the preamble.

X. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on

the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We utilize HCPCS codes for Medicare payment purposes. The HCPCS is a national drug coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medical providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are 5-digit numeric codes, and Category III codes which are temporary codes to track emerging technology, services, and procedures.

The AMA issues an annual update of the CPT code set each Fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a CY basis. Annual coding changes are not available to the public until the Fall immediately preceding the annual January update of the PFS. Because of the timing of the release of these new codes, it is impracticable for CMS to provide prior notice and solicit comment on these codes and the RVUs assigned to them in advance of publication of the final rule that implements the PFS. Yet, it is imperative that these coding changes be accounted for and recognized timely under the PFS for payment because services represented by these codes will be provided to Medicare beneficiaries by physicians during the CY in which they become effective. Moreover, regulations implementing HIPAA (42 CFR parts 160 and 162) require that the HCPCS be used to report health care services, including services paid under the PFS. We also assign interim RVUs to any new codes based on a review of the RUC recommendations for valuing these services. By reviewing these RUC recommendations for the new codes, we are able to assign RVUs to services based on input from the medical community and to establish payment for them, on an interim basis, that corresponds to the relative resources associated with furnishing the services. If we did not assign RVUs to new codes on an interim basis, the alternative would be to either not pay for these services during the initial CY or have each carrier establish a payment rate for these new codes. We believe both of these alternatives are contrary to the public interest, particularly since the RUC process allows for an assessment of the valuation of these services by the medical community prior to our establishing payment for these codes on an interim basis. Therefore, we believe it would be contrary to the public interest to delay establishment of fee schedule payment amounts for these codes.

For the reasons outlined above in this section, we find good cause to waive the notice of proposed rulemaking for the interim RVUs for selected procedure codes identified in Addendum C and to establish RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

Section II.F. of this final rule with comment period discusses the identification and review of potentially misvalued codes by a workgroup of the AMA RUC, as well as our review and decisions regarding the AMA RUC workgroup's recommendations. Similar to the AMA RUC recommendations for new and revised codes discussed above, due to the timing of the AMA RUC workgroup's recommendations for the potentially misvalued codes, it was impracticable for CMS to solicit public comment regarding specific proposals for revision prior to this final rule with comment period. We believe it is in the public interest to implement the revised RVUs for the codes that were identified as misvalued, and that have been reviewed and re-evaluated by the AMA RUC workgroup, on an interim final basis for CY 2010. The revisions of RVUs for these codes will establish a more appropriate payment that better corresponds to the relative resources associated with furnishing these services. A delay in implementing revised values for these misvalued codes would not only perpetuate the known misvaluation for these services, it would also perpetuate a distortion in the payment for other services under the PFS. Implementing the changes now allows for a more equitable distribution of payments across all PFS services. We believe a delay in implementation of these revisions would be contrary to the public interest, particularly since the AMA RUC process allows for an assessment of the valuation of these services by the medical community prior to the AMA RUC's recommendation to CMS. For the reasons described above, we find good cause to waive notice and comment procedures with respect to the misvalued codes identified in Table 5, and to revise RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

We ordinarily provide a 60-day delay in the effective date of the provisions of a rule in accordance with the Administrative Procedure Act (APA) (5 U.S.C. 553(d)), which requires a 30-day delayed effective date, and the Congressional Review Act (5 U.S.C. 801(a)(3)), which requires a 60-day delayed effective date for major rules. However, we can waive the delay in the effective date if the Secretary finds, for good cause, that the delay is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the rule issued (5 U.S.C. 553(d)(3); 5 U.S.C. 808(2)).

In section II. G. 6 of this final rule with comment period, we are finalizing our proposed criteria for designating organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services as specified in section 1834(e) of the Act. We also discuss our expectation to publish a notice the same day that this final rule is issued to solicit applications from entities for the purpose of becoming a designated accreditation organization. We note that section 1834(e) of the Act requires us to designate organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services by January 1, 2010. Given the statutory deadline to designate organizations and the timing of the publication of this final rule with comment period, we believe it is impracticable to delay the effective date of these criteria for designating organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services. Therefore, we believe that we have good cause for making the imaging accreditation provisions effective upon publication.

XI. Collection of Information Requirements

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

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

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

A. ICRs Regarding Pulmonary Rehabilitation Program: Conditions for Coverage (§ 410.47)

Section 410.47(c) lists the components of a pulmonary rehabilitation program. Specifically, § 410.47(c)(3) through (c)(5) discuss psychosocial assessments, outcome assessments and individualized treatment plans, respectively, and the role of these tools in pulmonary rehabilitation programs. The burden associated with meeting the requirements for conducting psychosocial assessments, outcome assessments, and individualized treatment plans is the time and effort necessary for providers to document the necessary information in the patient record. While these requirements are subject the PRA, we believe the associated burden is exempt as stated under 5 CFR 1320.3(b)(2). Psychosocial assessments, outcome assessments and individualized treatment plans are routine tools used in pulmonary rehabilitation programs and the practice of using these tools is generally recognized as an industry standard as part of usual and customary business practices.

B. ICRs Regarding Kidney Disease Education Services (§ 410.48)

Section 410.48(f) states qualified persons will develop outcomes assessments designed to:

- Measure beneficiary knowledge about chronic kidney disease (CKD) and its treatment;
- Assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to CKD; and
- Assess program effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

The assessment will be administered to the beneficiary during one of the kidney disease education (KDE) sessions prescribed by the referring physician. The assessments will be made available to CMS upon request.

The burden associated with these requirements is the time and effort necessary to conduct an outcomes assessment, maintain record of the assessment, and to make the documentation available to CMS upon request. At this time, we are not able to accurately quantify the burden because we cannot estimate the number of entities that must comply with these requirements. Additionally, we are trying to determine if the use and maintenance of outcome assessments in KDE services is a standard industry business practice. Our preliminary research gathered during a CMS Open Door Forum held on November 6, 2008 and a stakeholders meeting hosted by the Agency for Healthcare Research and Quality (AHRQ) on December 16, 2008 indicates that outcome assessments are used by most but not all of the entities bound by the requirements in § 410.48. We solicited comments pertaining to this issue in the proposed rule that published July 13, 2009 (74 FR 33520); however, we did not receive any information to assist us in accurately quantifying the number of entities that must comply with this requirement. We will continue to evaluate the issue. If we find that the number of affected entities approaches the threshold of 10 as specified in 5 CFR 1320.3(c)(4), we will submit an information collection request to OMB for review and approval.

C. ICRs Regarding Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage (§ 410.49)

Section 410.49(b)(2) lists the required components of a cardiac rehabilitation program. Four of the five required components, including cardiac risk factor modification, psychosocial assessments, outcomes assessments and individualized treatment plans, impose information collection burdens. The burden associated with these requirements is the time and effort necessary to providers to customize each patient's cardiac risk modification program. Additionally, there is burden associated with conducting psychosocial assessments and outcome assessments and drafting individualized treatment plans. Although section 144(a) of the MIPPA sets forth these information collection requirements, we believe the associated information collection burden is exempt as stated under 5 CFR 1320.3(b)(2). Performing cardiac risk modification, psychosocial assessments, outcome assessments, and individualized treatment plans are routine tools used in cardiac rehabilitation programs. As stated earlier in the preamble of this final rule with comment period, intensive cardiac rehabilitation programs typically involve the same elements as general cardiac rehabilitation programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of cardiac rehabilitation and also may be more rigorous. The ICRs and associated burden are generally recognized as an industry standard as part of usual and customary business practices.

Section 410.49(c)(1) states that to be approved as an intensive cardiac rehabilitation program, a program in an approved setting must be approved through the national coverage determination (NCD) process which may be generated internally by CMS or requested by a non-CMS entity. To be approved as an intensive cardiac rehabilitation program, the program must demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iii), as well as statistically significant reductions in 5 or more of the measures listed in § 410.49(c)(2)(i) through (vi). As described in § 410.49(c)(4), all prospective intensive cardiac rehabilitation sites must apply to enroll as an intensive cardiac rehabilitation program site using the designated forms as specified at § 424.510.

The burden associated with the requirements in § 410.49(c) is the time and effort necessary for a program to demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iii), as well as statistically significant reductions in 5 or more of the measures listed in § 410.49(c)(2)(i) through (vi) and the time and effort necessary for intensive cardiac rehabilitation sites to apply to enroll using the designated forms as specified at 424.510. At this time, we are not able to accurately quantify the burden because we cannot estimate the number of entities that will seek approval as intensive cardiac rehabilitation programs. We solicited comments pertaining to this issue in the CY 2010 PFS proposed rule (74 FR 33520); however, we did not receive any information to assist us in accurately quantifying the number of entities that must comply with this requirement. We will continue to evaluate the issue. If we find that the number of affected entities

approaches the threshold of 10 as specified in 5 CFR 1320.3(c)(4), we will submit an information collection request to OMB for review and approval.

D. ICRs Regarding Imaging Accreditation (§ 414.68)

Section 414.68(b) contains the application and reapplication procedures for accreditation organizations. Specifically, an independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services must furnish CMS with all of the information listed in § 414.68(b)(1) through (14). The requirements include but are not limited to reporting, notification, documentation, and survey requirements.

The burden associated with the collection requirements in § 414.68(b) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(b)(1) through (14). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit a complete application for approval or reapproval authority to become an accrediting organization approved by CMS.

Section 414.68(c) contains the information collection requirements pertaining to CMS approved accrediting organizations. An accrediting organization approved by CMS must undertake all of the activities listed in § 414.68(c)(1) through (6). The burden associated with the collection requirements in § 414.68(c) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(c)(1) through (6). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit the required information on an ongoing basis.

For the aforementioned requirements in § 414.68(b) and § 414.68(c), we are aware that the potential respondent universe is greater than 10 entities; however, at this time, there are only three entities committed to the program. If the number of respondents approaches the threshold of 10 or more persons as defined in 5 CFR 1320.3(c)(4), we will develop and submit an information collection request to OMB for review and approval.

Section 414.68(d)(1) states that CMS or our contractor may conduct an audit of an accredited supplier, examine the results of a CMS-approved accreditation organization's survey of a supplier, or observe a CMS-approved accreditation organization's onsite survey of a supplier, in order to validate the CMS-approved accreditation organizations accreditation process. The burden associated with this requirement is the time and effort necessary for an accrediting organization to comply with the components of the validation audit. While this requirement is subject to the PRA, we believe the associated burden is exempt as stated in 5 CFR 1320.3(h)(6). The burden associated with a request for facts addressed to a single person, as defined in 5 CFR 1320.3(j), is not subject to the PRA.

As stated in § 414.68(e)(1), an accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not to renew the approval of deeming authority to an accreditation organization if the accrediting organization files a written request for reconsideration by our authorized officials or through its legal representative. The written request must be filed within 30 calendar days of the receipt of CMS' notice of an adverse determination or nonrenewal. In addition, the request must also specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

The burden associated with this requirement is the time and effort necessary for an accrediting organization to develop and file a written request for reconsideration. While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; accrediting organizations are submitting requests for reconsideration after receiving a notice of an adverse determination or nonrenewal.

E. ICRs Regarding Payment Rules (§ 414.408)

Section 414.408(j)(5) contains the notification requirements for suppliers electing to become grandfathered suppliers. Specifically, § 414.408(j)(5)(i) states that a noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the requirements as listed in § 414.408(j)(5)(i)(A) through (G).

Subsequent to the initial 30-day notice to the beneficiary, as required by § 414.408(j)(5)(ii), suppliers must also obtain and maintain a record of the beneficiary's election choice, the date the choice was made, and the manner through which the beneficiary communicated his or her choice. Additionally, § 414.408(j)(5)(iii) states that if a beneficiary chooses not to continue to receive a grandfathered item(s) from his or her current supplier, the supplier must provide the beneficiary with two more notices prior to the supplier picking up its equipment. The supplier must provide a 10-day notification and a 2-day notification. These notification requirements must meet the criteria listed in § 414.408(j)(5)(iii)(A) though (C).

Section § 414.408(j)(5)(iv) requires suppliers that elect to become grandfathered suppliers to provide a written notification to CMS of its election decision. The notification must meet the requirements as specified in § 414.408(j)(5)(iv)(A) through (D).

The burden associated with the information collection requirements contained in § 414.408(j)(5) is the time and effort necessary for a noncontract supplier to make the aforementioned notifications to both beneficiaries and CMS. We estimate that 1,305 suppliers will elect to become grandfathered suppliers. Similarly, we estimate that each grandfathered supplier will need to make an average of 53 notifications based on an average of 52 beneficiaries per supplier and one notice to CMS. We estimate that it will take 2 hours to develop the notification to the beneficiary and 2 hours to develop the notification to CMS. Similarly, we estimate that each notification will take 15 minutes to send. The total estimated burden associated with each of the 1305 suppliers complying with the requirements in § 414.408(j)(5) is 17.25 hours per supplier for a total of 22,511 hours.

Section 414.408(j)(6) contains the information collection requirements pertaining to suppliers that choose not to become grandfathered suppliers. A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification. Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to

become a grandfathered supplier to its Medicare beneficiaries who are currently renting certain DME competitively bid item(s) and who reside in a CBA. These notifications must meet all of the requirements listed in § 414.408(j)(5)(i) and (ii) for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers. However, there are exceptions regarding the 30-day notice for noncontract suppliers electing not to become grandfathered suppliers. The exceptions are listed in § 414.408(j)(6)(iii)(A) through (C). In addition, suppliers must also comply with the criteria listed in § 414.408(j)(6)(iv).

The burden associated with the information collection requirements in § 414.408(j)(6) is the time and effort necessary for a supplier to make the required notifications to beneficiaries. We estimate that 145 suppliers will not elect to become grandfathered suppliers. Similarly, we estimate that each nongrandfathered supplier will need to make an average of 156 notifications based on an average of 52 beneficiaries per supplier. We estimate that it will take 2 hours to develop the 30-day notification to the beneficiary and 15 minutes to send out each notification. The 10-day notification will take approximately 15 minutes and the 2-day will take approximately 15 minutes. We estimate to send out all 3 notifications it will take a total of approximately 45 minutes. The total burden associated with the requirements in § 414.408(j)(6) is approximately 5,945 hours.

F. ICRs Regarding Claims for Damages (§ 414.425)

Section 414.425(a) states that any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP), may file a claim under this section for certain alleged damages arising out of MIPPA's termination of the Round 1 DMEPOS CBP contracts. Section 414.425(b) states that a completed claim, including all documentation, must be filed within 90 days of the effective date of the final rule on damages, unless that day is a holiday or Sunday in which case it will revert to the next business day. Section 414.425(c) lists the required documentation for submitting a claim.

The burden associated with this requirement is the time and effort necessary to gather required documentation as specified in § 414.425(c) and submit a claim for damages. This requirement is for a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their contracts by MIPPA. We awarded contracts to 329 suppliers. We expect that it will take approximately 3 hours for a supplier to gather the necessary documents and to file a claim. We anticipate that anywhere between 5 and 250 suppliers may submit a claim for damages.

While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; suppliers are submitting claims for damages caused by the termination of contracts awarded in 2008 under the DMEPOS CBP that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

G. ICRs Dispute Resolution and Process for Suspension or Termination of Approved CAP Contract and Termination of Physician Participation Under Exigent Circumstances (§ 414.917)

As stated in § 414.97, an approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

The burden associated with this requirement is the time and effort necessary for a CAP vendor to request a reconsideration of the termination. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The burden associated with collecting information subsequent to an administrative action is not subject to the PRA.

H. ICRs Regarding Compendia for Determination of Medically-accepted Indications for Off-label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen (§ 414.930)

As stated in the definition for a publicly transparent process for evaluating therapies in § 414.930(a), a compendium must make the following materials available to the public on its Web site, coincident with the compendium's publication of the related recommendation:

(i) The internal or external request for listing of a therapy recommendation including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the request.

(iii) A listing of all individuals who have substantively participated in the review or disposition of the request.

(iv) Minutes and voting records of meetings for the review and disposition of the request.

The definition for a publicly transparent process for identifying conflicts of interests in § 414.930(a), states that a compendium must make the following materials available to the public, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium. This may include, for example, compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals or the spouse or minor child of individuals who have substantively participated in the review and disposition of the request and the manufacturer or seller of the drug or biological being reviewed by the compendium.

(ii) Ownership or investment interests between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium.

Based on our estimate, the burden we derived for all our conflict of interest and transparency provisions above, the total burden would range from 1950 hours per compendium with 75 responses to 2600 hours per compendium with 100 responses. The variation in responses is due to the varying size of compendia publications and different processes used by compendia publishers to generate a recommendation. In our estimate we also found that the total burden from respondents would range from 30 hours per compendium with 10 respondents to 2535 hours per compendium with 845 respondents. The variation in respondents depends on a compendium's use of internal or external staff to generate compendia recommendations. Therefore, based on these burden totals, the total burden hours per compendium to comply with our conflict of interest and transparency

provisions ranges from 1980 hours (a compendium with 75 responses and 10 respondents) to 5135 hours (a compendium with 100 responses and 845 respondents). In order to capture the maximum burden for an individual compendium, we are using the highest total hour estimate, 5135 hours, per compendium to comply with our conflict of interest and transparency provisions. In addition, all these provisions could be managed by a qualified administrative assistant at an hourly rate of $33.51 per hour based on the average salary of $69,500 obtained from the Department of Labor.

We are soliciting public comments on the aforementioned requirements and the associated burden estimates in an emergency PRA notice published elsewhere in this **Federal Register.**

TABLE 47—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB Control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 414.408(j)(5)	0938–New	1305	69,165	17.25	22,511
§ 414.408(j)(6)	0938–New	145	22,620	41	5,945
§ 414.930	0938–New	845	900	*1.83	5,135
Total					33,591

*The average burden for the six tasks associated with the requirements in § 414.930.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this final rule with comment period; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, *Attention:* CMS Desk Officer, [CMS–1413–P]. *Fax:* (202) 395–6974; or *E-mail: OIRA_submission@omb.eop.gov.*

Additional Information Collection Requirements

This final rule with comment period imposes collection of information requirements as outlined in the regulation text and specified above. However, this final rule with comment period also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

Part B Drug Payment

The discussion of average sales price (ASP) issues in section II.H.1 of this final rule with comment period does not contain any new information collection requirements with respect to payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The ASP reporting requirements are set forth in section 1927(b) of the Act. The burden associated with this requirement is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921.

Competitive Acquisition Program (CAP)

Section II.H.2. of this final rule with comment period discusses issues related to the competitive acquisition program for Part B drug payment. There are no new information collection requirements associated with the CAP; however, there are several previously approved information collection requests (ICR) associated with the CAP.

TABLE 48—OMB CONTROL NUMBERS

Program component	OMB Control No.	Expiration date
Medicare Part B Drug and Biological CAP	0938–0954	06/30/2011
Medicare Part B Drug and Biological Competitive Acquisition Program Applications [1]	0938–0955	08/31/2012
Competitive Acquisition Program (CAP) for Medicare Part B Drugs: CAP Physician Election Agreement	0938–0987	12/31/2011

[1] An extension of the currently approved ICR is currently in the middle of the mandatory 60-day **Federal Register** notice and comment period. The ICR will be submitted to OMB for review and approval prior to the expiration date.

Physician Quality Reporting Initiative (PQRI)

Section II.G.2. of this final rule with comment period discusses the background of the PQRI, provides information about the measures to be available to eligible professionals who choose to participate in the 2010 PQRI, and the criteria for satisfactory reporting in 2010. Beginning on January 1, 2010, the Secretary is also required by section 1848(m)(3)(C) of the Act, to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under the PQRI.

With respect to satisfactory submission of data on quality measures by eligible professionals, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2010, the eligible professional must meet one of the criteria for satisfactory reporting described in sections II.G.2.e. and II.G.2.f. of this final rule with comment period.

For individual eligible professionals, the burden associated with the requirements of this voluntary reporting

initiative is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information and the time and effort associated with eligible professionals selecting a reporting option. We believe it is difficult to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating quality measures reporting into the office work flows and are given flexibility for determining which reporting option best fits their needs.

We believe the burden associated with participating in PQRI has declined for those familiar with the program and who have satisfactorily participated in the 2007 PQRI and/or the 2008 PQRI. However, because we anticipate even greater participation in the 2010 PQRI, including participation by eligible professionals who are participating in PQRI for the first time in 2010, we will assign 5 hours as the amount of time needed for eligible professionals to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, incorporate reporting of the measures selected by the eligible professional into the office work flows, and select a 2010 PQRI reporting option. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of $50 per hour per practice. To account for salary increases over time, we will use an average practice labor cost of $55 per hour in our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, incorporate reporting of the selected measures into the office work flows, and select a 2010 PQRI reporting option to be approximately $275 per eligible professional ($55 per hour × 5 hours).

We continue to expect the ongoing costs associated with PQRI participation to decline based on an eligible professional's familiarity with and understanding of the PQRI, experience with participating in the PQRI, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

In addition, for claims-based reporting, eligible professionals must gather the required information, select the appropriate quality data codes, and include the appropriate quality data codes on the claims they submit for payment. The PQRI will collect quality data codes as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms or modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2010.

Because this is a voluntary program, it is difficult to accurately estimate how many eligible professionals will opt to participate in the PQRI in CY 2010. Information from the ''PQRI 2007 Reporting Experience Report,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 PQRI, we will assume that all eligible professionals who attempted to participate in the 2007 PQRI will also attempt to participate in the 2010 PQRI.

Moreover, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, incorporate reporting of the selected measures into the office work flows, and select a 2010 PQRI reporting option is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Since eligible professionals are generally required to report on at least 3 measures to earn a PQRI incentive, we will assume that each eligible professional who attempts to submit PQRI quality measures data is attempting to earn a PQRI incentive payment and that each eligible professional reports on an average of 3 measures for this burden analysis.

Based on our experience with the PVRP, we continue to estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. With an average practice labor cost of $55 per hour, the cost associated with this burden ranges from $0.23 in labor time to about $11.00 in labor time for more complicated cases and/or measures, with the cost for the median practice being $1.44.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. Results from the 2007 PQRI indicate that eligible professionals reported on 1 to 3,331 eligible instances per measure. For all 2007 PQRI measures, the median number of eligible instances reported on per measure was less than 60. On average the median number of eligible instances reported on per measure was about 9. Therefore, for this burden analysis we estimate that for each measure, an eligible professional reports the quality data on 9 cases. The actual number of cases on which an eligible professional will be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual burden per eligible professional associated with claims-based reporting to range from 306.75 minutes, or 5.1125 hours [(0.25 minutes per measure × 3 measures × 9 cases per measure) + 5 hours] to 624 minutes, or 10.4 hours [(12 minutes per measure × 3 measures × 9 cases per measure) + 5 hours]. We estimate the total annual cost per eligible professional associated with claims-based reporting to range from $281.21 [($0.23 per measure × 3 measures × 9 cases per measure) + $275] to $572 [($11.00 per measure × 3 measures × 9 cases per measure) + $275].

For registry-based reporting, we are estimating that it would cost an eligible professional approximately $1,000 to participate in a registry based on input we received from commenters (these comments are addressed in the section II.G.2.a. of the preamble). This takes into account the participation fee charged by registries and the fact that this fee often includes services above and beyond what is required for PQRI. However, registries vary in their participation fees as some registries do not charge a participation fee at all or charge only nominal fees. Eligible professionals also need to authorize or instruct the registry to submit quality measures results and

numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf.

Registries interested in submitting quality measure results and numerator and denominator data on quality measures to CMS on their participants' behalf in 2010 will need to complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals unless the registry was qualified to submit on behalf of eligible professionals for the 2009 PQRI and does so successfully. We estimate that the self-nomination process for qualifying additional registries to submit on behalf of eligible professionals for the 2010 PQRI involves approximately 1 hour per registry to draft the letter of intent for self-nomination. It is estimated that each self-nominated entity will also spend 2 hours for the interview with CMS officials and 2 hours for the development of a measure flow. However, the time it takes to complete the measure flow could vary depending on the registry's experience. Additionally, part of the self-nomination process involves the completion of an XML submission by the registry, which is estimated to take approximately 5 hours, but may vary depending on the registry's experience. We estimate that the registry staff involved in the registry self-nomination process have an average labor cost of $50 per hour. Therefore, assuming the total burden hours per registry associated with the registry self-nomination process is 10 hours, we estimate the total cost to a registry associated with the registry self-nomination process to be approximately $500 ($50 per hour × 10 hours per registry).

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measure results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measure results, and submit the measure results and numerator and denominator data on the quality measures on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, since it is customary for most registries to provide their participants with information that can be used for the participants' internal quality improvement efforts, we believe that registries already perform many of these activities for their participants. The number of measures that the registry intends to report to CMS and how similar the registry's measures are to CMS' PQRI measures will determine the time burden to the registry.

For EHR-based reporting, the eligible professional must review the quality measures on which we will be accepting PQRI data extracted from EHRs, select the appropriate quality measures, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS will be new to PQRI for 2010 and participation in this reporting initiative is voluntary, we believe it is difficult to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI through the EHR mechanism in CY 2010. The time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting. Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on PQRI quality measures should be minimal.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit PQRI quality measures data to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered ''qualified'' for 2010. It is difficult for us to accurately quantify the burden associated with the EHR self-nomination process as there is variation regarding the technical capabilities and experience among vendors. For purposes of this burden analysis, however, we estimate that the time required for an EHR vendor to complete the self-nomination process will be similar to the time required for registries to self-nominate, that is, approximately 10 hours at $50 per hour for a total of $500 per EHR vendor ($50 per hour × 10 hours per EHR vendor).

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The time needed for an EHR vendor to review the quality measures and other information and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total burden hours to be 40 hours at a rate of $50 per hour for a total burden estimate of $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately 200 hours at $50 per hour, for a total estimate of $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2. of this final rule with comment period, group practices interested in participating in the 2010 PQRI through the group practice reporting option must complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. Therefore, we estimate that the self-nomination process for the group practices for the 2010 PQRI involves approximately 2 hours per group practice to review the 2010 PQRI reporting option and make the decision to participate as a group rather than individually and an additional 2 hours per group practice to draft the letter of intent for self-nomination, gather the requested TIN and NPI information, and provide this requested information. It is estimated that each self-nominated entity will also spend 2 hours undergoing the vetting process with CMS officials. We assume that the group practice staff involved in the group practice self-nomination process have an average practice labor cost of $55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 6 hours, we estimate the total cost to a group

practice associated with the group practice self-nomination process to be approximately $330 ($55 per hour × 6 hours per group practice).

The burden associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For group practices, this would be the time associated with the group practice completing the data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011, for use in the Physician Group Practice, Medicare Care Management Performance (MCMP), and EHR demonstrations. Based on burden estimates for the PGP demonstration, which uses the same data submission methods as what we will be using for PQRI, we estimate the burden associated with a group practice completing the data collection tool will be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group would be approximately 85 hours (2 hours for decision-making + 4 hours for self-nomination + 79 hours for data submission). Based on an average labor cost of $55 per physician group, we estimate the cost per physician group associated with participating in the PQRI group practice reporting option would be $4,675 ($55 per hour × 85 hours per group practice).

The Electronic Prescribing (E-Prescribing) Incentive Program

We believe it is difficult to accurately estimate how many eligible professionals will opt to participate in the E-Prescribing Incentive Program in CY 2010. Information from the ''PQRI 2007 Reporting Experience Report,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 E-Prescribing Incentive Program, we will assume that as many eligible professionals who attempted to participate in the 2007 PQRI will attempt to participate in the 2010 E-Prescribing Incentive Program. As such, we can estimate that nearly 110,000 unique TIN/NPI combinations will participate in the 2010 E-Prescribing Incentive Program.

Section II.G.5. of the preamble discusses the background of the E-Prescribing Incentive Program. Section II.G.5.c. of the preamble provides information on how eligible professionals can qualify to be considered a successful electronic prescriber in 2010 in order to earn an incentive payment. Similar to the PQRI, the E-Prescribing Incentive Program is a voluntary initiative. Eligible professionals may choose whether to participate and, to the extent they meet (1) certain thresholds with respect to the volume of covered professional services furnished and (2) the criteria to be considered a successful electronic prescriber described in section II.G.5.c. of this final rule with comment period, they can qualify to receive an incentive payment for 2010.

For the 2010 E-Prescribing Incentive Program, as discussed in section II.G.5. of the preamble, each eligible professional will need to report the 2010 electronic prescribing measure, which indicates that at least 1 prescription created during an eligible encounter was generated and transmitted electronically using a qualified electronic prescribing system. Similar to PQRI, this measure will be reportable through claims, a qualified registry, or a qualified EHR.

Similar to claims-based reporting for the PQRI, we estimate that the burden associated with the requirements of this incentive program is the time and effort associated with eligible professionals determining whether the electronic prescribing quality measure applies to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. We expect the ongoing costs associated with participation in the E-Prescribing Incentive Program to decline based on an eligible professional's familiarity with and understanding of the E-Prescribing Incentive Program, experience with participating in the E-Prescribing Incentive Program, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the electronic prescribing measure and incorporate reporting of the measure into their office work flows and an additional hour as the amount of time needed for eligible professionals to select an appropriate reporting mechanism for them. At an average cost of approximately $55 per hour (see section XIII.E.2. above for a discussion of how we arrived at this figure), we estimate the total cost to eligible professionals for reviewing the e-prescribing measure, incorporating the reporting of the measure into the office work flows, and selecting an appropriate reporting mechanism to be approximately $110 ($55 per hour × 2 hours).

For claims-based reporting, the quality data codes will be collected as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms or modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2010.

Based on our experience with the PVRP described in section II.G.5., we estimate that the time needed to perform all the steps necessary to report the electronic prescribing measure via claims to be 1.75 minutes. We also estimate the cost to perform all the steps necessary to report the electronic prescribing measure to be $1.44 based on the experience with the PVRP described above.

Based on the 2010 criteria for determination of whether an eligible professional is a successful electronic prescriber, we estimate that each eligible professional will report the electronic prescribing measure in 25 instances during the reporting period.

Therefore, we estimate the total annual burden per eligible professional who chooses to participate in the 2010 E-Prescribing Incentive Program through claims-based reporting of the electronic prescribing measure to be 163.75 minutes, or 2.73 hours [(1.75 minutes per measure × 1 measure × 25 cases per measure) + 2 hours]. The total estimated cost per eligible professional to report the electronic prescribing measure is estimated to be $146 [($1.44 per measure × 1 measure × 25 cases per measure) + $110].

Because registry-based reporting of the electronic prescribing measure to CMS will be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes

(particularly eligible professionals who are already participating in PQRI via the registry-based reporting mechanism). Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, in addition to the 2 hours estimated for the time needed by eligible professionals to review the applicability of the electronic prescribing measure, incorporate reporting of the measure in their practice work flows, and review the available reporting mechanisms to select the registry reporting mechanism, eligible professionals will need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

Based on our policy to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there will be no need for a registry to undergo a separate self-nomination process for the E-Prescribing Incentive Program other than to indicate to us its desire to become a qualified registry for the E-Prescribing Incentive Program at the time that it does so for PQRI. Therefore, we estimate that any additional associated with the registry self-nomination process would be minimal.

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measure results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry. However, we believe that registries already perform many of these activities for their participants. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the burden associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS will be new for 2010 and participation in this reporting initiative is voluntary, it is difficult to accurately estimate how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The time needed for an eligible professional to review the electronic prescribing measure and other information to determine whether the measure is applicable to his or her patients and the services he or she furnishes to them and to review the available reporting mechanisms to select the EHR reporting mechanism is expected to be similar for EHR-based reporting and claims-based reporting. Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on the electronic prescribing measure should be minimal.

Based on our policy to consider only EHR products qualified for the 2010 PQRI to be qualified for the 2010 E-Prescribing Incentive Program, there will be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional burden associated with the self-nomination process.

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI will be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

Finally, with respect to the process for group practices to be treated as successful electronic prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5., a group practice will be required to report the electronic prescribing measure in at least 2,500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the electronic prescribing measure is the number of times that a group practice is required to report the electronic prescribing measure. Reporting of the electronic prescribing measure can continue to occur at the individual eligible professional level under the electronic prescribing group practice reporting option. In our analysis of the information, however, we will aggregate all of the information reported by the eligible professionals within the group practice to determine whether the group practice reported the measure a sufficient number of times. For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claims-based reporting of the electronic prescribing measure, we estimate the total annual burden to be 74.92 hours [(1.75 minutes per measure $\times$ 1 measure $\times$ 2,500 cases per measure) + 2 hours]. The total estimated cost per group practice to report the electronic prescribing measure through claims-based reporting is estimated to be $3,710 [($1.44 per measure $\times$ 1 measure $\times$ 2,500 cases per measure) + $110].

For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the

electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes, such as for the PQRI. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, in addition to the 2 hours estimated for the time needed by group practices to review the electronic prescribing measure to determine its applicability to the practice, incorporate reporting of the electronic prescribing measure into the practice's work flows, and review available reporting mechanisms to select group practice reporting of the measure through a qualified registry, the group practices will need to authorize or instruct the registry to submit the measure results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measure results and numerator and denominator data on the electronic prescribing measure to CMS on its behalf.

For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices will also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we are limiting participation in the electronic prescribing group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there will not be a separate group practice self-nomination process for the E-Prescribing Incentive Program and, thus, no additional burden.

We invite comments on this burden analysis, including the underlying assumptions used in developing our burden estimates.

XII. Response to Comments

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

XIII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate, as discussed below in this section, that the PFS provisions included in this final rule with comment period will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of less than $7.0 million to $34.5 million in any 1 year) (for details see the SBA's Web site at *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series). Individuals and States are not included in the definition of a small entity.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of $7 million or less based on SBA size standards. Approximately 95 percent of physicians are considered to be small entities. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA, approximately 85 percent of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are considered small businesses according to the SBA size standards. We estimate that approximately 105,000 DMEPOS suppliers are enrolled in Medicare currently and bill Medicare for DMEPOS each year. Total annual estimated Medicare revenues for DMEPOS suppliers are approximately $11.7 billion in 2008 for which $8.7 billion was for fee-for-service (FFS) and $3.0 billion was for managed care.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the SBA size standards.

Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $7 million to $34.5 million or less in any year. We note that a considerable number of ESRD facilities are owned and operated by large dialysis organizations (LDOs) or regional chains,

which would have total revenues more than $34.5 million in any year if revenues from all locations are combined. However, the claims data we use to estimate payments for this RFA and RIA does not identify which dialysis facilities are parts of an LDO, regional chain, or other type of ownership. Each individual dialysis facility has its own provider number and bills Medicare using this number. Therefore, we consider each ESRD to be a small entity for purposes of the RFA. We consider a substantial number of entities to be significantly affected if the final rule with comment period has an annual average impact on small entities of 3 to 5 percent or more. The majority of ESRD facilities will experience impacts of less than 2 percent of total revenues. There are 946 nonprofit ESRD facilities with a combined increase of 0.9 percent in overall payments relative to current overall payments. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section and elsewhere in this final rule with comment period complies with the RFA requirements.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this final rule with comment period constitutes our regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Any such regulatory impact analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this final rule with comment period has impact on significant operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding. While there are 176 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 176 rural hospital-based dialysis facilities will experience an estimated 1.1 percent increase in payments. As a result, this rule will not have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this final rule with comment period will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold is approximately $133 million. This final rule with comment period will not mandate any requirements for State, local, or tribal governments. Medicare beneficiaries are considered to be part of the private sector and as a result a more detailed discussion is presented on the Impact of Beneficiaries in section V. of this regulatory impact analysis. Rather, it focuses on certain categories of cost, mainly those ''Federal mandate'' costs resulting from (A) imposing enforceable duties on State, local, or tribal governments, or on the private sector, or (B) increasing the stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined this final rule with comment period in accordance with Executive Order 13132 and have determined that this regulation would not have any substantial direct effect on State or local governments, would not preempt States, or otherwise have a Federalism implication.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this final rule with comment period; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this final rule with comment period. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this final rule with comment period. The relevant sections of this rule contain a description of significant alternatives if applicable.

Comment: We received comments on the CY 2010 PFS proposed rule stating that we failed to address the impact of the changes on small businesses and did not propose any measures for mitigating the negative impact the proposals might have on such businesses. One commenter stated that most portable x-ray suppliers are small businesses and that the policy changes will adversely affect them. Another commenter, representing providers of integrated cancer care, also expressed concern about the negative impact the proposed changes would have on small businesses that furnish radiation therapy services. The commenters outlined specific concerns with respect to the proposals concerning practice expense, including the change with respect to assumption for equipment utilization, the changes to malpractice RVUs, as well as application of the projected −21.5 update adjustment under the SGR.

Response: In Addendum B of the CY 2010 PFS proposed rule, we provided the proposed payment rates for the HCPCS codes paid under the PFS. Any physician or supplier of PFS services can determine the impact of the proposed Medicare payment rates using their own mix of services. In addition, we publish average impacts by Medicare specialty to assist the public in commenting on the proposed rule. The methodology that we use to develop the RVUs is publicly available as are the data files that we use in the calculations and impact analyses.

We did review the potential impact of our revised policies in the regulatory impact analysis. In light of the comments received on the proposed rule, we have revised many of the proposals made in the proposed rule such that we estimate that the impact on portable x-ray suppliers and providers of radiation therapy services in this final rule with comment period will be significantly different than in the proposed rule, as shown in Table 49. However, the PFS update, which is based in part on the SGR, is required by law, affects all PFS services, and we have no discretion to waive this provision for small businesses.

B. RVU Impacts

1. Resource-Based Work, PE, and MP RVUs

Section 1848(c)(2)(B)(ii) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by

more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve BN.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2009 with payment rates for CY 2010 using CY 2008 Medicare utilization for all years. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 49. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 49 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 49:

- Specialty: The physician specialty or type of practitioner/supplier.
- Allowed charges: Allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Impact of Work RVU changes for the CY 2010 PFS.
- Impact of PE RVU changes (Full) if these changes were fully implemented in CY 2010 PFS. These are not the estimated CY 2010 impacts since we have implemented a 4-year transition to the new PE RVUs for existing codes.
- Impact of the CY 2010 PE RVU changes under the 4-year transition (Tran) adopted in this final rule with comment period. These are the estimated CY 2010 impacts. Note that the transition does not apply to new and significantly revised codes.
- Impact of MP RVU changes for the CY 2010 PFS.
- Combined impact of all RVU changes (Full) if these changes were fully implemented in CY 2010 PFS. These are not the estimated CY 2010 impacts since we have implemented a 4-year transition to the new PE RVUs for existing codes. These impacts are prior to the application of the CY 2010 negative PFS CF update under the current statute.
- Combined impact of all of the estimated CY 2010 RVU changes under the 4-year transition (Tran) adopted in this final rule with comment period for the PE changes. These are the estimated CY 2010 impacts, prior to the application of the CY 2010 negative PFS CF update under the current statute.

BILLING CODE 4120–01–P

TABLE 49: CY 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes*

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
				Impact of PE RVU Changes**				
	Specialty	Allowed Charges (mil $)	Impact of Work RVU Changes	Full	Tran	Impact of MP RVU Changes	Combined Impact Full	Combined Impact Tran
1	TOTAL	77,796	0%	0%	0%	0%	0%	0%
2	ALLERGY/IMMUNOLOGY	173	0%	-1%	0%	0%	-2%	0%
3	ANESTHESIOLOGY	1,744	0%	4%	1%	0%	3%	0%
4	CARDIAC SURGERY	373	-1%	-1%	0%	2%	1%	1%
5	CARDIOLOGY	7,158	-1%	-10%	-5%	-1%	-13%	-8%
6	COLON AND RECTAL SURGERY	130	-1%	4%	1%	1%	4%	1%
7	CRITICAL CARE	223	-1%	2%	1%	1%	3%	1%
8	DERMATOLOGY	2,520	1%	1%	1%	1%	3%	3%
9	EMERGENCY MEDICINE	2,416	0%	2%	1%	0%	3%	1%
10	ENDOCRINOLOGY	374	-1%	3%	0%	0%	2%	0%
11	FAMILY PRACTICE	5,094	2%	5%	2%	1%	7%	4%
12	GASTROENTEROLOGY	1,792	-2%	0%	0%	1%	0%	-1%
13	GENERAL PRACTICE	727	1%	4%	1%	0%	6%	3%
14	GENERAL SURGERY	2,227	-1%	3%	1%	1%	4%	1%
15	GERIATRICS	170	1%	6%	2%	1%	8%	3%
16	HAND SURGERY	89	-1%	3%	1%	-1%	2%	-1%
17	HEMATOLOGY/ONCOLOGY	1,897	0%	-5%	-1%	0%	-6%	-1%
18	INFECTIOUS DISEASE	554	-1%	3%	0%	1%	3%	0%
19	INTERNAL MEDICINE	10,133	1%	4%	1%	1%	5%	2%
20	INTERVENTIONAL PAIN MANAGE.	356	-2%	3%	-1%	0%	0%	-3%
21	INTERVENTIONAL RADIOLOGY	225	-1%	-9%	-2%	0%	-10%	-3%
22	NEPHROLOGY	1,803	-1%	2%	0%	1%	2%	1%
23	NEUROLOGY	1,414	-3%	4%	1%	0%	1%	-2%
24	NEUROSURGERY	591	-1%	2%	0%	0%	1%	-1%
25	NUCLEAR MEDICINE	74	-5%	-15%	-10%	-2%	-23%	-18%
26	OBSTETRICS/GYNECOLOGY	624	0%	0%	-1%	0%	0%	-1%
27	OPHTHALMOLOGY	4,758	0%	11%	3%	2%	13%	5%
28	ORTHOPEDIC SURGERY	3,261	0%	3%	1%	-1%	2%	0%
29	OTOLARNGOLOGY	933	-1%	1%	-1%	0%	0%	-2%
30	PATHOLOGY	994	0%	-1%	1%	-1%	-3%	-1%
31	PEDIATRICS	65	1%	3%	1%	0%	4%	2%
32	PHYSICAL MEDICINE	824	-1%	6%	2%	0%	5%	1%
33	PLASTIC SURGERY	284	0%	4%	1%	1%	5%	2%
34	PSYCHIATRY	1,095	0%	2%	1%	1%	3%	2%
35	PULMONARY DISEASE	1,765	-1%	2%	0%	1%	2%	0%
36	RADIATION ONCOLOGY	1,809	0%	-3%	0%	-2%	-5%	-1%
37	RADIOLOGY	5,056	0%	-14%	-3%	-2%	-16%	-5%
38	RHEUMATOLOGY	493	0%	-1%	0%	0%	-2%	-1%
39	THORACIC SURGERY	389	-1%	0%	0%	2%	1%	1%
40	UROLOGY	1,993	-1%	-8%	-3%	0%	-10%	-4%
41	VASCULAR SURGERY	656	-1%	-3%	-2%	0%	-3%	-2%
42	AUDIOLOGIST	36	-1%	-16%	-9%	-7%	-23%	-17%
43	CHIROPRACTOR	713	0%	3%	1%	1%	4%	2%
44	CLINICAL PSYCHOLOGIST	544	0%	-8%	-2%	0%	-8%	-2%
45	CLINICAL SOCIAL WORKER	362	0%	-7%	-1%	0%	-7%	-1%
46	NURSE ANESTHETIST	681	0%	4%	1%	0%	4%	1%
47	NURSE PRACTITIONER	1,018	1%	5%	1%	1%	6%	3%
48	OPTOMETRY	848	1%	10%	3%	1%	12%	5%
49	ORAL/MAXILLOFACIAL	36	-1%	4%	1%	0%	3%	0%

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
	Specialty	Allowed Charges (mil $)	Impact of Work RVU Changes	Impact of PE RVU Changes**		Impact of MP RVU Changes	Combined Impact	
				Full	Tran		Full	Tran
	SURGERY							
50	PHYSICAL/OCCUPATIONAL THERAPY	1,883	0%	9%	3%	-1%	8%	2%
51	PHYSICIAN ASSISTANT	757	0%	4%	1%	0%	5%	2%
52	PODIATRY	1,682	1%	6%	2%	-1%	6%	2%
53	DIAGNOSTIC TESTING FACILITY	923	-1%	-29%	-7%	-4%	-34%	-12%
54	INDEPENDENT LABORATORY	970	0%	-5%	0%	-1%	-7%	-1%
55	PORTABLE X-RAY SUPPLIER	87	0%	8%	3%	-1%	7%	2%

* Does not include the impact of the current statute CY 2010 negative update except as applied in the OPPS imaging cap comparison (see next footnote). Rows may not sum to total due to rounding.

** Note: The statute caps the PFS imaging payment amount at the comparable payment amount in the hospital outpatient prospective payment system (OPPS) cap. In the absence of the negative current statute CY 2010 PFS update, the proposed fully implemented PE change to the equipment utilization rate for expensive diagnostic equipment from 50 percent to 90 percent would increase expenditures by less than 1 percent due to a loss of savings from the OPPS cap.

BILLING CODE 4120–01–C

2. Resource-Based Work, PE, and MP RVUs Impacts

a. Work RVU Impacts

The average work RVU impacts are primarily attributable to the changes for consultation services. As described earlier in this final rule with comment period, we are proposing to no longer recognize the billing codes for consultation services so we are budget neutrally eliminating the use of all consultation codes (except for telehealth) and have allocated the work RVUs that were allotted to these services to the work RVUs for new and established office visit services, initial hospital visits, and initial nursing facility visits to reflect this change.

In addition, the impacts reflect the work done by the AMA RUC related to the Five-Year Review Identification Workgroup's Codes Reported Together screen. Based upon the AMA RUCs review of the myocardial perfusion imaging family of services, it was determined that some of the existing codes for these services are performed together more than 95 percent of the time and were thus referred to CPT for creation of new bundled services. In recognition of the efficiencies associated with the services being performed together, there are less aggregate RVUs under the new bundled 2010 CPT coding structure and pricing than there are under the current 2009 CPT coding structure and pricing. These fewer aggregate RVUs will be offset by an adjustment to the CF in order to maintain overall BN. For further information on the myocardial perfusion imaging family coding changes, see section III.F.4. of this final rule with comment period.

b. PE RVUs Impacts

The PE RVU impacts are primarily attributable to the incorporation of PE data from the Physician Practice Information Survey (PPIS). For a discussion of the use of this updated survey data, see section II.A.2. of this final rule with comment period. The impacts are shown both as if they were fully implemented in CY 2010 and under our 4-year transition policy to the new PE RVUs for existing codes that have not been substantially revised.

For IDTFs, the impact of our change in the utilization rate for expensive diagnostic equipment is also significant. We estimate that for IDTFs, the utilization rate change will result in a fully implemented impact of approximately −2 percent after taking into account the OPPS payment cap. This −2 percent impact is included in the −29 percent fully implemented PE RVU impact shown in Table 49 for IDTFs. The change in the utilization rate for expensive diagnostic imaging equipment does not significantly impact overall payments for other specialties after taking into account the OPPS payment cap.

The impacts also reflect the reduced utilization for the myocardial perfusion imaging family of services stemming from the AMA RUC's review of these services as described above.

The payment impact for an individual physician may be different from the average, based on the mix of services the physician provides. Using the RVU information contained in Appendix B, an impact can be calculated for any particular mix of services either under the fully implemented RVUs or the 4-year transition RVUs.

c. Malpractice RVU Impacts

The average MP RVU impacts are attributable to the changes adopted for the Five-Year Review of MP RVUs described earlier in this final rule with comment period. Of particular note are the impacts on the specialties of Audiology (−7 percent), and IDTFs (−4 percent). These impacts are primarily driven by the expansion of the MP premium data collection and the changes to the methodology for TC services.

d. Combined Impact

Column E of Table 49 displays the combined average impact of all RVU changes by specialty. The impacts are shown both as if the new PE RVUs were fully implemented in CY 2010 and under our 4-year transition policy to the new PE RVUs for existing codes that have not been significantly revised.

The estimated CY 2010 transition impacts range from increases of +5 percent for ophthalmology to decreases of −18 percent for nuclear medicine. The effect of our policies on primary care specialties such as General Practice, Family Practice, Internal Medicine, and Geriatrics are positive with CY 2010 transition increases ranging from +2 percent to +4 percent. Again, these impacts are prior to the application of the negative CY 2010 CF update under the current statute.

Table 49 shows the estimated transition impact on total payments for selected high-volume procedures of all of the changes discussed previously, including the effect of the CY 2010 negative PFS CF update. We selected

these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the non-facility rates. For an explanation of facility and non-facility PE, refer to Addendum A of this final rule with comment period.

BILLING CODE 4120–01–P

TABLE 50: Impact of the Final Rule with Comment Period and Estimated Physician Update on 2010 Payment for Selected Procedures

CPT[1]/ HCPCS	MOD	Description	Facility			Non-facility		
			2009 ($)	2010 ($)	Percent Change	2009 ($)	2010 ($)	Percent Change
11721		Debride nail, 6 or more	27.77	20.74	-25%	40.39	31.25	-23%
17000		Destruct premalg lesion	48.69	40.90	-16%	69.97	57.95	-17%
27130		Total hip arthroplasty	1359.71	1082.84	-20%	NA	NA	NA
27244		Treat thigh fracture	1144.39	917.52	-20%	NA	NA	NA
27447		Total knee arthroplasty	1456.37	1158.40	-20%	NA	NA	NA
33533		CABG, arterial, single	1892.05	1534.21	-19%	NA	NA	NA
35301		Rechanneling of artery	1067.93	868.66	-19%	NA	NA	NA
43239		Upper GI endoscopy, biopsy	165.55	134.08	-19%	323.16	257.08	-20%
66821		After cataract laser surgery	251.38	216.45	-14%	266.53	228.67	-14%
66984		Cataract surg w/iol, 1 stage	638.74	549.09	-14%	NA	NA	NA
67210		Treatment of retinal lesion	561.56	478.93	-15%	580.67	493.98	-15%
71010		Chest x-ray	NA	NA	NA	24.16	18.18	-25%
71010	26	Chest x-ray	9.02	7.10	-21%	9.02	7.10	-21%
77056		Mammogram, both breasts	NA	NA	NA	107.48	82.95	-23%
77056	26	Mammogram, both breasts	44.36	34.66	-22%	44.36	34.66	-22%
77057		Mammogram, screening	NA	NA	NA	81.15	61.64	-24%
77057	26	Mammogram, screening	35.71	27.84	-22%	35.71	27.84	-22%
77427		Radiation tx management, x5	188.27	153.11	-19%	188.27	153.11	-19%
78465	26	Heart image (3d), multiple	78.99	62.21	-21%	78.99	62.21	-21%
88305	26	Tissue exam by pathologist	37.15	28.97	-22%	37.15	28.97	-22%
90801		Psy dx interview	128.04	100.27	-22%	152.92	121.01	-21%
90862		Medication management	45.08	35.79	-21%	55.18	44.31	-20%
90935		Hemodialysis, one evaluation	66.36	53.12	-20%	NA	NA	NA
92012		Eye exam established pat	45.80	38.35	-16%	70.69	58.80	-17%

CPT[1]/ HCPCS	MOD	Description	Facility			Non-facility		
			2009 ($)	2010 ($)	Percent Change	2009 ($)	2010 ($)	Percent Change
92014		Eye exam & treatment	70.33	58.80	-16%	103.15	85.79	-17%
92980		Insert intracoronary stent	847.93	644.53	-24%	NA	NA	NA
93000		Electrocardiogram, complete	20.92	NA	NA	20.92	15.62	-25%
93010		Electrocardiogram report	9.02	7.10	-21%	9.02	7.10	-21%
93015		Cardiovascular stress test	100.27	73.00	-27%	100.27	73.00	-27%
93307	26	Echo exam of heart	49.77	38.35	-23%	49.77	38.35	-23%
93510	26	Left heart catheterization	248.86	185.21	-26%	248.86	185.21	-26%
98941		Chiropractic manipulation	30.30	24.15	-20%	33.90	27.27	-20%
99203		Office/outpatient visit, new	68.17	57.38	-16%	91.97	76.98	-16%
99213		Office/outpatient visit, est	44.72	38.06	-15%	61.31	51.70	-16%
99214		Office/outpatient visit, est	69.25	58.80	-15%	92.33	77.55	-16%
99222		Initial hospital care	122.63	100.27	-18%	NA	NA	NA
99223		Initial hospital care	180.33	147.14	-18%	NA	NA	NA
99231		Subsequent hospital care	37.15	30.11	-19%	NA	NA	NA
99232		Subsequent hospital care	66.72	54.26	-19%	NA	NA	NA
99233		Subsequent hospital care	95.58	77.83	-19%	NA	NA	NA
99236		Observ/hosp same date	207.38	166.18	-20%	NA	NA	NA
99239		Hospital discharge day	96.30	77.83	-19%	NA	NA	NA
99243		Office consultation	97.38	Discontinued	Discontinued	124.79	Discontinued	Discontinued
99244		Office consultation	154.00	Discontinued	Discontinued	184.30	Discontinued	Discontinued
99253		Inpatient consultation	114.69	Discontinued	Discontinued	NA	NA	NA
99254		Inpatient consultation	165.55	Discontinued	Discontinued	NA	NA	NA
99283		Emergency dept visit	61.31	48.57	-21%	NA	NA	NA
99284		Emergency dept visit	114.33	91.18	-20%	NA	NA	NA
99291		Critical care, first hour	212.07	170.15	-20%	253.91	203.39	-20%
99292		Critical care, addïl 30 min	106.04	84.93	-20%	114.69	91.75	-20%
99348		Home visit, est patient	NA	NA	NA	79.35	63.91	-19%
99350		Home visit, est patient	NA	NA	NA	160.86	130.38	-19%
G0008		Admin influenza virus vac	NA	NA	NA	20.92	16.76	-20%

1 CPT codes and descriptions are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS.

BILLING CODE 4120–01–C

C. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.B. of this final rule with comment period, the application of the 1.000 work GPCI floor, as extended by section 134(a) of the MIPPA, expires effective January 1, 2010. As a result, 54 (out of 89) PFS localities will receive a decrease in their work GPCI. Puerto Rico receives the largest decrease (−9.6 percent), followed by South Dakota (−5.8 percent), North Dakota (−5.3 percent), Rest of Missouri (−5.1 percent), and Montana (−5.0 percent).

D. Medicare Telehealth Services

In section II.D. of this final rule with comment period, we are adding individual health behavior and assessment services (as described by HCPCS codes 96150 through 96152) to the list of telehealth services. We are also revising § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and skilled nursing facilities.

The total annual Medicare payment amount for telehealth services (including the originating site facility fee) is approximately $2 million. Previous additions to the list of telehealth services have not resulted in a significant increase in Medicare program expenditures. While we believe that these proposals will provide more beneficiaries with access to these services, we do not anticipate that these changes will have a significant budgetary impact on the Medicare program.

E. MIPPA Provisions

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

This section of the MIPPA will have a positive impact on Medicare patients because coinsurance payment percentages for outpatient mental health services will be gradually reduced from January 1, 2010 through January 1, 2014. At the conclusion of this 5-year period, Medicare patients will pay the same coinsurance payment percentage for outpatient mental health services as they currently pay for most other health services under the Medicare Part B program.

Since the inception of the Medicare Part B program, Medicare patients have been required to pay for a greater percentage of the cost of outpatient mental health treatment services than for other health services because of the Medicare payment limitation (the outpatient mental health treatment limitation). While a dollar cap that previously applied to mental health services was eliminated January 1, 1991, the statute maintained the 62½ percent limitation on the recognition of incurred expenses for these services. This limitation of 62½ percent effectively reduces the program's payment for mental health services to 50 percent, leaving a Medicare patient responsible for paying the other half of these expenses through coinsurance. The 62½ percent limitation will remain in effect until December 31, 2009.

During the transition, the Medicare Part B program will incur increased expenditures as Medicare patients pay less out-of-pocket for outpatient mental health services until, in 2014, patients will pay only the deductible (if applicable) and 20 percent coinsurance. Section 102 of the MIPPA will shift cost-sharing for mental health services from Medicare patients to the program. This provision will result in a cost impact to the Medicare program of approximately $100 million for CY 2010. As section 102 of the MIPPA is implemented, the impact of the changes to the coinsurance payment percentages (that is, recognized incurred expenses) for Medicare patients and the program is as shown in Table 51.

TABLE 51: Impact of the Changes to the Coinsurance Payment Percentages under Section 102 of the MIPPA

CY 2009 and prior calendar years – Medicare limitation, 62.50 percent of recognized incurred expenses
Medicare Patient pays – 50%
Medicare Part B pays – 50%
CY 2010 and CY 2011 – Medicare limitation, 68.75 percent of recognized incurred expenses
Medicare Patient pays – 45%
Medicare Part B pays – 55%
CY 2012 – Medicare limitation, 75 percent of recognized incurred expenses
Medicare Patient pays – 40%
Medicare Part B pays – 60%
CY 2014 – No limitation, 100.00 percent of recognized incurred expenses
Medicare Patient pays – 20%
Medicare Part B pays – 80%

2. Section 131(b): Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

As discussed in section II.G.2. of this final rule with comment period, the 2010 PQRI measures satisfy the requirement of section 1848(k)(2)(D) of the Act that the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish. As discussed in section II.G.2.d. of this final rule with comment period, we are also offering options in 2010 for reporting the 2010 PQRI measures via submission of data to a qualified clinical registry, options for reporting some of the 2010 PQRI measures via submission of data extracted from a qualified EHR, options for reporting on measures groups rather than individual measures, and options for group practices to be treated as satisfactorily submitting quality data under the PQRI. We received some comments regarding the cost estimates for PQRI included in the CY 2010 PFS proposed rule (74 FR 33655 through 33657). These comments have been addressed in section II.G.2. of this final rule with comment period or by revisions to our cost estimates below, where appropriate.

Although there may be some cost incurred for maintaining the measures used in the PQRI and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the PQRI, we do not anticipate a significant cost impact on the Medicare program.

Participation in the PQRI by eligible professionals is voluntary and eligible professionals and group practices may have different processes for integrating the PQRI into their practices' work flows. Therefore, it is difficult to accurately estimate the impact of the PQRI on providers. We note also that for eligible professionals who satisfactorily submit PQRI quality measures, some (if not all) of the costs incurred by the professional to participate in PQRI may be offset by the PQRI incentive payment amount earned.

With respect to satisfactory submission of data on quality measures by eligible professionals, one factor that influences the cost to eligible professionals is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We have no way to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity, understanding of the PQRI, and experience with participating in the PQRI, and the reporting option selected by the eligible professional. In addition, eligible professionals may employ different methods for incorporating reporting of their selected measures into the office work flows. Therefore, based on an assumption that eligible professionals will select 3 measures on average and our own estimates that it takes at least 1 hour to read and understand each measure, we will assign 3 hours as the amount of time needed for eligible professionals to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate reporting of the selected measures into the office work flows. After considering the comments received, that indicated that we need to include time for eligible professionals to review all of the reporting options, and our own estimates of the amount of time it takes to read and digest the reporting options, we will also assign an additional 2 hours as the amount of time needed for eligible professionals to review the 2010 PQRI reporting options and select the option most appropriate for their practice. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average practice labor cost of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $55 per hour for our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, incorporate reporting of the selected measures into the office work flows, review, and select an appropriate reporting option to be approximately $275 per eligible professional ($55 per hour × 5 hours).

For claims-based PQRI reporting, one factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the Medicare Part B claims an eligible professional submits for payment. Information from the PVRP estimates that the time needed to perform all the steps necessary to report each measure 1 time (that is, reporting the relevant quality data code(s) for a measure on 1 case) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. With an average practice labor cost of $55 per hour, the cost to eligible professionals to perform all the steps necessary to report 1 quality measure 1 time ranges from $0.23 in labor time to about $11.00 in labor time for more complicated cases and/or measures. For the median practice, the cost is about $1.44 in labor time per measure per reporting instance. Eligible professionals generally are required to report at least 3 measures to satisfactorily report PQRI quality measures data. Therefore, for purposes of this impact analysis we will assume that eligible professionals participating in the 2010 PQRI will report an average of 3 measures each.

The cost of implementing claims-based reporting of PQRI quality measures data will vary with the volume of claims on which quality data is reported. Results from the 2007 PQRI indicate that eligible professionals reported on 1 to 3,331 eligible instances per measure. For all 2007 PQRI measures, the median number of eligible instances reported on per measure was less than 60. On average the median number of eligible instances reported on per measure was about 9. Therefore, for this analysis we estimate that for each measure, an eligible professional reports the quality data on 9 cases. The actual number of cases on which an eligible professional will be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications include a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual cost per eligible professional associated with claims-based reporting to range from $281.21 [($0.23 per measure × 3 measures × 9 cases per measure) + $275] to $572.00 [($11.00 per measure × 3 measures × 9 cases per measure) + $275].

For registry-based reporting, eligible professionals must generally incur a cost to submit data to registries. Estimated fees for using a qualified registry range from no charge, or a nominal charge, for an eligible professional to use the registry to costing eligible professionals several thousand dollars, with a majority of registries charging fees ranging from $500–$1,000. Registries also often

provide services above and beyond what is required for PQRI though and our impact analysis is limited to the incremental costs associated with participation in PQRI. Nevertheless, after considering the information above with respect to the qualified registries and the comments received, which offered anecdotal information that the annual cost to one practice of participating in a specific registry is approximately $3,000, we will estimate the cost incurred by an eligible professional to participate in PQRI via registry-based reporting to be approximately $1,000 per eligible professional.

In addition, an eligible professional who chooses to submit PQRI quality measures results and numerator and denominator data on quality measures through a registry more than likely is already reporting data to the registry for other purposes. Little, if any, additional data needs to be reported to the registry for purposes of participation in the 2010 PQRI. Therefore, there should be little additional cost to the eligible professional associated with submitting data to the registry.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf must complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals. We estimate the registry self-nomination process to cost approximately $500 per registry ($50 per hour × 10 hours per registry). This cost estimate includes the cost of submitting the self-nomination letter to CMS and completing the CMS vetting process. Our estimate of a $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer.

The cost to the registry associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, since it is customary for most registries to provide their participants with information that can be used for the participants' internal quality improvement efforts, we believe that registries already perform many of these activities for their participants.

For EHR-based reporting, an eligible professional generally would incur a cost associated with purchasing an EHR product. The cost of purchasing an EHR product can range anywhere from as low as $500 to well over $50,000. After considering the information above and the comments received, we estimate that, on average, it costs between $15,000 and $25,000 to purchase an EHR product. An EHR vendor interested in having their product(s) be used by eligible professionals to submit PQRI quality measures data to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered ''qualified'' for 2010. Therefore, one factor in the cost to EHR vendors is the cost associated with completing the self-nomination process in order for the vendor's EHR product(s) to be considered ''qualified.'' Similar to the estimated cost to the registry associated with the registry self-nomination process, the estimated cost for an EHR vendor to complete the self-nomination process, including the vetting process with CMS officials, is conservatively estimated to be $500 ($50 per hour × 10 hours per EHR vendor). Our estimate of a $50 per hour average labor cost for EHR vendors is based on the assumption that EHR vendor staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer.

Another factor in the cost to EHR vendors is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The cost associated with the time and effort needed for an EHR vendor to review the quality measures and other information and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total cost to be approximately $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2.g. of this final rule with comment period, group practices interested in participating in the 2010 PQRI through the group practice reporting option must complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. We estimate that the group practice staff involved in the group practice self-nomination process have an average labor cost of $55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 4 hours, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $220 ($55 per hour × 4 hours per group practice). After considering the comments received, we will also assign an additional 2 hours as the time needed by group practices to review the 2010 PQRI reporting options and make the decision to participate as a group rather than individually. The total costs associated with the decision-making process is estimated to be $110 ($55 per hour × 2 hours per group practice)

The cost associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For physician group practices, this would be the time associated with the physician group completing the data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011. Based on cost estimates for the Physician Group Practice (PGP) demonstration, we estimate the cost associated with a physician group completing the data collection tool will be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group to be approximately 85 hours (2 hours for decision-making process + 4 hours for self-nomination + 79 hours for data submission). Based on

an average labor cost of $55 per physician group, we estimate the cost per physician group associated with participating in the PQRI group practice reporting option would be $4,675 ($55 per hour × 85 hours per group practice).

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

As discussed in section II.G.3. of this final rule with comment period, section 131(c) of the MIPPA amends section 1848 of the Act by adding subsection (n), which requires the Secretary to establish and implement by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. If determined appropriate by the Secretary, the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. We anticipate the impact of this section to be negligible for the work completed in the Program to date.

4. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

Section II.G.5. of this final rule with comment period describes the 2010 E-Prescribing Incentive Program. To be considered a successful electronic prescriber in 2010, an eligible professional must meet the requirements in section II.G.5.c. of this final rule with comment period.

We anticipate that the cost impact of the E-Prescribing Incentive Program on the Medicare program will be the cost incurred for maintaining the electronic prescribing measure and its associated code set, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and, potentially, EHR-based reporting for the electronic prescribing measure. We, however, do not anticipate a significant cost impact on the Medicare program since much of this infrastructure had already been established for the PQRI.

Participation in the E-Prescribing Incentive Program by eligible professionals is voluntary and eligible professionals may have different processes for integrating the E-Prescribing Incentive Program into their practices' work flows. Therefore, it is difficult to accurately estimate the impact of the E-Prescribing Incentive Program on eligible professionals. In addition, for eligible professionals who are successful electronic prescribers, some (if not all) of the cost of participating in the E-Prescribing Incentive Program may be offset by the incentive payment earned.

Similar to claims-based reporting for PQRI, one factor in the cost to eligible professionals, for those eligible professionals who choose to report the electronic prescribing measure through claims, is the time and effort associated with eligible professionals determining whether the quality measure is applicable to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the electronic prescribing measure and incorporate reporting of the selected measures into their office work flows and an additional hour as the amount of time needed for eligible professionals to select an appropriate reporting mechanism for them. At an average cost of approximately $55 per hour (see section XIII.E.2. above for a discussion of how we arrived at this figure), we estimate the total cost to eligible professionals for reviewing the electronic prescribing measure, incorporating reporting of the selected measures into the office work flows, and selecting an appropriate reporting mechanism to be approximately $110 ($55 per hour × 2 hours).

Another factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims an eligible professional submits for payment. Information from the PVRP estimates that the time needed to perform all the steps necessary to report 1 measure 1 time (that is, reporting the relevant quality data code(s) for the measure for 1 case) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. With an average practice labor cost of $55 per hour, the cost to eligible professionals to perform all of the steps necessary to report 1 quality measure 1 time on claims ranges from $0.23 in labor time to about $11.00 in labor time for more complicated cases and/or measures. For the median practice, the cost is about $1.44 in labor time per measure. Therefore, we estimate the costs to eligible professionals to perform all the steps necessary to report the electronic prescribing measure once on a claim to be approximately $1.44.

The cost for this requirement will also vary along with the volume of claims on which quality data is reported. Based on our proposal to require an eligible professional to report the electronic prescribing measure for at least 25 instances, we estimate the total annual estimated cost per eligible professional to report the electronic prescribing measure to be $146.00 [($1.44 per measure × 1 measure × 25 cases per measure) + $110].

Because registry-based reporting of the electronic prescribing measure to CMS will be new for 2010 and participation in this reporting initiative is voluntary, it is difficult to accurately estimate how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional cost for eligible professionals to report data to a registry as we believe that most eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes, such reporting data to the registry for the PQRI. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. Furthermore, the same information has to be reported for the E-Prescribing Incentive Program and for the same number of instances regardless of the reporting mechanism selected by the eligible professional. That is, the eligible professional must report that he or she generated and transmitted at least one prescription electronically for at least 25 eligible patient encounters during the reporting period.

One potential cost to some eligible professionals associated with either claims-based reporting or registry-based reporting would be the cost of purchasing and using an electronic prescribing system. There are currently many commercial packages available for electronic prescribing. The cost to an eligible professional of obtaining and utilizing an electronic prescribing system varies not only by the commercial software package selected but also by the level at which the professional currently employs information technology in his or her practice and the level of training needed. One study indicated that a mid-range complete electronic medical record with electronic prescribing functionality costs $2500 per license with an annual fee of $90 per license for

quarterly updates of the drug database after setup costs while a standalone prescribing, messaging, and problem list system costs $1200 per physician per year after setup costs. Hardware costs and setup fees substantially add to the final cost of any software package. (Corley, S.T. (2003). ''Electronic prescribing: a review of costs and benefits.'' Topics in Health Information Management 24(1): 29–38.). Thus, for the purpose of this impact analysis, we estimate that eligible professionals who opt to purchase a standalone electronic prescribing system would incur an average cost of $1200 per physician per year. Eligible professionals who opt to purchase an EHR with electronic prescribing functionality would incur an average cost of $2500 per license with an annual fee of $90 per license for quarterly updates of the drug database.

Based on our policy to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, we do not anticipate any cost to the registry associated with becoming a registry qualified to submit the electronic prescribing measure for 2010.

The cost associated with the registry-based reporting requirements of this voluntary reporting initiative for the registry will be the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants since the registries are already required to perform these activities for the PQRI. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the cost associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her qualified EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS will be new for 2010 and participation in this reporting initiative is voluntary, it is difficult to accurately estimate how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The cost associated with an eligible professional reviewing the electronic prescribing measure and other information to determine whether the measure is applicable to his or her patients and the services he or she furnishes to them and to review the available reporting mechanisms to select the EHR reporting mechanism is expected to be similar for EHR-based reporting and claims-based reporting (that is, $110 at a rate of $55 per hour). Once the EHR is programmed by the vendor to allow data submission to CMS, the cost to the eligible professional associated with the time and effort to submit data on the electronic prescribing measure should be minimal.

Based on our policy to consider only EHR products qualified for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there will be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional cost associated with the self-nomination process.

The cost to the EHR vendor associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI will be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

With respect to the process for group practices to be treated as successful electronic prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5.e. of this final rule with comment period, a group practice will be required to report the electronic prescribing measure in at least 2,500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the electronic prescribing measure is the number of times a group practice is required to report the electronic prescribing measure. Reporting of the electronic prescribing measure can continue to occur at the individual eligible professional level under the electronic prescribing group practice reporting option. In our analysis of the information, however, we will aggregate all of the information reported by the eligible professionals within the group practice to determine whether the group practice reported the measure a sufficient number of times. For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claims-based reporting of the electronic prescribing measure, we estimate the total annual estimated cost per group practice to be $3,710 [($1.44 per measure $\times$ 1 measure $\times$ 2,500 cases per measure) + $110].

For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes, such as the PQRI. Little, if any, additional data would need to be reported to the registry for

purposes of participation in the 2010 E-Prescribing Incentive Program. However, in addition to the 2 hours estimated for the group practice to review the electronic prescribing measure to determine whether it is applicable to their practice and to review the available reporting mechanisms to select the group practice reporting option, group practices will need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices will also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we are limiting participation in the E-Prescribing Incentive Program group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there will be no additional burden associated with the group practice self-nomination process for the E-Prescribing Incentive Program.

5. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services.

As discussed in section II.G.6. of this final rule with comment period, suppliers that provide the TC of advanced diagnostic imaging services will have to be accredited by an approved accreditation organization in order to receive Medicare payment for advanced diagnostic imaging services described in section 1848(b)(4)(B) furnished to beneficiaries. This section of the rule will impact the suppliers that provide the TC of advanced diagnostic imaging services and the organizations that accredit suppliers of such services. Suppliers that provide the TC of advanced diagnostic imaging services will incur costs for becoming accredited. Accreditation organizations will incur costs to accredit suppliers. To estimate the impact on suppliers, we calculate the total cost of accreditation as the sum of accreditation fees and other accreditation costs, and we multiply this cost by the number of providers of care requiring accreditation.

a. Factors Affecting the Cost Impact

According to our Services Tracking and Reporting System (STARS) database for 2008, there are a total of 1,131,115 physicians, IDTFs, and others billing Part B for the TC of advanced diagnostic imaging. This total includes both suppliers and providers that furnish items under Medicare Part B as suppliers.

Currently, there are suppliers accredited by one of three of the nationally recognized accreditation. We anticipate that the following accreditation organizations will seek approval from CMS to accredit suppliers that provide the TC of advanced diagnostic imaging services:

- American College of Radiology;
- Intersocietal Accreditation Commission; and
- The Joint Commission.

b. Accreditation Fees

Fees vary between accreditation organizations and, in general, currently cover all of the following items: application fee, manuals, initial accreditation fee, onsite surveys or other auditing (generally once every 3 years), and travel, when necessary for survey personnel. Accreditation costs also vary by the size of the supplier seeking accreditation, its number of locations, and the number of services it provides. Because of these factors, it is sometimes difficult to compare fees across accreditation organizations. We obtained information on total accreditation fees from the three accreditation organizations that currently accredit suppliers who provide the TC of advanced diagnostic imaging services. Based on all information we obtained, we estimate accreditation fees for each review cycle and modality will be approximately $5,000 for an advanced diagnostic imaging supplier. Because accreditation is for a 3-year period, the estimated average cost per year would be approximately $1,666 per modality.

We recognize that becoming accredited may impose a burden on suppliers that provide the TC of advanced diagnostic imaging services, especially small suppliers. We have attempted to minimize that burden. We have implemented the following options to minimize the burden of accreditation on suppliers, including small businesses:

- *Multiple accreditation organizations:* We expect that more than one accrediting organization will apply to become and be designated as an advanced diagnostic imaging accrediting organization. We believe that selection of more than one accreditation organization will introduce competition resulting in reductions in accreditation costs.
- *Required plan for small businesses:* During the application process we will require accreditation organizations to include a plan that details their methodology to reduce accreditation fees and burden for small or specialty suppliers. This will need to include that the accreditation organization's fees are based on the size of the organization.
- *Reasonable quality standards:* The quality standards that will be used to evaluate the services rendered for each imaging modality are industry standards. Many suppliers that provide the TC of advanced diagnostic imaging services already comply with the standards and have incorporated these practices into their daily operations. We have been told that that those suppliers with private insurance contracts must be accredited, thus our requirements would not be duplicative. It is our belief and has been stated by those suppliers already accredited that compliance with the quality standards will result in more efficient and effective business practices and will assist suppliers in reducing overall costs.

c. Other Accreditation Costs

It is difficult to precisely estimate the costs of preparing for accreditation. We do recognize there is cost to the supplier in order to come into compliance initially and thus prepare for the accreditation survey. This should result in minimal preparation and cost.

d. Additional Considerations

There are at least two important sources of uncertainty in estimating the impact of accreditation on suppliers that provide the TC of advanced diagnostic imaging services. First, our estimates assume that all current suppliers with positive Medicare payments will seek accreditation. We assume that suppliers who currently receive no Medicare allowed charges will choose not to seek

accreditation. It is also possible that many of the suppliers with allowed charges between $1 and $10,000 may decide not to incur the costs of accreditation.

Second, it is unclear what accreditation fees will be in the future. However, we are requiring the accreditation organization to submit their fees that are based on the size of the supplier, or on the amount billed. Our experience with another accreditation program has lead us to believe that the accreditation rates will go up, although minimally, if travel costs continue to rise.

In summary, suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012. In these options, we have attempted to minimize the burden of accreditation on suppliers, which include approving multiple accreditation organizations that consider the small suppliers. Also, the fact that the surveys will be either performed as a desk review or unannounced deletes the time and cost for the accreditation organization in travel, if required.

6. Section 139: Improvements for Medicare Anesthesia Teaching Programs

As discussed in section II.G.7., this final rule with comment period would provide for increased payments under the Medicare PFS for certain cases involving teaching anesthesiologists with anesthesia residents or for teaching CRNAs with student nurse anesthetists. This provision of the MIPPA is anticipated to have a minimal budgetary impact.

7. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Cardiac Rehabilitation Services

As described in section II.G.8. of this final rule with comment period, current levels of coverage for CR programs are expected to continue under this rule, and new ICR programs will likely develop and request approval by CMS to receive Medicare payments. Because the payment amount for ICR services under section 144(a) of the MIPPA is higher than for CR services, this expansion of coverage will result in greater costs to the Medicare program. The requirements for ICR programs, also specified in section 144(a) of the MIPPA, are extensive and will likely limit the number of individual ICR program sites that request approval. As a result, significantly fewer ICR programs and ICR program sites than CR programs will function throughout the country; however, we currently do not know how many ICR programs may request approval or how many individual sites may furnish ICR services under an approved program.

We believe that the expansion of coverage for ICR programs will enable beneficiaries to take advantage of more focused and rigorous programs that will more quickly lead to improved cardiovascular health. Having the choice of CR and ICR programs, beneficiaries eligible for coverage will be able to determine the best manner in which to achieve improved cardiovascular health, through traditional CR or more rigorous ICR program. We also expect this expansion of coverage to bring more attention to the importance of cardiac rehabilitation and the extensive benefits these programs provide to beneficiaries. As a result, the number of beneficiaries participating in CR programs may increase. We estimate that the provisions for establishing coverage of cardiac rehabilitation and intensive cardiac rehabilitation programs, as discussed in section II.G.8. of this final rule with comment period, will have a minimal budgetary impact on the Medicare program.

8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Pulmonary Rehabilitation Services

As discussed in section II.G.9. of this final rule with comment period, the implementation of the Medicare pulmonary rehabilitation program will allow Medicare, for the first time, to provide for payment for exercise and other services as part of a comprehensive treatment plan for beneficiaries with moderate to very severe COPD. We believe this program has the potential of not only improving the quality of life for beneficiaries who engage in it, but also reducing Medicare costs in the long range by decreasing the chances of exacerbations and further rehabilitation related to their chronic respiratory disease. We estimate this provision will have a minimal budgetary impact on the Medicare program.

9. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment—Repeal of Transfer of Title for Oxygen Equipment

The revisions pertaining to oxygen and oxygen equipment in section II.G.10. of this final rule reflect changes made by the MIPPA of 2008. Section 1834(a)(5)(F) of the Act limited monthly payments to suppliers furnishing oxygen equipment to 36 months of continuous use. Prior to the MIPPA, at the end of this 36-month period, suppliers were required to transfer title to oxygen equipment to the beneficiary. Section 144(b) of the MIPPA repealed the transfer of title requirement. In its place, section 144(b) amends section 1834(a)(5)(F) of the Act by adding additional payment rules and supplier responsibilities discussed previously in this preamble that apply after the 36 month rental cap.

Based on data from the Small Business Administration (SBA), we estimate that 85 percent of suppliers of the items and services affected by this rule would be defined as small entities with total revenues of $7 million or less in any 1 year. In the case of oxygen and oxygen equipment, it is difficult to estimate the impact of section 144(b) of the MIPPA on small entities and oxygen and oxygen equipment suppliers in general. Nevertheless, we do believe that the net impact on small entities and other suppliers of oxygen and oxygen equipment will be positive rather than negative. This is based on the fact that this change allows suppliers to retain ownership of oxygen equipment in all cases when it is no longer needed by the beneficiary. Prior to this change, suppliers were required to relinquish ownership of oxygen equipment after 36 continuous rental months. While suppliers will be required to continue furnishing the equipment after the 36 month rental period for up to 2 additional years in some cases until the 5 year reasonable useful lifetime of the equipment ends, they will retain ownership of equipment when it is no longer needed and can furnish the equipment to other patients. As explained in more detail below, we estimate that suppliers could potentially receive approximately $58 million per year in payments for furnishing oxygen equipment that is returned to them after the 36 month cap and before the end of the 5 year reasonable useful lifetime. Suppliers in these situations are able to forgo the expense of purchasing new equipment from manufacturers to replace equipment they would have transferred to beneficiaries had the transfer of title requirement not been repealed.

Our data indicates that most beneficiaries who receive stationary oxygen equipment are furnished with a stationary oxygen concentrator. As we have indicated previously, oxygen concentrators require very minimal maintenance and servicing if less than

5 years old, and, as described in more detail below, suppliers will receive an annual payment, beginning 6 months after the end of the 36 month rental cap, for maintenance and servicing of the oxygen concentrator. Therefore, suppliers' costs for maintaining this equipment after the cap should be minimal unless they are furnishing equipment that is older than 5 years, in which case they will probably have received significantly more than 36 monthly rental payments from Medicare or other payers for rental of the equipment. In addition, since approximately 76 percent of Medicare beneficiaries that need oxygen do not use the oxygen equipment for more than 36 months, the changes mandated by section 144(b) of the MIPPA will have no impact on suppliers or beneficiaries in the majority of cases. The 76 percent figure is based on the most recent Medicare data available (see Table 52).

Again, if a beneficiary discontinues use of oxygen after the 36-month rental cap but before the end of the reasonable useful lifetime of the equipment (currently 5 years), the supplier will be able to retrieve the equipment and rent it to another Medicare beneficiary or other customer and receive additional rental payments for the remainder of the equipment's reasonable useful lifetime. It is difficult to estimate the magnitude of this positive impact on suppliers. If the equipment is older than 5 years at the time the 36-month rental cap is reached, the supplier may have already received 24 monthly payments or more from Medicare or other payers for rental of the equipment prior to the start of the most recent 36 month rental payment period for the equipment. Combined with the 36 monthly payments made by Medicare in situations where the cap is reached (24 percent of cases based on current data), this would equal or exceed 60 monthly payments for the equipment. On the other hand, assuming the equipment is brand new at the time it is initially furnished in the 24 percent of cases where the cap is reached, the supplier will only have received 36 monthly payments for the new equipment before the rental cap is reached. However, since the equipment will only be 3 years old at this point, depending on when the beneficiary's medical need for or use of the equipment ends, the supplier will be able to furnish the equipment to other patients for any months remaining in the equipment's 5 year or 60 month reasonable useful lifetime. Table 52 illustrates earnings that the supplier could realize from furnishing oxygen equipment that they would have been required to transfer to the beneficiary prior to the enactment of MIPPA.

BILLING CODE 4120–01–P

TABLE 52: Potential Earnings of Suppliers Given the Retention of Title to the Oxygen Equipment

Month in the Reasonable Useful Lifetime	Percentage of Beneficiaries Using Oxygen Equipment for this Number of Months	Number of Beneficiaries	Number of Months that Equipment can be Rented to another Beneficiary before the end of the Reasonable Useful Lifetime	Earnings for Supplier for a Given Month
36	24.4%			
37	23.8%	8,288	23	$33,511,396
38	23.1%	5,954	22	$23,025,830
39	22.6%	6,487	21	$23,945,761
40	22.0%	5,923	20	$20,822,401
41	21.5%	5,782	19	$19,310,298
42	21.1%	7,599	18	$24,044,916
43	20.4%	6,095	17	$18,214,092
44	19.9%	5,108	16	$14,366,355
45	19.5%	5,735	15	$15,121,029
46	19.0%	5,750	14	$14,151,521
47	18.5%	5,593	13	$12,782,641
48	18.1%	6,831	12	$14,410,424
49	17.5%	5,813	11	$11,240,241
50	17.0%	4,152	10	$7,298,858
51	16.7%	5,108	9	$8,081,075
52	16.2%	4,371	8	$6,147,566
53	15.9%	4,575	7	$5,629,760
54	15.5%	5,327	6	$5,618,743
55	15.1%	3,917	5	$3,442,857
56	14.7%	4,230	4	$2,974,629
57	14.4%	3,901	3	$2,057,452
58	14.1%	4,058	2	$1,426,720
59	13.7%	3,400	1	$597,680
60+	13.4%	161,146	0	$0
			Five-year Total =	288,222,244
			Annual Total =	57,644,449

The data is from Medicare claims data as arrayed by the CMS Pricing, Data Analysis, and Coding (PDAC) contractor in September 2009. The Medicare claims are from January 1, 2002 thru December 31, 2007. We estimate that there were approximately 1.2 million beneficiaries using oxygen equipment during this time based on our analysis of Medicare data. The earnings are calculated using the 2009 monthly payment amount for oxygen and oxygen equipment of $175.79.

BILLING CODE 4120–01–C

Again, we understand that oxygen equipment is very durable and should need few repairs in the first 5 years. Therefore, we have determined that any costs suppliers may incur in repairs and service visits would be more than offset by the gains they achieve by retaining ownership of the equipment they can then reuse and by payments received for maintenance and servicing after the cap that are established as a result of this final rule with comment period.

Finally, Medicare program expenditures will increase slightly as a result of the payments for maintenance and servicing after the 36 month rental cap for oxygen concentrators and transfilling equipment. Medicare will make maintenance and servicing payments at 6 month intervals following the 36th month payment rental cap. Through June 30, 2010, the payment for these visits is based on 30 minutes of labor. After June 30, 2010, the payment rate is a reasonable fee not to exceed 10 percent of the purchase price for a stationary oxygen concentrator. The total cost in terms of allowed charges per year is calculated to be about $8 million.

10. Section 152(b): Coverage of Kidney Disease Patient Education Services

The implementation of Medicare coverage of kidney disease patient education services as discussed in section II.G.11. of this final rule with comment period will allow Medicare to provide for payment for kidney disease education services for beneficiaries with Stage IV chronic kidney disease. We believe this program can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. We believe this program has the potential of improving the quality of life for beneficiaries since they will be better equipped to make informed decisions. We estimate a cost to the Medicare program of approximately $10 million for CY 2010, because the statute limits the number of kidney disease education sessions to 6, as a lifetime maximum.

11. Section 153: Renal Dialysis Provisions

A discussion of the impact of section 153 of the MIPPA is addressed in section V.H. of this regulatory impact analysis in conjunction with the other ESRD provisions of this rule.

12. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen

We anticipate that the proposals related to the compendia discussed in section II.G.13. of this final rule with comment period will have a negligible cost to the Medicare program and to the public. The information that is required to be collected and published on the compendia Web sites is information that is already collected in the normal course of business by the compendia publishers, which all have Web sites. The changes will enable CMS to efficiently implement the provisions of section 182(b) of the MIPPA that require transparent evaluative and conflict of interest policies and practices for current and future listed compendia on and after January 1, 2010.

G. Payment for Covered Outpatient Drugs and Biologicals

1. Average Sales Price (ASP) Issues

The changes discussed in section II.H.1. of this final rule with comment period with respect to payment for covered outpatient drugs and biologicals, are estimated to have no impact on Medicare expenditures as we are not making any change to the AMP/WAMP threshold and the change concerning the immunosuppressive drug period of eligibility is a conforming change to reflect the statute.

2. Competitive Acquisition Program (CAP) Issues

As discussed in section II.H.2., this final rule with comment period finalizes several CAP proposals and updates to regulations, specifically the frequency of drug payment amount updates, changes to the CAP drug list, the geographic area served by the CAP, CAP drug stock at the physician's office, exclusion of CAP sales from ASP calculations, the annual CAP payment amount update mechanism, and updates to proposals made in the 2009 PFS rule. Our changes and refinements may improve compliance, promote program flexibility, improve the quality, and maintain the availability of services for participating CAP physicians. We anticipate that these changes associated with the CAP will not result in significant additional cost savings or increases relative to the ASP payment system for two reasons. First, in 2006 through 2008, the dollar volume of claims paid under the CAP was small compared to the volume of claims paid under section 1847A of the Act, and although we anticipate that the CAP will continue to grow, we do not anticipate a significant change in the proportion of claims paid under these payment systems. Second, because CAP payment amounts are limited to prices calculated under section 1847A of the Act, we expect payment rates for the two programs to remain very similar.

H. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

The ESRD-related provisions are discussed in sections II.G.11 and II.I. of this final rule with comment period. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2009 payments) to estimated payments under the revisions to the composite rate payment system (CY 2010 payments) as discussed in section II.I. of this final rule with comment period. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and estimates of payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities that we are able to calculate both current 2009 payments and 2010 payments.

ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the June 2009 update of CY 2008 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Due to data limitations, we are unable to estimate current and payments for 42 of the 5186 ESRD facilities that bill for ESRD dialysis treatments.

Table 53 shows the impact of this year's changes to CY 2010 payments to hospital-based and independent ESRD facilities. The first column of Table 53 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of all changes to the ESRD wage index for CY 2010 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage adjusted composite rate payments in CY 2010 to aggregate ESRD wage adjusted

composite rate payments in CY 2009. In CY 2009, ESRD facilities receive 100 percent of the CBSA wage adjusted composite rate and 0 percent of the MSA wage adjusted composite rate, ending a 4-year transition period in which they had received an increasing percent of payments based on the CBSA wage adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2010 ESRD wage index has been multiplied by a wage index BN adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index.

The fifth column shows the effect of changes to the ESRD wage index in CY 2010 and the effect of the MIPPA provisions on ESRD facilities. Section 153(a) of MIPPA amended section 1881(b)(12)(G) of the Act to revise payments to ESRD facilities. For services furnished on or after January 1, 2010, MIPPA provides a 1 percent increase to the composite rate component of the payment system. The fifth column also reflects the changes in payment based on changes to the wage index from CY 2009 to CY 2010.

The sixth column shows the overall effect of the changes in composite rate payments to ESRD providers including the drug add-on. The overall effect is measured as the percent change between the CY 2010 payments to ESRD facilities with all changes as finalized in this rule and CY 2009 payments to ESRD facilities under current payment policies. These payment amounts are computed by multiplying the wage adjusted composite rate including the drug add-on for each provider times the number of dialysis treatments from the CY 2008 claims. The CY 2010 payments are the wage adjusted composite rate for each provider (with the 15.0 percent drug add-on) times dialysis treatments from CY 2008 claims. The CY 2009 current payments are the wage adjusted composite rate for each provider (with the current 15.2 percent drug add-on) times dialysis treatments from CY 2008 claims.

The overall impact to ESRD providers in aggregate is 0.8 percent as shown in Table 53. Most ESRD facilities will see an increase in payments as a result of the MIPPA provision. While the MIPPA provision includes a 1 percent increase to the ESRD composite rate for services provided on or after January 1, 2009, this 1 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this final rule with comment period is a 0.8 percent increase for all ESRD providers. Overall, payments to independent ESRD facilities will increase by 0.8 percent and payments to hospital-based ESRD facilities will increase by 1.0 percent.

BILLING CODE 4120–01–P

TABLE 53: Impact of CY 2010 Changes in Payments to Hospital Based and Independent ESRD Facilities

[Percent change in composite rate payments to ESRD facilities]

1	2	3	4	5	6
	Number Of facilities	Number of Dialysis Treatments (in millions)	Effect of Changes in Wage Index 1/	Effect of Changes in Wage Index and of MIPPA provision/2	Overall Effect of Wage Index MIPPA & Drug Add-on 3/
All Providers	5,144	37.5	0.0%	1.0%	0.8%
Independent	4,580	33.8	0.0%	1.0%	0.8%
Hospital Based	564	3.7	0.2%	1.2%	1.0%
By Facility Size					
Less than 5000 treatments	1,929	5.4	0.1%	1.1%	0.9%
5000 to 9999 treatments	2,014	14.7	0.0%	1.0%	0.8%
Greater than 9999 treatments	1,201	17.4	0.0%	1.0%	0.8%
Type of Ownership					
Profit	4,198	30.8	0.0%	1.0%	0.8%
Nonprofit	946	6.7	0.1%	1.1%	0.9%
By Geographic Location					
Rural	1,120	6.1	0.1%	1.1%	1.0%
Urban	4,024	31.4	0.0%	1.0%	0.8%
By Region					
New England	158	1.3	0.3%	1.3%	1.1%
Middle Atlantic	584	4.7	-0.2%	0.8%	0.7%
East North Central	841	5.8	-0.2%	0.8%	0.6%
West North Central	394	2.0	0.3%	1.3%	1.1%
South Atlantic	1,156	8.5	0.1%	1.1%	0.9%
East South Central	403	2.8	0.1%	1.2%	1.0%
West South Central	707	5.4	-0.1%	0.9%	0.8%
Mountain	291	1.7	0.8%	1.8%	1.7%
Pacific	573	4.8	0.0%	1.0%	0.8%
Puerto Rico & Virgin Islands	37	0.4	-2.4%	-1.4%	-1.6%

Notes: Payments have been adjusted to reflect budget neutrality. CY 2009 includes the MIPPA 1 percent increase and site neutral rates. CY 2009 and CY 2010 both reflect 100 percent CBSA wage adjusted composite rate.

[1] This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments are computed using the final CY 2010 wage indexes which are compared to composite rate payments using the current CY 2009 wage indexes.

[2] This column shows the effect of the changes in the wage indexes and the MIPPA provision which includes a 1 percent increase to the composite rate. This provision is effective for services furnished on or after January 1, 2010.

[3] This column shows the percent change between CY 2010 and CY 2009 composite rate payments to ESRD facilities. The CY 2010 payments include the CY 2010 wage adjusted composite rate, a 1 percent increase due to MIPPA effective 1/1/10 and the drug add-on of 15.0 percent.

The CY 2009 payments include the CY 2009 wage adjusted composite rate, a 1 percent increase and site neutral rates effective 1/1/09 and the drug add-on of 15.2 percent. This column shows the effect of wage index, MIPPA, and drug add-on changes. While the MIPPA provision includes a 1 percent increase to the composite rate, this 1 percent increase does not apply to the drug add-on to the composite rate. The impact of all changes in this final rule is a 0.8 percent increase for all ESRD providers.

BILLING CODE 4120–01–C

I. Chiropractic Demonstration—Application of Budget Neutrality

As discussed in section II.J. of this final rule with comment period, we are going to recoup the $50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period. We will recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014.

To implement this required BN adjustment, we will reduce the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) by approximately 2 percent.

J. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

The revisions to the conditions of participation (CoP) discussed in section II.K. of this final rule with comment period make technical corrections and update the regulations to reflect current industry standards for respiratory therapists. The revisions to the regulations will clarify the qualifications necessary for respiratory therapists' to continue to qualify to furnish respiratory therapy services to CORF patients. These changes are similar to prior rules and will have no impact on CORFs cost.

K. Physician Self-Referral Provisions

In section II N.1. of this final rule with comment period, we discuss our clarification of the physician stand in the shoes provisions at § 411.354(c)(3)(i). This revision will assist designated health services entities in structuring legitimate compensation arrangements by clarifying that the standard for determining compensation between the parties will be dictated by the language of the exceptions within § 411.355 and § 411.357. Furthermore, like other physician self-referral policies, we anticipate that this clarification will result in savings to the Medicare program by reducing overutilization and anti-competitive business arrangements. However, we cannot gauge with any degree of certainty the extent of these savings to the Medicare program.

L. Durable Medical Equipment Related Issues

1. Damages Process

In section II.O.1. of this final rule with comment period, we establish a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their supplier contracts by MIPPA. The DMEPOS Competitive Bidding Program that was implemented on July 1st, 2008, awarded contracts to 329 suppliers. The following factors may be considered by a contract supplier before deciding to submit a claim:

- The contract itself stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program;
- The contract does not guarantee any amount of business or profits, therefore, an efficient business would not be expected to incur large expenses without any guaranteed increase in business and profits;
- The contract stipulates that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized pursuant to the contract;
- Upon termination of the contracts by MIPPA, payments reverted back to the fee schedule amount, which was on average 26 percent higher than under the DMEPOS Competitive Bidding Program.
- There is a required responsibility under contract law for a company to take action to mitigate expenses to any stop work order.
- CMS listed the winning suppliers on the Medicare Web site at *http://www.Medicare.gov* in the supplier locator tool, a supplier is allowed to keep any new customers they may have obtained as a result of being listed on the supplier locator tool.

By mentioning the list above, we are not suggesting that there would not be legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

Based on these reasons and because there have been so few inquiries or responses to the reference in the MIPPA to damages (fewer than 7 suppliers), we believe that as few as 1 percent of the 329 winning suppliers may make a claim for damages. However, as a high estimate, we would estimate that approximately 76 percent of the suppliers (250) may submit a claim. We anticipate that it will take approximately 3 hours at $34/hour (3 × $34 = $102) for an accountant and a company official to review and gather the necessary documents to file a claim for a total of $25,500 (250 × $102). The hourly accountant rate was based on the Bureau of Labor Statistics data collected for June 2006 which was then adjusted to account for inflation. We estimate that this regulation will not have a large budgetary impact. The total cost range of $408 to $25,500 for potential claims from contract suppliers will not result in expenditures of $133 million or more annually. An analysis of the damage payments that may result would be dependent upon an evaluation of the actual claims once they are received.

2. Grandfathering Process

In section II.O.2. of this final rule with comment period, we are revising the definition of a *grandfathered item* to refer to all rented items within a competitively bid product category that the supplier currently rents. The definition of a *grandfathered item* would avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier may choose to be a grandfathered supplier. Under the revised definition, a noncontract supplier will have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it will be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code.

We also believe the revision of this definition will have a negligible impact on suppliers as product categories consist of related items routinely provided by suppliers. We are only requiring a supplier to provide those rented items within a product category that the supplier was currently furnishing at the start of the competitive bidding program.

While difficult to estimate, we believe that based on 2008 data, there were approximately 1,850 suppliers in the 9 CBAs, for which we will be doing the Round 1 rebid that rented competitively bid items, on average at different points in time during 2008. Therefore, we are using this number to indicate how many suppliers would be renting a DME competitively bid item at the start of the competitive bid program. We believe some suppliers may decide not to bid because of the cost of bidding and accreditation requirements while other suppliers may not qualify for a contract. Since not all suppliers will be awarded contracts and some may not choose to submit a bid, we estimate that in the worst case scenario there will be 1,450 suppliers that will not be awarded contracts, would be renting DME competitive bid items at the time the program is implemented.

Based on our experience from the competitive bidding demonstrations, of the 1,450 suppliers who are not

awarded a contract, we expect 90 percent or 1,305 of these noncontract suppliers will offer to be grandfathered suppliers (0.90 × 1,450 = 1,305) and 10 percent or 145 (0.10 × 1,450 = 145) of the suppliers will choose not to grandfather. We believe most suppliers will not want to pick up their items before the end of the full rental period.

Based on 2008 data, we estimate that there will be 96,000 beneficiaries who reside in a CBA and are renting competitively bid items from suppliers at the start of the round 1 rebid. Based on the 2007 round 1 of the competitive bidding program, we estimate that there would be 74,880 (96,000 × 0.78 = 74,880) beneficiaries who would be renting items from a noncontract supplier.

a. Notification Requirement for Suppliers That Choose To Grandfather

(1) Notification to CMS

For those suppliers that choose to grandfather (1,305), we estimate that it would take the supplier on average 2 hours to develop the 30-day notification that it is required to send to CMS. We estimate that the cost to the supplier to develop the 30-day notification to CMS would be $89.60 for skilled administrative staff (2 hours × $44.80 per hour). The $44.80 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate that the cost to the supplier to send the notification to CMS would be $5.51 for clerical staff (0.25 hour to send the notification × $22.02 per hour = $5.51). The $22.02 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate the cost of supplies necessary to send the notification would be $2.00. The total cost for sending the notification would be $7.51 which includes the cost of clerical staff ($5.51) and supplies ($2.00). The individual costs for all suppliers to notify CMS would be $97.11 ($89.60 for development of the letter + $7.51 for preparing and sending each notification = $97.11). The overall cost for suppliers to notify CMS would be approximately $126,728.55 ($97.11 per supplier × 1,305 suppliers = $126,728.55).

(2) Notification to the Beneficiary

We estimate based on 2008 data, we expect that there will be 74,880 beneficiaries who will have been renting competitive bid items from a noncontract supplier at the start of the round 1 rebid of the CBP. Of the 74,880, we believe that approximately 100 percent of these beneficiaries will accept the offer to continue to rent competitively bid items from the noncontract supplier that offers to be a grandfathered supplier. We believe that the beneficiaries will choose to continue to rent from a grandfathered supplier if given the choice because it would be more convenient, assure continuity of care, and eliminate the need to have equipment taken from their home.

Based upon the number of suppliers and beneficiaries, we estimate that there will be an average of 52 beneficiaries per supplier that was not awarded a contract (74,880 beneficiaries/1,450 suppliers = 52). Therefore, we estimate that each noncontract supplier that chooses to grandfather would send the 30-day notification on average to 52 beneficiaries.

We expect that the cost of developing the 30-day notification to a beneficiary will be equivalent to the cost of developing the 30-day notification to CMS ($89.60 per notification). We also expect the cost of sending the 30-day notification per beneficiary to be equivalent to sending the 30-day notification to CMS ($7.51 per notification). The total costs for the 30-day notification to beneficiaries for suppliers that choose the grandfathering option would be $89.60 for development of the letter, and $7.51 for preparing and sending each notification. To calculate the total cost we multiplied $7.51 × 52 beneficiaries and added the development cost for the letter of $89.60 for a total of $480.12 per supplier. The overall cost for these suppliers to provide the 30-day notification to their beneficiaries will be approximately $626,556.60 ($480.12 per supplier × 1,305 suppliers = $626,556.60).

b. Notification Requirement for Suppliers That Choose Not To Grandfather

(1) 30-day Notification to the Beneficiary

We expect that suppliers who choose not to grandfather will incur costs equivalent to the cost of developing and sending the 30-day notification to a beneficiary by those suppliers that choose to grandfather. The overall cost for all suppliers who choose not to grandfather to provide the 30-day notification to the beneficiary is approximately $69,617.40 ($480.12 total cost per supplier × 145 non-grandfathered suppliers = $69,617.40). The estimate of 145 suppliers not choosing to be grandfathered suppliers represents 10 percent of the total number of noncontract suppliers.

While the cost for the 30-day notification to beneficiaries will be exactly the same for all suppliers, those who choose not to become a grandfathered supplier will also incur the cost of the 10-day and 2-day notification.

(2) 10-day and 2-day Notification

For the 10-day notification to a beneficiary, we estimate the supplier will make at least 1 phone call that would take an average of 15 minutes to discuss that the beneficiary must switch to a contract supplier, the schedule for picking up the current equipment by the noncontract supplier, and the delivery of new equipment by the contract supplier. For the 2-day notification to the beneficiary, we estimate that the supplier will make at least 1 phone call that would take an average of 15 minutes to ensure that all of the arrangements are finalized and to answer any last minute questions. We anticipate that clerical staff will perform both of these tasks.

The estimated cost of the 10-day notification totals $5.51 (.25 of an hour × $22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = $5.51). The estimated cost of the 2-day notification totals $5.51 (.25 of an hour × $22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = $5.51). Therefore, the 10-day and 2-day notifications for each supplier will cost approximately $11.02. The total cost for each supplier would be approximately $573.04 ($11.02 × 52 beneficiaries = $573.04). The overall impact for all suppliers to make the 10-day and 2-day notifications will be approximately $83,090.80 (145 suppliers × $573.04 per supplier = $83,090.80).

We anticipate that this process will not place a greater burden on the overall small supplier community. This process is only going to affect those small suppliers that were renting items when the competitive bidding program begins and who did not win a contract. The burden on these suppliers will generally be less because small suppliers will have fewer beneficiaries to furnish notifications to.

As an alternative, we considered relying on suppliers to develop their own schedule for informing beneficiaries regarding grandfathering. This alternative would have left the beneficiaries vulnerable to having equipment removed from the home before new equipment was delivered. The process finalized in this regulation ensures the beneficiaries can make an informed decision about the transition policy that works best for them. The alternative we selected ensures the

beneficiaries will have continued access to medically necessary items and be properly informed about the steps they must take so that their services will not be interrupted.

M. Changes to Allowed and Actual Expenditures for Calculating the Physician Fee Schedule Update

In sections V. and VI. of this final rule with comment period, we described our decision to remove drugs from the calculation of allowed and actual expenditures since the 1996/1997 base year and the SGR rate of increase for future years. While removing physician-administered drugs from allowed and actual expenditures will not change the −21.3 percent physician payment rate update (the −21.2 percent change to the CF accounts for an additional 0.1 percent BN adjustment for changes to the RVUs) for services furnished on or after January 1, 2010, this change reduces the discrepancy between actual and target expenditures. Based on the President's budget, we estimate this proposal will cost $45.4 billion from 2010 to 2014 and $122 billion for 2010 to 2019.

N. Alternatives Considered

This final rule with comment period contains a range of policies, including some provisions related to specific MIPPA provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, responds to comments on our proposals, presents rationale for our decisions and, where relevant, alternatives that were considered.

O. Impact on Beneficiaries

There are a number of changes in this final rule with comment period that would have an effect on beneficiaries. In general, we believe these changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the coding provisions related to the IPPE and consultation services, the changes with respect to telehealth services, the kidney disease patient education, pulmonary rehabilitation and intensive cardiac rehabilitation proposals will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. Additionally, the grandfathering process for DME suppliers will help ensure that beneficiaries are contacted and informed about this process and the choices they have concerning whether or not to use a grandfathered supplier. Moreover, the notice will help to ensure that beneficiaries do not have necessary DME equipment taken from them unexpectedly by a noncontact supplier.

As explained in more detail subsequently in this section, the regulatory provisions may affect beneficiary liability in some cases. Most changes aggregate in beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible). Beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provision on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings). In 2010, total cost sharing (coinsurance and deductible) per Part B enrollee associated with PFS services is estimated to be $399. In addition, the portion of the 2010 standard monthly Part B premium attributable to PFS services is estimated to be $25.70.

To illustrate this point, as shown in Table 50, the 2009 national payment amount in the non-facility setting for CPT code 99203 (Office/outpatient visit, new), is $91.97 which means that in 2009 a beneficiary is responsible for 20 percent of this amount, or $18.39. Based on this rule, the 2010 national payment amount in the non-facility setting for CPT code 99203, as shown in Table 49, is $76.98 which means that, in 2010, the beneficiary coinsurance for this service would be $15.40.

Policies discussed in this rule, such as the coding changes with respect to the RVUs for IPPE and the changes to consultation services, would similarly impact beneficiaries' coinsurance.

P. Accounting Statement

As required by OMB Circular A–4, in Table 54, we have prepared an accounting statement showing the classification of the expenditures associated with this final rule with comment period. This estimate includes the incurred benefit impact associated with the estimated CY 2010 PFS update based on the 2009 Trustees Report baseline, as well as certain MIPPA provisions. All estimated impacts are classified as transfers.

TABLE 54—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES CY 2010

Category	Transfers
Annualized Monetized Transfers	Estimated decrease in expenditures (from CY 2009 to CY 2010) of $13.3 Billion.
From Whom to Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.
Annualized Monetized Transfers	Estimated increase in expenditures of $110 Million for MIPPA Provisions (sections 102 and 152(b)).
From Whom to Whom?	Federal Government to providers.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

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

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and record keeping requirements.

42 CFR Part 414

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

42 CFR Part 415

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

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

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

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

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

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart B—Medical and Other Health Services

■ 2. Section 410.30 is amended by revising paragraph (b) to read as follows:

§ 410.30 Prescription drugs used in immunosuppressive therapy.

* * * * *

(b) *Eligibility.* For drugs furnished on or after December 21, 2000, coverage is available only for prescription drugs used in immunosuppressive therapy, furnished to an individual who received an organ or tissue transplant for which Medicare payment is made, provided the individual is eligible to receive Medicare Part B benefits.

* * * * *

■ 3. Section 410.47 is added to read as follows:

§ 410.47 Pulmonary rehabilitation program: Conditions for coverage.

(a) *Definitions.* As used in this section:

Individualized treatment plan means a written plan established, reviewed, and signed by a physician every 30 days, that describes all of the following:

(i) The individual's diagnosis.

(ii) The type, amount, frequency, and duration of the items and services under the plan.

(iii) The goals set for the individual under the plan.

Medical director means the physician who oversees or supervises the PR program.

Outcomes assessment means a written evaluation of the patient's progress as it relates to the individual's rehabilitation which includes the following:

(i) Beginning and end evaluations, based on patient-centered outcomes, which are conducted by the physician at the start and end of the program.

(ii) Objective clinical measures of effectiveness of the PR program for the individual patient, including exercise performance and self-reported measures of shortness of breath and behavior.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Physician-prescribed exercise means physical activity, including aerobic exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level.

Psychosocial assessment means a written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition.

Pulmonary rehabilitation means a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

Supervising physician means a physician that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished under the PR program.

(b) *Beneficiaries who may be covered.* (1) Medicare covers pulmonary rehabilitation for beneficiaries with moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease.

(2) Additional medical indications for coverage for pulmonary rehabilitation program services may be established through a national coverage determination (NCD).

(c) *Components.* Pulmonary rehabilitation includes all of the following components:

(1) *Physician-prescribed exercise.* This physical activity includes techniques such as exercise conditioning, breathing retraining, step, and strengthening exercises. Some aerobic exercise must be included in each pulmonary rehabilitation session.

(2) *Education or training.* (i) Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs.

(ii) Education includes information on respiratory problem management and, if appropriate, brief smoking cessation counseling.

(iii) Any education or training prescribed must assist in achievement of individual goals towards independence in activities of daily living, adaptation to limitations and improved quality of life.

(3) *Psychosocial assessment.* The psychosocial assessment must meet the criteria as defined in paragraph (a) of this section and includes:

(i) An assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment.

(ii) A psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

(4) *Outcomes assessment.* The outcomes assessment must meet the criteria as defined in paragraph (a) of this section.

(5) *Individualized treatment plan.* The individualized treatment plan must be established, reviewed, and signed by a physician, who is involved in the patient's care and has knowledge related to his or her condition, every 30 days.

(d) *Settings.* (1) Medicare Part B pays for a pulmonary rehabilitation in the following settings:

(i) Physician's offices.

(ii) Hospital outpatient settings.

(2) All settings must have the following available for immediate use and accessible at all times:

(i) The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

(ii) A physician must be immediately available and accessible for medical consultations and emergencies at all times when services are being provided under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26 of this subpart and for hospital outpatient services at § 410.27 of this subpart.

(e) *Physician standards.* Medicare Part B pays for pulmonary rehabilitation services for PR programs supervised by a physician who meets the following requirements—

(1) Is responsible and accountable for the pulmonary rehabilitation program, including oversight of the PR staff.

(2) Is involved substantially, in consultation with staff, in directing the progress of the individual in the program including direct patient contact related to the periodic review of his or her treatment plan.

(3) Has expertise in the management of individuals with respiratory pathophysiology, and cardiopulmonary training and/or certification including basic life support.

(4) Is licensed to practice medicine in the State in which the pulmonary rehabilitation program is offered.

(f) *Limitations on coverage: Sessions.* Medicare Part B pays for services provided in connection with a pulmonary rehabilitation exercise

program for up to 36 sessions, no more than two sessions per day. Up to an additional 36 sessions may be approved by the Medicare contractor, based on medical necessity in accordance with section 1862(a)(1)(A) of the Act.

(g) *Effective date.* Coverage for pulmonary rehabilitation program services is effective January 1, 2010.

■ 4. Section 410.48 is added to read as follows:

§ 410.48 Kidney disease education services.

(a) *Definitions.* As used in this section:

Kidney disease patient education services means face-to-face educational services provided to patients with Stage IV chronic kidney disease.

Physician means a physician as defined in section 1861(r)(1) of the Act.

Qualified person means either of the following healthcare entities that meets the qualifications and requirements specified in this section to provide kidney disease patient education services—

(i) One of the following healthcare professionals who furnishes services for which payment may be made under the physician fee schedule:

(A) Physician (as defined in section 1861(r)(1) of the Act).

(B) Physician assistant as defined in section 1861(aa)(5) of the Act and § 410.74 of this subpart).

(C) Nurse practitioner as defined in section 1861(aa)(5) of the Act and § 410.75 of this subpart).

(D) Clinical nurse specialist (as defined in section 1861(aa)(5) of the Act and § 410.76 of this subpart),

(ii)(A) A hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice that is located in a rural area as defined in § 412.64(b)(ii)(C) of this chapter; or

(B) A hospital or critical access hospital that is treated as being rural under § 412.103 of this chapter.

Renal dialysis facility means a unit, which is approved to furnish dialysis service(s) directly to end-stage renal disease (ESRD) patients, as defined in § 405.2102 of this chapter.

Stage IV chronic kidney disease means kidney damage with a severe decrease in glomerular filtration rate (GFR) quantitatively defined by a GFR value of 15–29 ml/min/1.73m^2, using the Modification of Diet in Renal Disease (MDRD) Study formula.

(b) *Covered beneficiaries.* Medicare Part B covers outpatient kidney disease patient education services if the beneficiary meets all of the conditions and requirements of this subpart, including all of the following:

(1) Is diagnosed with Stage IV chronic kidney disease.

(2) Obtains a referral from the physician (as defined in section 1861(r)(1) of the Act) managing the beneficiary's kidney condition.

(c) *Qualified person.* (1) Medicare Part B covers outpatient kidney disease patient education services provided by a qualified person as defined in paragraph (a) of this section and must be able to properly receive Medicare payment under part 424 of this chapter.

(2) A qualified person does not include either of the following:

(i) A hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice if kidney disease patient education services are provided outside of a rural area as defined in § 412.64(b)(ii)(C) of this chapter unless the services are furnished in a hospital or critical access hospital that is treated as being in a rural area under § 412.103 of this chapter.

(ii) A renal dialysis facility, as defined in § 405.2102 of this chapter.

(d) *Standards for content of kidney disease patient education services.* The content of the kidney disease patient education services includes the following:

(1) The management of comorbidities including for the purpose of delaying the need for dialysis which includes, but not limited to, the following topics:

(i) Prevention and treatment of cardiovascular disease.

(ii) Prevention and treatment of diabetes.

(iii) Hypertension management.

(iv) Anemia management.

(v) Bone disease and disorders of calcium and phosphorus metabolism management.

(vi) Symptomatic neuropathy management.

(vii) Impairments in functioning and well-being.

(2) The prevention of uremic complications which includes, but not limited to, the following topics:

(i) Information on how the kidneys work and what happens when the kidneys fail.

(ii) Understanding if remaining kidney function can be protected, preventing disease progression, and realistic chances of survival.

(iii) Diet and fluid restrictions.

(iv) Medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision-making if the patient decides not to take a specific drug.

(3) Therapeutic options, treatment modalities, and settings, including a discussion of the advantages and disadvantages of each treatment option and how the treatments replace the kidney, which includes, but not limited to, the following topics:

(i) Hemodialysis, both at home and in-facility.

(ii) Peritoneal dialysis (PD), including intermittent PD, continuous ambulatory PD, and continuous cycling PD, both at home and in-facility.

(iii) All dialysis access options for hemodialysis and peritoneal dialysis.

(iv) Transplantation.

(4) Opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved which includes, but not limited to, the following topics:

(i) Physical symptoms.

(ii) Impact on family and social life.

(iii) Exercise.

(iv) The right to refuse treatment.

(v) Impact on work and finances.

(vi) The meaning of test results.

(vii) Psychological impact.

(5) Qualified persons must develop outcomes assessments designed to measure beneficiary knowledge about chronic kidney disease and its treatment.

(i) The outcomes assessments serve to assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to chronic kidney disease.

(ii) The outcomes assessments serve to assess the program's effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

(iii) The assessment must be administered to the beneficiary during a kidney disease education session.

(iv) The outcomes assessments must be made available to CMS upon request.

(e) *Limitations for coverage of kidney disease education services.* (1) Medicare Part B makes payment for up to 6 sessions of kidney disease patient education services.

(2) A session is 1 hour long and may be provided individually or in group settings of 2 to 20 individuals who need not all be Medicare beneficiaries.

(f) *Effective date.* Medicare Part B covers kidney disease patient education services for dates of service on or after January 1, 2010.

■ 5. Section 410.49 is added to read as follows:

§ 410.49 Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage.

(a) *Definitions.* As used in this section:

Cardiac rehabilitation (CR) means a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Individualized treatment plan means a written plan tailored to each individual patient that includes all of the following:

(i) A description of the individual's diagnosis.

(ii) The type, amount, frequency, and duration of the items and services furnished under the plan.

(iii) The goals set for the individual under the plan.

Intensive cardiac rehabilitation (ICR) program means a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements described in paragraph (c) of this section.

Intensive cardiac rehabilitation site means a hospital outpatient setting or physician's office that is providing intensive cardiac rehabilitation utilizing an approved ICR program.

Medical director means a physician that oversees or supervises the cardiac rehabilitation or intensive cardiac rehabilitation program at a particular site.

Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes all of the following:

(i) Minimally, assessments from the commencement and conclusion of cardiac rehabilitation and intensive cardiac rehabilitation, based on patient-centered outcomes which must be measured by the physician immediately at the beginning of the program and at the end of the program.

(ii) Objective clinical measures of exercise performance and self-reported measures of exertion and behavior.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Physician-prescribed exercise means aerobic exercise combined with other types of exercise (that is, strengthening, stretching) as determined to be appropriate for individual patients by a physician.

Psychosocial assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

Supervising physician means a physician that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished to individuals under cardiac rehabilitation and intensive cardiac rehabilitation programs.

(b) *General rule.* (1) *Covered beneficiary rehabilitation services.* Medicare part B covers cardiac rehabilitation and intensive cardiac rehabilitation program services for beneficiaries who have experienced one or more of the following:

(i) An acute myocardial infarction within the preceding 12 months;

(ii) A coronary artery bypass surgery;

(iii) Current stable angina pectoris;

(iv) Heart valve repair or replacement;

(v) Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;

(vi) A heart or heart-lung transplant.

(vii) For cardiac rehabilitation only, other cardiac conditions as specified through a national coverage determination.

(2) *Components of a cardiac rehabilitation program and an intensive cardiac rehabilitation program.* Cardiac rehabilitation programs and intensive cardiac rehabilitation programs must include all of the following:

(i) Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished.

(ii) Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the patients' individual needs.

(iii) Psychosocial assessment.

(iv) Outcomes assessment.

(v) An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

(3) *Settings.* (i) Medicare Part B pays for cardiac rehabilitation and intensive cardiac rehabilitation in one of the following settings:

(A) A physician's office.

(B) A hospital outpatient setting.

(ii) All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services, at § 410.26 of this subpart; and for hospital outpatient services at § 410.27 of this subpart.

(c) *Standards for an intensive cardiac rehabilitation program.* (1) To be approved as an intensive cardiac rehabilitation program, a program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following for its patients:

(i) Positively affected the progression of coronary heart disease.

(ii) Reduced the need for coronary bypass surgery.

(iii) Reduced the need for percutaneous coronary interventions;

(2) An intensive cardiac rehabilitation program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in 5 or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

(i) Low density lipoprotein.

(ii) Triglycerides.

(iii) Body mass index.

(iv) Systolic blood pressure.

(v) Diastolic blood pressure.

(vi) The need for cholesterol, blood pressure, and diabetes medications.

(3) A list of approved intensive cardiac rehabilitation programs, identified through the national coverage determination process, will be posted to the CMS Web site and listed in the **Federal Register.**

(4) All prospective intensive cardiac rehabilitation sites must apply to enroll as an intensive cardiac rehabilitation program site using the designated forms as specified at § 424.510 of this chapter. For purposes of appealing an adverse determination concerning site approval, an intensive cardiac rehabilitation site is considered a supplier (or prospective supplier) as defined in § 498.2 of this chapter.

(d) *Standards for the physician responsible for cardiac rehabilitation program.* A physician responsible for a cardiac rehabilitation program or intensive cardiac rehabilitation programs is identified as the medical directors. The medical director, in consultation with staff, are involved in directing the progress of individuals in the program, must possess all of the following:

(1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Cardiopulmonary training in basic life support or advanced cardiac life support.

(3) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

(e) *Standards for supervising-physicians.* Physicians acting as the supervising-physician must possess all of the following:

(1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Cardiopulmonary training in basic life support or advanced cardiac life support.

(3) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

(f) *Limitations for coverage of cardiac rehabilitation programs.* (1) *Cardiac Rehabilitation:* The number of cardiac rehabilitation program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor under section 1862(a)(1)(A) of the Act.

(2) *Intensive Cardiac Rehabilitation:* Intensive cardiac rehabilitation program sessions are limited to 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

■ 6. Section 410.78 is amended by—

■ A. Revising the introductory text of paragraph (b).

■ B. Revising paragraph (e).

The revisions read as follows:

§ 410.78 Telehealth services.

* * * * *

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, the neurobehavioral status exam, initial and follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals and SNFs, and individual health and behavior assessment and intervention services furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

(e) *Limitations.* (1) A clinical psychologist and a clinical social worker may bill and receive payment for individual psychotherapy via a telecommunications system, but may not seek payment for medical evaluation and management services.

(2) The physician visits required under § 483.40(c) of this title may not be furnished as telehealth services.

* * * * *

Subpart I—Payment of SMI Benefits

■ 7. Section 410.155 is amended by—

■ A. Revising paragraphs (a), (b)(2)(i), (b)(2)(ii), (b)(2)(iv), (b)(2)(v), and (c).

■ B. Adding paragraph (b)(3).

The revisions and addition read as follows:

§ 410.155 Outpatient mental health treatment limitation.

(a) *Limitation.* For services subject to the limitation as specified in paragraph (b) of this section, the percentage of the expenses incurred for such services during a calendar year that is considered incurred expenses under Medicare Part B when determining the amount of payment and deductible under § 410.152 and § 410.160 of this part, respectively, is as follows:

(1) For expenses incurred in years before 2010, 62½ percent.

(2) For expenses incurred in 2010 and 2011, 68¾ percent.

(3) For expenses incurred in 2012, 75 percent.

(4) For expenses incurred in 2013, 81¼ percent.

(5) For expenses incurred in CY 2014 and subsequent years, 100 percent.

(b) * * *

(2) * * *

(i) Services furnished to a hospital inpatient.

(ii) Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders *billed under HCPCS code M0064 (or its successor).*

* * * * *

(iv) Psychiatric diagnostic services billed under CPT codes 90801 and 90802 (or successor codes) and diagnostic psychological and neuropsychological tests billed under CPT code range 96101 through 96125 (or successor codes) that are performed to establish a diagnosis.

(v) Medical management such as that furnished under CPT code 90862 (or its successor code), as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

(3) *Payment amounts.* The Medicare payment amount and the patient liability amounts for outpatient mental health services subject to the limitation for each year during which the limitation is phased out are as follows:

Calendar year	Recognized incurred expenses	Patient pays	Medicare pays
CY 2009 and prior calendar years	62.50%	50%	50%
CYs 2010 and 2011	68.75%	45%	55%
CY 2012	75.00%	40%	60%
CY 2013	81.25%	35%	65%
CY 2014	100.00%	20%	80%

(c) *General formula.* A general formula for calculating the amount of Medicare payment and the patient liability for outpatient mental health services subject to the limitation is as follows:

(1) Multiply the Medicare approved amount by the percentage of incurred expenses that is recognized as incurred expenses for Medicare payment purposes for the year involved;

(2) Subtract from this amount the amount of any remaining Part B deductible for the patient and year involved; and,

(3) Multiply this amount by 0.80 (80 percent) to obtain the Medicare payment amount.

(4) Subtract the Medicare payment amount from the Medicare-approved amount to obtain the patient liability amount.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

■ 9. Section 411.354 is amended by revising paragraph (c)(3)(i) to read as follows:

§ 411.354 Financial relationship, compensation, and ownership or investment interest.

* * * * *

(c) * * *

(3)(i) For purposes of paragraphs (c)(1)(ii) and (c)(2)(iv) of this section, a physician who ''stands in the shoes'' of his or her physician organization is deemed to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization. When applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated ''between the parties'' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).

* * * * *

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

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

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

Subpart B—Physicians and Other Practitioners

■ 11. Section 414.46 is amended by revising paragraphs (d)(2) and (e) to read as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * *

(d) * * *

(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.

(i) 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.

(ii) For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single anesthesia resident case that is concurrent to another case which is paid under the medical direction payment rules as specified in paragraph (e) of this section.

* * * * *

(e) *Special payment rule for teaching anesthesiologist involved in a single resident case or two concurrent cases.* For physicians' services furnished on or after January 1, 2010, if the teaching anesthesiologist is involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount must be 100 percent of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist and the teaching anesthesiologist fulfilled the criteria in § 415.178 of this chapter. This special payment rule also applies if the teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under the medical direction payment rules.

* * * * *

■ 12. Section 414.61 is added to read as follows:

§ 414.61 Payment for anesthesia services furnished by a teaching CRNA.

(a) *Basis for payment.* Beginning January 1, 2010, anesthesia services furnished by a teaching CRNA may be paid under one of the following conditions:

(1) The teaching CRNA, who is not under medical direction of a physician, is present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base units payment and is continuously present during anesthesia time in a single case with a student nurse anesthetist.

(2) The teaching CRNA, who is not under the medical direction of a physician, is involved with two concurrent anesthesia cases with student nurse anesthetists. The teaching CRNA must be present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base unit. For the anesthesia time of the two concurrent cases, the teaching CRNA can only be involved with those two concurrent cases and may not perform services for other patients.

(b) *Level of payment.* The allowance for the service of the teaching CRNA, furnished under paragraph (a) of this section, is determined in the same way as for a physician who personally performs the anesthesia service alone as specified in § 414.46(c) of this subpart.

■ 13. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management, end-stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, and individual health and behavior assessment and intervention services furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

(i) *Initial inpatient telehealth consultations.* The Medicare payment amount for initial inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to initial hospital care provided by a physician or practitioner.

(ii) *Follow-up inpatient telehealth consultations.* The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

* * * * *

■ 14. Section 414.68 is added to subpart B to read as follows:

§ 414.68 Imaging accreditation.

(a) *Scope and purpose.* Section 1834(e) of the Act requires the Secretary to designate and approve independent accreditation organizations for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services and establish procedures to ensure that the criteria used by an accreditation organization is specific to each imaging modality. Suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012.

(b) *Definitions.* As used in this section, the following definitions are applicable:

Accredited supplier means a supplier that has been accredited by a CMS-designated accreditation organization as specified in this part.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic resonance imaging.

(ii) Computed tomography.

(iii) Nuclear medicine.

(iv) Positron emission tomography.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified in section 1834(e) of the Act.

(c) *Application and reapplication procedures for accreditation organizations.* An independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the TC of advanced diagnostic imaging services is required to furnish CMS with all of the following:

(1) A detailed description of how the organization's accreditation criteria satisfy the statutory standards authorized by section 1834(e)(3) of the Act, specifically—

(i) Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

(ii) Qualifications and responsibilities of medical directors and supervising physicians (who may be the same person), such as their training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

(iii) Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier, including a thorough evaluation of equipment performance and safety;

(iv) Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished;

(v) Procedures to assist the beneficiary in obtaining the beneficiary's imaging records on request; and

(vi) Procedures to notify the accreditation organization of any changes to the modalities subsequent to the organization's accreditation decision.

(2) An agreement to conform accreditation requirements to any changes in Medicare statutory requirements authorized by section 1834(e) of the Act. The accreditation organization must maintain or adopt standards that are equal to, or more stringent than, those of Medicare.

(3) Information that demonstrates the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.

(4) The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation, including any plans for reducing the burden and cost of accreditation to small and rural suppliers.

(5) Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

(6) A detailed description of the organization's survey process, including the following:

(i) Type and frequency of the surveys performed.

(ii) The ability of the organization to conduct timely reviews of accreditation applications, to include the organizations national capacity.

(iii) Description of the organization's audit procedures, including random site visits, site audits, or other strategies for ensuring suppliers maintain compliance for the duration of accreditation.

(iv) Procedures for performing unannounced site surveys.

(v) Copies of the organization's survey forms.

(vi) A description of the accreditation survey review process and the accreditation status decision-making process, including the process for addressing deficiencies identified with the accreditation requirements, and the procedures used to monitor the correction of deficiencies found during an accreditation survey.

(vii) Procedures for coordinating surveys with another accrediting organization if the organization does not accredit all products the supplier provides.

(viii) Detailed information about the individuals who perform evaluations for the accreditation organization, including all of the following information:

(A) The number of professional and technical staff that are available for surveys.

(B) The education, employment, and experience requirements surveyors must meet.

(C) The content and length of the orientation program.

(ix) The frequency and types of in-service training provided to survey personnel.

(x) The evaluation systems used to monitor the performance of individual surveyors and survey teams.

(xi) The policies and procedures regarding an individual's participation in the survey or accreditation decision process of any organization with which the individual is professionally or financially affiliated.

(xii) The policies and procedures used when an organization has a dispute regarding survey findings or an adverse decision.

(7) Detailed information about the size and composition of survey teams for each category of advanced medical imaging service supplier accredited.

(8) A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(9) The organization's procedures for responding to and for the investigation of complaints against accredited facilities, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and CMS.

(10) The organization's policies and procedures for the withholding or removal of accreditation status for facilities that fail to meet the accreditation organization's standards or requirements, and other actions taken by the organization in response to noncompliance with its standards and requirements. These policies and procedures must include notifying CMS of Medicare facilities that fail to meet the requirements of the accrediting organization.

(11) A list of all currently accredited suppliers, the type and category of accreditation currently held by each supplier, and the expiration date of each supplier's current accreditation.

(12) A written presentation that demonstrates the organization's ability to furnish CMS with electronic data in ASCII comparable code.

(13) A resource analysis that demonstrates that the organization's staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(14) A statement acknowledging that, as a condition for approval of designation, the organization agrees to carry out the following activities:

(i) Prioritize surveys for those suppliers needing to be accredited by January 1, 2012.

(ii) Notify CMS, in writing, of any Medicare supplier that had its accreditation revoked, withdrawn, revised, or any other remedial or adverse action taken against it by the accreditation organization within 30 calendar days of any such action taken.

(iii) Notify all accredited suppliers within 10 calendar days of the organization's removal from the list of designated accreditation organizations.

(iv) Notify CMS, in writing, at least 30 calendar days in advance of the effective date of any significant proposed changes in its accreditation requirements.

(v) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(vi) Notify CMS, in writing (electronically or hard copy), within 2 business days of a deficiency identified in any accreditation supplier from any source where the deficiency poses an immediate jeopardy to the supplier's beneficiaries or a hazard to the general public.

(vii) Provide, on an annual basis, summary data specified by CMS that relates to the past year's accreditations and trends.

(viii) Attest that the organization will not perform any accreditation surveys of Medicare-participating suppliers with which it has a financial relationship in which it has an interest.

(ix) Conform accreditation requirements to changes in Medicare requirements.

(x) If CMS withdraws an accreditation organization's approved status, work collaboratively with CMS to direct suppliers to the remaining accreditation organizations within a reasonable period of time.

(d) *Determination of whether additional information is needed.* If CMS determines that additional information is necessary to make a determination for approval or denial of the accreditation organization's application for designation, the organization must be notified and afforded an opportunity to provide the additional information.

(e) *Visits to the organization's office.* CMS may visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, reviewing documents and interviewing the organization's staff.

(f) *Formal notice from CMS.* The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied the notice includes the basis for denial and reconsideration and reapplication procedures.

(g) *Ongoing responsibilities of a CMS-approved accreditation organization.* An accreditation organization approved by CMS must carry out the following activities on an ongoing basis:

(1) Provide CMS with all of the following in written format (either electronic or hard copy):

(i) Copies of all accreditation surveys, together with any survey-related information that CMS may require (including corrective action plans and summaries of findings with respect to unmet CMS requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to suppliers.

(iv) Information about all accredited suppliers against which the accreditation organization has taken remedial or adverse action, including revocation, withdrawal, or revision of the supplier's accreditation.

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without CMS' approval, CMS may withdraw its approval of the accreditation organization.

(2) Within 30 calendar days after a change in CMS requirements, the accreditation organization must submit an acknowledgment of receipt of CMS' notification to CMS.

(3) The accreditation organization must permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(4) Within 2 business days of identifying a deficiency of an accredited supplier that poses immediate jeopardy to a beneficiary or to the general public, the accreditation organization must provide CMS with written notice of the deficiency and any adverse action implemented by the accreditation organization.

(5) Within 10 calendar days after CMS' notice to a CMS-approved accreditation organization that CMS intends to withdraw approval of the accreditation organization, the accreditation organization must provide written notice of the withdrawal to all of the organization's accredited suppliers.

(6) The organization must provide, on an annual basis, summary data specified by CMS that relate to the past year's accreditation activities and trends.

(h) *Continuing Federal oversight of approved accreditation organizations.* This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of a CMS-approved accreditation organization.

(1) *Validation audits.* (i) CMS or its contractor may conduct an audit of an accredited supplier to validate the survey accreditation process of approved accreditation organizations for the TC of advanced diagnostic imaging services.

(ii) The audits must be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards.

(A) When conducted on a representative sample basis, the audit is comprehensive and addresses all of the standards, or may focus on a specific standard in issue.

(B) When conducted in response to an allegation, CMS audits any standards that CMS determines are related to the allegations.

(2) *Notice of intent to withdraw approval.* (i) If, during the audit specified in paragraph (h)(1) of this section, CMS identifies any accreditation programs for which validation audit results indicate—

(A) A 10 percent or greater rate of disparity between findings by the accreditation organization and findings by CMS on standards that do not constitute immediate jeopardy to patient health and safety if unmet; or

(B) Any disparity between findings by the accreditation organization and findings by CMS on standards that constitute immediate jeopardy to patient health and safety if unmet; or,

(C) Irrespective of the rate of disparity, widespread or systemic problems in an organization's accreditation process such that accreditation by that accreditation organization no longer provides CMS with adequate assurance that suppliers meet or exceed the Medicare requirements; then CMS will give the organization written notice of its intent to withdraw approval as specified in paragraph (h)(3) of this section.

(ii) CMS may also provide the organization written notice of its intent to withdraw approval if an equivalency review, onsite observation, or CMS' daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this section.

(3) *Withdrawal of approval.* CMS may withdraw its approval of an accreditation organization at any time if CMS determines that—

(i) Accreditation by the organization no longer adequately assures that the suppliers furnishing the technical component of advanced diagnostic imaging service are meeting the established industry standards for each modality and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a

significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations with respect to application or reapplication procedures.

(i) *Reconsideration.* An accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not renew the approval of designation to accreditation organizations if the accreditation organization files a written request for reconsideration by its authorized officials or through its legal representative.

(1) *Filing requirements.* (i) The request must be filed within 30 calendar days of the receipt of CMS notice of an adverse determination or non-renewal.

(ii) The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

(iii) A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination.

(2) *CMS response to a filing request.* In response to a request for reconsideration, CMS provides the accreditation organization with—

(i) The opportunity for an informal hearing to be conducted by a hearing officer appointed by the Administrator of CMS and provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew designation; and

(ii) Written notice of the time and place of the informal hearing at least 10 business days before the scheduled date.

(3) *Hearing requirements and rules.* (i) The informal reconsideration hearing is open to all of the following:

(A) CMS.

(B) The organization requesting the reconsideration including—

(*1*) Authorized representatives;

(*2*) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and

(*3*) Legal counsel.

(ii) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.

(iii) Testimony and other evidence may be accepted by the hearing officer even though such evidence may be inadmissible under the Federal Rules of Civil Procedure.

(iv) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

(v) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.

(vi) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer.

(vii) The hearing officer's decision is final.

Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

■ 15. Section 414.210 is amended by—

■ A. Revising paragraph (e)(2).

■ B. Adding paragraph (e)(5).

The revision and addition read as follows:

§ 414.210 General payment rules.

* * * * *

(e) * * *

(2) *Maintenance and servicing payment for certain oxygen equipment furnished after the 36-month rental period from January 1, 2009 through June 30, 2010.* The carrier makes a maintenance and servicing payment for oxygen equipment other than liquid and gaseous equipment (stationary and portable) as follows:

(i) For the first 6-month period following the date on which the 36-month rental period ends in accordance with § 414.226(a)(1) of this subpart, no payments are made.

(ii) For each succeeding 6-month period, payment may be made during the first month of that period for 30 minutes of labor for routine maintenance and servicing of the equipment in the beneficiary's home (including an institution used as the beneficiary's home).

(iii) The supplier must visit the beneficiary's home (including an institution used as the beneficiary's home) to inspect the equipment during the first month of the 6-month period.

* * * * *

(5) *Maintenance and servicing payment for certain oxygen equipment furnished after the 36-month rental period and on or after July 1, 2010.* For oxygen equipment other than liquid and gaseous equipment (stationary and portable), the carrier makes payment as follows:

(i) For the first 6-month period following the date on which the 36-month rental period ends in accordance with § 414.226(a)(1) of this subpart, no payments are made.

(ii) For each succeeding 6-month period, payment may be made during the first month of that period for routine maintenance and servicing of the equipment in the beneficiary's home (including an institution used as the beneficiary's home).

(iii) Payment for maintenance and servicing is made based on a reasonable fee not to exceed 10 percent of the purchase price for a stationary oxygen concentrator. This payment includes payment for maintenance and servicing of all oxygen equipment other than liquid or gaseous equipment (stationary or portable).

(iv) The supplier must visit the beneficiary's home (including an institution used as the beneficiary's home) to inspect the equipment during the first month of the 6-month period.

* * * * *

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

■ 16. Section 414.402 is amended by revising the definition ''Grandfathered item'' to read as follows:

§ 414.402 Definitions.

* * * * *

Grandfathered item means all rented items within a product category for which payment was made prior to the implementation of a competitive bidding program to a grandfathered supplier that chooses to continue to furnish the items in accordance with § 414.408(j) of this subpart and that fall within the following payment categories for competitive bidding:

(1) An inexpensive or routinely purchased item described in § 414.220 of this part.

(2) An item requiring frequent and substantial servicing, as described in § 414.222 of this part.

(3) Oxygen and oxygen equipment described in § 414.226 of this part.

(4) Other DME described in § 414.229 of this part.

* * * * *

■ 17. Section 414.408 is amended by—

■ A. Redesignating paragraph (j)(5) as (j)(7).

■ B. Adding new paragraphs (j)(5) and (j)(6).

■ C. Revising paragraph (k)(2).

The additions and revision read as follows:

§ 414.408 Payment rules.

* * * * *

(j) * * *

(5) *Notification of beneficiaries and CMS by suppliers that choose to become grandfathered suppliers.* (i) *Notification of beneficiaries by suppliers.* (A) *Requirements of notification.* A noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the following requirements:

(*1*) Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the competitive bidding program for the CBA in which the beneficiary resides.

(*2*) Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.

(*3*) Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.

(*4*) State that the supplier is willing to continue to furnish certain rented Durable Medical Equipment (DME), oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the competitive bidding program) and is willing to continue to provide these items to the beneficiary for the remaining rental months.

(*5*) State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.

(*6*) Provide the supplier's telephone number and instruct the beneficiary to call the supplier with any questions and to notify the supplier of his or her decision to use or not use the supplier as a grandfathered supplier.

(*7*) State that the beneficiary can obtain information about the competitive bidding program by calling 1–800–MEDICARE or on the Internet at *http://www.Medicare.gov*.

(B) *Record of beneficiary's choice.* The supplier should obtain an election from the beneficiary regarding whether to use or not use the supplier as a grandfathered supplier. The supplier must maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. When the supplier obtains such an election, the supplier must maintain a record of the beneficiary decision including the date the choice was made, and how the beneficiary communicated his or her choice to the supplier.

(C) *Notification.* If the beneficiary chooses not to continue to receive a grandfathered item(s) from their current supplier, the supplier must provide the beneficiary with 2 more notices in addition to the 30-day notice prior to the supplier picking up its equipment.

(*1*) *10-day notification:* Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up. This should occur on the first anniversary date after the start of the CBP or on another date agreed to by the beneficiary or the beneficiary's caregiver. The beneficiary's anniversary date occurs every month and is the date of the month on which the item was first delivered to the beneficiary by the current supplier. When a date other than the anniversary date is chosen by the beneficiary or the beneficiary's caregiver, the noncontract supplier will still receive payment up to the anniversary date after the start of the CBP, and the new contract supplier may not bill for any period of time before the anniversary date.

(*2*) *2-day notification:* Two business days prior to picking up the item the supplier should contact the beneficiary or the beneficiary's caregiver by phone to notify the beneficiary of the date the supplier will pick up the item. This date should not be before the beneficiary's first anniversary date that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(D) *Pickup procedures.* (*1*) The pickup of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(*2*) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(*3*) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary.

(*4*) The contract supplier may not submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP, and the contract supplier may not begin billing until the first anniversary date that occurs after the beginning of the CBP.

(*5*) The noncontract supplier must submit a claim to be paid up to the first anniversary date that occurs after the beginning of the CBP. Therefore, they should not pick up the equipment before that date unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(ii) *Notification to CMS by suppliers.* A noncontract supplier that elects to become a grandfathered supplier must provide a written notification to CMS of this decision. This notification must meet the following requirements:

(A) State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the competitive bidding program) in a CBA and will continue to provide these items to these beneficiaries for the remaining months of the rental period.

(B) Include the following information:

(*1*) Name and address of the supplier.

(*2*) The 6-digit NSC number of the supplier.

(*3*) Product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.

(C) State that the supplier agrees to meet all the terms and conditions pertaining to grandfathered suppliers.

(D) Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of the Medicare DMEPOS Competitive Bidding Program.

(6) *Suppliers that choose not to become grandfathered suppliers.* (i) *Requirement for non-grandfathered supplier.* A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification.

(ii) *Notification.* Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are

currently renting certain DME competitively bid item(s) and who reside in a CBA.

(iii) *Requirements of notification.* These notifications must meet all of the requirements listed in paragraph (j)(5)(i) of this section for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, with the following exceptions for the 30-day notice.

(A) State that, for those items for which the supplier has decided not to be a grandfathered supplier, the supplier will only continue to rent these competitively bid item(s) to its beneficiaries up to the first anniversary date that occurs after the start of the Medicare DMEPOS Competitive Bidding Program.

(B) State that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

(C) Refer the beneficiary to the contract supplier locator tool on and to 1–800–MEDICARE to obtain information about the availability of contract suppliers for the beneficiary's area.

(iv) *Pickup procedures.* (A) The pick-up of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(B) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(C) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are agreeable to the beneficiary.

(D) The contract supplier cannot submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP.

* * * * *

(k) * * *

(2) Additional payments are made in accordance with § 414.210(e)(2), (e)(3) and (e)(5) of this part for the maintenance and servicing of oxygen equipment if performed by a contract supplier or a noncontract supplier having a valid Medicare billing number.

* * * * *

■ 18. Section 414.425 is added to read as follows:

§ 414.425 Claims for damages.

(a) *Eligibility for filing a claim for damages as a result of the termination of supplier contracts by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).*

(1) Any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP) that believes it has been damaged by the termination of its competitive bid contract, may file a claim under this section.

(2) A subcontractor of a contract supplier is not eligible to submit a claim under this section.

(b) *Timeframe for filing a claim.* (1) A completed claim, including all documentation, must be filed within 90 days of January 1, 2010 (the effective date of these damages provisions), unless that day is a Federal holiday or Sunday in which case it will fall to the next business day.

(2) The date of filing is the actual date of receipt by the CBIC of a completed claim that includes all the information required by this rule.

(c) *Information that must be included in a claim.* (1) Supplier's name, name of authorized official, U.S. Post Office mailing address, phone number, email address and bidding number, and National Supplier Clearinghouse Number;

(2) A copy of the signed contract entered into with CMS for the Round 1 DMEPOS Competitive Bidding Program;

(3) A detailed explanation of the damages incurred by this supplier as a direct result of the termination of the Round 1 competitive bid contract by MIPPA. The explanation must include all of the following:

(i) Documentation of the supplier's damages through receipts.

(ii) Records that substantiate the supplier's damages and demonstrate that the damages are directly related to performance of the Round 1 contract and are consistent with information the supplier provided as part of their bid.

(4) The supplier must explain how it would be damaged if not reimbursed.

(5) The claim must document steps the supplier took to mitigate any damages they may have incurred due to the contract termination, including a detailed explanation of the steps of all attempts to use for other purposes, return or dispose of equipment or other assets purchased or rented for the use in the Round 1 DMEPOS CBP contract performance.

(d) *Items that will not be considered in a claim.* The following items will not be considered in a claim:

(1) The cost of submitting a bid.

(2) Any fees or costs incurred for consulting or marketing.

(3) Costs associated with accreditation or licensure.

(4) Costs incurred before March 20, 2008.

(5) Costs incurred for contract performance after July 14, 2008 except for costs incurred to mitigate damages.

(6) Any profits a supplier may have expected from the contract.

(7) Costs that would have occurred without a contract having been awarded.

(8) Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.

(9) Costs that the supplier has recouped by any means, and may include use of personnel, material, suppliers, or equipment in the supplier's business operations.

(e) *Filing a claim.* (1) A claim, with all supporting documentation, must be filed with the CMS Competitive Bidding Implementation Contractor (CBIC).

(2) Claims must include a statement from a supplier's authorized official certifying the accuracy of the information provided on the claim and all supporting documentation.

(3) The CBIC does not accept electronic submissions of claims for damages.

(f) *Review of claim.* (1) *Role of the CBIC.* (i) The CBIC will review the claim to ensure it is submitted timely, complete, and by an eligible claimant. When the CBIC identifies that a claim is incomplete or not filed timely, it will make a recommendation to the Determining Authority not to process the claim further. Incomplete or untimely claims may be dismissed by the Determining Authority without further processing.

(ii) For complete, timely claims, the CBIC will review the claim on its merits to determine if damages are warranted and may seek further information from the claimant when making its recommendation to the Determining Authority. The CBIC may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iii) The CBIC will make a recommendation to the Determining Authority for each claim filed and

include an explanation that supports its recommendation.

(iv) The recommendation must be either to award damages for a particular amount (which may not be the same amount requested by the claimant) or that no damages should be awarded.

(A) If the CBIC recommends that damages are warranted, the CBIC will calculate a recommended reasonable amount of damages based on the claim submitted.

(B) The reasonable amount will consider both costs incurred and the contractor's attempts and action to limit the damages;

(v) The recommendation will be sent to the Determining Authority for a final determination.

(2) *CMS' role as the Determining Authority.* (i) The Determining Authority shall review the recommendation of the CBIC.

(ii) The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.

(iii) The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iv) If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the decision and the reasons for the final decision.

(v) If the Determining Authority non-concurs with the CBIC recommendation, the Determining Authority may return the claim for further processing or the Determining Authority may:

(A) Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety;

(B) Direct the CBIC to write said determination for the Determining Authority's signature; or

(C) Return the claim to the CBIC with further instructions.

(vi) The Determining Authority's determination is final and not subject to administrative or judicial review.

(g) *Timeframe for determinations.* (1) Every effort will be made to make a determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later.

(2) In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

(h) *Notification to claimant of damage determination.* The CBIC must mail the Determining Authority's determination to the claimant by certified mail return receipt requested, at the address provided in the claim.

Subpart H—Fee Schedule for Ambulance Services

■ 19. Section 414.610 is amended by revising paragraph (c)(5)(i) to read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

(5) * * *

(i) For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and, for services furnished before January 1, 2004, by 25 percent for miles 18 through 50. The standard mileage rate applies to every mile over 50 miles and, for services furnished after December 31, 2003, to every mile over 17 miles. For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.

* * * * *

Subpart J—Submission of Manufacturer's Average Sales Price Data

■ 20. Section 414.802 is amended by revising the definition of ''unit'' to read as follows:

§ 414.802 Definitions.

* * * * *

Unit means the product represented by the 11-digit National Drug Code. The method of counting units excludes units of CAP drugs (as defined in § 414.902 of this part) sold to an approved CAP vendor (as defined in § 414.902 of this part) for use under the CAP (as defined in § 414.902 of this part).

Subpart K—Payment for Drugs and Biologicals Under Part B

§ 414.904 [Amended]

■ 21. Amend § 414.904(d)(3) by removing the phrase ''and 2009'' and adding in its place the phrase ''2009, and 2010.''

■ 22. Section 414.906 is amended by—

■ A. Adding the introductory text to paragraph (c).

■ B. Revising paragraph (c)(1).

■ C. Redesignating paragraph (c)(2) as (c)(3).

■ D. Adding new paragraph (c)(2).

■ E. Adding a paragraph heading to newly designated paragraph (c)(3).

■ F. Adding paragraphs (f)(2)(v), (f)(3)(iv), and (g).

The revision and additions read as follows:

§ 414.906 Competitive acquisition program as the basis for payment.

* * * * *

(c) *Computation of payment amount.* Except as specified in paragraph (c)(2) of this section, payment for CAP drugs is based on bids submitted as a result of the bidding process as described in § 414.910 of this subpart.

(1) *Single payment amount.* (i) A single payment amount for each CAP drug in the competitive acquisition area is determined on the basis of the bids submitted and accepted and updated from the bidding period to the beginning of the payment year.

(ii) The single payment amount is then updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for that category as determined by CMS, and limited by the weighted payment amount established under section 1847A of the Act across all drugs for which a composite bid is required in the category.

(iii) The payment amount for each other drug for which the approved CAP vendor submits a bid in accordance with § 414.910 of this subpart and each other drug that is approved by CMS for the approved CAP vendor to furnish under the CAP is also updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for each HCPCS code and limited by the payment amount established under section 1847A of the Act.

(2) *Updates to payment amount.* (i) The first update is effective on the first day of claims processing for the first quarter of an approved CAP vendor's contract. The first quarterly contract update is based on the reasonable net acquisition cost (RNAC) data reported to CMS or its designee for any purchases of drug before the beginning of CAP claims processing for the contract period and reported to CMS no later than 30 days before the beginning of CAP claims processing.

(ii) For subsequent quarters, each approved CAP vendor must report to CMS or its designee RNAC data for a quarter of CAP drug purchases within 30 days of the close of that quarter.

(iii) For all quarters, only RNAC data from approved CAP vendors that are supplying CAP drugs under their CAP contract at the time updates are being calculated must be used to calculate updated CAP payment amounts.

(iv) CMS excludes such RNAC data submitted by an approved CAP vendor if, during the time calculations are being

done, CMS knows that the approved CAP vendor will not be under contract for the applicable quarterly update.

(v) The payment amount weights must be calculated based on the more recent of the following:

(A) Contract bidding weights.

(B) CAP claims data.

(vi) The payment limit must be determined using the most recent payment limits available to CMS under section 1847A of the Act.

(vii) The following payment amount update calculation must be applied for the group of all drugs for which a composite bid is required.

(A) The most recent previous composite payment amount for the group is updated by—

(*1*) Calculating the percent change in reasonable net acquisition costs for each approved CAP vendor;

(*2*) Calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts; and

(*3*) Limiting the payment as described in paragraph (c)(1) of this section.

(B) The median percent change, subject to the limit described in paragraph (c)(1) of this section, must be the update percentage for that quarter.

(C) The single update percentage must be applied to the payment amount for each drug in the group of drugs for which a composite bid is required in the category.

(viii) The following payment amount update calculation must be applied for each of the following items: Each HCPCS code not included in the composite bid list; Each HCPCS code added to the drug list during the contract period; and each drug that has not yet been assigned a HCPCS code, but for which a HCPCS code will be established.

(A) The most recent previous payment amount for each drug must be updated by calculating the percent change in reasonable net acquisition costs for each approved CAP vendor, then calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts.

(B) The median percent change calculated for each drug, subject to the limit described in paragraph (c)(1) of this section, must be applied to the payment amount for each drug.

(3) *Alternative payment amount.*

* * *

* * * * *

(f) * * *

(2) * * *

(v) On or after January 1, 2010, the proposed addition of drugs with similar therapeutic uses to drugs already supplied under the CAP by the approved CAP vendor(s).

(3) * * *

(iv) In the case of additions requested under paragraph (f)(2)(v) of this section, address and document the need for such an expansion based on demand for the product(s).

* * * * *

(g) *Deletion of drugs on an approved CAP vendor's CAP drug list.* Deletion of drugs on an approved CAP vendor's CAP drug list due to unavailability requires a written request and approval as described in paragraphs (f)(3)(i) through (iii) and (f)(4) of this section.

■ 23. Section 414.908 is amended by revising paragraph (a)(3)(xii) to read as follows:

§ 414.908 Competitive acquisition program.

(a) * * *

(3) * * *

(xii) Agrees not to transport CAP drugs from one practice location or place of service to another location except in accordance with a written agreement between the participating CAP physician and the approved CAP vendor that requires that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported.

* * * * *

■ 24. Section 414.914 is amended by revising paragraph (f)(12) to read as follows:

§ 414.914 Terms of contract.

* * * * *

(f) * * *

(12) Supply CAP drugs upon receipt of a prescription order to all participating CAP physicians who have selected the approved CAP vendor, except when the conditions of paragraph (h) of this section or § 414.916(b) of this subpart are met;

* * * * *

■ 25. Section 414.916 is amended by—

■ A. Redesignating paragraph (b)(4) as (b)(5).

■ B. Adding new paragraph (b)(4).

The addition reads as follows:

§ 414.916 Dispute resolution for vendors and beneficiaries.

* * * * *

(b) * * *

(4) Upon notification from CMS of a participating CAP physician's suspension from the program, the approved CAP vendor must cease delivery of CAP drugs to the suspended participating CAP physician until the suspension has been lifted.

* * * * *

■ 26. Section 414.917 is amended by revising paragraph (b)(4) to read as follows:

§ 414.917 Dispute resolution and process for suspension or termination of approved CAP contract and termination of physician participation under exigent circumstances.

* * * * *

(b) * * *

(4) The approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

* * * * *

■ 27. Section 414.930 is amended by—

■ A. Revising paragraph (a).

■ B. Redesignating paragraph (b)(1)(v) as paragraph (b)(1)(vi).

■ C. Adding new paragraph (b)(1)(v).

The revision and addition read as follows:

§ 414.930 Compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen.

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

Compendium means a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example a compendium of anti-cancer treatment. A compendium—

(i) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases.

(ii) Is indexed by drug or biological.

(iii) Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Publicly transparent process for evaluating therapies means that the process provides that the following information from an internal or external request for inclusion of a therapy in a compendium are available to the public for a period of not less than 5 years, which includes availability on the compendium's Web site for a period of not less than 3 years, coincident with the compendium's publication of the related recommendation:

(i) The internal or external request for listing of a therapy recommendation including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the request.

(iii) A listing of all individuals who have substantively participated in the review or disposition of the request.

(iv) Minutes and voting records of meetings for the review and disposition of the request.

Publicly transparent process for identifying potential conflicts of interests means that process provides that the following information is identified and made timely available in response to a public request for a period of not less than 5 years, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium. This may include, for example, compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals or the spouse or minor child of individuals who have substantively participated in the review and disposition of the request and the manufacturer or seller of the drug or biological being reviewed by the compendium.

(ii) Ownership or investment interests between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium.

(b) * * *

(1) * * *

(v) Considers whether the publication that is the subject of the request meets the definition of a compendium in this section.

* * * * *

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

■ 28. The authority citation for part 415 continues to read as follows:

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

Subpart D—Physician Services in Teaching Settings

■ 29. Section 415.178 is revised to read as follows:

§ 415.178 Anesthesia services.

(a) *General rule.* (1) *For services furnished prior to January 1, 2010*, 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. Additional rules for payment of anesthesia services involving residents are specified in § 414.46(c)(1)(iii) of this chapter.

(2) *For services furnished on or after January 1, 2010*, payment made under § 414.46(e) of this chapter if the teaching anesthesiologist (or different teaching anesthesiologists in the same anesthesia group practice) is present during all critical or key portions of the anesthesia service or procedure involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(b) *Documentation.* Documentation must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 30. The authority citation for part 485 continues to read as follows:

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

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

■ 31. Section 485.70 is amended by revising paragraph (j) to read as follows:

§ 485.70 Personnel qualifications.

* * * * *

(j) A respiratory therapist must complete one the following criteria:

(1) *Criterion 1.* All of the following must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have successfully completed a nationally-accredited educational program for respiratory therapists.

(iii)(A) Be eligible to take the registry examination administered by the National Board for Respiratory Care for respiratory therapists; or

(B) Have passed the registry examination administered by the National Board for Respiratory Care for respiratory therapists.

(2) *Criterion 2:* All of the following must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have equivalent training and experience as determined by the National Board for Respiratory Care.

* * * * *

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

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

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

Subpart A—General Provisions

■ 33. Section 498.2 is amended by adding paragraph (13) to the definition of ''supplier'' to read as follows:

§ 498.2 Definitions.

* * * * *

Supplier * * *

(13) A site approved by CMS to furnish intensive cardiac rehabilitation services.

Authority: Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.

Dated: October 26, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2009.

Kathleen Sebelius,

Secretary.

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

Addendum A: Explanation and Use of Addendum B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2010. Addendum

B contains the RVUs for work, non-facility practice expense (PE), facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

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

• An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the non-facility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an ''NA'' in the non-facility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.

• Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

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. A code for: the global values (both professional and technical); modifier-26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier-53 is shown for a discontinued procedure, for example a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

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

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

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

C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

D * = Deleted/discontinued code.

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

F = Deleted/discontinued codes. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G = Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Codes subject to a 90-day grace period.) This indicator is no longer effective with the 2005 PFS as of January 1, 2005.

H * = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the database with the H status indicator.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero (($0.00) charge and are denied) on the MPFSDB.

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

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

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

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of ''physicians' services'' for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (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 2010.

6. *Fully implemented non-facility PE RVUs.* These are the fully implemented resource-based practice PE RVUs for non-facility settings.

7. *2010 Transitional non-facility PE RVUs.* These are the 2010 resource-based PE RVUs for non-facility settings.

8. *Fully implemented facility PE RVUs.* These are the fully implemented resource-based practice PE RVUs for facility settings.

9. *2010 Transitional facility PE RVUs.* These are the 2010 resource-based PE RVUs for facility settings.

* Codes with these indicators had a 90-day grace period before January 1, 2005.

10. *Malpractice expense RVUs*. These are the RVUs for the malpractice expense for the service for 2010.

Note: The BN reduction resulting from the chiropractic demonstration is *not* reflected in the RVUs for CPT codes 98940, 98941 and 98942. The required reduction will only be reflected in the files used for Medicare payment.

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

XXX = The global concept does not apply.

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

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and PE are associated with intra service time and in some instances in the post service time.

BILLING CODE 4120–01–P

ADDENDUM B: Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	0016T
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	0017T
0019T		C	Extracorp shock wv tx,ms nos	0.00	0.00	0.00	0.00	0.00	0.00	0019T
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	0030T
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	0042T
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	0048T
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	0050T
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	0051T
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	0052T
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	0053T
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	0054T
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	0055T
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	0071T
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	0072T
0073T		A	Delivery, comp imrt	0.00	12.00	13.88	NA	NA	0.01	0073T
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	0075T
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	0075T
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	0075T
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	0076T
0076T	TC	C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	0076T
0076T	26	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	0076T
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	0078T
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	0079T
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	0080T
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	0081T
0085T		N	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	0085T
0092T		C	Artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	0092T
0095T		C	Artific diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	0095T
0098T		C	Rev artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	0098T
0099T		C	Implant corneal ring	0.00	0.00	0.00	0.00	0.00	0.00	0099T
0100T		C	Prosth retina receive&gen	0.00	0.00	0.00	0.00	0.00	0.00	0100T
0101T		C	Extracorp shockwv tx,hi enrg	0.00	0.00	0.00	0.00	0.00	0.00	0101T
0102T		C	Extracorp shockwv tx,anesth	0.00	0.00	0.00	0.00	0.00	0.00	0102T
0103T		C	Holotranscobalamin	0.00	0.00	0.00	0.00	0.00	0.00	0103T
0104T		C	At rest cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	0104T
0105T		C	Exerc cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	0105T
0106T		C	Touch quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0106T
0107T		C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0107T
0108T		C	Cool quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0108T
0109T		C	Heat quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0109T
0110T		C	Nos quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0110T
0111T		C	Rbc membranes fatty acids	0.00	0.00	0.00	0.00	0.00	0.00	0111T
0123T		C	Scleral fistulization	0.00	0.00	0.00	0.00	0.00	0.00	0123T
0124T		C	Conjunctival drug placement	0.00	0.00	0.00	0.00	0.00	0.00	0124T
0126T		C	Chd risk imt study	0.00	0.00	0.00	0.00	0.00	0.00	0126T
0130T		C	Chron care drug investigatn	0.00	0.00	0.00	0.00	0.00	0.00	0130T
0140T		C	Exhaled breath condensate ph	0.00	0.00	0.00	0.00	0.00	0.00	0140T
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	0141T
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	0142T
0143T		I	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	0.00	0.00	0143T
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	0155T
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	0156T
0157T		C	Open impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	0157T
0158T		C	Open remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	0158T
0159T		C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	0159T
0159T	TC	C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	0159T
0159T	26	C	Cad breast mri	0.00	0.00	0.00	0.00	0.00	0.00	0159T
0160T		C	Tcranial magn stim tx plan	0.00	0.00	0.00	0.00	0.00	0.00	0160T
0161T		C	Tcranial magn stim tx deliv	0.00	0.00	0.00	0.00	0.00	0.00	0161T
0163T		C	Lumb artif diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	0163T
0164T		C	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	0164T
0165T		C	Revise lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	0165T
0166T		C	Tcath vsd close w/o bypass	0.00	0.00	0.00	0.00	0.00	0.00	0166T
0167T		C	Tcath vsd close w bypass	0.00	0.00	0.00	0.00	0.00	0.00	0167T
0168T		C	Rhinophototx light app bilat	0.00	0.00	0.00	0.00	0.00	0.00	0168T
0169T		C	Place stereo cath brain	0.00	0.00	0.00	0.00	0.00	0.00	0169T
0171T		C	Lumbar spine proces distract	0.00	0.00	0.00	0.00	0.00	0.00	0171T
0172T		C	Lumbar spine process addl	0.00	0.00	0.00	0.00	0.00	0.00	0172T
0173T		C	Iop monit io pressure	0.00	0.00	0.00	0.00	0.00	0.00	0173T
0174T		C	Cad cxr with interp	0.00	0.00	0.00	0.00	0.00	0.00	0174T
0175T		C	Cad cxr remote	0.00	0.00	0.00	0.00	0.00	0.00	0175T
0176T		C	Aqu canal dilat w/o retent	0.00	0.00	0.00	0.00	0.00	0.00	0176T
0177T		C	Aqu canal dilat w retent	0.00	0.00	0.00	0.00	0.00	0.00	0177T
0178T		C	64 lead ecg w i&r	0.00	0.00	0.00	0.00	0.00	0.00	0178T
0179T		C	64 lead ecg w tracing	0.00	0.00	0.00	0.00	0.00	0.00	0179T

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
0180T		C	64 lead ecg w i&r only	0.00	0.00	0.00	0.00	0.00	0.00	0180T
0181T		C	Corneal hysteresis	0.00	0.00	0.00	0.00	0.00	0.00	0181T
0182T		C	Hdr elect brachytherapy	0.00	0.00	0.00	NA	NA	0.00	0182T
0182T	TC	C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	0.00	0.00	0182T
0182T	26	C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	0.00	0.00	0182T
0183T		C	Wound ultrasound	0.00	0.00	0.00	0.00	0.00	0.00	0183T
0184T		C	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	0.00	0.00	0184T
0185T		C	Comptr probability analysis	0.00	0.00	0.00	0.00	0.00	0.00	0185T
0186T		C	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	0.00	0.00	0186T
0187T		C	Ophthalmic dx image anterior	0.00	0.00	0.00	0.00	0.00	0.00	0187T
0188T		N	Videoconf crit care 74 min	0.00	0.00	0.00	0.00	0.00	0.00	0188T
0189T		N	Videoconf crit care addl 30	0.00	0.00	0.00	0.00	0.00	0.00	0189T
0190T		C	Place intraoc radiation src	0.00	0.00	0.00	0.00	0.00	0.00	0190T
0191T		C	Insert ant segment drain int	0.00	0.00	0.00	0.00	0.00	0.00	0191T
0192T		C	Insert ant segment drain ext	0.00	0.00	0.00	0.00	0.00	0.00	0192T
0193T		C	Rf bladder neck microremodel	0.00	0.00	0.00	0.00	0.00	0.00	0193T
0195T		C	Arthrod presac interbody	0.00	0.00	0.00	0.00	0.00	0.00	0195T
0196T		C	Arthrod presac interbody eac	0.00	0.00	0.00	0.00	0.00	0.00	0196T
0197T		C	Intrafraction track motion	0.00	0.00	0.00	0.00	0.00	0.00	0197T
0198T		C	Ocular blood flow measure	0.00	0.00	0.00	0.00	0.00	0.00	0198T
0199T		C	Physiologic tremor record	0.00	0.00	0.00	0.00	0.00	0.00	0199T
0200T		C	Perq sacral augmt unilat inj	0.00	0.00	0.00	0.00	0.00	0.00	0200T
0201T		C	Perq sacral augmt bilat inj	0.00	0.00	0.00	0.00	0.00	0.00	0201T
0202T		C	Post vert arthrplst 1 lumbar	0.00	0.00	0.00	0.00	0.00	0.00	0202T
0203T		C	Unattend sleep study w/time	0.00	0.00	0.00	0.00	0.00	0.00	0203T
0203T	TC	C	Unattend sleep study w/time	0.00	0.00	0.00	0.00	0.00	0.00	0203T
0203T	26	C	Unattend sleep study w/time	0.00	0.00	0.00	0.00	0.00	0.00	0203T
0204T		C	Unattended sleep study	0.00	0.00	0.00	0.00	0.00	0.00	0204T
0204T	TC	C	Unattended sleep study	0.00	0.00	0.00	0.00	0.00	0.00	0204T
0204T	26	C	Unattended sleep study	0.00	0.00	0.00	0.00	0.00	0.00	0204T
0205T		C	Inirs each vessel add-on	0.00	0.00	0.00	0.00	0.00	0.00	0205T
0206T		C	Remote algorithm analys ecg	0.00	0.00	0.00	0.00	0.00	0.00	0206T
0207T		C	Clear eyelid gland w/heat	0.00	0.00	0.00	0.00	0.00	0.00	0207T
0208T		C	Automated audiometry air	0.00	0.00	0.00	0.00	0.00	0.00	0208T
0209T		C	Auto audiometry air/bone	0.00	0.00	0.00	0.00	0.00	0.00	0209T
0210T		C	Auto audiometry sp thresh	0.00	0.00	0.00	0.00	0.00	0.00	0210T
0211T		C	Auto audiometry sp thresh	0.00	0.00	0.00	0.00	0.00	0.00	0211T
0212T		C	Comprehen auto audiometry	0.00	0.00	0.00	0.00	0.00	0.00	0212T
0213T		C	Us facet jt inj cerv/t 1 lev	0.00	0.00	0.00	0.00	0.00	0.00	0213T

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
0214T		C	Us facet jt inj cerv/t 2 lev	0.00	0.00	0.00	0.00	0.00	0.00	0214T
0215T		C	Us facet jt inj cerv/t 3 lev	0.00	0.00	0.00	0.00	0.00	0.00	0215T
0216T		C	Us facet jt inj ls 1 level	0.00	0.00	0.00	0.00	0.00	0.00	0216T
0217T		C	Us facet jt inj ls 2 level	0.00	0.00	0.00	0.00	0.00	0.00	0217T
0218T		C	Us facet jt inj ls 3 level	0.00	0.00	0.00	0.00	0.00	0.00	0218T
0219T		C	Fuse spine facet jt cerv	0.00	0.00	0.00	0.00	0.00	0.00	0219T
0220T		C	Fuse spine facet jt thor	0.00	0.00	0.00	0.00	0.00	0.00	0220T
0221T		C	Fuse spine facet jt lumbar	0.00	0.00	0.00	0.00	0.00	0.00	0221T
0222T		C	Fuse spine facet jt add seg	0.00	0.00	0.00	0.00	0.00	0.00	0222T
0528F		I	Rcmnd flw-up 10 yrs docd	0.00	0.00	0.00	0.00	0.00	0.00	0528F
0535F		I	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	0.00	0.00	0535F
0545F		I	Follow up care plan mdd docd	0.00	0.00	0.00	0.00	0.00	0.00	0545F
0575F		I	HIV rna plan care docd	0.00	0.00	0.00	0.00	0.00	0.00	0575F
10021		A	Fna w/o image	1.27	2.31	2.23	0.52	0.46	0.15	10021
10022		A	Fna w/image	1.27	2.05	2.24	0.42	0.43	0.11	10022
10040		A	Acne surgery	1.21	1.36	1.31	1.05	0.99	0.12	10040
10060		A	Drainage of skin abscess	1.22	1.67	1.50	1.22	1.10	0.09	10060
10061		A	Drainage of skin abscess	2.45	2.30	2.10	1.69	1.57	0.22	10061
10080		A	Drainage of pilonidal cyst	1.22	3.04	2.86	1.32	1.17	0.14	10080
10081		A	Drainage of pilonidal cyst	2.50	4.13	3.82	1.83	1.59	0.33	10081
10120		A	Remove foreign body	1.25	2.25	2.08	1.13	1.01	0.12	10120
10121		A	Remove foreign body	2.74	3.99	3.65	1.94	1.77	0.29	10121
10140		A	Drainage of hematoma/fluid	1.58	2.46	2.23	1.41	1.34	0.14	10140
10160		A	Puncture drainage of lesion	1.25	2.01	1.85	1.19	1.12	0.12	10160
10180		A	Complex drainage, wound	2.30	3.69	3.35	2.11	1.95	0.34	10180
11000		A	Debride infected skin	0.60	0.77	0.71	0.17	0.18	0.04	11000
11001		A	Debride infected skin add-on	0.30	0.25	0.24	0.09	0.09	0.02	11001
11004		A	Debride genitalia & perineum	10.80	NA	NA	3.89	3.70	1.37	11004
11005		A	Debride abdom wall	14.24	NA	NA	5.31	4.73	2.15	11005
11006		A	Debride genit/per/abdom wall	13.10	NA	NA	4.80	4.53	1.72	11006
11008		A	Remove mesh from abd wall	5.00	NA	NA	1.87	1.66	0.75	11008
11010		A	Debride skin, fx	4.19	7.89	7.23	2.88	2.63	0.56	11010
11011		A	Debride skin/muscle, fx	4.94	8.08	7.66	2.61	2.35	0.70	11011
11012		A	Debride skin/muscle/bone, fx	6.87	10.49	10.15	3.87	3.61	0.95	11012
11040		A	Debride skin, partial	0.50	0.72	0.66	0.16	0.17	0.03	11040
11041		A	Debride skin, full	0.60	0.77	0.72	0.20	0.22	0.04	11041
11042		A	Debride skin/tissue	0.80	1.07	1.00	0.29	0.30	0.08	11042
11043		A	Debride tissue/muscle	3.14	4.07	3.66	3.07	2.75	0.36	11043
11044		A	Debride tissue/muscle/bone	4.26	5.68	5.06	4.27	3.87	0.52	11044

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
11055		R	Trim skin lesion	0.43	0.84	0.77	0.10	0.13	0.02	11055
11056		R	Trim skin lesions, 2 to 4	0.61	0.92	0.84	0.15	0.17	0.03	11056
11057		R	Trim skin lesions, over 4	0.79	1.02	0.95	0.19	0.22	0.04	11057
11100		A	Biopsy, skin lesion	0.81	1.74	1.75	0.47	0.43	0.08	11100
11101		A	Biopsy, skin add-on	0.41	0.42	0.41	0.24	0.22	0.04	11101
11200		A	Removal of skin tags	0.82	1.34	1.24	1.01	0.92	0.08	11200
11201		A	Remove skin tags add-on	0.29	0.20	0.17	0.15	0.13	0.03	11201
11300		A	Shave skin lesion	0.51	1.21	1.17	0.27	0.24	0.05	11300
11301		A	Shave skin lesion	0.85	1.47	1.44	0.48	0.43	0.09	11301
11302		A	Shave skin lesion	1.05	1.72	1.69	0.60	0.53	0.11	11302
11303		A	Shave skin lesion	1.24	2.01	1.97	0.69	0.61	0.13	11303
11305		A	Shave skin lesion	0.67	1.12	1.04	0.22	0.23	0.05	11305
11306		A	Shave skin lesion	0.99	1.43	1.37	0.43	0.41	0.08	11306
11307		A	Shave skin lesion	1.14	1.70	1.65	0.57	0.53	0.11	11307
11308		A	Shave skin lesion	1.41	1.76	1.69	0.55	0.55	0.11	11308
11310		A	Shave skin lesion	0.73	1.38	1.35	0.40	0.35	0.08	11310
11311		A	Shave skin lesion	1.05	1.61	1.58	0.60	0.54	0.11	11311
11312		A	Shave skin lesion	1.20	1.87	1.84	0.69	0.63	0.13	11312
11313		A	Shave skin lesion	1.62	2.20	2.16	0.91	0.81	0.17	11313
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.90	2.09	1.99	1.10	0.99	0.10	11400
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.28	2.35	2.24	1.32	1.20	0.14	11401
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.45	2.58	2.46	1.40	1.27	0.17	11402
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.84	2.83	2.64	1.83	1.62	0.22	11403
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.11	3.21	2.98	1.94	1.72	0.26	11404
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.52	4.12	3.67	2.59	2.21	0.48	11406
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.03	2.00	1.87	1.05	0.98	0.09	11420
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.47	2.39	2.26	1.32	1.22	0.15	11421
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.68	2.62	2.47	1.72	1.57	0.18	11422
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.06	2.92	2.76	1.90	1.72	0.24	11423
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.48	3.28	3.06	2.05	1.85	0.30	11424
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.09	4.12	3.79	2.79	2.47	0.51	11426
11440		A	Exc face-mm b9+marg 0.5 < cm	1.05	2.22	2.13	1.51	1.39	0.11	11440
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.53	2.59	2.47	1.77	1.63	0.17	11441
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.77	2.85	2.72	1.89	1.74	0.20	11442
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.34	3.19	3.01	2.15	1.97	0.27	11443
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.19	3.81	3.55	2.59	2.31	0.38	11444
11446		A	Exc face-mm b9+marg > 4 cm	4.80	4.89	4.39	3.43	2.99	0.58	11446
11450		A	Removal, sweat gland lesion	3.22	5.96	5.40	2.98	2.54	0.46	11450
11451		A	Removal, sweat gland lesion	4.43	7.22	6.68	3.54	3.06	0.64	11451
11462		A	Removal, sweat gland lesion	3.00	6.08	5.53	3.00	2.56	0.42	11462
11463		A	Removal, sweat gland lesion	4.43	7.48	6.98	3.64	3.20	0.64	11463
11470		A	Removal, sweat gland lesion	3.74	6.32	5.69	3.26	2.79	0.51	11470
11471		A	Removal, sweat gland lesion	4.89	7.49	6.83	3.78	3.22	0.65	11471
1150F		I	Doc pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	1150F
1151F		I	Doc no pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	1151F
1152F		I	Doc advncd dis comfort 1st	0.00	0.00	0.00	0.00	0.00	0.00	1152F
1153F		I	Doc advncd dis cmfrt not 1st	0.00	0.00	0.00	0.00	0.00	0.00	1153F
1157F		I	Advnc care plan in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	1157F
1158F		I	Advnc care plan tlk docd	0.00	0.00	0.00	0.00	0.00	0.00	1158F
1159F		I	Med list docd in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	1159F
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.63	3.05	2.83	1.39	1.20	0.17	11600
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.07	3.55	3.39	1.73	1.56	0.22	11601
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	2.27	3.84	3.71	1.91	1.73	0.24	11602
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.82	4.18	3.97	2.18	1.92	0.31	11603
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3.17	4.58	4.31	2.30	2.01	0.37	11604
11606		A	Exc tr-ext mlg+marg > 4 cm	5.02	6.09	5.49	3.09	2.59	0.64	11606
1160F		I	Rvw meds by rx/dr in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	1160F
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.64	3.11	2.91	1.43	1.24	0.18	11620
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.08	3.59	3.43	1.76	1.59	0.22	11621
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.41	3.93	3.80	1.99	1.81	0.26	11622
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.11	4.35	4.12	2.33	2.06	0.35	11623
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.62	4.78	4.48	2.53	2.22	0.43	11624
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.61	5.54	5.15	2.92	2.59	0.57	11626
11640		A	Exc face-mm malig+marg 0.5 <	1.67	3.23	3.06	1.51	1.34	0.18	11640
11641		A	Exc face-mm malig+marg 0.6-1	2.17	3.70	3.59	1.84	1.71	0.23	11641
11642		A	Exc face-mm malig+marg 1.1-2	2.62	4.11	4.00	2.11	1.95	0.29	11642
11643		A	Exc face-mm malig+marg 2.1-3	3.42	4.55	4.34	2.51	2.26	0.39	11643
11644		A	Exc face-mm malig+marg 3.1-4	4.34	5.49	5.19	2.99	2.69	0.51	11644
11646		A	Exc face-mm mlg+marg > 4 cm	6.26	6.67	6.20	3.95	3.54	0.75	11646
11719		R	Trim nail(s)	0.17	0.39	0.36	0.04	0.05	0.01	11719
11720		A	Debride nail, 1-5	0.32	0.48	0.44	0.08	0.09	0.02	11720
11721		A	Debride nail, 6 or more	0.54	0.56	0.53	0.13	0.16	0.03	11721
11730		A	Removal of nail plate	1.10	1.39	1.29	0.27	0.31	0.06	11730
11732		A	Remove nail plate, add-on	0.57	0.57	0.53	0.14	0.17	0.03	11732

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
11740		A	Drain blood from under nail	0.37	0.84	0.76	0.45	0.42	0.02	11740
11750		A	Removal of nail bed	2.50	3.14	2.86	1.99	1.89	0.14	11750
11752		A	Remove nail bed/finger tip	3.63	4.45	3.99	3.05	2.93	0.28	11752
11755		A	Biopsy, nail unit	1.31	2.11	1.96	0.79	0.78	0.09	11755
11760		A	Repair of nail bed	1.63	4.00	3.44	1.71	1.59	0.18	11760
11762		A	Reconstruction of nail bed	2.94	4.14	3.67	1.88	1.89	0.22	11762
11765		A	Excision of nail fold, toe	0.74	2.84	2.54	1.07	0.97	0.04	11765
11770		A	Removal of pilonidal lesion	2.66	4.05	3.66	1.90	1.65	0.37	11770
11771		A	Removal of pilonidal lesion	6.09	7.93	6.93	4.66	3.99	0.88	11771
11772		A	Removal of pilonidal lesion	7.35	9.52	8.41	6.80	5.88	1.04	11772
1180F		I	Thromboemb risk assessed	0.00	0.00	0.00	0.00	0.00	0.00	1180F
11900		A	Injection into skin lesions	0.52	0.87	0.87	0.30	0.27	0.05	11900
11901		A	Added skin lesions injection	0.80	0.99	0.96	0.48	0.43	0.08	11901
11920		R	Correct skin color defects	1.61	2.62	2.72	1.32	1.19	0.22	11920
11921		R	Correct skin color defects	1.93	2.99	3.02	1.52	1.36	0.27	11921
11922		R	Correct skin color defects	0.49	1.03	0.99	0.28	0.25	0.07	11922
11950		R	Therapy for contour defects	0.84	1.05	1.01	0.54	0.44	0.08	11950
11951		R	Therapy for contour defects	1.19	1.45	1.30	0.74	0.58	0.17	11951
11952		R	Therapy for contour defects	1.69	1.43	1.66	0.67	0.77	0.17	11952
11954		R	Therapy for contour defects	1.85	2.18	2.06	1.13	0.96	0.26	11954
11960		A	Insert tissue expander(s)	11.49	NA	NA	11.65	11.09	1.27	11960
11970		A	Replace tissue expander	8.01	NA	NA	7.42	6.63	1.11	11970
11971		A	Remove tissue expander(s)	3.41	8.16	7.94	4.63	4.17	0.44	11971
11975		N	Insert contraceptive cap	1.48	1.81	1.76	0.54	0.53	0.07	11975
11976		R	Removal of contraceptive cap	1.78	1.80	1.82	0.68	0.59	0.22	11976
11977		N	Removal/reinsert contra cap	3.30	2.30	2.47	1.20	1.18	0.17	11977
11980		A	Implant hormone pellet(s)	1.48	1.16	1.10	0.62	0.55	0.16	11980
11981		A	Insert drug implant device	1.48	1.78	1.86	0.58	0.63	0.17	11981
11982		A	Remove drug implant device	1.78	1.80	2.01	0.68	0.77	0.18	11982
11983		A	Remove/insert drug implant	3.30	2.13	2.53	1.13	1.38	0.25	11983
12001		A	Repair superficial wound(s)	1.75	2.16	1.90	0.97	0.81	0.20	12001
12002		A	Repair superficial wound(s)	1.91	2.22	1.96	1.09	0.92	0.23	12002
12004		A	Repair superficial wound(s)	2.29	2.54	2.25	1.19	1.02	0.28	12004
12005		A	Repair superficial wound(s)	2.91	3.07	2.73	1.36	1.18	0.36	12005
12006		A	Repair superficial wound(s)	3.71	3.66	3.26	1.65	1.44	0.46	12006
12007		A	Repair superficial wound(s)	4.16	3.99	3.66	1.84	1.67	0.52	12007
1200F		I	Seizure type(s)+ frq docd	0.00	0.00	0.00	0.00	0.00	0.00	1200F
12011		A	Repair superficial wound(s)	1.81	2.31	2.06	0.96	0.82	0.22	12011
12013		A	Repair superficial wound(s)	2.04	2.49	2.22	1.11	0.96	0.25	12013
12014		A	Repair superficial wound(s)	2.51	2.77	2.48	1.22	1.07	0.30	12014
12015		A	Repair superficial wound(s)	3.24	3.34	3.01	1.40	1.23	0.40	12015
12016		A	Repair superficial wound(s)	3.97	3.83	3.46	1.61	1.45	0.49	12016
12017		A	Repair superficial wound(s)	4.75	NA	NA	1.51	1.59	0.60	12017
12018		A	Repair superficial wound(s)	5.57	NA	NA	1.64	2.12	0.70	12018
12020		A	Closure of split wound	2.67	4.15	3.86	2.07	1.90	0.31	12020
12021		A	Closure of split wound	1.89	2.11	1.94	1.56	1.43	0.22	12021
12031		A	Intmd wnd repair s/tr/ext	2.20	3.97	3.67	1.99	1.73	0.25	12031
12032		A	Intmd wnd repair s/tr/ext	2.52	5.03	4.98	2.44	2.30	0.28	12032
12034		A	Intmd wnd repair s/tr/ext	2.97	4.73	4.42	2.24	2.01	0.36	12034
12035		A	Intmd wnd repair s/tr/ext	3.47	5.84	5.48	2.50	2.28	0.46	12035
12036		A	Intmd wnd repair s/tr/ext	4.09	6.09	5.64	2.70	2.46	0.57	12036
12037		A	Intmd wnd repair s/tr/ext	4.71	6.65	6.21	3.14	2.90	0.66	12037
12041		A	Intmd wnd repair n-hf/genit	2.42	4.04	3.72	2.03	1.77	0.27	12041
12042		A	Intmd wnd repair n-hg/genit	2.79	4.45	4.32	2.33	2.12	0.30	12042
12044		A	Intmd wnd repair n-hg/genit	3.19	5.65	5.10	2.23	2.02	0.37	12044
12045		A	Intmd wnd repair n-hg/genit	3.68	5.66	5.32	2.50	2.28	0.45	12045
12046		A	Intmd wnd repair n-hg/genit	4.29	8.03	6.66	3.51	2.84	0.61	12046
12047		A	Intmd wnd repair n-hg/genit	4.69	8.24	6.98	3.98	3.15	0.66	12047
12051		A	Intmd wnd repair face/mm	2.52	4.18	4.02	2.15	1.95	0.28	12051
12052		A	Intmd wnd repair face/mm	2.87	4.79	4.61	2.75	2.47	0.31	12052
12053		A	Intmd wnd repair face/mm	3.17	5.38	5.04	2.36	2.14	0.36	12053
12054		A	Intmd wnd repair, face/mm	3.50	5.63	5.17	2.31	2.09	0.41	12054
12055		A	Intmd wnd repair face/mm	4.47	6.47	5.90	2.58	2.28	0.54	12055
12056		A	Intmd wnd repair face/mm	5.28	7.81	6.97	2.04	2.62	0.49	12056
12057		A	Intmd wnd repair face/mm	6.00	7.94	7.56	3.41	3.36	0.55	12057
1205F		I	EPI etiol synd rvwd and docd	0.00	0.00	0.00	0.00	0.00	0.00	1205F
13100		A	Repair of wound or lesion	3.17	4.57	4.52	2.77	2.62	0.36	13100
13101		A	Repair of wound or lesion	3.96	5.87	5.79	3.29	3.11	0.44	13101
13102		A	Repair wound/lesion add-on	1.24	1.45	1.37	0.67	0.60	0.16	13102
13120		A	Repair of wound or lesion	3.35	4.69	4.64	2.88	2.71	0.37	13120
13121		A	Repair of wound or lesion	4.42	6.59	6.45	3.94	3.68	0.47	13121
13122		A	Repair wound/lesion add-on	1.44	1.51	1.46	0.75	0.66	0.18	13122
13131		A	Repair of wound or lesion	3.83	5.07	5.00	3.19	3.02	0.41	13131
13132		A	Repair of wound or lesion	6.58	7.94	7.71	5.44	5.11	0.69	13132
13133		A	Repair wound/lesion add-on	2.19	2.04	1.94	1.23	1.11	0.25	13133
13150		A	Repair of wound or lesion	3.85	5.03	4.91	3.15	2.93	0.44	13150
13151		A	Repair of wound or lesion	4.49	5.62	5.52	3.61	3.43	0.48	13151
13152		A	Repair of wound or lesion	6.37	7.66	7.45	4.51	4.26	0.68	13152

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
13153		A	Repair wound/lesion add-on	2.38	2.28	2.14	1.31	1.17	0.28	13153
13160		A	Late closure of wound	12.04	NA	NA	8.30	7.59	1.60	13160
14000		A	Skin tissue rearrangement	6.37	9.13	8.75	6.40	6.00	0.79	14000
14001		A	Skin tissue rearrangement	8.78	11.20	10.76	7.92	7.52	1.08	14001
14020		A	Skin tissue rearrangement	7.22	10.18	9.80	7.28	6.93	0.84	14020
14021		A	Skin tissue rearrangement	9.72	12.15	11.74	8.74	8.44	1.10	14021
14040		A	Skin tissue rearrangement	8.60	10.67	10.28	7.77	7.45	0.93	14040
14041		A	Skin tissue rearrangement	10.83	13.00	12.64	9.31	8.98	1.15	14041
14060		A	Skin tissue rearrangement	9.23	10.42	9.94	8.14	7.71	1.01	14060
14061		A	Skin tissue rearrangement	11.48	14.10	13.70	10.02	9.69	1.23	14061
14301		A	Skin tissue rearrangement	12.65	14.34	14.34	9.96	9.96	1.53	14301
14302		A	Skin tissue rearrange add-on	3.73	2.08	2.08	2.08	2.08	0.45	14302
14350		A	Skin tissue rearrangement	11.05	NA	NA	7.72	7.25	1.10	14350
15002		A	Wound prep, trk/arm/leg	3.65	4.88	4.43	2.14	1.86	0.48	15002
15003		A	Wound prep, addl 100 cm	0.80	1.05	0.95	0.36	0.31	0.11	15003
15004		A	Wound prep, f/n/hf/g	4.58	5.46	5.12	2.48	2.26	0.49	15004
15005		A	Wnd prep, f/n/hf/g, addl cm	1.60	1.49	1.32	0.73	0.60	0.23	15005
15040		A	Harvest cultured skin graft	2.00	4.35	4.19	1.30	1.13	0.27	15040
15050		A	Skin pinch graft	5.57	8.61	7.83	5.81	5.33	0.63	15050
15100		A	Skin splt grft, trnk/arm/leg	9.90	11.40	10.91	8.13	7.46	1.39	15100
15101		A	Skin splt grft t/a/l, add-on	1.72	2.81	2.83	1.07	1.00	0.25	15101
15110		A	Epidrm autogrft trnk/arm/leg	10.97	10.32	9.53	7.76	6.86	1.55	15110
15111		A	Epidrm autogrft t/a/l add-on	1.85	1.05	1.04	0.78	0.73	0.28	15111
15115		A	Epidrm a-grft face/nck/hf/g	11.28	10.46	9.60	7.95	7.25	1.32	15115
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	1.82	1.53	1.46	1.16	0.35	15116
15120		A	Skn splt a-grft fac/nck/hf/g	11.16	12.94	11.82	9.00	8.10	1.37	15120
15121		A	Skn splt a-grft f/n/hf/g add	2.67	3.91	3.78	1.65	1.50	0.37	15121
15130		A	Derm autograft, trnk/arm/leg	7.53	9.10	8.69	6.57	6.06	1.05	15130
15131		A	Derm autograft t/a/l add-on	1.50	0.75	0.82	0.55	0.59	0.23	15131
15135		A	Derm autograft face/nck/hf/g	11.03	10.93	9.95	8.44	7.67	1.35	15135
15136		A	Derm autograft, f/n/hf/g add	1.50	0.72	0.67	0.59	0.52	0.08	15136
15150		A	Cult epiderm grft t/arm/leg	9.39	7.66	7.35	6.24	5.94	1.44	15150
15151		A	Cult epiderm grft t/a/l addl	2.00	0.96	1.01	0.74	0.77	0.31	15151
15152		A	Cult epiderm graft t/a/l +%	2.50	1.16	1.38	0.93	1.11	0.36	15152
15155		A	Cult epiderm graft, f/n/hf/g	10.14	5.74	7.03	4.60	5.86	0.55	15155
15156		A	Cult epidrm grft f/n/hfg add	2.75	1.46	1.48	1.26	1.25	0.42	15156
15157		A	Cult epiderm grft f/n/hfg +%	3.00	1.35	1.59	1.10	1.28	0.15	15157
15170		A	Acell graft trunk/arms/legs	5.99	5.03	4.41	3.48	2.95	0.78	15170
15171		A	Acell graft t/arm/leg add-on	1.55	0.80	0.72	0.65	0.59	0.23	15171

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
15175		A	Acellular graft, f/n/hf/g	7.99	5.22	4.96	3.78	3.59	0.75	15175
15176		A	Acell graft, f/n/hf/g add-on	2.45	1.27	1.17	1.00	0.94	0.29	15176
15200		A	Skin full graft, trunk	9.15	11.50	10.53	7.87	7.00	1.17	15200
15201		A	Skin full graft trunk add-on	1.32	2.30	2.25	0.63	0.60	0.18	15201
15220		A	Skin full graft sclp/arm/leg	8.09	11.14	10.58	7.59	7.11	0.98	15220
15221		A	Skin full graft add-on	1.19	2.19	2.14	0.66	0.59	0.16	15221
15240		A	Skin full grft face/genit/hf	10.41	13.03	12.19	10.08	9.27	1.20	15240
15241		A	Skin full graft add-on	1.86	2.76	2.61	1.04	0.93	0.24	15241
15260		A	Skin full graft een & lips	11.64	13.81	13.00	10.51	9.80	1.24	15260
15261		A	Skin full graft add-on	2.23	3.18	3.01	1.44	1.33	0.27	15261
15300		A	Apply skinallogrft, t/arm/lg	4.65	4.22	3.69	2.78	2.41	0.62	15300
15301		A	Apply sknallogrft t/a/l addl	1.00	0.60	0.53	0.45	0.40	0.14	15301
15320		A	Apply skin allogrft f/n/hf/g	5.36	4.24	3.92	2.69	2.53	0.54	15320
15321		A	Aply sknallogrft f/n/hfg add	1.50	0.86	0.77	0.67	0.60	0.22	15321
15330		A	Aply acell alogrft t/arm/leg	3.99	4.19	3.70	2.72	2.40	0.56	15330
15331		A	Aply acell grft t/a/l add-on	1.00	0.60	0.53	0.46	0.41	0.14	15331
15335		A	Apply acell graft, f/n/hf/g	4.50	3.63	3.46	2.25	2.20	0.37	15335
15336		A	Aply acell grft f/n/hf/g add	1.43	0.55	0.63	0.35	0.44	0.08	15336
15340		A	Apply cult skin substitute	3.82	4.19	3.92	3.03	2.81	0.37	15340
15341		A	Apply cult skin sub add-on	0.50	0.71	0.65	0.16	0.16	0.05	15341
15360		A	Apply cult derm sub, t/a/l	4.02	5.00	4.79	3.67	3.48	0.42	15360
15361		A	Aply cult derm sub t/a/l add	1.15	0.63	0.57	0.44	0.39	0.14	15361
15365		A	Apply cult derm sub f/n/hf/g	4.30	4.42	4.30	3.23	3.12	0.29	15365
15366		A	Apply cult derm f/hf/g add	1.45	0.62	0.63	0.43	0.45	0.11	15366
15400		A	Apply skin xenograft, t/a/l	4.47	5.94	5.29	4.60	4.23	0.49	15400
15401		A	Apply skn xenogrft t/a/l add	1.00	1.14	1.22	0.42	0.38	0.15	15401
15420		A	Apply skin xgraft, f/n/hf/g	4.98	6.16	5.87	4.89	4.62	0.47	15420
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.39	1.27	0.67	0.57	0.22	15421
15430		A	Apply acellular xenograft	6.20	7.62	6.85	7.01	6.35	0.72	15430
15431		C	Apply acellular xgraft add	0.00	0.00	0.00	0.00	0.00	0.00	15431
15570		A	Form skin pedicle flap	10.21	11.99	11.17	7.97	7.18	1.47	15570
15572		A	Form skin pedicle flap	10.12	11.75	10.73	8.62	7.64	1.29	15572
15574		A	Form skin pedicle flap	10.70	12.30	11.31	8.95	8.05	1.29	15574
*15576		A	Form skin pedicle flap	9.37	11.00	10.25	7.94	7.18	1.09	15576
15600		A	Skin graft	2.01	5.82	5.93	3.13	2.95	0.27	15600
15610		A	Skin graft	2.52	6.13	5.60	3.51	3.30	0.33	15610
15620		A	Skin graft	3.75	7.08	6.95	4.48	4.11	0.43	15620
15630		A	Skin graft	4.08	7.35	7.23	4.75	4.49	0.46	15630
15650		A	Transfer skin pedicle flap	4.77	7.72	7.74	4.93	4.78	0.56	15650

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
15731		A	Forehead flap w/vasc pedicle	14.38	14.52	13.44	11.84	10.77	1.73	15731
15732		A	Muscle-skin graft, head/neck	19.90	18.22	16.60	14.54	12.59	2.54	15732
15734		A	Muscle-skin graft, trunk	19.86	18.33	17.16	14.24	12.90	2.85	15734
15736		A	Muscle-skin graft, arm	17.04	16.17	15.47	12.16	11.02	2.41	15736
15738		A	Muscle-skin graft, leg	19.04	16.34	15.59	12.57	11.47	2.74	15738
15740		A	Island pedicle flap graft	11.80	13.99	13.36	10.39	9.78	1.25	15740
15750		A	Neurovascular pedicle graft	12.96	NA	NA	10.45	9.47	1.64	15750
15756		A	Free myo/skin flap microvasc	36.94	NA	NA	23.78	21.04	4.59	15756
15757		A	Free skin flap, microvasc	37.15	NA	NA	23.28	20.67	4.27	15757
15758		A	Free fascial flap, microvasc	36.90	NA	NA	22.99	20.64	4.28	15758
15760		A	Composite skin graft	9.86	11.72	10.89	8.42	7.66	1.12	15760
15770		A	Derma-fat-fascia graft	8.96	NA	NA	8.12	7.23	1.15	15770
15775		R	Hair transplant punch grafts	3.95	3.53	3.70	1.78	1.67	0.20	15775
15776		R	Hair transplant punch grafts	5.53	4.84	5.07	2.36	2.43	0.28	15776
15780		A	Abrasion treatment of skin	8.73	11.79	11.67	7.12	7.18	0.84	15780
15781		A	Abrasion treatment of skin	5.02	8.54	8.20	5.83	5.61	0.55	15781
15782		A	Abrasion treatment of skin	4.44	10.41	9.68	6.46	5.87	0.44	15782
15783		A	Abrasion treatment of skin	4.41	7.65	7.56	5.14	4.83	0.44	15783
15786		A	Abrasion, lesion, single	2.08	4.12	3.87	1.52	1.38	0.24	15786
15787		A	Abrasion, lesions, add-on	0.33	0.92	0.88	0.16	0.13	0.03	15787
15788		R	Chemical peel, face, epiderm	2.09	9.25	8.62	4.18	3.85	0.26	15788
15789		R	Chemical peel, face, dermal	4.91	8.62	8.91	5.62	5.60	0.50	15789
15792		R	Chemical peel, nonfacial	1.86	8.81	8.55	4.66	4.58	0.22	15792
15793		A	Chemical peel, nonfacial	3.96	8.10	7.84	5.22	4.97	0.39	15793
15819		A	Plastic surgery, neck	10.65	NA	NA	8.10	7.48	1.49	15819
15820		A	Revision of lower eyelid	6.27	8.02	7.12	6.77	5.86	0.86	15820
15821		A	Revision of lower eyelid	6.84	8.53	7.42	7.12	6.03	0.95	15821
15822		A	Revision of upper eyelid	4.62	6.54	5.82	5.31	4.61	0.57	15822
15823		A	Revision of upper eyelid	8.32	9.68	8.30	8.30	6.97	1.09	15823
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15824
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15825
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15826
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15828
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15829
15830		R	Exc skin abd	17.11	NA	NA	12.50	10.90	2.42	15830
15832		A	Excise excessive skin tissue	12.85	NA	NA	9.85	8.81	1.84	15832
15833		A	Excise excessive skin tissue	11.90	NA	NA	10.34	8.80	1.68	15833
15834		A	Excise excessive skin tissue	12.17	NA	NA	10.50	8.49	1.72	15834
15835		A	Excise excessive skin tissue	12.99	NA	NA	10.96	8.89	1.84	15835
15836		A	Excise excessive skin tissue	10.61	NA	NA	7.28	7.13	1.49	15836
15837		A	Excise excessive skin tissue	9.55	10.20	9.26	6.81	6.57	1.45	15837
15838		A	Excise excessive skin tissue	8.25	NA	NA	6.79	6.13	0.75	15838
15839		A	Excise excessive skin tissue	10.50	11.47	10.36	8.09	7.20	1.37	15839
15840		A	Graft for face nerve palsy	14.99	NA	NA	11.54	10.12	1.73	15840
15841		A	Graft for face nerve palsy	25.99	NA	NA	16.60	15.30	2.40	15841
15842		A	Flap for face nerve palsy	41.01	NA	NA	20.12	22.07	3.78	15842
15845		A	Skin and muscle repair, face	14.32	NA	NA	11.93	9.84	1.30	15845
15847		C	Exc skin abd add-on	0.00	0.00	0.00	0.00	0.00	0.00	15847
15850		B	Removal of sutures	0.78	1.37	1.44	0.28	0.28	0.04	15850
15851		A	Removal of sutures	0.86	1.54	1.45	0.34	0.29	0.09	15851
15852		A	Dressing change not for burn	0.86	NA	NA	0.33	0.31	0.11	15852
15860		A	Test for blood flow in graft	1.95	NA	NA	1.15	0.84	0.28	15860
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	15876
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	15877
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	15878
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	15879
15920		A	Removal of tail bone ulcer	8.29	NA	NA	6.79	6.00	1.22	15920
15922		A	Removal of tail bone ulcer	10.38	NA	NA	7.33	7.35	1.46	15922
15931		A	Remove sacrum pressure sore	10.07	NA	NA	6.88	6.06	1.49	15931
15933		A	Remove sacrum pressure sore	11.77	NA	NA	9.35	8.21	1.74	15933
15934		A	Remove sacrum pressure sore	13.68	NA	NA	9.61	8.42	2.01	15934
15935		A	Remove sacrum pressure sore	15.78	NA	NA	12.06	10.61	2.28	15935
15936		A	Remove sacrum pressure sore	13.16	NA	NA	9.23	8.19	1.93	15936
15937		A	Remove sacrum pressure sore	15.14	NA	NA	10.97	9.82	2.20	15937
15940		A	Remove hip pressure sore	10.20	NA	NA	7.16	6.34	1.50	15940
15941		A	Remove hip pressure sore	12.41	NA	NA	10.41	9.24	1.79	15941
15944		A	Remove hip pressure sore	12.44	NA	NA	9.98	8.86	1.80	15944
15945		A	Remove hip pressure sore	13.75	NA	NA	11.21	9.91	1.96	15945
15946		A	Remove hip pressure sore	24.12	NA	NA	17.30	15.30	3.44	15946
15950		A	Remove thigh pressure sore	8.03	NA	NA	6.34	5.75	1.14	15950
15951		A	Remove thigh pressure sore	11.58	NA	NA	8.35	7.91	1.63	15951
15952		A	Remove thigh pressure sore	12.31	NA	NA	8.14	8.03	1.89	15952
15953		A	Remove thigh pressure sore	13.57	NA	NA	11.80	9.72	1.92	15953
15956		A	Remove thigh pressure sore	16.79	NA	NA	12.01	10.75	2.44	15956
15958		A	Remove thigh pressure sore	16.75	NA	NA	12.70	11.39	2.42	15958
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	15999
16000		A	Initial treatment of burn(s)	0.89	0.89	0.80	0.33	0.27	0.10	16000
16020		A	Dress/debrid p-thick burn, s	0.80	1.33	1.21	0.70	0.60	0.09	16020

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
16025		A	Dress/debrid p-thick burn, m	1.85	1.97	1.74	1.15	0.99	0.22	16025
16030		A	Dress/debrid p-thick burn, l	2.08	2.48	2.22	1.32	1.13	0.27	16030
16035		A	Incision of burn scab, initi	3.74	NA	NA	1.35	1.38	0.45	16035
16036		A	Escharotomy; addl incision	1.50	NA	NA	0.63	0.56	0.19	16036
17000		A	Destruct premalg lesion	0.65	1.36	1.33	0.77	0.73	0.06	17000
17003		A	Destruct premalg les, 2-14	0.07	0.10	0.11	0.04	0.04	0.01	17003
17004		A	Destroy premlg lesions 15+	1.85	2.41	2.46	1.51	1.51	0.19	17004
17106		A	Destruction of skin lesions	3.69	4.82	4.76	3.28	3.20	0.38	17106
17107		A	Destruction of skin lesions	4.79	6.00	6.20	3.98	4.14	0.53	17107
17108		A	Destruction of skin lesions	7.49	8.17	7.88	5.49	5.41	0.81	17108
17110		A	Destruct b9 lesion, 1-14	0.70	2.01	2.02	1.06	1.01	0.06	17110
17111		A	Destruct lesion, 15 or more	0.97	2.27	2.26	1.21	1.15	0.09	17111
17250		A	Chemical cautery, tissue	0.50	1.43	1.34	0.43	0.39	0.05	17250
17260		A	Destruction of skin lesions	0.96	1.39	1.40	0.79	0.74	0.10	17260
17261		A	Destruction of skin lesions	1.22	2.31	2.30	1.13	1.07	0.12	17261
17262		A	Destruction of skin lesions	1.63	2.67	2.65	1.38	1.30	0.16	17262
17263		A	Destruction of skin lesions	1.84	2.90	2.88	1.50	1.39	0.18	17263
17264		A	Destruction of skin lesions	1.99	3.10	3.06	1.57	1.46	0.20	17264
17266		A	Destruction of skin lesions	2.39	3.40	3.34	1.79	1.63	0.25	17266
17270		A	Destruction of skin lesions	1.37	2.34	2.30	1.19	1.11	0.14	17270
17271		A	Destruction of skin lesions	1.54	2.52	2.49	1.32	1.24	0.15	17271
17272		A	Destruction of skin lesions	1.82	2.82	2.79	1.49	1.40	0.18	17272
17273		A	Destruction of skin lesions	2.10	3.07	3.04	1.65	1.53	0.21	17273
17274		A	Destruction of skin lesions	2.64	3.50	3.44	1.95	1.81	0.27	17274
17276		A	Destruction of skin lesions	3.25	3.90	3.77	2.28	2.07	0.34	17276
17280		A	Destruction of skin lesions	1.22	2.24	2.22	1.11	1.04	0.12	17280
17281		A	Destruction of skin lesions	1.77	2.62	2.60	1.45	1.36	0.18	17281
17282		A	Destruction of skin lesions	2.09	3.01	2.97	1.64	1.54	0.21	17282
17283		A	Destruction of skin lesions	2.69	3.48	3.41	1.99	1.84	0.27	17283
17284		A	Destruction of skin lesions	3.26	3.93	3.83	2.31	2.13	0.33	17284
17286		A	Destruction of skin lesions	4.48	4.67	4.45	2.96	2.72	0.48	17286
17311		A	Mohs, 1 stage, h/n/hf/g	6.20	10.00	10.66	3.72	3.43	0.63	17311
17312		A	Mohs addl stage	3.30	6.30	6.79	1.98	1.82	0.34	17312
17313		A	Mohs, 1 stage, t/a/l	5.56	9.20	9.83	3.34	3.08	0.57	17313
17314		A	Mohs, addl stage, t/a/l	3.06	5.84	6.30	1.83	1.69	0.31	17314
17315		A	Mohs surg, addl block	0.87	1.11	1.15	0.52	0.48	0.09	17315
17340		A	Cryotherapy of skin	0.77	0.54	0.45	0.48	0.40	0.08	17340
17360		A	Skin peel therapy	1.46	1.81	1.80	1.12	1.05	0.15	17360
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	17380

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	17999
19000		A	Drainage of breast lesion	0.84	1.82	1.93	0.27	0.30	0.08	19000
19001		A	Drain breast lesion add-on	0.42	0.25	0.26	0.13	0.15	0.04	19001
19020		A	Incision of breast lesion	3.83	7.54	6.88	3.65	3.19	0.55	19020
19030		A	Injection for breast x-ray	1.53	2.36	2.69	0.46	0.55	0.11	19030
19100		A	Bx breast percut w/o image	1.27	2.36	2.18	0.47	0.40	0.19	19100
19101		A	Biopsy of breast, open	3.23	5.04	4.63	2.22	1.97	0.48	19101
19102		A	Bx breast percut w/image	2.00	3.13	3.53	0.62	0.71	0.15	19102
19103		A	Bx breast percut w/device	3.69	9.43	10.34	1.18	1.28	0.34	19103
19105		A	Cryosurg ablate fa, each	3.69	43.39	50.09	1.30	1.32	0.29	19105
19110		A	Nipple exploration	4.44	7.47	6.63	4.00	3.43	0.66	19110
19112		A	Excise breast duct fistula	3.81	7.41	6.60	3.87	3.32	0.57	19112
19120		A	Removal of breast lesion	5.92	6.12	5.35	4.24	3.63	0.89	19120
19125		A	Excision, breast lesion	6.69	6.71	5.81	4.62	3.93	1.01	19125
19126		A	Excision, addl breast lesion	2.93	NA	NA	1.08	0.92	0.45	19126
19260		A	Removal of chest wall lesion	17.78	NA	NA	12.08	11.14	2.84	19260
19271		A	Revision of chest wall	22.19	NA	NA	18.32	17.35	3.60	19271
19272		A	Extensive chest wall surgery	25.17	NA	NA	19.11	18.41	4.26	19272
19290		A	Place needle wire, breast	1.27	2.57	2.86	0.38	0.46	0.09	19290
19291		A	Place needle wire, breast	0.63	1.02	1.14	0.19	0.22	0.05	19291
19295		A	Place breast clip, percut	0.00	2.08	2.32	NA	NA	0.01	19295
19296		A	Place po breast cath for rad	3.63	93.13	95.73	1.61	1.42	0.54	19296
19297		A	Place breast cath for rad	1.72	NA	NA	0.64	0.55	0.26	19297
19298		A	Place breast rad tube/caths	6.00	22.36	26.35	2.59	2.39	0.56	19298
19300		A	Removal of breast tissue	5.31	7.35	6.76	4.74	4.07	0.79	19300
19301		A	Partical mastectomy	10.13	NA	NA	6.00	4.90	1.54	19301
19302		A	P-mastectomy w/ln removal	13.99	NA	NA	8.05	6.89	2.14	19302
19303		A	Mast, simple, complete	15.85	NA	NA	9.15	7.41	2.42	19303
19304		A	Mast, subq	7.95	NA	NA	6.14	5.32	1.19	19304
19305		A	Mast, radical	17.46	NA	NA	10.50	8.93	2.66	19305
19306		A	Mast, rad, urban type	18.13	NA	NA	11.47	9.61	2.76	19306
19307		A	Mast, mod rad	18.23	NA	NA	11.34	9.60	2.76	19307
19316		A	Suspension of breast	11.09	NA	NA	8.39	7.57	1.58	19316
19318		A	Reduction of large breast	16.03	NA	NA	12.19	11.04	2.27	19318
19324		A	Enlarge breast	6.80	NA	NA	5.26	4.78	1.02	19324
19325		A	Enlarge breast with implant	8.64	NA	NA	7.73	6.94	1.20	19325
19328		A	Removal of breast implant	6.48	NA	NA	6.03	5.39	0.90	19328
19330		A	Removal of implant material	8.54	NA	NA	7.47	6.64	1.18	19330
19340		A	Immediate breast prosthesis	13.78	NA	NA	11.45	5.19	0.89	19340

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
19342		A	Delayed breast prosthesis	12.63	NA	NA	10.91	9.70	1.76	19342
19350		A	Breast reconstruction	9.11	11.44	11.19	7.97	7.22	1.27	19350
19355		A	Correct inverted nipple(s)	8.52	8.66	8.50	5.55	5.10	1.29	19355
19357		A	Breast reconstruction	21.07	NA	NA	18.75	16.69	2.92	19357
19361		A	Breast reconstr w/lat flap	23.36	NA	NA	20.24	17.24	3.31	19361
19364		A	Breast reconstruction	42.58	NA	NA	28.17	24.97	5.95	19364
19366		A	Breast reconstruction	21.84	NA	NA	12.98	11.40	3.22	19366
19367		A	Breast reconstruction	26.80	NA	NA	18.93	16.98	3.77	19367
19368		A	Breast reconstruction	33.90	NA	NA	22.95	20.14	4.80	19368
19369		A	Breast reconstruction	31.31	NA	NA	21.43	18.46	4.43	19369
19370		A	Surgery of breast capsule	9.17	NA	NA	8.24	7.36	1.26	19370
19371		A	Removal of breast capsule	10.62	NA	NA	9.32	8.33	1.48	19371
19380		A	Revise breast reconstruction	10.41	NA	NA	9.20	8.23	1.45	19380
19396		A	Design custom breast implant	2.17	4.63	3.48	1.12	1.03	0.33	19396
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	19499
20000		A	Incision of abscess	2.17	3.00	2.84	1.68	1.63	0.19	20000
20005		A	Incision of deep abscess	3.58	4.16	3.82	2.36	2.20	0.42	20005
20100		A	Explore wound, neck	10.38	NA	NA	4.84	4.04	1.43	20100
20101		A	Explore wound, chest	3.23	6.45	6.33	1.69	1.62	0.50	20101
20102		A	Explore wound, abdomen	3.98	7.91	7.37	2.37	2.06	0.57	20102
20103		A	Explore wound, extremity	5.34	9.01	8.36	3.47	3.18	0.70	20103
20150		A	Excise epiphyseal bar	14.75	NA	NA	8.29	8.30	2.09	20150
20200		A	Muscle biopsy	1.46	3.42	3.22	0.85	0.77	0.23	20200
20205		A	Deep muscle biopsy	2.35	4.48	4.06	1.41	1.24	0.41	20205
20206		A	Needle biopsy, muscle	0.99	4.79	5.43	0.52	0.60	0.08	20206
20220		A	Bone biopsy, trocar/needle	1.27	2.47	3.05	0.62	0.71	0.09	20220
20225		A	Bone biopsy, trocar/needle	1.87	11.30	14.37	0.95	1.08	0.17	20225
20240		A	Bone biopsy, excisional	3.28	NA	NA	2.40	2.28	0.38	20240
20245		A	Bone biopsy, excisional	8.95	NA	NA	6.86	6.33	1.17	20245
20250		A	Open bone biopsy	5.19	NA	NA	4.11	3.77	0.88	20250
20251		A	Open bone biopsy	5.72	NA	NA	4.44	4.17	0.95	20251
20500		A	Injection of sinus tract	1.28	1.35	1.55	0.89	1.03	0.09	20500
20501		A	Inject sinus tract for x-ray	0.76	2.12	2.45	0.23	0.28	0.05	20501
2050F		I	Wound char size etc docd	0.00	0.00	0.00	0.00	0.00	0.00	2050F
20520		A	Removal of foreign body	1.90	3.07	2.81	1.76	1.62	0.22	20520
20525		A	Removal of foreign body	3.54	8.16	7.85	2.70	2.48	0.46	20525
20526		A	Ther injection, carp tunnel	0.94	0.94	0.89	0.51	0.47	0.11	20526
20550		A	Inj tendon sheath/ligament	0.75	0.71	0.68	0.33	0.29	0.06	20550
20551		A	Inj tendon origin/insertion	0.75	0.78	0.69	0.38	0.33	0.06	20551

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
20552		A	Inj trigger point, 1/2 muscl	0.66	0.71	0.65	0.33	0.27	0.05	20552
20553		A	Inject trigger points, =/> 3	0.75	0.83	0.74	0.37	0.29	0.06	20553
20555		A	Place ndl musc/tis for rt	6.00	NA	NA	2.60	2.44	0.62	20555
20600		A	Drain/inject, joint/bursa	0.66	0.72	0.69	0.35	0.33	0.05	20600
20605		A	Drain/inject, joint/bursa	0.68	0.82	0.77	0.38	0.35	0.06	20605
2060F		I	Pt talk eval hlthwkr re mdd	0.00	0.00	0.00	0.00	0.00	0.00	2060F
20610		A	Drain/inject, joint/bursa	0.79	1.20	1.10	0.49	0.44	0.09	20610
20612		A	Aspirate/inj ganglion cyst	0.70	0.81	0.74	0.38	0.36	0.07	20612
20615		A	Treatment of bone cyst	2.33	3.04	3.01	1.66	1.61	0.20	20615
20650		A	Insert and remove bone pin	2.28	2.73	2.54	1.60	1.54	0.21	20650
20660		A	Apply, rem fixation device	4.00	NA	NA	1.84	1.69	0.79	20660
20661		A	Application of head brace	5.26	NA	NA	6.58	5.98	1.17	20661
20662		A	Application of pelvis brace	6.38	NA	NA	4.00	5.07	0.44	20662
20663		A	Application of thigh brace	5.74	NA	NA	5.81	5.14	0.80	20663
20664		A	Halo brace application	10.06	NA	NA	10.07	8.56	2.57	20664
20665		A	Removal of fixation device	1.36	1.42	1.56	1.07	1.09	0.09	20665
20670		A	Removal of support implant	1.79	7.48	7.80	1.93	1.85	0.21	20670
20680		A	Removal of support implant	5.96	9.37	8.69	4.78	4.30	0.75	20680
20690		A	Apply bone fixation device	8.78	NA	NA	6.01	4.96	1.15	20690
20692		A	Apply bone fixation device	16.27	NA	NA	11.94	9.62	2.00	20692
20693		A	Adjust bone fixation device	6.06	NA	NA	5.35	5.04	0.76	20693
20694		A	Remove bone fixation device	4.28	6.21	5.99	4.18	3.88	0.55	20694
20696		A	Comp multiplane ext fixation	17.56	NA	NA	9.96	8.60	0.87	20696
20697		A	Comp ext fixate strut change	0.00	38.72	35.07	NA	NA	0.01	20697
20802		A	Replantation, arm, complete	42.62	NA	NA	19.27	18.01	2.14	20802
20805		A	Replant forearm, complete	51.46	NA	NA	30.88	24.37	7.31	20805
20808		A	Replantation hand, complete	63.09	NA	NA	42.00	37.99	8.97	20808
20816		A	Replantation digit, complete	31.95	NA	NA	19.81	22.11	2.87	20816
20822		A	Replantation digit, complete	26.66	NA	NA	17.70	19.19	3.77	20822
20824		A	Replantation thumb, complete	31.95	NA	NA	19.90	21.91	4.54	20824
20827		A	Replantation thumb, complete	27.48	NA	NA	18.11	20.40	3.89	20827
20838		A	Replantation foot, complete	42.88	NA	NA	21.15	20.16	2.15	20838
20900		A	Removal of bone for graft	3.00	7.23	7.03	2.49	2.95	0.41	20900
20902		A	Removal of bone for graft	4.58	NA	NA	3.14	3.66	0.64	20902
20910		A	Remove cartilage for graft	5.53	NA	NA	5.23	5.06	0.50	20910
20912		A	Remove cartilage for graft	6.54	NA	NA	5.95	5.48	0.69	20912
20920		A	Removal of fascia for graft	5.51	NA	NA	4.88	4.54	0.50	20920
20922		A	Removal of fascia for graft	6.93	7.90	7.94	5.44	5.32	0.91	20922
20924		A	Removal of tendon for graft	6.68	NA	NA	5.96	5.57	0.85	20924

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
20926		A	Removal of tissue for graft	5.79	NA	NA	5.20	4.83	0.83	20926
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	0.00	0.00	20930
20931		A	Sp bone algrft struct add-on	1.81	NA	NA	0.85	0.81	0.40	20931
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	0.00	0.00	20936
20937		A	Sp bone agrft morsel add-on	2.79	NA	NA	1.35	1.28	0.49	20937
20938		A	Sp bone agrft struct add-on	3.02	NA	NA	1.44	1.37	0.60	20938
20950		A	Fluid pressure, muscle	1.26	4.64	4.75	1.01	0.94	0.16	20950
20955		A	Fibula bone graft, microvasc	40.26	NA	NA	24.87	22.53	4.81	20955
20956		A	Iliac bone graft, microvasc	41.18	NA	NA	25.26	23.01	5.85	20956
20957		A	Mt bone graft, microvasc	42.61	NA	NA	26.46	19.82	6.05	20957
20962		A	Other bone graft, microvasc	39.21	NA	NA	27.43	24.09	5.61	20962
20969		A	Bone/skin graft, microvasc	45.43	NA	NA	27.57	24.66	4.80	20969
20970		A	Bone/skin graft, iliac crest	44.58	NA	NA	27.30	24.61	6.33	20970
20972		A	Bone/skin graft, metatarsal	44.51	NA	NA	14.55	17.22	2.46	20972
20973		A	Bone/skin graft, great toe	47.27	NA	NA	20.82	19.04	2.37	20973
20974		A	Electrical bone stimulation	0.62	1.20	1.01	0.60	0.54	0.10	20974
20975		A	Electrical bone stimulation	2.60	NA	NA	1.74	1.64	0.42	20975
20979		A	Us bone stimulation	0.62	0.70	0.67	0.23	0.24	0.06	20979
20982		A	Ablate, bone tumor(s) perq	7.27	75.64	85.22	2.48	2.85	0.59	20982
20985		A	Cptr-asst dir ms px	2.50	NA	NA	1.22	1.12	0.35	20985
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	20999
21010		A	Incision of jaw joint	11.04	NA	NA	8.98	7.26	1.01	21010
21011		A	Exc face les sc < 2 cm	2.99	5.18	5.18	3.33	3.33	0.32	21011
21012		A	Exc face les sc = 2 cm	4.45	NA	NA	4.12	4.12	0.52	21012
21013		A	Exc face tum deep < 2 cm	5.42	7.18	7.18	4.69	4.69	0.59	21013
21014		A	Exc face tum deep = 2 cm	7.13	NA	NA	6.09	6.09	0.82	21014
21015		A	Resect face tum < 2 cm	9.89	NA	NA	7.95	5.50	0.76	21015
21016		A	Resect face tum = 2 cm	15.26	NA	NA	10.90	10.90	2.07	21016
21025		A	Excision of bone, lower jaw	10.03	12.65	11.69	9.37	8.39	1.02	21025
21026		A	Excision of facial bone(s)	5.70	9.87	9.02	7.03	6.40	0.58	21026
21029		A	Contour of face bone lesion	8.39	11.03	10.08	7.95	7.15	1.17	21029
21030		A	Excise max/zygoma b9 tumor	4.91	8.07	7.35	5.69	5.11	0.55	21030
21031		A	Remove exostosis, mandible	3.30	6.54	6.05	4.21	3.79	0.30	21031
21032		A	Remove exostosis, maxilla	3.34	6.65	6.16	4.12	3.67	0.30	21032
21034		A	Excise max/zygoma mlg tumor	17.38	16.79	15.41	12.99	11.69	1.76	21034
21040		A	Excise mandible lesion	4.91	8.21	7.46	5.77	5.08	0.53	21040
21044		A	Removal of jaw bone lesion	12.80	NA	NA	10.25	9.15	1.26	21044
21045		A	Extensive jaw surgery	18.37	NA	NA	13.80	12.22	1.82	21045
21046		A	Remove mandible cyst complex	14.21	NA	NA	14.51	12.75	1.29	21046

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
21047		A	Excise lwr jaw cyst w/repair	20.07	NA	NA	14.16	12.31	1.85	21047
21048		A	Remove maxilla cyst complex	14.71	NA	NA	14.76	12.74	1.34	21048
21049		A	Excis uppr jaw cyst w/repair	19.32	NA	NA	13.05	12.06	1.79	21049
21050		A	Removal of jaw joint	11.76	NA	NA	10.33	9.52	1.65	21050
21060		A	Remove jaw joint cartilage	11.07	NA	NA	10.04	8.54	1.70	21060
21070		A	Remove coronoid process	8.62	NA	NA	8.09	7.13	0.79	21070
21073		A	Mnpj of tmj w/anesth	3.45	5.99	5.64	3.17	2.58	0.47	21073
21076		A	Prepare face/oral prosthesis	13.40	11.66	10.11	8.56	7.00	1.24	21076
21077		A	Prepare face/oral prosthesis	33.70	27.75	24.33	21.66	18.07	3.14	21077
21079		A	Prepare face/oral prosthesis	22.31	19.96	17.44	14.49	11.93	2.08	21079
21080		A	Prepare face/oral prosthesis	25.06	22.65	19.94	16.00	13.28	2.34	21080
21081		A	Prepare face/oral prosthesis	22.85	20.88	18.38	14.71	12.20	2.13	21081
21082		A	Prepare face/oral prosthesis	20.84	20.44	17.63	14.38	11.68	1.95	21082
21083		A	Prepare face/oral prosthesis	19.27	19.93	17.32	13.42	10.86	0.97	21083
21084		A	Prepare face/oral prosthesis	22.48	22.51	19.82	15.37	12.70	2.10	21084
21085		A	Prepare face/oral prosthesis	8.99	9.14	7.92	5.93	4.92	2.42	21085
21086		A	Prepare face/oral prosthesis	24.88	19.98	17.26	15.85	12.90	2.32	21086
21087		A	Prepare face/oral prosthesis	24.88	19.78	17.23	15.61	12.88	2.32	21087
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	21088
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	21089
21100		A	Maxillofacial fixation	4.73	13.01	12.97	5.03	5.16	0.45	21100
21110		A	Interdental fixation	5.99	14.03	12.77	10.95	9.90	0.54	21110
21116		A	Injection, jaw joint x-ray	0.81	3.15	2.98	0.39	0.30	0.05	21116
21120		A	Reconstruction of chin	5.10	11.23	10.36	8.02	7.27	0.71	21120
21121		A	Reconstruction of chin	7.81	11.78	11.14	8.72	8.25	0.39	21121
21122		A	Reconstruction of chin	8.71	NA	NA	7.89	8.53	0.43	21122
21123		A	Reconstruction of chin	11.34	NA	NA	11.85	10.03	0.56	21123
21125		A	Augmentation, lower jaw bone	10.80	76.00	67.85	9.94	8.19	1.53	21125
21127		A	Augmentation, lower jaw bone	12.44	84.18	79.24	9.08	8.81	1.13	21127
21137		A	Reduction of forehead	10.24	NA	NA	9.00	7.60	1.45	21137
21138		A	Reduction of forehead	12.87	NA	NA	10.39	9.15	1.30	21138
21139		A	Reduction of forehead	15.02	NA	NA	9.26	9.57	0.75	21139
21141		A	Reconstruct midface, lefort	19.57	NA	NA	15.13	13.69	2.75	21141
21142		A	Reconstruct midface, lefort	20.28	NA	NA	16.37	13.11	2.86	21142
21143		A	Reconstruct midface, lefort	21.05	NA	NA	13.56	13.15	3.21	21143
21145		A	Reconstruct midface, lefort	23.94	NA	NA	18.24	14.69	1.18	21145
21146		A	Reconstruct midface, lefort	24.87	NA	NA	19.52	16.22	3.50	21146
21147		A	Reconstruct midface, lefort	26.47	NA	NA	18.62	16.32	1.31	21147
21150		A	Reconstruct midface, lefort	25.96	NA	NA	14.76	15.01	1.29	21150

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
21151		A	Reconstruct midface, lefort	29.02	NA	NA	20.25	21.04	2.69	21151
21154		A	Reconstruct midface, lefort	31.29	NA	NA	21.71	19.95	2.89	21154
21155		A	Reconstruct midface, lefort	35.22	NA	NA	25.39	21.04	1.77	21155
21159		A	Reconstruct midface, lefort	43.14	NA	NA	27.42	24.07	3.99	21159
21160		A	Reconstruct midface, lefort	47.19	NA	NA	22.80	23.37	2.37	21160
21172		A	Reconstruct orbit/forehead	28.20	NA	NA	20.12	16.03	2.62	21172
21175		A	Reconstruct orbit/forehead	33.56	NA	NA	21.69	18.80	8.71	21175
21179		A	Reconstruct entire forehead	22.65	NA	NA	13.81	13.17	3.22	21179
21180		A	Reconstruct entire forehead	25.58	NA	NA	15.30	14.94	2.38	21180
21181		A	Contour cranial bone lesion	10.28	NA	NA	7.36	6.93	0.94	21181
21182		A	Reconstruct cranial bone	32.58	NA	NA	18.64	17.73	3.02	21182
21183		A	Reconstruct cranial bone	35.70	NA	NA	23.94	20.51	5.09	21183
21184		A	Reconstruct cranial bone	38.62	NA	NA	23.12	20.46	5.50	21184
21188		A	Reconstruction of midface	23.15	NA	NA	21.57	18.25	2.15	21188
21193		A	Reconst lwr jaw w/o graft	18.90	NA	NA	10.16	10.96	2.89	21193
21194		A	Reconst lwr jaw w/graft	21.82	NA	NA	14.49	13.33	2.01	21194
21195		A	Reconst lwr jaw w/o fixation	19.16	NA	NA	16.08	14.37	1.77	21195
21196		A	Reconst lwr jaw w/fixation	20.83	NA	NA	17.67	15.57	1.92	21196
21198		A	Reconstr lwr jaw segment	15.71	NA	NA	14.20	12.97	1.55	21198
21199		A	Reconstr lwr jaw w/advance	16.73	NA	NA	10.14	8.93	1.55	21199
21206		A	Reconstruct upper jaw bone	15.59	NA	NA	16.08	13.26	2.20	21206
21208		A	Augmentation of facial bones	11.42	36.47	32.55	10.19	9.22	1.59	21208
21209		A	Reduction of facial bones	7.82	14.99	12.87	9.71	8.32	1.08	21209
21210		A	Face bone graft	11.69	44.40	40.67	10.63	9.02	1.05	21210
21215		A	Lower jaw bone graft	12.23	85.88	78.01	11.01	9.25	1.71	21215
21230		A	Rib cartilage graft	11.17	NA	NA	9.15	7.84	1.58	21230
21235		A	Ear cartilage graft	7.50	11.02	10.49	7.22	6.67	0.77	21235
21240		A	Reconstruction of jaw joint	16.07	NA	NA	12.83	11.21	1.47	21240
21242		A	Reconstruction of jaw joint	14.59	NA	NA	11.84	10.54	1.33	21242
21243		A	Reconstruction of jaw joint	24.53	NA	NA	20.36	16.96	2.24	21243
21244		A	Reconstruction of lower jaw	13.62	NA	NA	13.97	12.56	1.37	21244
21245		A	Reconstruction of jaw	13.12	15.81	15.01	10.31	9.63	1.19	21245
21246		A	Reconstruction of jaw	12.92	NA	NA	8.91	8.10	1.18	21246
21247		A	Reconstruct lower jaw bone	24.37	NA	NA	16.29	15.24	3.43	21247
21248		A	Reconstruction of jaw	12.74	15.57	13.75	10.73	9.10	1.16	21248
21249		A	Reconstruction of jaw	18.77	20.18	17.62	14.71	12.02	1.74	21249
21255		A	Reconstruct lower jaw bone	18.46	NA	NA	16.42	16.55	1.70	21255
21256		A	Reconstruction of orbit	17.66	NA	NA	13.93	11.80	1.62	21256
21260		A	Revise eye sockets	17.90	NA	NA	12.21	14.29	0.89	21260
21261		A	Revise eye sockets	34.07	NA	NA	23.50	21.47	4.83	21261
21263		A	Revise eye sockets	31.01	NA	NA	18.71	18.68	1.55	21263
21267		A	Revise eye sockets	20.69	NA	NA	20.36	18.14	2.92	21267
21268		A	Revise eye sockets	27.07	NA	NA	27.97	21.33	3.82	21268
21270		A	Augmentation, cheek bone	10.63	14.18	12.32	8.64	7.11	1.07	21270
21275		A	Revision, orbitofacial bones	11.76	NA	NA	9.71	8.28	1.66	21275
21280		A	Revision of eyelid	7.13	NA	NA	7.46	6.33	0.98	21280
21282		A	Revision of eyelid	4.27	NA	NA	5.36	4.66	0.55	21282
21295		A	Revision of jaw muscle/bone	1.90	NA	NA	2.60	2.48	0.26	21295
21296		A	Revision of jaw muscle/bone	4.78	NA	NA	6.58	5.94	0.43	21296
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	21299
21310		A	Treatment of nose fracture	0.58	2.35	2.12	0.14	0.13	0.07	21310
21315		A	Treatment of nose fracture	1.83	5.03	4.72	1.99	1.87	0.19	21315
21320		A	Treatment of nose fracture	1.88	4.60	4.34	1.65	1.52	0.19	21320
21325		A	Treatment of nose fracture	4.18	NA	NA	7.69	7.51	0.47	21325
21330		A	Treatment of nose fracture	5.79	NA	NA	8.65	8.39	0.53	21330
21335		A	Treatment of nose fracture	9.02	NA	NA	9.91	9.28	0.87	21335
21336		A	Treat nasal septal fracture	6.77	NA	NA	9.79	9.27	0.65	21336
21337		A	Treat nasal septal fracture	3.39	6.77	6.37	4.15	3.78	0.36	21337
21338		A	Treat nasoethmoid fracture	6.87	NA	NA	11.85	11.27	0.96	21338
21339		A	Treat nasoethmoid fracture	8.50	NA	NA	12.81	11.77	1.19	21339
21340		A	Treatment of nose fracture	11.49	NA	NA	8.38	8.21	1.05	21340
21343		A	Treatment of sinus fracture	14.32	NA	NA	16.48	14.45	2.02	21343
21344		A	Treatment of sinus fracture	21.57	NA	NA	18.13	15.63	5.56	21344
21345		A	Treat nose/jaw fracture	9.06	11.35	10.72	7.56	7.11	0.82	21345
21346		A	Treat nose/jaw fracture	11.45	NA	NA	12.33	11.95	1.04	21346
21347		A	Treat nose/jaw fracture	13.53	NA	NA	13.14	13.31	1.24	21347
21348		A	Treat nose/jaw fracture	17.52	NA	NA	11.42	10.51	1.62	21348
21355		A	Treat cheek bone fracture	4.45	6.70	6.41	4.02	3.68	0.40	21355
21356		A	Treat cheek bone fracture	4.83	7.71	7.30	4.83	4.45	0.51	21356
21360		A	Treat cheek bone fracture	7.19	NA	NA	6.65	5.97	0.65	21360
21365		A	Treat cheek bone fracture	16.77	NA	NA	12.06	10.56	2.01	21365
21366		A	Treat cheek bone fracture	18.60	NA	NA	14.21	11.57	2.64	21366
21385		A	Treat eye socket fracture	9.57	NA	NA	8.45	7.96	0.88	21385
21386		A	Treat eye socket fracture	9.57	NA	NA	7.01	6.68	1.34	21386
21387		A	Treat eye socket fracture	10.11	NA	NA	8.70	8.14	1.43	21387
21390		A	Treat eye socket fracture	11.23	NA	NA	9.29	8.04	1.35	21390
21395		A	Treat eye socket fracture	14.70	NA	NA	9.45	8.90	1.35	21395
21400		A	Treat eye socket fracture	1.50	3.16	2.92	2.32	2.12	0.18	21400

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
21401		A	Treat eye socket fracture	3.68	8.02	7.91	3.84	3.61	0.51	21401
21406		A	Treat eye socket fracture	7.42	NA	NA	6.14	5.83	0.68	21406
21407		A	Treat eye socket fracture	9.02	NA	NA	7.66	6.77	1.14	21407
21408		A	Treat eye socket fracture	12.78	NA	NA	10.33	8.86	1.82	21408
21421		A	Treat mouth roof fracture	6.02	13.97	12.33	10.66	9.51	0.82	21421
21422		A	Treat mouth roof fracture	8.73	NA	NA	8.55	7.77	0.80	21422
21423		A	Treat mouth roof fracture	10.85	NA	NA	9.40	8.63	1.53	21423
21431		A	Treat craniofacial fracture	7.90	NA	NA	11.96	10.66	1.10	21431
21432		A	Treat craniofacial fracture	8.82	NA	NA	8.03	7.59	1.24	21432
21433		A	Treat craniofacial fracture	26.29	NA	NA	15.58	15.01	3.73	21433
21435		A	Treat craniofacial fracture	20.26	NA	NA	13.37	12.68	1.87	21435
21436		A	Treat craniofacial fracture	30.30	NA	NA	22.38	18.83	4.29	21436
21440		A	Treat dental ridge fracture	3.44	10.70	9.90	8.15	7.59	0.47	21440
21445		A	Treat dental ridge fracture	6.26	13.00	12.31	9.60	9.01	0.56	21445
21450		A	Treat lower jaw fracture	3.71	11.09	10.23	8.30	7.84	0.45	21450
21451		A	Treat lower jaw fracture	5.65	13.36	12.49	10.45	9.73	0.51	21451
21452		A	Treat lower jaw fracture	2.40	11.23	12.16	6.01	5.86	0.33	21452
21453		A	Treat lower jaw fracture	6.64	15.90	14.50	12.84	11.96	0.73	21453
21454		A	Treat lower jaw fracture	7.36	NA	NA	7.37	6.43	0.66	21454
21461		A	Treat lower jaw fracture	9.31	43.20	39.23	14.56	13.51	0.98	21461
21462		A	Treat lower jaw fracture	11.01	44.72	41.04	15.53	14.16	1.00	21462
21465		A	Treat lower jaw fracture	13.12	NA	NA	10.85	9.46	1.85	21465
21470		A	Treat lower jaw fracture	17.54	NA	NA	13.69	11.88	2.06	21470
21480		A	Reset dislocated jaw	0.61	1.67	1.62	0.23	0.19	0.07	21480
21485		A	Reset dislocated jaw	4.77	12.72	11.62	9.96	9.15	0.42	21485
21490		A	Repair dislocated jaw	12.95	NA	NA	10.71	9.55	1.82	21490
21495		A	Treat hyoid bone fracture	6.79	NA	NA	11.57	10.51	0.61	21495
21497		A	Interdental wiring	4.64	12.32	11.75	9.78	9.33	0.63	21497
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	21499
21501		A	Drain neck/chest lesion	3.98	7.32	6.82	4.12	3.81	0.53	21501
21502		A	Drain chest lesion	7.55	NA	NA	5.68	5.18	1.14	21502
21510		A	Drainage of bone lesion	6.20	NA	NA	4.75	4.94	1.02	21510
21550		A	Biopsy of neck/chest	2.11	4.30	4.20	1.88	1.83	0.22	21550
21552		A	Exc neck les sc = 3 cm	6.49	NA	NA	4.74	4.74	0.91	21552
21554		A	Exc neck tum deep = 5 cm	11.13	NA	NA	7.31	7.31	1.50	21554
21555		A	Exc neck les sc < 3 cm	3.96	6.30	5.97	3.77	3.57	0.63	21555
21556		A	Exc neck tum deep < 5 cm	7.66	NA	NA	5.78	4.66	0.76	21556
21557		A	Resect neck tum < 5 cm	14.75	NA	NA	9.67	6.16	1.21	21557
21558		A	Resect neck tum = 5 cm	21.58	NA	NA	12.92	12.92	2.93	21558

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
21600		A	Partial removal of rib	7.26	NA	NA	6.86	6.26	1.11	21600
21610		A	Partial removal of rib	15.91	NA	NA	11.82	9.74	4.10	21610
21615		A	Removal of rib	10.45	NA	NA	5.97	5.75	1.78	21615
21616		A	Removal of rib and nerves	12.69	NA	NA	6.20	7.46	2.17	21616
21620		A	Partial removal of sternum	7.28	NA	NA	5.58	5.40	1.15	21620
21627		A	Sternal debridement	7.30	NA	NA	6.35	6.07	1.17	21627
21630		A	Extensive sternum surgery	19.18	NA	NA	12.23	11.58	2.90	21630
21632		A	Extensive sternum surgery	19.68	NA	NA	11.04	10.58	3.53	21632
21685		A	Hyoid myotomy & suspension	15.26	NA	NA	11.04	9.87	1.40	21685
21700		A	Revision of neck muscle	6.31	NA	NA	3.18	3.95	1.07	21700
21705		A	Revision of neck muscle/rib	9.92	NA	NA	4.23	5.22	1.70	21705
21720		A	Revision of neck muscle	5.80	NA	NA	4.86	4.19	1.49	21720
21725		A	Revision of neck muscle	7.19	NA	NA	6.19	5.64	1.01	21725
21740		A	Reconstruction of sternum	17.57	NA	NA	8.11	8.43	2.50	21740
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	21742
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	21743
21750		A	Repair of sternum separation	11.40	NA	NA	5.85	5.86	1.96	21750
21800		A	Treatment of rib fracture	1.01	1.64	1.44	1.71	1.49	0.12	21800
21805		A	Treatment of rib fracture	2.88	NA	NA	3.65	3.46	0.47	21805
21810		A	Treatment of rib fracture(s)	7.03	NA	NA	5.43	5.12	1.17	21810
21820		A	Treat sternum fracture	1.36	2.09	1.87	2.16	1.92	0.17	21820
21825		A	Treat sternum fracture	7.76	NA	NA	6.32	5.99	1.30	21825
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	21899
21920		A	Biopsy soft tissue of back	2.11	4.31	4.21	2.01	1.87	0.24	21920
21925		A	Biopsy soft tissue of back	4.63	6.14	5.63	4.02	3.60	0.67	21925
21930		A	Exc back les sc < 3 cm	4.94	6.61	6.23	4.13	3.89	0.75	21930
21931		A	Exc back les sc = 3 cm	6.88	NA	NA	4.82	4.82	1.01	21931
21932		A	Exc back tum deep < 5 cm	9.82	NA	NA	6.95	6.95	1.50	21932
21933		A	Exc back tum deep = 5 cm	11.13	NA	NA	7.31	7.31	1.71	21933
21935		A	Resect back tum < 5 cm	15.72	NA	NA	9.95	9.41	2.72	21935
21936		A	Resect back tum = 5 cm	22.55	NA	NA	13.14	13.14	3.30	21936
22010		A	I&d, p-spine, c/t/cerv-thor	12.75	NA	NA	9.98	9.16	2.36	22010
22015		A	I&d, p-spine, l/s/ls	12.64	NA	NA	10.01	9.17	2.19	22015
22100		A	Remove part of neck vertebra	11.00	NA	NA	9.58	8.56	2.81	22100
22101		A	Remove part, thorax vertebra	11.08	NA	NA	10.43	8.79	2.83	22101
22102		A	Remove part, lumbar vertebra	11.08	NA	NA	8.98	8.38	1.91	22102
22103		A	Remove extra spine segment	2.34	NA	NA	1.14	1.07	0.47	22103
22110		A	Remove part of neck vertebra	14.00	NA	NA	10.80	10.00	3.59	22110
22112		A	Remove part, thorax vertebra	14.07	NA	NA	11.83	9.71	3.61	22112

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
22114		A	Remove part, lumbar vertebra	14.07	NA	NA	10.89	9.90	1.99	22114
22116		A	Remove extra spine segment	2.32	NA	NA	1.11	1.04	0.43	22116
22206		A	Cut spine 3 col, thor	37.18	NA	NA	21.93	19.79	5.29	22206
22207		A	Cut spine 3 col, lumb	36.68	NA	NA	21.87	19.64	6.63	22207
22208		A	Cut spine 3 col, addl seg	9.66	NA	NA	4.70	4.24	1.88	22208
22210		A	Revision of neck spine	25.38	NA	NA	17.29	15.99	4.85	22210
22212		A	Revision of thorax spine	20.99	NA	NA	15.15	13.79	3.55	22212
22214		A	Revision of lumbar spine	21.02	NA	NA	15.22	13.95	3.66	22214
22216		A	Revise, extra spine segment	6.03	NA	NA	2.93	2.77	1.08	22216
22220		A	Revision of neck spine	22.94	NA	NA	16.09	14.39	4.61	22220
22222		A	Revision of thorax spine	23.09	NA	NA	15.98	12.05	3.26	22222
22224		A	Revision of lumbar spine	23.09	NA	NA	15.66	14.31	3.85	22224
22226		A	Revise, extra spine segment	6.03	NA	NA	2.87	2.73	1.13	22226
22305		A	Treat spine process fracture	2.13	2.59	2.34	2.19	1.97	0.29	22305
22310		A	Treat spine fracture	3.89	3.66	3.21	3.10	2.71	0.54	22310
22315		A	Treat spine fracture	10.11	11.38	10.36	8.75	7.92	1.82	22315
22318		A	Treat odontoid fx w/o graft	22.72	NA	NA	15.42	14.19	5.53	22318
22319		A	Treat odontoid fx w/graft	25.33	NA	NA	16.86	15.16	6.54	22319
22325		A	Treat spine fracture	19.87	NA	NA	14.57	13.19	4.06	22325
22326		A	Treat neck spine fracture	20.84	NA	NA	14.45	13.21	4.54	22326
22327		A	Treat thorax spine fracture	20.77	NA	NA	14.93	13.44	4.01	22327
22328		A	Treat each add spine fx	4.60	NA	NA	2.21	2.06	0.97	22328
22505		A	Manipulation of spine	1.87	NA	NA	1.15	1.02	0.21	22505
22520		A	Percut vertebroplasty thor	9.22	44.19	47.16	3.88	4.40	0.76	22520
22521		A	Percut vertebroplasty lumb	8.65	44.12	46.50	3.73	4.21	0.72	22521
22522		A	Percut vertebroplasty addl	4.30	NA	NA	1.53	1.66	0.40	22522
22523		A	Percut kyphoplasty, thor	9.26	NA	NA	5.10	5.21	1.31	22523
22524		A	Percut kyphoplasty, lumbar	8.86	NA	NA	4.94	5.05	1.25	22524
22525		A	Percut kyphoplasty, add-on	4.47	NA	NA	1.94	1.96	0.68	22525
22526		N	Idet, single level	6.10	50.22	44.46	2.91	2.20	0.39	22526
22527		N	Idet, 1 or more levels	3.03	43.14	37.03	1.11	0.72	0.17	22527
22532		A	Lat thorax spine fusion	25.99	NA	NA	16.84	15.27	5.45	22532
22533		A	Lat lumbar spine fusion	24.79	NA	NA	16.39	14.78	4.60	22533
22534		A	Lat thor/lumb, addl seg	5.99	NA	NA	2.87	2.71	1.15	22534
22548		A	Neck spine fusion	27.06	NA	NA	17.89	16.22	7.00	22548
22554		A	Neck spine fusion	17.69	NA	NA	12.55	11.78	3.93	22554
22556		A	Thorax spine fusion	24.70	NA	NA	15.58	14.43	4.77	22556
22558		A	Lumbar spine fusion	23.53	NA	NA	14.35	13.07	4.06	22558
22585		A	Additional spinal fusion	5.52	NA	NA	2.60	2.45	1.15	22585

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
22590		A	Spine & skull spinal fusion	21.76	NA	NA	15.39	14.13	5.08	22590
22595		A	Neck spinal fusion	20.64	NA	NA	14.82	13.57	4.72	22595
22600		A	Neck spine fusion	17.40	NA	NA	13.15	12.02	3.81	22600
22610		A	Thorax spine fusion	17.28	NA	NA	12.92	11.85	3.48	22610
22612		A	Lumbar spine fusion	23.53	NA	NA	15.20	14.02	4.49	22612
22614		A	Spine fusion, extra segment	6.43	NA	NA	3.08	2.93	1.27	22614
22630		A	Lumbar spine fusion	22.09	NA	NA	15.06	13.83	4.52	22630
22632		A	Spine fusion, extra segment	5.22	NA	NA	2.50	2.36	1.08	22632
22800		A	Fusion of spine	19.50	NA	NA	13.61	12.55	3.51	22800
22802		A	Fusion of spine	32.11	NA	NA	19.67	18.41	5.42	22802
22804		A	Fusion of spine	37.50	NA	NA	22.21	20.86	6.14	22804
22808		A	Fusion of spine	27.51	NA	NA	16.79	15.71	5.24	22808
22810		A	Fusion of spine	31.50	NA	NA	18.40	16.97	5.71	22810
22812		A	Fusion of spine	34.25	NA	NA	21.30	19.24	4.86	22812
22818		A	Kyphectomy, 1-2 segments	34.33	NA	NA	20.31	18.58	4.88	22818
22819		A	Kyphectomy, 3 or more	39.38	NA	NA	24.03	21.61	10.20	22819
22830		A	Exploration of spinal fusion	11.22	NA	NA	8.47	7.83	2.08	22830
22840		A	Insert spine fixation device	12.52	NA	NA	6.02	5.69	2.52	22840
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	22841
22842		A	Insert spine fixation device	12.56	NA	NA	6.03	5.71	2.49	22842
22843		A	Insert spine fixation device	13.44	NA	NA	6.46	6.07	2.53	22843
22844		A	Insert spine fixation device	16.42	NA	NA	8.01	7.66	2.67	22844
22845		A	Insert spine fixation device	11.94	NA	NA	5.67	5.35	2.64	22845
22846		A	Insert spine fixation device	12.40	NA	NA	5.89	5.55	2.73	22846
22847		A	Insert spine fixation device	13.78	NA	NA	6.42	6.17	3.58	22847
22848		A	Insert pelv fixation device	5.99	NA	NA	2.93	2.80	1.00	22848
22849		A	Reinsert spinal fixation	19.17	NA	NA	12.41	11.48	3.71	22849
22850		A	Remove spine fixation device	9.82	NA	NA	7.64	7.04	1.89	22850
22851		A	Apply spine prosth device	6.70	NA	NA	3.20	3.01	1.37	22851
22852		A	Remove spine fixation device	9.37	NA	NA	7.39	6.80	1.75	22852
22855		A	Remove spine fixation device	15.86	NA	NA	10.88	10.00	3.42	22855
22856		A	Cerv artific diskectomy	24.05	NA	NA	15.31	14.28	5.26	22856
22857		R	Lumbar artif diskectomy	27.13	NA	NA	13.74	13.98	4.17	22857
22861		A	Revise cerv artific disc	33.36	NA	NA	14.52	14.02	1.68	22861
22862		R	Revise lumbar artif disc	32.63	NA	NA	15.77	14.47	4.64	22862
22864		A	Remove cerv artif disc	29.40	NA	NA	13.08	12.64	1.48	22864
22865		R	Remove lumb artif disc	31.75	NA	NA	19.72	18.91	4.51	22865
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	22899
22900		A	Exc back tum deep < 5 cm	8.32	NA	NA	5.68	4.13	0.92	22900

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
22901		A	Exc back tum deep = 5 cm	10.11	NA	NA	6.36	6.36	1.51	22901
22902		A	Exc abd les sc < 3 cm	4.42	6.41	6.41	4.14	4.14	0.51	22902
22903		A	Exc abd les sc > 3 cm	6.39	NA	NA	4.63	4.63	0.86	22903
22904		A	Resect abd tum < 5 cm	16.69	NA	NA	8.91	8.91	2.56	22904
22905		A	Resect abd tum > 5 cm	21.58	NA	NA	11.62	11.62	3.30	22905
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	22999
23000		A	Removal of calcium deposits	4.48	9.47	8.58	4.61	4.21	0.62	23000
23020		A	Release shoulder joint	9.36	NA	NA	7.85	7.26	1.27	23020
23030		A	Drain shoulder lesion	3.47	7.13	6.78	2.84	2.67	0.49	23030
23031		A	Drain shoulder bursa	2.79	6.95	6.62	2.49	2.33	0.38	23031
23035		A	Drain shoulder bone lesion	9.16	NA	NA	7.74	7.31	1.28	23035
23040		A	Exploratory shoulder surgery	9.75	NA	NA	8.13	7.54	1.36	23040
23044		A	Exploratory shoulder surgery	7.59	NA	NA	6.69	6.18	1.06	23044
23065		A	Biopsy shoulder tissues	2.30	3.11	2.94	1.94	1.81	0.28	23065
23066		A	Biopsy shoulder tissues	4.30	8.94	8.13	4.36	3.95	0.60	23066
23071		A	Exc shoulder les sc > 3 cm	5.91	NA	NA	4.52	4.52	0.86	23071
23073		A	Exc shoulder tum deep > 5 cm	10.13	NA	NA	7.11	7.11	1.48	23073
23075		A	Exc shoulder les sc < 3 cm	4.21	7.06	4.59	3.92	2.34	0.36	23075
23076		A	Exc shoulder tum deep < 5 cm	7.41	NA	NA	5.88	5.63	1.14	23076
23077		A	Resect shoulder tum < 5 cm	17.66	NA	NA	11.18	10.44	2.67	23077
23078		A	Resect shoulder tum > 5 cm	22.55	NA	NA	11.98	11.98	3.45	23078
23100		A	Biopsy of shoulder joint	6.20	NA	NA	6.13	5.58	0.86	23100
23101		A	Shoulder joint surgery	5.72	NA	NA	5.36	5.04	0.79	23101
23105		A	Remove shoulder joint lining	8.48	NA	NA	7.30	6.81	1.18	23105
23106		A	Incision of collarbone joint	6.13	NA	NA	6.09	5.43	0.85	23106
23107		A	Explore treat shoulder joint	8.87	NA	NA	7.54	7.01	1.23	23107
23120		A	Partial removal, collar bone	7.39	NA	NA	7.12	6.51	1.02	23120
23125		A	Removal of collar bone	9.64	NA	NA	7.94	7.26	1.35	23125
23130		A	Remove shoulder bone, part	7.77	NA	NA	7.27	6.77	1.08	23130
23140		A	Removal of bone lesion	7.12	NA	NA	5.82	5.28	1.00	23140
23145		A	Removal of bone lesion	9.40	NA	NA	7.82	7.23	1.32	23145
23146		A	Removal of bone lesion	8.08	NA	NA	7.26	6.45	1.13	23146
23150		A	Removal of humerus lesion	8.91	NA	NA	7.52	6.91	1.23	23150
23155		A	Removal of humerus lesion	10.86	NA	NA	8.81	8.14	1.53	23155
23156		A	Removal of humerus lesion	9.11	NA	NA	7.68	7.08	1.28	23156
23170		A	Remove collar bone lesion	7.21	NA	NA	6.62	5.71	1.01	23170
23172		A	Remove shoulder blade lesion	7.31	NA	NA	6.67	5.96	1.02	23172
23174		A	Remove humerus lesion	10.05	NA	NA	8.72	8.08	1.42	23174
23180		A	Remove collar bone lesion	8.99	NA	NA	7.57	7.40	1.28	23180

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
23182		A	Remove shoulder blade lesion	8.61	NA	NA	7.80	7.34	1.20	23182
23184		A	Remove humerus lesion	9.90	NA	NA	8.38	7.99	1.36	23184
23190		A	Partial removal of scapula	7.47	NA	NA	6.66	6.00	1.05	23190
23195		A	Removal of head of humerus	10.36	NA	NA	8.38	7.72	1.46	23195
23200		A	Resect clavicle tumor	22.71	NA	NA	15.21	10.03	1.82	23200
23210		A	Resect scapula tumor	27.21	NA	NA	17.41	10.97	1.89	23210
23220		A	Resect prox humerus tumor	30.21	NA	NA	18.64	12.16	2.20	23220
23330		A	Remove shoulder foreign body	1.90	4.00	3.63	1.92	1.74	0.26	23330
23331		A	Remove shoulder foreign body	7.63	NA	NA	7.01	6.51	1.06	23331
23332		A	Remove shoulder foreign body	12.37	NA	NA	9.64	8.95	1.73	23332
23350		A	Injection for shoulder x-ray	1.00	2.51	2.86	0.32	0.36	0.07	23350
23395		A	Muscle transfer,shoulder/arm	18.54	NA	NA	13.65	12.58	2.58	23395
23397		A	Muscle transfers	16.76	NA	NA	11.69	10.89	2.38	23397
23400		A	Fixation of shoulder blade	13.87	NA	NA	10.29	9.62	1.97	23400
23405		A	Incision of tendon & muscle	8.54	NA	NA	7.14	6.64	1.19	23405
23406		A	Incise tendon(s) & muscle(s)	11.01	NA	NA	8.36	7.84	1.56	23406
23410		A	Repair rotator cuff, acute	11.39	NA	NA	9.09	8.54	1.59	23410
23412		A	Repair rotator cuff, chronic	11.93	NA	NA	9.37	8.84	1.68	23412
23415		A	Release of shoulder ligament	9.23	NA	NA	7.98	7.47	1.28	23415
23420		A	Repair of shoulder	13.54	NA	NA	10.63	9.96	1.91	23420
23430		A	Repair biceps tendon	10.17	NA	NA	8.20	7.63	1.42	23430
23440		A	Remove/transplant tendon	10.64	NA	NA	8.23	7.67	1.49	23440
23450		A	Repair shoulder capsule	13.70	NA	NA	9.93	9.22	1.95	23450
23455		A	Repair shoulder capsule	14.67	NA	NA	10.41	9.73	2.06	23455
23460		A	Repair shoulder capsule	15.82	NA	NA	11.34	10.62	2.25	23460
23462		A	Repair shoulder capsule	15.72	NA	NA	11.01	10.23	2.24	23462
23465		A	Repair shoulder capsule	16.30	NA	NA	11.51	10.74	2.32	23465
23466		A	Repair shoulder capsule	15.80	NA	NA	12.27	11.25	2.22	23466
23470		A	Reconstruct shoulder joint	17.89	NA	NA	12.38	11.53	2.52	23470
23472		A	Reconstruct shoulder joint	22.65	NA	NA	14.89	13.81	3.18	23472
23480		A	Revision of collar bone	11.54	NA	NA	8.87	8.22	1.63	090
23485		A	Revision of collar bone	13.91	NA	NA	10.03	9.36	1.96	090
23490		A	Reinforce clavicle	12.16	NA	NA	9.27	8.42	1.73	090
23491		A	Reinforce shoulder bones	14.54	NA	NA	10.75	9.99	2.07	090
23500		A	Treat clavicle fracture	2.21	3.12	2.84	3.20	2.84	0.29	090
23505		A	Treat clavicle fracture	3.83	4.78	4.36	4.33	3.92	0.52	090
23515		A	Treat clavicle fracture	9.69	NA	NA	8.45	7.53	1.35	090
23520		A	Treat clavicle dislocation	2.29	3.33	2.96	3.41	3.00	0.31	090
23525		A	Treat clavicle dislocation	3.79	5.56	4.56	4.89	3.99	0.52	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
23530		A	Treat clavicle dislocation	7.48	NA	NA	6.66	5.65	1.05	090
23532		A	Treat clavicle dislocation	8.20	NA	NA	7.23	6.70	1.15	090
23540		A	Treat clavicle dislocation	2.36	3.09	2.82	3.17	2.79	0.30	090
23545		A	Treat clavicle dislocation	3.43	4.52	4.11	3.83	3.49	0.42	090
23550		A	Treat clavicle dislocation	7.59	NA	NA	6.59	6.15	1.04	090
23552		A	Treat clavicle dislocation	8.82	NA	NA	7.56	7.00	1.22	090
23570		A	Treat shoulder blade fx	2.36	3.30	3.01	3.46	3.11	0.32	090
23575		A	Treat shoulder blade fx	4.23	5.54	4.96	4.96	4.42	0.59	090
23585		A	Treat scapula fracture	14.23	NA	NA	10.41	9.17	1.99	090
23600		A	Treat humerus fracture	3.11	4.79	4.41	4.32	3.87	0.42	090
23605		A	Treat humerus fracture	5.06	6.33	5.88	5.44	5.01	0.69	090
23615		A	Treat humerus fracture	12.30	NA	NA	9.79	8.95	1.73	090
23616		A	Treat humerus fracture	18.37	NA	NA	12.80	12.19	2.58	090
23620		A	Treat humerus fracture	2.55	4.02	3.66	3.72	3.32	0.34	090
23625		A	Treat humerus fracture	4.10	5.23	4.81	4.64	4.24	0.55	090
23630		A	Treat humerus fracture	10.57	NA	NA	8.92	7.89	1.48	090
23650		A	Treat shoulder dislocation	3.53	3.88	3.54	3.33	2.95	0.43	090
23655		A	Treat shoulder dislocation	4.76	NA	NA	4.98	4.47	0.63	090
23660		A	Treat shoulder dislocation	7.66	NA	NA	6.85	6.29	1.06	090
23665		A	Treat dislocation/fracture	4.66	5.77	5.28	5.10	4.67	0.63	090
23670		A	Treat dislocation/fracture	12.28	NA	NA	9.64	8.45	1.73	090
23675		A	Treat dislocation/fracture	6.27	7.13	6.60	6.00	5.58	0.84	090
23680		A	Treat dislocation/fracture	13.15	NA	NA	10.03	9.01	1.85	090
23700		A	Fixation of shoulder	2.57	NA	NA	2.27	2.10	0.35	010
23800		A	Fusion of shoulder joint	14.73	NA	NA	10.80	10.04	2.09	090
23802		A	Fusion of shoulder joint	18.42	NA	NA	13.57	12.03	2.60	090
23900		A	Amputation of arm & girdle	20.72	NA	NA	13.95	11.66	2.94	090
23920		A	Amputation at shoulder joint	16.23	NA	NA	11.85	10.13	2.30	090
23921		A	Amputation follow-up surgery	5.72	NA	NA	4.80	4.00	0.96	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.99	5.70	5.51	2.39	2.22	0.43	010
23931		A	Drainage of arm bursa	1.84	5.00	4.86	2.09	1.96	0.25	010
23935		A	Drain arm/elbow bone lesion	6.38	NA	NA	5.98	5.55	0.88	090
24000		A	Exploratory elbow surgery	6.08	NA	NA	5.73	5.28	0.83	090
24006		A	Release elbow joint	9.74	NA	NA	7.99	7.39	1.29	090
24065		A	Biopsy arm/elbow soft tissue	2.13	4.19	4.05	2.10	1.98	0.25	010
24066		A	Biopsy arm/elbow soft tissue	5.35	9.62	8.87	4.80	4.28	0.76	090
24071		A	Exc arm/elbow les sc = 3 cm	5.70	NA	NA	4.44	4.44	0.82	090
24073		A	Ex arm/elbow tum deep > 5 cm	10.13	NA	NA	7.23	7.23	1.45	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
24075		A	Exc arm/elbow les sc < 3 cm	4.24	7.55	7.40	3.99	3.56	0.57	090
24076		A	Ex arm/elbow tum deep < 5 cm	7.41	NA	NA	6.03	5.13	0.92	090
24077		A	Resect arm/elbow tum < 5 cm	15.72	NA	NA	10.27	8.08	1.76	090
24079		A	Resect arm/elbow tum > 5 cm	20.61	NA	NA	11.26	11.26	3.15	090
24100		A	Biopsy elbow joint lining	5.07	NA	NA	5.20	4.68	0.71	090
24101		A	Explore/treat elbow joint	6.30	NA	NA	6.04	5.64	0.86	090
24102		A	Remove elbow joint lining	8.26	NA	NA	7.06	6.51	1.10	090
24105		A	Removal of elbow bursa	3.78	NA	NA	4.79	4.38	0.51	090
24110		A	Remove humerus lesion	7.58	NA	NA	6.93	6.40	1.06	090
24115		A	Remove/graft bone lesion	10.12	NA	NA	6.91	7.14	1.43	090
24116		A	Remove/graft bone lesion	12.23	NA	NA	9.21	8.52	1.74	090
24120		A	Remove elbow lesion	6.82	NA	NA	6.23	5.73	0.93	090
24125		A	Remove/graft bone lesion	8.14	NA	NA	7.20	6.53	1.14	090
24126		A	Remove/graft bone lesion	8.62	NA	NA	7.44	6.87	1.21	090
24130		A	Removal of head of radius	6.42	NA	NA	6.18	5.72	0.85	090
24134		A	Removal of arm bone lesion	10.22	NA	NA	8.31	7.85	1.44	090
24136		A	Remove radius bone lesion	8.40	NA	NA	7.21	6.09	1.18	090
24138		A	Remove elbow bone lesion	8.50	NA	NA	8.15	7.51	1.18	090
24140		A	Partial removal of arm bone	9.55	NA	NA	7.99	7.67	1.26	090
24145		A	Partial removal of radius	7.81	NA	NA	6.82	6.62	1.09	090
24147		A	Partial removal of elbow	7.84	NA	NA	7.52	7.23	1.07	090
24149		A	Radical resection of elbow	16.22	NA	NA	13.16	11.92	2.12	090
24150		A	Resect distal humerus tumor	23.46	NA	NA	15.48	10.87	1.97	090
24152		A	Resect radius tumor	19.99	NA	NA	13.78	8.90	1.46	090
24155		A	Removal of elbow joint	12.09	NA	NA	9.13	8.38	1.72	090
24160		A	Remove elbow joint implant	8.00	NA	NA	7.05	6.54	1.07	090
24164		A	Remove radius head implant	6.43	NA	NA	5.86	5.46	0.90	090
24200		A	Removal of arm foreign body	1.81	3.21	3.00	1.68	1.51	0.23	010
24201		A	Removal of arm foreign body	4.70	8.91	8.56	4.37	4.05	0.66	090
24220		A	Injection for elbow x-ray	1.31	2.60	2.93	0.46	0.50	0.09	000
24300		A	Manipulate elbow w/anesth	4.04	NA	NA	5.96	5.54	0.50	090
24301		A	Muscle/tendon transfer	10.38	NA	NA	8.28	7.73	1.47	090
24305		A	Arm tendon lengthening	7.62	NA	NA	6.83	6.33	0.97	090
24310		A	Revision of arm tendon	6.12	NA	NA	5.73	5.30	0.84	090
24320		A	Repair of arm tendon	10.86	NA	NA	8.53	7.82	1.54	090
24330		A	Revision of arm muscles	9.79	NA	NA	8.00	7.43	1.37	090
24331		A	Revision of arm muscles	10.95	NA	NA	8.57	8.04	1.55	090
24332		A	Tenolysis, triceps	7.91	NA	NA	7.22	6.67	1.10	090
24340		A	Repair of biceps tendon	8.08	NA	NA	7.13	6.63	1.13	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
24341		A	Repair arm tendon/muscle	9.49	NA	NA	9.06	8.20	1.29	090
24342		A	Repair of ruptured tendon	10.86	NA	NA	8.57	7.98	1.49	090
24343		A	Repr elbow lat ligmnt w/tiss	9.16	NA	NA	8.50	7.83	1.19	090
24344		A	Reconstruct elbow lat ligmnt	15.21	NA	NA	12.07	11.12	2.15	090
24345		A	Repr elbw med ligmnt w/tissu	9.16	NA	NA	8.37	7.70	1.20	090
24346		A	Reconstruct elbow med ligmnt	15.21	NA	NA	12.07	11.18	2.15	090
24357		A	Repair elbow, perc	5.44	NA	NA	5.62	5.23	0.73	090
24358		A	Repair elbow w/deb, open	6.66	NA	NA	6.33	5.87	0.88	090
24359		A	Repair elbow deb/attch open	8.98	NA	NA	7.48	6.76	1.20	090
24360		A	Reconstruct elbow joint	12.67	NA	NA	9.68	9.03	1.80	090
24361		A	Reconstruct elbow joint	14.41	NA	NA	10.63	9.97	2.05	090
24362		A	Reconstruct elbow joint	15.32	NA	NA	11.07	10.29	2.18	090
24363		A	Replace elbow joint	22.65	NA	NA	15.08	13.74	3.03	090
24365		A	Reconstruct head of radius	8.62	NA	NA	7.21	6.74	1.21	090
24366		A	Reconstruct head of radius	9.36	NA	NA	7.62	7.09	1.25	090
24400		A	Revision of humerus	11.33	NA	NA	9.11	8.48	1.57	090
24410		A	Revision of humerus	15.11	NA	NA	11.20	10.16	2.14	090
24420		A	Revision of humerus	13.73	NA	NA	10.88	10.12	1.95	090
24430		A	Repair of humerus	15.25	NA	NA	11.26	10.22	2.11	090
24435		A	Repair humerus with graft	14.99	NA	NA	11.93	10.91	2.08	090
24470		A	Revision of elbow joint	8.93	NA	NA	7.67	6.42	1.25	090
24495		A	Decompression of forearm	8.41	NA	NA	7.48	7.41	1.27	090
24498		A	Reinforce humerus	12.28	NA	NA	9.29	8.69	1.74	090
24500		A	Treat humerus fracture	3.41	5.26	4.81	4.53	4.04	0.45	090
24505		A	Treat humerus fracture	5.39	6.86	6.35	5.76	5.31	0.73	090
24515		A	Treat humerus fracture	12.12	NA	NA	9.72	9.01	1.70	090
24516		A	Treat humerus fracture	12.19	NA	NA	9.28	8.63	1.73	090
24530		A	Treat humerus fracture	3.69	5.58	5.12	4.75	4.28	0.49	090
24535		A	Treat humerus fracture	7.11	8.08	7.49	6.99	6.44	0.97	090
24538		A	Treat humerus fracture	9.77	NA	NA	8.58	8.08	1.37	090
24545		A	Treat humerus fracture	13.15	NA	NA	10.06	9.08	1.84	090
24546		A	Treat humerus fracture	14.91	NA	NA	11.07	10.38	2.07	090
24560		A	Treat humerus fracture	2.98	4.83	4.42	4.06	3.59	0.39	090
24565		A	Treat humerus fracture	5.78	7.24	6.39	6.22	5.45	0.80	090
24566		A	Treat humerus fracture	9.06	NA	NA	8.64	7.96	1.26	090
24575		A	Treat humerus fracture	9.71	NA	NA	8.50	7.92	1.33	090
24576		A	Treat humerus fracture	3.06	5.22	4.74	4.42	3.94	0.41	090
24577		A	Treat humerus fracture	6.01	7.41	6.63	6.33	5.61	0.83	090
24579		A	Treat humerus fracture	11.44	NA	NA	9.38	8.65	1.58	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
24582		A	Treat humerus fracture	10.14	NA	NA	9.81	8.91	1.41	090
24586		A	Treat elbow fracture	15.78	NA	NA	11.34	10.60	2.18	090
24587		A	Treat elbow fracture	15.79	NA	NA	11.52	10.61	2.10	090
24600		A	Treat elbow dislocation	4.37	4.49	4.20	3.82	3.45	0.55	090
24605		A	Treat elbow dislocation	5.64	NA	NA	5.87	5.37	0.77	090
24615		A	Treat elbow dislocation	9.83	NA	NA	7.93	7.38	1.31	090
24620		A	Treat elbow fracture	7.22	NA	NA	6.35	5.98	0.95	090
24635		A	Treat elbow fracture	8.80	NA	NA	7.93	8.56	1.19	090
24640		A	Treat elbow dislocation	1.25	1.97	1.68	0.98	0.85	0.15	010
24650		A	Treat radius fracture	2.31	4.04	3.70	3.55	3.14	0.30	090
24655		A	Treat radius fracture	4.62	6.11	5.64	5.21	4.76	0.61	090
24665		A	Treat radius fracture	8.36	NA	NA	7.82	7.24	1.13	090
24666		A	Treat radius fracture	9.86	NA	NA	8.42	7.78	1.32	090
24670		A	Treat ulnar fracture	2.69	4.37	4.03	3.72	3.35	0.35	090
24675		A	Treat ulnar fracture	4.91	6.23	5.82	5.31	4.94	0.66	090
24685		A	Treat ulnar fracture	8.37	NA	NA	7.85	7.25	1.15	090
24800		A	Fusion of elbow joint	11.41	NA	NA	9.17	7.99	1.61	090
24802		A	Fusion/graft of elbow joint	14.32	NA	NA	10.60	9.78	2.03	090
24900		A	Amputation of upper arm	10.18	NA	NA	7.95	7.21	1.45	090
24920		A	Amputation of upper arm	10.13	NA	NA	8.05	7.12	1.43	090
24925		A	Amputation follow-up surgery	7.30	NA	NA	6.66	6.14	1.02	090
24930		A	Amputation follow-up surgery	10.83	NA	NA	8.39	7.46	1.53	090
24931		A	Amputate upper arm & implant	13.44	NA	NA	7.04	6.71	0.67	090
24935		A	Revision of amputation	16.45	NA	NA	12.22	9.05	2.33	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.55	NA	NA	4.72	4.82	0.45	090
25001		A	Incise flexor carpi radialis	3.79	NA	NA	4.68	4.27	0.47	090
25020		A	Decompress forearm 1 space	6.06	NA	NA	8.14	7.84	0.75	090
25023		A	Decompress forearm 1 space	13.83	NA	NA	14.02	12.86	1.96	090
25024		A	Decompress forearm 2 spaces	10.79	NA	NA	8.46	7.88	1.51	090
25025		A	Decompress forearm 2 spaces	17.94	NA	NA	12.63	11.11	2.54	090
25028		A	Drainage of forearm lesion	5.39	NA	NA	7.38	7.04	0.73	090
25031		A	Drainage of forearm bursa	4.26	NA	NA	4.68	4.75	0.59	090
25035		A	Treat forearm bone lesion	7.65	NA	NA	6.52	7.51	1.04	090
25040		A	Explore/treat wrist joint	7.50	NA	NA	6.50	6.23	0.97	090
25065		A	Biopsy forearm soft tissues	2.04	4.26	4.11	2.12	2.02	0.23	010
25066		A	Biopsy forearm soft tissues	4.27	NA	NA	4.52	4.72	0.57	090
25071		A	Exc forearm les sc > 3 cm	5.91	NA	NA	4.74	4.74	0.83	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
25073		A	Exc forearm tum deep = 3 cm	7.13	NA	NA	6.20	6.20	0.96	090
25075		A	Exc forearm les sc < 3 cm	3.96	7.56	4.96	3.96	4.04	0.54	090
25076		A	Exc forearm tum deep < 3 cm	6.74	NA	NA	6.02	5.74	0.68	090
25077		A	Resect forearm/wrist tum<3cm	12.93	NA	NA	9.12	8.23	1.45	090
25078		A	Resect forearm/wrist tum=3cm	17.69	NA	NA	10.18	10.18	2.71	090
25085		A	Incision of wrist capsule	5.64	NA	NA	5.48	5.44	0.79	090
25100		A	Biopsy of wrist joint	4.02	NA	NA	4.47	4.30	0.56	090
25101		A	Explore/treat wrist joint	4.83	NA	NA	5.17	4.94	0.64	090
25105		A	Remove wrist joint lining	6.02	NA	NA	6.00	5.82	0.78	090
25107		A	Remove wrist joint cartilage	7.70	NA	NA	7.66	7.25	0.96	090
25109		A	Excise tendon forearm/wrist	6.94	NA	NA	6.47	5.80	0.88	090
25110		A	Remove wrist tendon lesion	4.04	NA	NA	4.35	4.55	0.54	090
25111		A	Remove wrist tendon lesion	3.53	NA	NA	4.32	4.09	0.47	090
25112		A	Reremove wrist tendon lesion	4.67	NA	NA	4.83	4.57	0.62	090
25115		A	Remove wrist/forearm lesion	10.09	NA	NA	8.91	9.25	1.27	090
25116		A	Remove wrist/forearm lesion	7.56	NA	NA	7.41	7.98	0.94	090
25118		A	Excise wrist tendon sheath	4.51	NA	NA	4.94	4.75	0.57	090
25119		A	Partial removal of ulna	6.21	NA	NA	6.04	5.94	0.87	090
25120		A	Removal of forearm lesion	6.27	NA	NA	6.06	6.82	0.83	090
25125		A	Remove/graft forearm lesion	7.67	NA	NA	6.97	7.68	1.07	090
25126		A	Remove/graft forearm lesion	7.74	NA	NA	7.00	7.65	1.08	090
25130		A	Removal of wrist lesion	5.43	NA	NA	5.69	5.44	0.69	090
25135		A	Remove & graft wrist lesion	7.08	NA	NA	7.05	6.53	0.99	090
25136		A	Remove & graft wrist lesion	6.14	NA	NA	6.00	5.74	0.86	090
25145		A	Remove forearm bone lesion	6.54	NA	NA	6.20	6.93	0.91	090
25150		A	Partial removal of ulna	7.38	NA	NA	6.63	6.51	0.97	090
25151		A	Partial removal of radius	7.68	NA	NA	6.90	7.50	1.08	090
25170		A	Resect radius/ulnar tumor	22.21	NA	NA	14.77	11.07	1.62	090
25210		A	Removal of wrist bone	6.12	NA	NA	6.06	5.78	0.76	090
25215		A	Removal of wrist bones	8.14	NA	NA	7.31	7.08	1.00	090
25230		A	Partial removal of radius	5.37	NA	NA	5.39	5.15	0.64	090
25240		A	Partial removal of ulna	5.31	NA	NA	5.37	5.30	0.66	090
25246		A	Injection for wrist x-ray	1.45	2.52	2.84	0.49	0.54	0.11	000
25248		A	Remove forearm foreign body	5.31	NA	NA	4.91	5.21	0.74	090
25250		A	Removal of wrist prosthesis	6.77	NA	NA	6.30	5.86	0.95	090
25251		A	Removal of wrist prosthesis	9.82	NA	NA	8.01	7.46	1.39	090
25259		A	Manipulate wrist w/anesthes	4.04	NA	NA	6.01	5.59	0.51	090
25260		A	Repair forearm tendon/muscle	8.04	NA	NA	7.63	8.18	1.05	090
25263		A	Repair forearm tendon/muscle	8.04	NA	NA	7.43	8.10	1.12	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
25265		A	Repair forearm tendon/muscle	10.10	NA	NA	8.44	9.04	1.42	090
25270		A	Repair forearm tendon/muscle	6.17	NA	NA	6.06	6.76	0.81	090
25272		A	Repair forearm tendon/muscle	7.21	NA	NA	6.55	7.31	0.94	090
25274		A	Repair forearm tendon/muscle	8.94	NA	NA	7.59	8.28	1.25	090
25275		A	Repair forearm tendon sheath	8.96	NA	NA	7.73	7.25	1.25	090
25280		A	Revise wrist/forearm tendon	7.39	NA	NA	6.75	7.39	0.92	090
25290		A	Incise wrist/forearm tendon	5.43	NA	NA	5.39	6.87	0.69	090
25295		A	Release wrist/forearm tendon	6.72	NA	NA	6.32	7.02	0.83	090
25300		A	Fusion of tendons at wrist	9.02	NA	NA	7.90	7.51	1.26	090
25301		A	Fusion of tendons at wrist	8.59	NA	NA	7.51	7.10	1.11	090
25310		A	Transplant forearm tendon	8.08	NA	NA	7.43	7.97	0.98	090
25312		A	Transplant forearm tendon	9.82	NA	NA	8.19	8.72	1.26	090
25315		A	Revise palsy hand tendon(s)	10.68	NA	NA	8.44	9.11	1.51	090
25316		A	Revise palsy hand tendon(s)	12.90	NA	NA	10.60	10.36	1.15	090
25320		A	Repair/revise wrist joint	12.75	NA	NA	11.98	10.98	1.60	090
25332		A	Revise wrist joint	11.74	NA	NA	9.26	8.63	1.56	090
25335		A	Realignment of hand	13.39	NA	NA	7.21	8.98	0.66	090
25337		A	Reconstruct ulna/radioulnar	11.73	NA	NA	10.55	9.88	1.44	090
25350		A	Revision of radius	9.09	NA	NA	7.75	8.42	1.15	090
25355		A	Revision of radius	10.53	NA	NA	8.47	9.11	1.49	090
25360		A	Revision of ulna	8.74	NA	NA	7.53	8.24	1.18	090
25365		A	Revise radius & ulna	12.91	NA	NA	9.82	10.19	1.83	090
25370		A	Revise radius or ulna	14.10	NA	NA	10.89	11.18	2.00	090
25375		A	Revise radius & ulna	13.55	NA	NA	7.27	9.96	0.67	090
25390		A	Shorten radius or ulna	10.70	NA	NA	8.64	9.16	1.35	090
25391		A	Lengthen radius or ulna	14.28	NA	NA	10.49	10.92	2.03	090
25392		A	Shorten radius & ulna	14.58	NA	NA	10.64	11.08	2.07	090
25393		A	Lengthen radius & ulna	16.56	NA	NA	11.61	12.02	2.35	090
25394		A	Repair carpal bone, shorten	10.85	NA	NA	8.59	7.96	1.53	090
25400		A	Repair radius or ulna	11.28	NA	NA	8.88	9.46	1.49	090
25405		A	Repair/graft radius or ulna	15.01	NA	NA	11.02	11.43	1.97	090
25415		A	Repair radius & ulna	13.80	NA	NA	10.68	11.07	1.96	090
25420		A	Repair/graft radius & ulna	17.04	NA	NA	12.06	12.51	2.42	090
25425		A	Repair/graft radius or ulna	13.72	NA	NA	10.21	11.65	1.95	090
25426		A	Repair/graft radius & ulna	16.45	NA	NA	11.55	10.61	2.34	090
25430		A	Vasc graft into carpal bone	9.71	NA	NA	8.93	7.77	0.86	090
25431		A	Repair nonunion carpal bone	10.89	NA	NA	8.68	7.93	1.54	090
25440		A	Repair/graft wrist bone	10.68	NA	NA	8.44	8.07	1.35	090
25441		A	Reconstruct wrist joint	13.29	NA	NA	10.81	9.60	1.18	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
25442		A	Reconstruct wrist joint	11.12	NA	NA	9.21	8.48	0.99	090
25443		A	Reconstruct wrist joint	10.66	NA	NA	8.70	8.16	1.50	090
25444		A	Reconstruct wrist joint	11.42	NA	NA	6.48	7.82	0.57	090
25445		A	Reconstruct wrist joint	9.88	NA	NA	8.12	7.53	1.27	090
25446		A	Wrist replacement	17.30	NA	NA	12.29	11.33	2.12	090
25447		A	Repair wrist joint(s)	11.14	NA	NA	9.60	8.73	1.40	090
25449		A	Remove wrist joint implant	14.94	NA	NA	10.80	10.09	2.12	090
25450		A	Revision of wrist joint	8.06	NA	NA	6.42	6.37	1.13	090
25455		A	Revision of wrist joint	9.71	NA	NA	5.87	6.78	0.48	090
25490		A	Reinforce radius	9.73	NA	NA	7.31	8.24	0.89	090
25491		A	Reinforce ulna	10.15	NA	NA	8.19	8.86	1.43	090
25492		A	Reinforce radius and ulna	12.66	NA	NA	9.79	10.21	1.80	090
25500		A	Treat fracture of radius	2.60	3.99	3.58	3.48	3.04	0.32	090
25505		A	Treat fracture of radius	5.45	6.92	6.37	5.96	5.43	0.72	090
25515		A	Treat fracture of radius	8.80	NA	NA	7.83	7.23	1.19	090
25520		A	Treat fracture of radius	6.50	7.40	6.53	6.72	5.89	0.90	090
25525		A	Treat fracture of radius	10.55	NA	NA	8.89	8.54	1.45	090
25526		A	Treat fracture of radius	13.15	NA	NA	10.42	10.40	1.86	090
25530		A	Treat fracture of ulna	2.24	4.10	3.75	3.52	3.15	0.29	090
25535		A	Treat fracture of ulna	5.36	6.67	6.09	5.84	5.33	0.71	090
25545		A	Treat fracture of ulna	7.94	NA	NA	7.52	7.03	1.06	090
25560		A	Treat fracture radius & ulna	2.59	4.10	3.68	3.49	3.03	0.33	090
25565		A	Treat fracture radius & ulna	5.85	6.97	6.48	5.85	5.40	0.78	090
25574		A	Treat fracture radius & ulna	8.80	NA	NA	7.94	7.24	1.21	090
25575		A	Treat fracture radius/ulna	12.29	NA	NA	10.11	9.33	1.70	090
25600		A	Treat fracture radius/ulna	2.78	4.35	3.99	3.77	3.34	0.36	090
25605		A	Treat fracture radius/ulna	7.25	8.14	7.41	7.31	6.60	0.97	090
25606		A	Treat fx distal radial	8.31	NA	NA	8.05	7.67	1.13	090
25607		A	Treat fx rad extra-articul	9.56	NA	NA	8.71	7.83	1.28	090
25608		A	Treat fx rad intra-articul	11.07	NA	NA	9.49	8.53	1.48	090
25609		A	Treat fx radial 3+ frag	14.38	NA	NA	11.79	10.59	1.92	090
25622		A	Treat wrist bone fracture	2.79	4.63	4.20	4.00	3.52	0.36	090
25624		A	Treat wrist bone fracture	4.77	6.61	6.12	5.64	5.16	0.63	090
25628		A	Treat wrist bone fracture	9.67	NA	NA	8.32	7.66	1.23	090
25630		A	Treat wrist bone fracture	3.03	4.47	4.07	3.89	3.41	0.39	090
25635		A	Treat wrist bone fracture	4.61	6.47	5.76	5.55	4.69	0.63	090
25645		A	Treat wrist bone fracture	7.42	NA	NA	6.63	6.15	1.04	090
25650		A	Treat wrist bone fracture	3.23	4.57	4.19	4.11	3.63	0.41	090
25651		A	Pin ulnar styloid fracture	5.82	NA	NA	6.18	5.62	0.78	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
25652		A	Treat fracture ulnar styloid	8.06	NA	NA	7.44	6.85	1.04	090
25660		A	Treat wrist dislocation	4.98	NA	NA	5.19	4.70	0.64	090
25670		A	Treat wrist dislocation	8.09	NA	NA	7.02	6.54	1.06	090
25671		A	Pin radioulnar dislocation	6.46	NA	NA	6.60	6.05	0.90	090
25675		A	Treat wrist dislocation	4.89	5.76	5.31	4.92	4.49	0.61	090
25676		A	Treat wrist dislocation	8.29	NA	NA	7.32	6.86	1.09	090
25680		A	Treat wrist fracture	6.23	NA	NA	5.46	4.86	0.75	090
25685		A	Treat wrist fracture	10.09	NA	NA	8.15	7.50	1.43	090
25690		A	Treat wrist dislocation	5.72	NA	NA	6.08	5.44	0.79	090
25695		A	Treat wrist dislocation	8.51	NA	NA	7.16	6.69	1.19	090
25800		A	Fusion of wrist joint	10.07	NA	NA	8.31	7.85	1.28	090
25805		A	Fusion/graft of wrist joint	11.73	NA	NA	9.23	8.87	1.66	090
25810		A	Fusion/graft of wrist joint	11.95	NA	NA	9.80	9.12	1.51	090
25820		A	Fusion of hand bones	7.64	NA	NA	7.69	7.16	0.97	090
25825		A	Fuse hand bones with graft	9.69	NA	NA	9.21	8.59	1.21	090
25830		A	Fusion, radioulnar jnt/ulna	10.88	NA	NA	12.60	12.07	1.53	090
25900		A	Amputation of forearm	9.61	NA	NA	8.01	8.35	1.29	090
25905		A	Amputation of forearm	9.59	NA	NA	7.79	8.07	1.35	090
25907		A	Amputation follow-up surgery	8.09	NA	NA	7.05	7.40	1.13	090
25909		A	Amputation follow-up surgery	9.31	NA	NA	7.65	7.99	1.31	090
25915		A	Amputation of forearm	17.52	NA	NA	6.52	11.04	2.23	090
25920		A	Amputate hand at wrist	9.03	NA	NA	8.17	7.55	1.27	090
25922		A	Amputate hand at wrist	7.65	NA	NA	5.23	5.97	0.38	090
25924		A	Amputation follow-up surgery	8.81	NA	NA	7.97	7.38	1.24	090
25927		A	Amputation of hand	9.09	NA	NA	10.77	9.97	1.27	090
25929		A	Amputation follow-up surgery	7.82	NA	NA	6.92	5.89	1.10	090
25931		A	Amputation follow-up surgery	8.04	NA	NA	8.56	8.97	1.22	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.59	4.71	4.55	1.83	1.65	0.19	010
26011		A	Drainage of finger abscess	2.24	7.13	7.04	2.37	2.19	0.29	010
26020		A	Drain hand tendon sheath	5.08	NA	NA	5.67	5.22	0.66	090
26025		A	Drainage of palm bursa	5.08	NA	NA	5.44	4.94	0.65	090
26030		A	Drainage of palm bursa(s)	6.25	NA	NA	6.02	5.53	0.82	090
26034		A	Treat hand bone lesion	6.63	NA	NA	6.70	6.17	0.86	090
26035		A	Decompress fingers/hand	11.37	NA	NA	9.85	8.73	1.59	090
26037		A	Decompress fingers/hand	7.57	NA	NA	6.65	6.11	1.02	090
26040		A	Release palm contracture	3.46	NA	NA	4.28	3.93	0.40	090
26045		A	Release palm contracture	5.73	NA	NA	5.84	5.40	0.77	090
26055		A	Incise finger tendon sheath	3.11	10.32	10.46	4.51	4.10	0.39	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
26060		A	Incision of finger tendon	2.91	NA	NA	3.66	3.40	0.39	090
26070		A	Explore/treat hand joint	3.81	NA	NA	3.83	3.43	0.46	090
26075		A	Explore/treat finger joint	3.91	NA	NA	4.14	3.74	0.48	090
26080		A	Explore/treat finger joint	4.47	NA	NA	5.15	4.74	0.56	090
26100		A	Biopsy hand joint lining	3.79	NA	NA	4.41	3.97	0.53	090
26105		A	Biopsy finger joint lining	3.83	NA	NA	4.43	4.06	0.53	090
26110		A	Biopsy finger joint lining	3.65	NA	NA	4.31	3.96	0.45	090
26111		A	Exc hand les sc > 1.5 cm	5.42	NA	NA	5.01	5.01	0.69	090
26113		A	Exc hand tum deep > 1.5 cm	7.13	NA	NA	6.61	6.61	0.89	090
26115		A	Exc hand les sc < 1.5 cm	3.96	8.07	10.11	4.36	4.46	0.51	090
26116		A	Exc hand tum deep < 1.5 cm	6.74	NA	NA	6.41	5.85	0.71	090
26117		A	Exc hand tum ra < 3 cm	10.13	NA	NA	8.60	7.16	1.13	090
26118		A	Exc hand tum ra > 3 cm	14.81	NA	NA	11.83	11.83	2.09	090
26121		A	Release palm contracture	7.73	NA	NA	7.16	6.62	0.99	090
26123		A	Release palm contracture	10.88	NA	NA	9.97	9.03	1.36	090
26125		A	Release palm contracture	4.60	NA	NA	2.41	2.23	0.59	ZZZ
26130		A	Remove wrist joint lining	5.59	NA	NA	5.80	5.30	0.74	090
26135		A	Revise finger joint, each	7.13	NA	NA	6.56	6.10	0.90	090
26140		A	Revise finger joint, each	6.34	NA	NA	6.20	5.75	0.80	090
26145		A	Tendon excision, palm/finger	6.49	NA	NA	6.24	5.77	0.83	090
26160		A	Remove tendon sheath lesion	3.57	10.27	10.08	4.66	4.24	0.46	090
26170		A	Removal of palm tendon, each	4.91	NA	NA	5.21	4.80	0.61	090
26180		A	Removal of finger tendon	5.35	NA	NA	5.72	5.27	0.65	090
26185		A	Remove finger bone	6.52	NA	NA	7.00	6.36	0.90	090
26200		A	Remove hand bone lesion	5.65	NA	NA	5.52	5.14	0.73	090
26205		A	Remove/graft bone lesion	7.93	NA	NA	6.94	6.51	1.11	090
26210		A	Removal of finger lesion	5.32	NA	NA	5.64	5.22	0.67	090
26215		A	Remove/graft finger lesion	7.27	NA	NA	6.62	6.10	1.02	090
26230		A	Partial removal of hand bone	6.47	NA	NA	5.95	5.56	0.80	090
26235		A	Partial removal, finger bone	6.33	NA	NA	6.00	5.54	0.78	090
26236		A	Partial removal, finger bone	5.46	NA	NA	5.53	5.10	0.69	090
26250		A	Extensive hand surgery	15.21	NA	NA	11.43	7.50	1.08	090
26260		A	Resect prox finger tumor	11.16	NA	NA	8.80	6.56	1.01	090
26262		A	Resect distal finger tumor	8.29	NA	NA	7.39	5.62	0.81	090
26320		A	Removal of implant from hand	4.10	NA	NA	4.51	4.16	0.50	090
26340		A	Manipulate finger w/anesth	2.80	NA	NA	5.36	4.91	0.35	090
26350		A	Repair finger/hand tendon	6.21	NA	NA	10.93	10.98	0.79	090
26352		A	Repair/graft hand tendon	7.87	NA	NA	11.76	11.63	1.10	090
26356		A	Repair finger/hand tendon	10.62	NA	NA	15.99	15.42	1.34	090
26357		A	Repair finger/hand tendon	8.77	NA	NA	12.21	12.07	1.23	090
26358		A	Repair/graft hand tendon	9.36	NA	NA	12.77	12.69	1.31	090
26370		A	Repair finger/hand tendon	7.28	NA	NA	11.12	11.19	0.96	090
26372		A	Repair/graft hand tendon	9.01	NA	NA	12.32	12.34	1.26	090
26373		A	Repair finger/hand tendon	8.41	NA	NA	12.03	11.98	1.18	090
26390		A	Revise hand/finger tendon	9.43	NA	NA	10.84	10.51	1.32	090
26392		A	Repair/graft hand tendon	10.50	NA	NA	13.05	12.81	1.48	090
26410		A	Repair hand tendon	4.77	NA	NA	8.81	8.88	0.63	090
26412		A	Repair/graft hand tendon	6.48	NA	NA	10.04	10.05	0.81	090
26415		A	Excision, hand/finger tendon	8.51	NA	NA	8.88	8.85	0.83	090
26416		A	Graft hand or finger tendon	9.56	NA	NA	11.86	9.87	1.34	090
26418		A	Repair finger tendon	4.47	NA	NA	9.36	9.36	0.58	090
26420		A	Repair/graft finger tendon	6.94	NA	NA	10.36	10.23	0.97	090
26426		A	Repair finger/hand tendon	6.32	NA	NA	6.16	7.09	0.81	090
26428		A	Repair/graft finger tendon	7.40	NA	NA	10.80	10.67	1.03	090
26432		A	Repair finger tendon	4.16	NA	NA	7.86	7.82	0.53	090
26433		A	Repair finger tendon	4.70	NA	NA	8.08	8.10	0.61	090
26434		A	Repair/graft finger tendon	6.26	NA	NA	9.29	9.11	0.87	090
26437		A	Realignment of tendons	5.99	NA	NA	9.08	8.98	0.73	090
26440		A	Release palm/finger tendon	5.16	NA	NA	9.78	9.90	0.64	090
26442		A	Release palm & finger tendon	9.75	NA	NA	13.79	13.31	1.22	090
26445		A	Release hand/finger tendon	4.45	NA	NA	9.43	9.57	0.56	090
26449		A	Release forearm/hand tendon	8.59	NA	NA	8.79	9.51	1.06	090
26450		A	Incision of palm tendon	3.79	NA	NA	6.07	5.91	0.49	090
26455		A	Incision of finger tendon	3.76	NA	NA	6.00	5.86	0.49	090
26460		A	Incise hand/finger tendon	3.58	NA	NA	5.92	5.79	0.44	090
26471		A	Fusion of finger tendons	5.90	NA	NA	9.03	8.87	0.73	090
26474		A	Release forearm/hand tendon	8.59	NA	NA	8.91	8.75	0.76	090
26476		A	Tendon lengthening	5.35	NA	NA	8.84	8.53	0.74	090
26477		A	Tendon shortening	5.32	NA	NA	8.75	8.62	0.71	090
26478		A	Lengthening of hand tendon	5.97	NA	NA	9.10	9.08	0.77	090
26479		A	Shortening of hand tendon	5.91	NA	NA	9.11	9.00	0.82	090
26480		A	Transplant hand tendon	6.90	NA	NA	11.35	11.29	0.86	090
26483		A	Transplant/graft hand tendon	8.48	NA	NA	11.83	11.88	1.11	090
26485		A	Transplant palm tendon	7.89	NA	NA	11.67	11.68	1.00	090
26489		A	Transplant/graft palm tendon	9.86	NA	NA	12.74	11.63	1.39	090
26490		A	Revise thumb tendon	8.60	NA	NA	10.39	10.27	1.20	090
26492		A	Tendon transfer with graft	9.84	NA	NA	11.53	11.21	1.39	090
26494		A	Hand tendon/muscle transfer	8.66	NA	NA	10.68	10.44	1.21	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
26496		A	Revise thumb tendon	9.78	NA	NA	11.34	10.93	1.18	090
26497		A	Finger tendon transfer	9.76	NA	NA	11.22	10.94	1.37	090
26498		A	Finger tendon transfer	14.21	NA	NA	13.68	13.26	2.02	090
26499		A	Revision of finger	9.17	NA	NA	10.93	10.63	1.29	090
26500		A	Hand tendon reconstruction	6.13	NA	NA	9.04	8.92	0.81	090
26502		A	Hand tendon reconstruction	7.31	NA	NA	9.80	9.61	1.02	090
26508		A	Release thumb contracture	6.18	NA	NA	8.94	8.88	0.78	090
26510		A	Thumb tendon transfer	5.60	NA	NA	8.86	8.80	0.68	090
26516		A	Fusion of knuckle joint	7.32	NA	NA	9.76	9.56	0.92	090
26517		A	Fusion of knuckle joints	9.08	NA	NA	10.88	10.69	1.27	090
26518		A	Fusion of knuckle joints	9.27	NA	NA	10.98	10.74	1.30	090
26520		A	Release knuckle contracture	5.47	NA	NA	10.22	10.30	0.69	090
26525		A	Release finger contracture	5.50	NA	NA	10.22	10.32	0.68	090
26530		A	Revise knuckle joint	6.88	NA	NA	6.50	5.98	0.87	090
26531		A	Revise knuckle with implant	8.13	NA	NA	7.48	6.87	0.99	090
26535		A	Revise finger joint	5.41	NA	NA	5.03	4.38	0.59	090
26536		A	Revise/implant finger joint	6.56	NA	NA	10.75	9.86	0.79	090
26540		A	Repair hand joint	6.60	NA	NA	9.38	9.27	0.84	090
26541		A	Repair hand joint with graft	8.81	NA	NA	10.83	10.55	1.08	090
26542		A	Repair hand joint with graft	6.95	NA	NA	9.35	9.40	0.89	090
26545		A	Reconstruct finger joint	7.11	NA	NA	9.84	9.62	0.90	090
26546		A	Repair nonunion hand	10.83	NA	NA	13.23	12.83	1.30	090
26548		A	Reconstruct finger joint	8.22	NA	NA	10.30	10.13	1.06	090
26550		A	Construct thumb replacement	21.68	NA	NA	18.68	15.20	3.08	090
26551		A	Great toe-hand transfer	48.48	NA	NA	33.43	28.93	6.89	090
26553		A	Single transfer, toe-hand	48.17	NA	NA	23.96	21.88	2.42	090
26554		A	Double transfer, toe-hand	57.01	NA	NA	27.52	29.03	2.86	090
26555		A	Positional change of finger	17.08	NA	NA	17.31	16.08	2.42	090
26556		A	Toe joint transfer	49.75	NA	NA	13.67	19.80	2.85	090
26560		A	Repair of web finger	5.52	NA	NA	8.43	8.20	0.77	090
26561		A	Repair of web finger	11.10	NA	NA	9.88	10.43	1.71	090
26562		A	Repair of web finger	16.68	NA	NA	11.39	14.04	0.82	090
26565		A	Correct metacarpal flaw	6.91	NA	NA	9.56	9.38	0.97	090
26567		A	Correct finger deformity	6.99	NA	NA	9.60	9.43	0.88	090
26568		A	Lengthen metacarpal/finger	9.27	NA	NA	12.45	12.24	1.30	090
26580		A	Repair hand deformity	19.75	NA	NA	17.35	14.70	2.79	090
26587		A	Reconstruct extra finger	14.50	NA	NA	9.10	8.60	2.23	090
26590		A	Repair finger deformity	18.67	NA	NA	15.88	12.47	2.65	090
26591		A	Repair muscles of hand	3.38	NA	NA	6.95	7.14	0.43	090
26593		A	Release muscles of hand	5.50	NA	NA	9.09	8.91	0.66	090
26596		A	Excision constricting tissue	9.14	NA	NA	9.44	8.55	1.28	090
26600		A	Treat metacarpal fracture	2.60	4.55	4.03	4.15	3.56	0.33	090
26605		A	Treat metacarpal fracture	3.03	4.82	4.43	4.16	3.76	0.39	090
26607		A	Treat metacarpal fracture	5.48	NA	NA	5.73	5.04	0.75	090
26608		A	Treat metacarpal fracture	5.55	NA	NA	6.23	5.82	0.73	090
26615		A	Treat metacarpal fracture	7.07	NA	NA	7.21	6.35	0.92	090
26641		A	Treat thumb dislocation	4.13	4.90	4.51	4.17	3.77	0.51	090
26645		A	Treat thumb fracture	4.58	5.85	5.18	5.04	4.41	0.63	090
26650		A	Treat thumb fracture	5.35	NA	NA	6.44	6.03	0.70	090
26665		A	Treat thumb fracture	7.94	NA	NA	7.68	6.92	1.03	090
26670		A	Treat hand dislocation	3.83	4.35	3.94	3.65	3.19	0.47	090
26675		A	Treat hand dislocation	4.83	6.25	5.55	5.40	4.74	0.67	090
26676		A	Pin hand dislocation	5.74	NA	NA	6.62	6.20	0.74	090
26685		A	Treat hand dislocation	7.07	NA	NA	7.20	6.50	0.98	090
26686		A	Treat hand dislocation	8.17	NA	NA	7.23	6.70	1.14	090
26700		A	Treat knuckle dislocation	3.83	4.01	3.60	3.57	3.11	0.47	090
26705		A	Treat knuckle dislocation	4.38	5.79	5.18	4.95	4.38	0.57	090
26706		A	Pin knuckle dislocation	5.31	NA	NA	5.62	5.07	0.67	090
26715		A	Treat knuckle dislocation	7.03	NA	NA	7.11	6.35	0.93	090
26720		A	Treat finger fracture, each	1.76	3.05	2.77	2.73	2.40	0.22	090
26725		A	Treat finger fracture, each	3.48	4.82	4.47	4.06	3.66	0.45	090
26727		A	Treat finger fracture, each	5.42	NA	NA	6.18	5.77	0.70	090
26735		A	Treat finger fracture, each	7.42	NA	NA	7.40	6.53	0.96	090
26740		A	Treat finger fracture, each	2.07	3.52	3.19	3.20	2.86	0.25	090
26742		A	Treat finger fracture, each	3.99	5.05	4.69	4.27	3.89	0.51	090
26746		A	Treat finger fracture, each	9.80	NA	NA	8.73	7.50	1.26	090
26750		A	Treat finger fracture, each	1.80	2.69	2.43	2.70	2.35	0.23	090
26755		A	Treat finger fracture, each	3.23	4.43	4.11	3.52	3.16	0.41	090
26756		A	Pin finger fracture, each	4.58	NA	NA	5.72	5.34	0.59	090
26765		A	Treat finger fracture, each	5.86	NA	NA	6.54	5.66	0.77	090
26770		A	Treat finger dislocation	3.15	3.55	3.19	3.10	2.67	0.38	090
26775		A	Treat finger dislocation	3.90	5.48	5.04	4.63	4.14	0.49	090
26776		A	Pin finger dislocation	4.99	NA	NA	5.90	5.53	0.65	090
26785		A	Treat finger dislocation	6.60	NA	NA	6.94	5.97	0.85	090
26820		A	Thumb fusion with graft	8.45	NA	NA	10.57	10.41	1.18	090
26841		A	Fusion of thumb	7.35	NA	NA	10.30	10.17	0.98	090
26842		A	Thumb fusion with graft	8.49	NA	NA	10.59	10.46	1.19	090
26843		A	Fusion of hand joint	7.78	NA	NA	10.03	9.84	1.09	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
26844		A	Fusion/graft of hand joint	8.98	NA	NA	10.83	10.63	1.26	090
26850		A	Fusion of knuckle	7.14	NA	NA	9.72	9.58	0.88	090
26852		A	Fusion of knuckle with graft	8.71	NA	NA	10.75	10.47	1.04	090
26860		A	Fusion of finger joint	4.88	NA	NA	8.72	8.65	0.60	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	NA	0.90	0.83	0.22	ZZZ
26862		A	Fusion/graft of finger joint	7.56	NA	NA	10.18	9.91	0.93	090
26863		A	Fuse/graft added joint	3.89	NA	NA	1.91	1.84	0.55	ZZZ
26910		A	Amputate metacarpal bone	7.79	NA	NA	9.65	9.36	1.06	090
26951		A	Amputation of finger/thumb	6.04	NA	NA	9.75	9.20	0.79	090
26952		A	Amputation of finger/thumb	6.48	NA	NA	9.16	9.08	0.85	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.95	NA	NA	7.43	6.91	1.12	090
26991		A	Drainage of pelvis bursa	7.06	10.20	9.71	5.96	5.44	0.99	090
26992		A	Drainage of bone lesion	13.48	NA	NA	10.41	9.65	1.93	090
27000		A	Incision of hip tendon	5.74	NA	NA	5.04	4.90	0.76	090
27001		A	Incision of hip tendon	7.14	NA	NA	6.28	5.82	0.99	090
27003		A	Incision of hip tendon	7.81	NA	NA	6.92	6.30	1.09	090
27005		A	Incision of hip tendon	10.07	NA	NA	8.02	7.44	1.42	090
27006		A	Incision of hip tendons	10.11	NA	NA	8.19	7.62	1.41	090
27025		A	Incision of hip/thigh fascia	12.89	NA	NA	9.84	8.88	1.84	090
27027		A	Buttock fasciotomy	13.04	NA	NA	9.09	8.08	0.65	090
27030		A	Drainage of hip joint	13.65	NA	NA	9.78	9.12	1.93	090
27033		A	Exploration of hip joint	14.11	NA	NA	10.17	9.49	2.00	090
27035		A	Denervation of hip joint	17.37	NA	NA	12.00	9.79	2.47	090
27036		A	Excision of hip joint/muscle	14.38	NA	NA	10.71	9.93	2.00	090
27040		A	Biopsy of soft tissues	2.92	5.44	5.39	2.08	2.04	0.34	010
27041		A	Biopsy of soft tissues	10.18	NA	NA	6.61	6.42	1.29	090
27043		A	Exc hip pelvis les sc > 3 cm	6.88	NA	NA	4.80	4.80	1.01	090
27045		A	Exc hip/pelv tum deep > 5 cm	11.13	NA	NA	7.42	7.42	1.63	090
27047		A	Exc hip/pelvis les sc < 3 cm	4.94	6.57	7.05	4.12	4.57	1.12	090
27048		A	Exc hip/pelv tum deep < 5 cm	8.85	NA	NA	6.34	5.22	0.95	090
27049		A	Resect hip/pelv tum < 5 cm	21.55	NA	NA	12.40	9.56	2.22	090
27050		A	Biopsy of sacroiliac joint	4.74	NA	NA	5.13	4.03	0.66	090
27052		A	Biopsy of hip joint	7.42	NA	NA	6.85	6.14	1.03	090
27054		A	Removal of hip joint lining	9.21	NA	NA	7.82	7.20	1.29	090
27057		A	Buttock fasciotomy w/dbrdmt	14.91	NA	NA	10.39	8.98	0.74	090
27059		A	Resect hip/pelv tum > 5 cm	29.35	NA	NA	15.95	15.95	4.17	090
27060		A	Removal of ischial bursa	5.87	NA	NA	4.61	4.47	0.82	090
27062		A	Remove femur lesion/bursa	5.75	NA	NA	5.51	5.08	0.80	090
27065		A	Removal of hip bone lesion	6.55	NA	NA	6.03	5.56	0.91	090
27066		A	Removal of hip bone lesion	11.20	NA	NA	9.00	8.30	1.59	090
27067		A	Remove/graft hip bone lesion	14.72	NA	NA	11.01	10.24	2.09	090
27070		A	Partial removal of hip bone	11.56	NA	NA	9.69	8.95	1.63	090
27071		A	Partial removal of hip bone	12.39	NA	NA	10.25	9.56	1.76	090
27075		A	Resect hip tumor	32.71	NA	NA	19.16	18.45	5.26	090
27076		A	Resect hip tum incl acetabul	40.21	NA	NA	22.86	16.14	3.46	090
27077		A	Resect hip tum w/innom bone	45.21	NA	NA	26.15	22.51	6.08	090
27078		A	Resect hip tum incl femur	32.21	NA	NA	19.77	12.21	2.09	090
27080		A	Removal of tail bone	6.89	NA	NA	5.76	5.13	1.01	090
27086		A	Remove hip foreign body	1.92	4.08	4.02	1.75	1.67	0.22	010
27087		A	Remove hip foreign body	8.83	NA	NA	6.96	6.43	1.22	090
27090		A	Removal of hip prosthesis	11.69	NA	NA	8.99	8.36	1.65	090
27091		A	Removal of hip prosthesis	24.35	NA	NA	15.85	14.43	3.45	090
27093		A	Injection for hip x-ray	1.30	3.39	3.51	0.54	0.52	0.11	000
27095		A	Injection for hip x-ray	1.50	4.24	4.33	0.64	0.59	0.12	000
27096		A	Inject sacroiliac joint	1.40	3.43	3.16	0.55	0.41	0.09	000
27097		A	Revision of hip tendon	9.27	NA	NA	7.63	6.82	1.30	090
27098		A	Transfer tendon to pelvis	9.32	NA	NA	5.88	5.81	1.31	090
27100		A	Transfer of abdominal muscle	11.35	NA	NA	9.14	8.45	1.60	090
27105		A	Transfer of spinal muscle	12.04	NA	NA	9.48	8.81	1.71	090
27110		A	Transfer of iliopsoas muscle	13.77	NA	NA	10.33	9.38	1.96	090
27111		A	Transfer of iliopsoas muscle	12.60	NA	NA	9.75	8.27	1.79	090
27120		A	Reconstruction of hip socket	19.25	NA	NA	13.21	11.99	2.73	090
27122		A	Reconstruction of hip socket	16.09	NA	NA	11.44	10.62	2.27	090
27125		A	Partial hip replacement	16.64	NA	NA	11.72	10.73	2.35	090
27130		A	Total hip arthroplasty	21.79	NA	NA	14.45	13.26	3.08	090
27132		A	Revise hip joint replacement	25.69	NA	NA	16.51	15.25	3.63	090
27134		A	Revise hip joint replacement	30.28	NA	NA	18.13	16.88	4.30	090
27137		A	Revise hip joint replacement	22.70	NA	NA	14.42	13.38	3.22	090
27138		A	Revise hip joint replacement	23.70	NA	NA	14.91	13.83	3.36	090
27140		A	Transplant femur ridge	12.78	NA	NA	9.57	8.91	1.82	090
27146		A	Incision of hip bone	18.92	NA	NA	13.17	11.84	2.68	090
27147		A	Revision of hip bone	22.07	NA	NA	14.71	13.54	3.13	090
27151		A	Incision of hip bones	24.12	NA	NA	15.72	13.24	3.42	090
27156		A	Revision of hip bones	26.23	NA	NA	16.75	15.28	3.72	090
27158		A	Revision of pelvis	21.04	NA	NA	14.01	12.55	2.99	090
27161		A	Incision of neck of femur	17.89	NA	NA	12.48	11.63	2.53	090
27165		A	Incision/fixation of femur	20.29	NA	NA	14.15	12.95	2.86	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
27170		A	Repair/graft femur head/neck	17.61	NA	NA	11.92	11.01	2.49	090
27175		A	Treat slipped epiphysis	9.38	NA	NA	7.20	6.63	1.32	090
27176		A	Treat slipped epiphysis	12.92	NA	NA	9.91	9.10	1.84	090
27177		A	Treat slipped epiphysis	16.09	NA	NA	11.68	10.78	2.28	090
27178		A	Treat slipped epiphysis	12.92	NA	NA	9.91	8.99	1.84	090
27179		A	Revise head/neck of femur	13.97	NA	NA	10.33	9.54	1.98	090
27181		A	Treat slipped epiphysis	16.18	NA	NA	11.82	10.74	2.29	090
27185		A	Revision of femur epiphysis	9.79	NA	NA	5.71	6.01	0.48	090
27187		A	Reinforce hip bones	14.23	NA	NA	10.53	9.81	2.02	090
27193		A	Treat pelvic ring fracture	6.09	5.57	5.10	5.72	5.21	0.84	090
27194		A	Treat pelvic ring fracture	10.20	NA	NA	7.13	6.90	1.19	090
27200		A	Treat tail bone fracture	1.92	2.51	2.24	2.68	2.35	0.25	090
27202		A	Treat tail bone fracture	7.31	NA	NA	5.90	7.55	1.03	090
27215		I	Treat pelvic fracture(s)	10.45	NA	NA	5.51	6.52	1.49	090
27216		I	Treat pelvic ring fracture	15.73	NA	NA	7.96	9.29	2.22	090
27217		I	Treat pelvic ring fracture	14.65	NA	NA	7.57	9.02	2.08	090
27218		I	Treat pelvic ring fracture	20.93	NA	NA	9.86	11.41	3.06	090
27220		A	Treat hip socket fracture	6.83	6.32	5.78	6.21	5.68	0.95	090
27222		A	Treat hip socket fracture	14.11	NA	NA	10.21	9.53	1.99	090
27226		A	Treat hip wall fracture	15.57	NA	NA	10.92	9.63	2.21	090
27227		A	Treat hip fracture(s)	25.41	NA	NA	16.32	15.11	3.59	090
27228		A	Treat hip fracture(s)	29.33	NA	NA	18.25	16.99	4.17	090
27230		A	Treat thigh fracture	5.81	5.95	5.45	5.87	5.31	0.80	090
27232		A	Treat thigh fracture	11.72	NA	NA	7.35	6.88	1.62	090
27235		A	Treat thigh fracture	13.00	NA	NA	9.65	9.00	1.84	090
27236		A	Treat thigh fracture	17.61	NA	NA	12.37	11.30	2.49	090
27238		A	Treat thigh fracture	5.75	NA	NA	5.63	5.14	0.80	090
27240		A	Treat thigh fracture	13.81	NA	NA	10.11	9.30	1.93	090
27244		A	Treat thigh fracture	18.18	NA	NA	12.64	11.56	2.57	090
27245		A	Treat thigh fracture	18.18	NA	NA	12.67	12.05	2.57	090
27246		A	Treat thigh fracture	4.83	4.68	4.32	4.72	4.35	0.67	090
27248		A	Treat thigh fracture	10.78	NA	NA	7.81	7.36	1.52	090
27250		A	Treat hip dislocation	3.82	NA	NA	0.81	1.52	0.48	000
27252		A	Treat hip dislocation	11.03	NA	NA	7.89	7.25	1.53	090
27253		A	Treat hip dislocation	13.58	NA	NA	9.93	9.25	1.93	090
27254		A	Treat hip dislocation	18.94	NA	NA	12.72	11.80	2.68	090
27256		A	Treat hip dislocation	4.28	2.93	2.80	1.74	1.65	0.54	010
27257		A	Treat hip dislocation	5.38	NA	NA	2.93	2.74	0.69	010
27258		A	Treat hip dislocation	16.18	NA	NA	11.51	10.61	2.30	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
27259		A	Treat hip dislocation	23.26	NA	NA	15.57	14.32	3.29	090
27265		A	Treat hip dislocation	5.24	NA	NA	4.51	4.26	0.66	090
27266		A	Treat hip dislocation	7.78	NA	NA	6.62	6.13	1.08	090
27267		A	Cltx thigh fx	5.50	NA	NA	5.40	4.64	0.76	090
27268		A	Cltx thigh fx w/mnpj	7.12	NA	NA	6.20	5.33	0.99	090
27269		A	Optx thigh fx	18.89	NA	NA	12.30	10.67	2.66	090
27275		A	Manipulation of hip joint	2.32	NA	NA	2.06	1.98	0.28	010
27280		A	Fusion of sacroiliac joint	14.64	NA	NA	11.00	10.13	2.17	090
27282		A	Fusion of pubic bones	11.85	NA	NA	9.38	7.92	1.68	090
27284		A	Fusion of hip joint	25.06	NA	NA	15.54	12.89	3.56	090
27286		A	Fusion of hip joint	25.17	NA	NA	16.23	15.13	3.57	090
27290		A	Amputation of leg at hip	24.55	NA	NA	16.10	13.96	3.48	090
27295		A	Amputation of leg at hip	19.66	NA	NA	11.86	11.01	2.90	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.78	9.61	9.09	5.63	5.15	0.97	090
27303		A	Drainage of bone lesion	8.63	NA	NA	7.27	6.72	1.21	090
27305		A	Incise thigh tendon & fascia	6.18	NA	NA	5.65	5.10	0.87	090
27306		A	Incision of thigh tendon	4.74	NA	NA	4.91	4.40	0.66	090
27307		A	Incision of thigh tendons	6.06	NA	NA	5.77	5.17	0.85	090
27310		A	Exploration of knee joint	10.00	NA	NA	8.19	7.53	1.41	090
27323		A	Biopsy, thigh soft tissues	2.33	4.38	4.17	2.15	2.03	0.30	010
27324		A	Biopsy, thigh soft tissues	5.04	NA	NA	4.58	4.19	0.74	090
27325		A	Neurectomy, hamstring	7.20	NA	NA	6.56	5.66	1.01	090
27326		A	Neurectomy, popliteal	6.47	NA	NA	6.20	5.37	0.90	090
27327		A	Exc thigh/knee les sc < 3 cm	3.96	7.19	6.42	3.83	3.76	0.67	090
27328		A	Exc thigh/knee tum deep <5cm	8.85	NA	NA	6.52	4.87	0.83	090
27329		A	Resect thigh/knee tum < 5 cm	15.72	NA	NA	10.37	9.38	2.30	090
27330		A	Biopsy, knee joint lining	5.11	NA	NA	4.79	4.48	0.68	090
27331		A	Explore/treat knee joint	6.02	NA	NA	5.74	5.32	0.84	090
27332		A	Removal of knee cartilage	8.46	NA	NA	7.44	6.89	1.18	090
27333		A	Removal of knee cartilage	7.55	NA	NA	6.91	6.39	1.06	090
27334		A	Remove knee joint lining	9.19	NA	NA	7.79	7.16	1.29	090
27335		A	Remove knee joint lining	10.55	NA	NA	8.49	7.87	1.49	090
27337		A	Exc thigh/knee les sc > 3 cm	5.91	NA	NA	4.55	4.55	0.86	090
27339		A	Exc thigh/knee tum deep >5cm	11.13	NA	NA	7.63	7.63	1.63	090
27340		A	Removal of kneecap bursa	4.32	NA	NA	4.81	4.44	0.60	090
27345		A	Removal of knee cyst	6.09	NA	NA	5.88	5.44	0.85	090
27347		A	Remove knee cyst	6.73	NA	NA	6.33	5.76	0.93	090
27350		A	Removal of kneecap	8.66	NA	NA	7.54	6.98	1.21	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
27355		A	Remove femur lesion	8.00	NA	NA	6.96	6.47	1.12	090
27356		A	Remove femur lesion/graft	10.09	NA	NA	8.25	7.63	1.43	090
27357		A	Remove femur lesion/graft	11.16	NA	NA	9.03	8.40	1.58	090
27358		A	Remove femur lesion/fixation	4.73	NA	NA	2.32	2.22	0.67	ZZZ
27360		A	Partial removal, leg bone(s)	11.46	NA	NA	9.68	9.01	1.63	090
27364		A	Resect thigh/knee tum >5 cm	24.49	NA	NA	14.54	14.54	3.56	090
27365		A	Resect femur/knee tumor	32.21	NA	NA	19.78	13.45	2.57	090
27370		A	Injection for knee x-ray	0.96	3.26	3.22	0.43	0.38	0.09	000
27372		A	Removal of foreign body	5.21	9.63	9.14	4.86	4.50	0.73	090
27380		A	Repair of kneecap tendon	7.45	NA	NA	7.24	6.77	1.04	090
27381		A	Repair/graft kneecap tendon	10.76	NA	NA	9.11	8.51	1.52	090
27385		A	Repair of thigh muscle	8.11	NA	NA	7.57	7.08	1.13	090
27386		A	Repair/graft of thigh muscle	11.13	NA	NA	9.53	8.88	1.57	090
27390		A	Incision of thigh tendon	5.53	NA	NA	5.51	5.05	0.77	090
27391		A	Incision of thigh tendons	7.49	NA	NA	6.75	6.25	1.05	090
27392		A	Incision of thigh tendons	9.63	NA	NA	8.02	7.28	1.35	090
27393		A	Lengthening of thigh tendon	6.59	NA	NA	6.01	5.57	0.92	090
27394		A	Lengthening of thigh tendons	8.79	NA	NA	7.45	6.89	1.22	090
27395		A	Lengthening of thigh tendons	12.24	NA	NA	9.58	8.92	1.74	090
27396		A	Transplant of thigh tendon	8.15	NA	NA	7.08	6.60	1.14	090
27397		A	Transplants of thigh tendons	12.66	NA	NA	10.10	9.25	1.79	090
27400		A	Revise thigh muscles/tendons	9.33	NA	NA	7.87	7.25	1.31	090
27403		A	Repair of knee cartilage	8.62	NA	NA	7.31	6.80	1.20	090
27405		A	Repair of knee ligament	9.08	NA	NA	7.73	7.18	1.27	090
27407		A	Repair of knee ligament	10.85	NA	NA	8.80	7.80	1.53	090
27409		A	Repair of knee ligaments	13.71	NA	NA	10.30	9.55	1.95	090
27412		A	Autochondrocyte implant knee	24.74	NA	NA	16.65	15.24	3.50	090
27416		A	Osteochondral knee autograft	20.00	NA	NA	14.30	13.05	2.83	090
27418		A	Repair degenerated kneecap	14.16	NA	NA	10.27	9.22	2.01	090
27420		A	Revision of unstable kneecap	11.60	NA	NA	9.11	8.51	1.63	090
27422		A	Revision of unstable kneecap	10.26	NA	NA	8.31	7.73	1.44	090
27424		A	Revision/removal of kneecap	10.21	NA	NA	8.32	7.72	1.44	090
27425		A	Lat retinacular release open	10.24	NA	NA	8.32	7.73	1.45	090
27427		A	Reconstruction, knee	5.39	NA	NA	5.62	5.22	0.75	090
27428		A	Reconstruction, knee	9.79	NA	NA	8.12	7.50	1.37	090
27429		A	Reconstruction, knee	15.58	NA	NA	12.15	11.18	2.20	090
27430		A	Revision of thigh muscles	17.54	NA	NA	13.70	12.50	2.47	090
27435		A	Incision of knee joint	10.16	NA	NA	8.28	7.66	1.43	090
		A		10.88	NA	NA	9.27	8.45	1.53	090
27437		A	Revise kneecap	8.93	NA	NA	7.45	6.93	1.25	090
27438		A	Revise kneecap with implant	11.89	NA	NA	9.12	8.40	1.69	090
27440		A	Revision of knee joint	11.09	NA	NA	8.72	7.59	1.57	090
27441		A	Revision of knee joint	11.54	NA	NA	8.94	7.74	1.63	090
27442		A	Revision of knee joint	12.37	NA	NA	9.39	8.60	1.76	090
27443		A	Revision of knee joint	11.41	NA	NA	8.88	8.24	1.61	090
27445		A	Revision of knee joint	18.66	NA	NA	12.79	11.83	2.65	090
27446		A	Revision of knee joint	16.38	NA	NA	11.35	10.58	2.32	090
27447		A	Total knee arthroplasty	23.25	NA	NA	15.45	14.25	3.29	090
27448		A	Incision of thigh	11.60	NA	NA	8.76	8.16	1.65	090
27450		A	Incision of thigh	14.61	NA	NA	10.78	10.02	2.08	090
27454		A	Realignment of thigh bone	19.17	NA	NA	13.29	11.99	2.71	090
27455		A	Realignment of knee	13.36	NA	NA	10.08	9.38	1.90	090
27457		A	Realignment of knee	14.03	NA	NA	9.98	9.33	2.00	090
27465		A	Shortening of thigh bone	18.60	NA	NA	12.71	11.34	2.64	090
27466		A	Lengthening of thigh bone	17.28	NA	NA	12.39	11.41	2.45	090
27468		A	Shorten/lengthen thighs	19.97	NA	NA	13.58	12.41	2.83	090
27470		A	Repair of thigh	17.14	NA	NA	12.36	11.45	2.42	090
27472		A	Repair/graft of thigh	18.72	NA	NA	12.98	12.08	2.66	090
27475		A	Surgery to stop leg growth	8.93	NA	NA	7.46	6.93	1.25	090
27477		A	Surgery to stop leg growth	10.14	NA	NA	8.05	7.48	1.43	090
27479		A	Surgery to stop leg growth	13.16	NA	NA	7.00	8.41	0.65	090
27485		A	Surgery to stop leg growth	9.13	NA	NA	7.49	6.99	1.28	090
27486		A	Revise/replace knee joint	21.12	NA	NA	14.26	13.16	2.99	090
27487		A	Revise/replace knee joint	27.11	NA	NA	17.23	15.95	3.83	090
27488		A	Removal of knee prosthesis	17.60	NA	NA	12.52	11.52	2.49	090
27495		A	Reinforce thigh	16.54	NA	NA	11.70	10.88	2.35	090
27496		A	Decompression of thigh/knee	6.78	NA	NA	6.62	5.59	0.95	090
27497		A	Decompression of thigh/knee	7.79	NA	NA	6.62	5.54	1.09	090
27498		A	Decompression of thigh/knee	8.66	NA	NA	7.54	6.02	1.21	090
27499		A	Decompression of thigh/knee	9.43	NA	NA	7.92	6.64	1.32	090
27500		A	Treatment of thigh fracture	6.30	6.51	5.96	5.61	5.08	0.87	090
27501		A	Treatment of thigh fracture	6.45	6.01	5.57	5.91	5.41	0.90	090
27502		A	Treatment of thigh fracture	11.36	NA	NA	8.19	7.62	1.57	090
27503		A	Treatment of thigh fracture	11.27	NA	NA	8.72	8.07	1.58	090
27506		A	Treatment of thigh fracture	19.65	NA	NA	13.87	12.74	2.77	090
27507		A	Treatment of thigh fracture	14.48	NA	NA	9.92	9.26	2.06	090
27508		A	Treatment of thigh fracture	6.20	6.78	6.24	6.06	5.52	0.85	090
27509		A	Treatment of thigh fracture	8.14	NA	NA	7.83	7.34	1.14	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
27510		A	Treatment of thigh fracture	9.80	NA	NA	7.49	7.01	1.34	090
27511		A	Treatment of thigh fracture	15.11	NA	NA	9.92	9.52	2.14	090
27513		A	Treatment of thigh fracture	19.25	NA	NA	11.95	11.56	2.73	090
27514		A	Treatment of thigh fracture	14.60	NA	NA	9.66	9.74	2.07	090
27516		A	Treat thigh fx growth plate	5.59	6.85	6.20	6.13	5.51	0.77	090
27517		A	Treat thigh fx growth plate	9.12	NA	NA	7.86	7.26	1.28	090
27519		A	Treat thigh fx growth plate	13.25	NA	NA	9.01	8.93	1.88	090
27520		A	Treat kneecap fracture	3.04	4.84	4.44	4.18	3.74	0.41	090
27524		A	Treat kneecap fracture	10.37	NA	NA	8.38	7.80	1.46	090
27530		A	Treat knee fracture	4.09	5.69	5.23	5.06	4.58	0.56	090
27532		A	Treat knee fracture	7.55	7.65	7.08	6.77	6.25	1.05	090
27535		A	Treat knee fracture	13.41	NA	NA	9.09	8.69	1.90	090
27536		A	Treat knee fracture	17.39	NA	NA	12.43	11.45	2.45	090
27538		A	Treat knee fracture(s)	5.09	6.47	5.99	5.78	5.29	0.69	090
27540		A	Treat knee fracture	11.30	NA	NA	8.96	8.50	1.59	090
27550		A	Treat knee dislocation	5.98	6.22	5.78	5.39	4.96	0.77	090
27552		A	Treat knee dislocation	8.18	NA	NA	7.33	6.76	1.14	090
27556		A	Treat knee dislocation	13.00	NA	NA	8.89	8.82	1.85	090
27557		A	Treat knee dislocation	15.90	NA	NA	10.31	10.20	2.26	090
27558		A	Treat knee dislocation	18.39	NA	NA	11.53	11.14	2.61	090
27560		A	Treat kneecap dislocation	3.99	5.31	4.80	4.69	4.04	0.55	090
27562		A	Treat kneecap dislocation	5.98	NA	NA	5.93	5.21	0.83	090
27566		A	Treat kneecap dislocation	12.71	NA	NA	9.53	8.86	1.81	090
27570		A	Fixation of knee joint	1.79	NA	NA	1.92	1.77	0.25	010
27580		A	Fusion of knee	21.10	NA	NA	14.97	13.91	2.98	090
27590		A	Amputate leg at thigh	13.47	NA	NA	7.33	6.68	2.12	090
27591		A	Amputate leg at thigh	13.94	NA	NA	8.73	8.25	2.09	090
27592		A	Amputate leg at thigh	10.98	NA	NA	6.55	6.13	1.71	090
27594		A	Amputation follow-up surgery	7.29	NA	NA	5.64	5.19	1.10	090
27596		A	Amputation follow-up surgery	11.29	NA	NA	7.19	6.65	1.73	090
27598		A	Amputate lower leg at knee	11.22	NA	NA	7.60	7.00	1.69	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	6.03	NA	NA	4.44	4.26	0.90	090
27601		A	Decompression of lower leg	6.05	NA	NA	5.05	4.74	0.90	090
27602		A	Decompression of lower leg	7.82	NA	NA	4.99	4.75	1.24	090
27603		A	Drain lower leg lesion	5.23	8.13	7.50	4.65	4.23	0.71	090
27604		A	Drain lower leg bursa	4.59	7.32	6.60	3.95	3.67	0.56	090
27605		A	Incision of achilles tendon	2.92	5.70	5.83	1.91	1.94	0.24	010
27606		A	Incision of achilles tendon	4.18	NA	NA	3.07	2.95	0.52	010

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
27607		A	Treat lower leg bone lesion	8.62	NA	NA	6.79	6.29	1.12	090
27610		A	Explore/treat ankle joint	9.13	NA	NA	7.28	6.78	1.17	090
27612		A	Exploration of ankle joint	8.15	NA	NA	6.04	5.77	0.82	090
27613		A	Biopsy lower leg soft tissue	2.22	4.08	3.90	1.95	1.88	0.23	010
27614		A	Biopsy lower leg soft tissue	5.80	8.68	7.89	4.52	4.23	0.73	090
27615		A	Resect leg/ankle tum < 5 cm	15.72	NA	NA	10.32	8.67	1.87	090
27616		A	Resect leg/ankle tum > 5 cm	19.63	NA	NA	12.32	12.32	2.81	090
27618		A	Exc leg/ankle tum < 3 cm	3.96	7.04	6.62	3.76	3.93	0.70	090
27619		A	Exc leg/ankle tum deep <5 cm	6.91	NA	NA	5.29	5.51	1.08	090
27620		A	Explore/treat ankle joint	6.15	NA	NA	5.42	5.08	0.74	090
27625		A	Remove ankle joint lining	8.49	NA	NA	6.13	5.91	0.91	090
27626		A	Remove ankle joint lining	9.10	NA	NA	6.87	6.44	1.09	090
27630		A	Removal of tendon lesion	4.94	8.92	8.17	4.31	4.10	0.56	090
27632		A	Exc leg/ankle les sc > 3 cm	5.91	NA	NA	4.47	4.47	0.80	090
27634		A	Exc leg/ankle tum deep >5 cm	10.13	NA	NA	6.81	6.81	1.28	090
27635		A	Remove lower leg bone lesion	8.03	NA	NA	6.76	6.34	1.06	090
27637		A	Remove/graft leg bone lesion	10.31	NA	NA	8.64	7.95	1.45	090
27638		A	Remove/graft leg bone lesion	10.99	NA	NA	8.45	7.88	1.55	090
27640		A	Partial removal of tibia	12.24	NA	NA	8.86	8.64	1.58	090
27641		A	Partial removal of fibula	9.84	NA	NA	7.18	6.95	1.20	090
27645		A	Resect tibia tumor	27.21	NA	NA	17.41	12.04	2.12	090
27646		A	Resect fibula tumor	23.21	NA	NA	15.45	10.59	1.90	090
27647		A	Resect talus/calcaneus tum	20.26	NA	NA	8.40	7.18	0.93	090
27648		A	Injection for ankle x-ray	0.96	3.15	3.08	0.41	0.37	0.09	000
27650		A	Repair achilles tendon	9.21	NA	NA	7.70	7.22	1.06	090
27652		A	Repair/graft achilles tendon	10.78	NA	NA	6.99	7.03	1.07	090
27654		A	Repair of achilles tendon	10.53	NA	NA	7.54	7.15	1.07	090
27656		A	Repair leg fascia defect	4.71	10.63	8.86	5.05	4.10	0.66	090
27658		A	Repair of leg tendon, each	5.12	NA	NA	4.50	4.24	0.56	090
27659		A	Repair of leg tendon, each	7.10	NA	NA	5.13	5.06	0.70	090
27664		A	Repair of leg tendon, each	4.73	NA	NA	4.42	4.19	0.54	090
27665		A	Repair of leg tendon, each	5.57	NA	NA	4.99	4.66	0.63	090
27675		A	Repair lower leg tendons	7.35	NA	NA	5.20	5.06	0.72	090
27676		A	Repair lower leg tendons	8.73	NA	NA	6.64	6.35	1.22	090
27680		A	Release of lower leg tendon	5.88	NA	NA	4.92	4.67	0.69	090
27681		A	Release of lower leg tendons	7.05	NA	NA	6.45	5.67	0.99	090
27685		A	Revision of lower leg tendon	6.69	9.91	8.86	5.18	4.99	0.65	090
27686		A	Revise lower leg tendons	7.75	NA	NA	6.12	5.91	0.93	090
27687		A	Revision of calf tendon	6.41	NA	NA	5.21	4.91	0.70	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
27690		A	Revise lower leg tendon	9.17	NA	NA	7.07	6.54	0.94	090
27691		A	Revise lower leg tendon	10.49	NA	NA	8.58	7.89	1.29	090
27692		A	Revise additional leg tendon	1.87	NA	NA	0.86	0.82	0.24	ZZZ
27695		A	Repair of ankle ligament	6.70	NA	NA	5.61	5.35	0.76	090
27696		A	Repair of ankle ligaments	8.58	NA	NA	5.64	5.64	0.82	090
27698		A	Repair of ankle ligament	9.61	NA	NA	6.77	6.44	1.07	090
27700		A	Revision of ankle joint	9.66	NA	NA	5.86	5.57	0.85	090
27702		A	Reconstruct ankle joint	14.42	NA	NA	10.18	9.69	1.91	090
27703		A	Reconstruction, ankle joint	16.94	NA	NA	11.75	10.99	2.29	090
27704		A	Removal of ankle implant	7.81	NA	NA	6.60	6.04	1.01	090
27705		A	Incision of fibula	10.86	NA	NA	8.30	7.73	1.45	090
27707		A	Incision of fibula	4.78	NA	NA	5.27	4.87	0.64	090
27709		A	Incision of tibia & fibula	17.48	NA	NA	11.92	10.44	2.41	090
27712		A	Realignment of lower leg	15.87	NA	NA	11.68	10.76	2.25	090
27715		A	Revision of lower leg	15.50	NA	NA	11.18	10.37	2.20	090
27720		A	Repair of tibia	12.36	NA	NA	9.58	8.93	1.73	090
27722		A	Repair/graft of tibia	12.45	NA	NA	9.68	8.84	1.77	090
27724		A	Repair/graft of tibia	19.31	NA	NA	12.56	11.73	2.73	090
27725		A	Repair of lower leg	17.41	NA	NA	12.99	11.88	2.46	090
27726		A	Repair fibula nonunion	14.34	NA	NA	10.08	8.56	2.01	090
27727		A	Repair of lower leg	14.84	NA	NA	10.98	9.05	2.11	090
27730		A	Repair of tibia epiphysis	7.70	NA	NA	6.80	6.28	1.08	090
27732		A	Repair of fibula epiphysis	5.46	NA	NA	5.56	4.55	0.76	090
27734		A	Repair lower leg epiphyses	8.83	NA	NA	5.28	5.44	0.44	090
27740		A	Repair of leg epiphyses	9.61	NA	NA	7.95	6.65	1.35	090
27742		A	Repair of leg epiphyses	10.63	NA	NA	8.69	6.65	1.50	090
27745		A	Reinforce tibia	10.49	NA	NA	8.40	7.79	1.48	090
27750		A	Treatment of tibia fracture	3.37	5.10	4.68	4.44	4.00	0.45	090
27752		A	Treatment of tibia fracture	6.27	7.01	6.49	6.05	5.59	0.86	090
27756		A	Treatment of tibia fracture	7.45	NA	NA	6.84	6.31	1.03	090
27758		A	Treatment of tibia fracture	12.54	NA	NA	9.71	8.97	1.77	090
27759		A	Treatment of tibia fracture	14.45	NA	NA	10.53	9.81	2.04	090
27760		A	Cltx medial ankle fx	3.21	5.01	4.59	4.32	3.87	0.40	090
27762		A	Cltx med ankle fx w/mnpj	5.47	6.39	5.99	5.45	5.09	0.71	090
27766		A	Optx medial ankle fx	7.89	NA	NA	7.30	6.81	1.06	090
27767		A	Cltx post ankle fx	2.64	4.30	3.73	4.34	3.76	0.34	090
27768		A	Cltx post ankle fx w/mnpj	5.14	NA	NA	5.67	4.80	0.71	090
27769		A	Optx post ankle fx	10.14	NA	NA	8.17	6.91	1.43	090
27780		A	Treatment of fibula fracture	2.83	4.62	4.19	3.98	3.53	0.37	090
27781		A	Treatment of fibula fracture	4.59	5.90	5.40	5.19	4.70	0.62	090
27784		A	Treatment of fibula fracture	9.67	NA	NA	8.22	7.34	1.33	090
27786		A	Treatment of ankle fracture	3.02	4.77	4.37	4.06	3.63	0.39	090
27788		A	Treatment of ankle fracture	4.64	5.79	5.39	4.95	4.58	0.60	090
27792		A	Treatment of ankle fracture	9.71	NA	NA	8.13	7.39	1.30	090
27808		A	Treatment of ankle fracture	3.03	5.14	4.72	4.35	3.93	0.39	090
27810		A	Treatment of ankle fracture	5.32	6.30	5.90	5.33	4.97	0.70	090
27814		A	Treatment of ankle fracture	10.62	NA	NA	8.72	8.12	1.47	090
27816		A	Treatment of ankle fracture	3.07	4.73	4.28	3.97	3.54	0.39	090
27818		A	Treatment of ankle fracture	5.69	6.24	5.86	5.12	4.81	0.74	090
27822		A	Treatment of ankle fracture	11.21	NA	NA	9.83	9.35	1.54	090
27823		A	Treatment of ankle fracture	13.16	NA	NA	10.77	10.19	1.82	090
27824		A	Treat lower leg fracture	3.31	4.38	4.03	4.17	3.77	0.43	090
27825		A	Treat lower leg fracture	6.69	6.88	6.38	5.71	5.28	0.91	090
27826		A	Treat lower leg fracture	11.10	NA	NA	9.76	8.98	1.52	090
27827		A	Treat lower leg fracture	14.79	NA	NA	12.23	11.54	2.06	090
27828		A	Treat lower leg fracture	18.43	NA	NA	14.06	13.10	2.58	090
27829		A	Treat lower leg joint	8.80	NA	NA	8.34	7.49	1.20	090
27830		A	Treat lower leg dislocation	3.96	5.34	4.64	4.73	4.08	0.55	090
27831		A	Treat lower leg dislocation	4.73	NA	NA	5.10	4.49	0.66	090
27832		A	Treat lower leg dislocation	10.17	NA	NA	8.58	7.41	1.43	090
27840		A	Treat ankle dislocation	4.77	NA	NA	4.20	3.82	0.59	090
27842		A	Treat ankle dislocation	6.46	NA	NA	5.76	5.27	0.86	090
27846		A	Treat ankle dislocation	10.28	NA	NA	8.13	7.60	1.40	090
27848		A	Treat ankle dislocation	11.68	NA	NA	8.91	8.47	1.61	090
27860		A	Fixation of ankle joint	2.39	NA	NA	1.98	1.92	0.29	010
27870		A	Fusion of ankle joint, open	15.41	NA	NA	10.87	10.15	2.02	090
27871		A	Fusion of tibiofibular joint	9.54	NA	NA	7.84	7.26	1.32	090
27880		A	Amputation of lower leg	15.37	NA	NA	8.20	7.41	2.39	090
27881		A	Amputation of lower leg	13.47	NA	NA	8.84	8.29	2.02	090
27882		A	Amputation of lower leg	9.79	NA	NA	5.82	5.57	1.53	090
27884		A	Amputation follow-up surgery	8.76	NA	NA	6.01	5.59	1.33	090
27886		A	Amputation follow-up surgery	10.02	NA	NA	6.87	6.36	1.52	090
27888		A	Amputation of foot at ankle	10.37	NA	NA	7.15	6.85	1.39	090
27889		A	Amputation of foot at ankle	10.86	NA	NA	5.96	5.88	1.73	090
27892		A	Decompression of leg	7.94	NA	NA	6.01	5.44	1.17	090
27893		A	Decompression of leg	7.90	NA	NA	5.88	5.57	1.20	090
27894		A	Decompression of leg	12.67	NA	NA	8.83	8.15	1.91	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
28001		A	Drainage of bursa of foot	2.78	4.20	3.86	1.65	1.70	0.16	010
28002		A	Treatment of foot infection	5.93	7.27	6.55	3.89	3.75	0.47	010
28003		A	Treatment of foot infection	9.06	8.38	7.72	4.91	4.87	0.75	090
28005		A	Treat foot bone lesion	9.44	NA	NA	5.95	5.84	0.72	090
28008		A	Incision of foot fascia	4.59	6.40	5.89	3.05	3.06	0.30	090
28010		A	Incision of toe tendon	2.97	3.02	2.82	2.47	2.40	0.19	090
28011		A	Incision of toe tendons	4.28	4.20	3.86	3.35	3.22	0.34	090
28020		A	Exploration of foot joint	5.15	8.17	7.33	3.98	3.83	0.48	090
28022		A	Exploration of foot joint	4.81	7.35	6.70	3.49	3.49	0.35	090
28024		A	Exploration of toe joint	4.52	6.97	6.42	3.28	3.34	0.31	090
28035		A	Decompression of tibia nerve	5.23	8.14	7.33	3.98	3.85	0.47	090
28039		A	Exc foot/toe tum sc > 1.5 cm	5.42	7.03	7.03	3.38	3.38	0.40	090
28041		A	Exc foot/toe tum deep >1.5cm	7.13	NA	NA	4.43	4.43	0.53	090
28043		A	Exc foot/toe tum sc < 1.5 cm	3.96	6.33	5.00	2.95	2.89	0.27	090
28045		A	Exc foot/toe tum deep <1.5cm	5.45	7.50	6.86	3.81	3.50	0.36	090
28046		A	Resect foot/toe tumor < 3 cm	12.38	NA	NA	6.94	6.29	1.03	090
28047		A	Resect foot/toe tumor > 3 cm	17.45	NA	NA	7.06	7.06	0.95	090
28050		A	Biopsy of foot joint lining	4.39	6.84	6.54	3.17	3.35	0.29	090
28052		A	Biopsy of foot joint lining	4.06	7.34	6.29	3.35	3.12	0.34	090
28054		A	Biopsy of toe joint lining	3.57	5.98	5.88	2.60	2.85	0.19	090
28055		A	Neurectomy, foot	6.29	NA	NA	3.61	3.61	0.39	090
28060		A	Partial removal, foot fascia	5.40	7.68	6.96	3.81	3.72	0.39	090
28062		A	Removal of foot fascia	6.69	8.26	7.72	3.96	3.94	0.43	090
28070		A	Removal of foot joint lining	5.24	7.67	6.98	3.62	3.61	0.40	090
28072		A	Removal of foot joint lining	4.72	8.42	7.45	4.01	3.91	0.46	090
28080		A	Removal of foot lesion	4.86	8.32	7.35	4.54	4.20	0.33	090
28086		A	Excise foot tendon sheath	4.92	8.72	8.01	4.25	4.08	0.52	090
28088		A	Excise foot tendon sheath	3.98	7.69	7.04	3.52	3.49	0.39	090
28090		A	Removal of foot lesion	4.55	7.36	6.62	3.43	3.33	0.34	090
28092		A	Removal of toe lesions	3.78	7.01	6.35	3.22	3.16	0.29	090
28100		A	Removal of ankle/heel lesion	5.83	9.09	8.43	4.51	4.36	0.54	090
28102		A	Remove/graft foot lesion	7.92	NA	NA	4.14	5.44	0.43	090
28103		A	Remove/graft foot lesion	6.67	NA	NA	3.70	4.29	0.36	090
28104		A	Removal of foot lesion	5.26	7.76	7.03	3.68	3.63	0.39	090
28106		A	Remove/graft foot lesion	7.35	NA	NA	4.00	4.32	0.40	090
28107		A	Remove/graft foot lesion	5.73	7.53	7.63	3.47	3.86	0.31	090
28108		A	Removal of toe lesions	4.30	6.80	6.12	3.16	3.10	0.28	090
28110		A	Part removal of metatarsal	4.22	7.42	6.73	3.25	3.17	0.29	090
28111		A	Part removal of metatarsal	5.15	7.71	7.17	3.49	3.43	0.42	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
28112		A	Part removal of metatarsal	4.63	7.75	7.10	3.48	3.42	0.37	090
28113		A	Part removal of metatarsal	6.11	9.01	8.13	4.95	4.69	0.44	090
28114		A	Removal of metatarsal heads	12.00	15.36	13.68	9.59	8.79	1.15	090
28116		A	Revision of foot	9.14	10.02	9.04	5.60	5.38	0.67	090
28118		A	Removal of heel bone	6.13	8.74	7.93	4.43	4.29	0.53	090
28119		A	Removal of heel spur	5.56	7.79	7.02	3.82	3.69	0.38	090
28120		A	Part removal of ankle/heel	8.27	10.23	8.51	5.86	4.59	0.56	090
28122		A	Partial removal of foot bone	7.72	9.01	8.35	5.15	5.04	0.58	090
28124		A	Partial removal of toe	5.00	7.16	6.54	3.61	3.56	0.30	090
28126		A	Partial removal of toe	3.64	6.41	5.75	2.83	2.79	0.24	090
28130		A	Removal of ankle bone	9.50	NA	NA	6.88	6.44	1.32	090
28140		A	Removal of metatarsal	7.14	8.45	7.92	4.46	4.40	0.65	090
28150		A	Removal of toe	4.23	6.87	6.20	3.19	3.11	0.31	090
28153		A	Partial removal of toe	3.80	6.74	5.99	3.11	2.93	0.26	090
28160		A	Partial removal of toe	3.88	6.91	6.16	3.18	3.10	0.28	090
28171		A	Resect tarsal tumor	16.41	NA	NA	6.35	5.59	0.54	090
28173		A	Resect metatarsal tumor	14.16	NA	NA	6.49	5.28	0.72	090
28175		A	Resect phalanx of toe tumor	8.29	NA	NA	4.83	3.98	0.43	090
28190		A	Removal of foot foreign body	2.01	4.40	4.00	1.47	1.41	0.14	010
28192		A	Removal of foot foreign body	4.78	7.20	6.60	3.40	3.35	0.34	090
28193		A	Removal of foot foreign body	5.90	7.78	7.12	3.81	3.76	0.40	090
28200		A	Repair of foot tendon	4.74	7.26	6.64	3.36	3.35	0.33	090
28202		A	Repair/graft of foot tendon	7.07	8.24	7.83	4.11	4.15	0.46	090
28208		A	Repair of foot tendon	4.51	7.39	6.54	3.49	3.33	0.35	090
28210		A	Repair/graft of foot tendon	6.52	8.08	7.48	4.11	4.03	0.45	090
28220		A	Release of foot tendon	4.67	6.82	6.18	3.22	3.20	0.30	090
28222		A	Release of foot tendons	5.76	7.27	6.68	3.44	3.54	0.36	090
28225		A	Release of foot tendon	3.78	6.36	5.71	2.83	2.77	0.25	090
28226		A	Release of foot tendons	4.67	6.62	6.49	3.03	3.36	0.25	090
28230		A	Incision of foot tendon(s)	4.36	6.62	6.04	2.99	3.08	0.28	090
28232		A	Incision of toe tendon	3.51	6.37	5.79	2.84	2.86	0.24	090
28234		A	Incision of foot tendon	3.54	6.87	6.18	3.32	3.22	0.25	090
28238		A	Revision of foot tendon	7.96	9.29	8.45	4.80	4.66	0.62	090
28240		A	Release of big toe	4.48	6.84	6.22	3.14	3.16	0.31	090
28250		A	Revision of foot fascia	6.06	8.47	7.53	4.28	4.10	0.55	090
28260		A	Release of midfoot joint	8.19	9.62	8.35	5.25	4.89	0.73	090
28261		A	Revision of foot tendon	13.11	11.27	10.55	6.58	6.71	0.91	090
28262		A	Revision of foot and ankle	17.21	18.00	15.91	11.48	10.61	2.15	090
28264		A	Release of midfoot joint	10.65	8.80	9.82	4.83	6.24	0.58	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
28270		A	Release of foot contracture	4.93	7.53	6.72	3.71	3.61	0.36	090
28272		A	Release of toe joint, each	3.92	6.12	5.58	2.73	2.72	0.22	090
28280		A	Fusion of toes	5.33	7.89	7.29	3.79	3.84	0.42	090
28285		A	Repair of hammertoe	4.76	7.24	6.51	3.57	3.46	0.33	090
28286		A	Repair of hammertoe	4.70	6.88	6.27	3.17	3.14	0.28	090
28288		A	Partial removal of foot bone	6.02	9.43	8.31	5.13	4.87	0.47	090
28289		A	Repair hallux rigidus	8.31	10.40	9.43	5.88	5.62	0.70	090
28290		A	Correction of bunion	5.83	8.98	8.03	4.33	4.24	0.50	090
28292		A	Correction of bunion	9.05	11.20	10.07	6.63	6.23	0.61	090
28293		A	Correction of bunion	11.48	15.24	13.96	7.17	6.89	0.66	090
28294		A	Correction of bunion	8.75	10.37	9.35	5.18	4.94	0.67	090
28296		A	Correction of bunion	8.35	9.96	9.29	5.29	5.22	0.55	090
28297		A	Correction of bunion	9.43	11.56	10.52	5.87	5.74	0.84	090
28298		A	Correction of bunion	8.13	10.23	9.21	5.01	4.86	0.62	090
28299		A	Correction of bunion	11.57	11.41	10.54	6.11	6.02	0.80	090
28300		A	Incision of heel bone	9.73	NA	NA	7.03	6.65	1.14	090
28302		A	Incision of ankle bone	9.74	NA	NA	8.01	6.83	1.37	090
28304		A	Incision of midfoot bones	9.41	10.88	9.76	5.81	5.56	0.86	090
28305		A	Incise/graft midfoot bones	10.77	NA	NA	6.64	6.52	0.59	090
28306		A	Incision of metatarsal	6.00	9.66	8.56	4.49	4.21	0.59	090
28307		A	Incision of metatarsal	6.50	12.74	10.92	6.18	5.26	0.91	090
28308		A	Incision of metatarsal	5.48	8.79	7.78	4.22	3.96	0.43	090
28309		A	Incision of metatarsals	14.16	NA	NA	8.84	8.06	1.50	090
28310		A	Revision of big toe	5.57	8.10	7.37	3.62	3.53	0.39	090
28312		A	Revision of toe	4.69	8.08	7.24	3.51	3.44	0.36	090
28313		A	Repair deformity of toe	5.15	8.38	7.37	4.17	4.13	0.50	090
28315		A	Removal of sesamoid bone	5.00	7.19	6.46	3.43	3.32	0.34	090
28320		A	Repair of foot bones	9.37	NA	NA	6.42	6.12	0.98	090
28322		A	Repair of metatarsals	8.53	11.45	10.16	6.32	5.88	0.93	090
28340		A	Resect enlarged toe tissue	7.15	7.84	7.60	3.81	4.00	0.39	090
28341		A	Resect enlarged toe	8.72	8.73	8.28	4.36	4.49	0.47	090
28344		A	Repair extra toe(s)	4.40	6.54	6.87	2.97	3.41	0.24	090
28345		A	Repair webbed toe(s)	6.09	7.39	7.47	3.56	4.04	0.33	090
28360		A	Reconstruct cleft foot	14.92	NA	NA	9.75	9.01	2.27	090
28400		A	Treatment of heel fracture	2.31	3.88	3.57	3.38	3.08	0.26	090
28405		A	Treatment of heel fracture	4.74	4.91	4.63	4.08	3.96	0.47	090
28406		A	Treatment of heel fracture	6.56	NA	NA	6.45	6.16	0.83	090
28415		A	Treat heel fracture	16.19	NA	NA	12.03	11.51	2.02	090
28420		A	Treat/graft heel fracture	17.52	NA	NA	13.69	12.01	2.48	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
28430		A	Treatment of ankle fracture	2.22	3.62	3.30	2.99	2.69	0.25	090
28435		A	Treatment of ankle fracture	3.54	5.26	4.32	4.36	3.66	0.49	090
28436		A	Treatment of ankle fracture	4.90	NA	NA	6.12	5.51	0.68	090
28445		A	Treat ankle fracture	15.76	NA	NA	11.23	10.43	1.99	090
28446		A	Osteochondral talus autogrft	17.71	NA	NA	12.83	11.38	2.51	090
28450		A	Treat midfoot fracture, each	2.03	3.35	3.08	2.79	2.54	0.21	090
28455		A	Treat midfoot fracture, each	3.24	4.36	3.84	3.62	3.30	0.32	090
28456		A	Treat midfoot fracture	2.86	NA	NA	5.11	4.12	0.39	090
28465		A	Treat midfoot fracture, each	8.80	NA	NA	6.77	6.36	0.90	090
28470		A	Treat metatarsal fracture	2.03	3.24	3.00	2.74	2.50	0.23	090
28475		A	Treat metatarsal fracture	3.01	3.47	3.28	2.78	2.74	0.28	090
28476		A	Treat metatarsal fracture	3.60	NA	NA	4.89	4.70	0.38	090
28485		A	Treat metatarsal fracture	7.44	NA	NA	6.21	5.78	0.68	090
28490		A	Treat big toe fracture	1.17	2.43	2.17	1.95	1.75	0.12	090
28495		A	Treat big toe fracture	1.68	2.75	2.50	2.08	1.98	0.13	090
28496		A	Treat big toe fracture	2.48	8.15	7.68	3.30	3.10	0.25	090
28505		A	Treat big toe fracture	7.44	9.48	8.72	5.41	4.88	0.66	090
28510		A	Treatment of toe fracture	1.17	1.92	1.72	1.84	1.66	0.10	090
28515		A	Treatment of toe fracture	1.56	2.47	2.23	2.03	1.90	0.12	090
28525		A	Treat toe fracture	5.62	8.78	8.05	4.67	4.21	0.50	090
28530		A	Treat sesamoid bone fracture	1.11	1.82	1.65	1.50	1.41	0.08	090
28531		A	Treat sesamoid bone fracture	2.57	9.10	6.96	3.50	2.49	0.36	090
28540		A	Treat foot dislocation	2.19	2.92	2.70	2.45	2.34	0.14	090
28545		A	Treat foot dislocation	2.60	4.60	3.60	3.81	3.05	0.36	090
28546		A	Treat foot dislocation	3.40	10.57	8.47	4.91	4.13	0.47	090
28555		A	Repair foot dislocation	9.65	12.46	11.30	7.34	6.66	1.14	090
28570		A	Treat foot dislocation	1.76	2.39	2.38	1.84	1.92	0.09	090
28575		A	Treat foot dislocation	3.49	5.42	4.61	4.59	4.01	0.48	090
28576		A	Treat foot dislocation	4.60	NA	NA	5.14	4.23	0.64	090
28585		A	Repair foot dislocation	11.13	13.06	11.31	7.92	7.18	1.18	090
28600		A	Treat foot dislocation	2.02	3.43	3.10	2.70	2.53	0.20	090
28605		A	Treat foot dislocation	2.89	5.07	3.94	4.30	3.42	0.39	090
28606		A	Treat foot dislocation	5.09	NA	NA	4.80	4.42	0.60	090
28615		A	Repair foot dislocation	10.70	NA	NA	9.10	8.52	1.24	090
28630		A	Treat toe dislocation	1.75	2.13	1.87	1.06	0.98	0.16	010
28635		A	Treat toe dislocation	1.96	2.41	2.28	1.40	1.41	0.15	010
28636		A	Treat toe dislocation	2.77	4.84	4.30	2.26	2.18	0.29	010
28645		A	Repair toe dislocation	7.44	9.02	7.95	4.96	4.54	0.57	090
28660		A	Treat toe dislocation	1.28	1.57	1.37	0.95	0.84	0.14	010

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
28665		A	Treat toe dislocation	1.97	2.02	1.82	1.47	1.40	0.17	010
28666		A	Treat toe dislocation	2.66	NA	NA	2.57	2.18	0.38	010
28675		A	Repair of toe dislocation	5.62	9.23	8.42	4.99	4.49	0.54	090
28705		A	Fusion of foot bones	20.33	NA	NA	12.63	11.86	2.48	090
28715		A	Fusion of foot bones	14.60	NA	NA	10.03	9.39	1.79	090
28725		A	Fusion of foot bones	12.18	NA	NA	7.88	7.50	1.33	090
28730		A	Fusion of foot bones	12.42	NA	NA	9.00	8.40	1.36	090
28735		A	Fusion of foot bones	12.23	NA	NA	8.04	7.60	1.26	090
28737		A	Revision of foot bones	11.03	NA	NA	6.57	6.48	0.91	090
28740		A	Fusion of foot bones	9.29	12.43	11.35	6.90	6.42	0.95	090
28750		A	Fusion of big toe joint	8.57	12.35	11.51	6.81	6.41	0.92	090
28755		A	Fusion of big toe joint	4.88	7.88	7.25	3.60	3.55	0.37	090
28760		A	Fusion of big toe joint	9.14	11.12	9.97	5.93	5.62	0.74	090
28800		A	Amputation of midfoot	8.79	NA	NA	5.59	5.40	0.93	090
28805		A	Amputation thru metatarsal	12.71	NA	NA	6.66	6.21	1.53	090
28810		A	Amputation toe & metatarsal	6.64	NA	NA	4.63	4.36	0.83	090
28820		A	Amputation of toe	5.00	8.32	7.84	3.92	3.74	0.52	090
28825		A	Partial amputation of toe	6.01	8.80	8.10	4.54	4.17	0.60	090
28890		A	High energy eswt, plantar f	3.45	5.20	4.98	2.51	2.28	0.25	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	3.59	3.95	1.76	1.79	0.13	000
29010		A	Application of body cast	2.06	2.31	3.31	0.85	1.43	0.29	000
29015		A	Application of body cast	2.41	3.67	3.34	1.34	1.45	0.31	000
29020		A	Application of body cast	2.11	3.29	3.28	1.28	1.35	0.07	000
29025		A	Application of body cast	2.40	4.70	3.91	2.10	1.86	0.34	000
29035		A	Application of body cast	1.77	3.97	3.93	1.64	1.60	0.25	000
29040		A	Application of body cast	2.22	3.75	3.34	1.66	1.54	0.32	000
29044		A	Application of body cast	2.12	4.21	4.06	1.82	1.78	0.30	000
29046		A	Application of body cast	2.41	4.27	4.26	1.91	2.00	0.34	000
29049		A	Application of figure eight	0.89	1.52	1.22	0.84	0.63	0.13	000
29055		A	Application of shoulder cast	1.78	3.61	3.20	1.66	1.48	0.25	000
29058		A	Application of shoulder cast	1.31	1.48	1.34	0.69	0.68	0.17	000
29065		A	Application of long arm cast	0.87	1.49	1.36	0.84	0.76	0.12	000
29075		A	Application of forearm cast	0.77	1.43	1.31	0.79	0.71	0.10	000
29085		A	Apply hand/wrist cast	0.87	1.48	1.34	0.83	0.73	0.11	000
29086		A	Apply finger cast	0.62	1.31	1.13	0.69	0.59	0.06	000
29105		A	Apply long arm splint	0.87	1.29	1.18	0.65	0.57	0.11	000
29125		A	Apply forearm splint	0.59	1.15	1.03	0.52	0.45	0.07	000
29126		A	Apply forearm splint	0.77	1.21	1.09	0.60	0.52	0.08	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
29130		A	Application of finger splint	0.50	0.52	0.47	0.24	0.21	0.06	000
29131		A	Application of finger splint	0.55	0.73	0.67	0.31	0.27	0.06	000
29200		A	Strapping of chest	0.65	0.75	0.66	0.43	0.37	0.04	000
29240		A	Strapping of shoulder	0.71	0.75	0.72	0.44	0.40	0.04	000
29260		A	Strapping of elbow or wrist	0.55	0.76	0.70	0.43	0.38	0.05	000
29280		A	Strapping of hand or finger	0.51	0.76	0.71	0.43	0.38	0.04	000
29305		A	Application of hip cast	2.03	3.96	3.56	1.92	1.76	0.29	000
29325		A	Application of hip casts	2.32	4.32	3.89	2.12	1.96	0.33	000
29345		A	Application of long leg cast	1.40	1.95	1.78	1.13	1.04	0.19	000
29355		A	Application of long leg cast	1.53	1.93	1.76	1.14	1.06	0.20	000
29358		A	Apply long leg cast brace	1.43	2.47	2.20	1.16	1.06	0.20	000
29365		A	Application of long leg cast	1.18	1.83	1.68	1.01	0.94	0.16	000
29405		A	Apply short leg cast	0.86	1.37	1.26	0.76	0.70	0.10	000
29425		A	Apply short leg cast	1.01	1.38	1.27	0.74	0.71	0.10	000
29435		A	Apply short leg cast	1.18	1.75	1.61	0.95	0.89	0.16	000
29440		A	Addition of walker to cast	0.57	0.75	0.69	0.31	0.28	0.06	000
29445		A	Apply rigid leg cast	1.78	1.78	1.68	1.02	0.95	0.17	000
29450		A	Application of leg cast	2.08	1.65	1.57	0.91	0.94	0.15	000
29505		A	Application, long leg splint	0.69	1.28	1.15	0.56	0.49	0.09	000
29515		A	Application lower leg splint	0.73	1.12	0.99	0.55	0.49	0.07	000
29520		A	Strapping of hip	0.54	0.71	0.68	0.40	0.38	0.03	000
29530		A	Strapping of knee	0.57	0.74	0.70	0.41	0.37	0.05	000
29540		A	Strapping of ankle and/or ft	0.51	0.57	0.53	0.31	0.31	0.03	000
29550		A	Strapping of toes	0.47	0.59	0.54	0.31	0.30	0.03	000
29580		A	Application of paste boot	0.55	0.79	0.73	0.38	0.35	0.05	000
29581		A	Apply multlay comprs lwr leg	0.60	1.74	1.74	0.23	0.23	0.06	000
29590		A	Application of foot splint	0.76	0.63	0.59	0.26	0.27	0.04	000
29700		A	Removal/revision of cast	0.57	1.03	0.97	0.29	0.28	0.07	000
29705		A	Removal/revision of cast	0.76	0.91	0.83	0.45	0.40	0.10	000
29710		A	Removal/revision of cast	1.34	1.69	1.49	0.76	0.67	0.19	000
29715		A	Removal/revision of cast	0.94	1.08	1.17	0.43	0.44	0.09	000
29720		A	Repair of body cast	0.68	1.35	1.23	0.42	0.39	0.09	000
29730		A	Windowing of cast	0.75	0.88	0.80	0.41	0.37	0.09	000
29740		A	Wedging of cast	1.12	1.13	1.08	0.52	0.50	0.12	000
29750		A	Wedging of clubfoot cast	1.26	1.38	1.18	0.71	0.62	0.18	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.84	NA	NA	6.21	5.77	0.96	090
29804		A	Jaw arthroscopy/surgery	8.87	NA	NA	7.64	6.79	1.24	090
29805		A	Shoulder arthroscopy, dx	6.03	NA	NA	5.64	5.28	0.84	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
29806		A	Shoulder arthroscopy/surgery	15.14	NA	NA	11.35	10.58	2.13	090
29807		A	Shoulder arthroscopy/surgery	14.67	NA	NA	11.15	10.40	2.06	090
29819		A	Shoulder arthroscopy/surgery	7.79	NA	NA	6.77	6.34	1.08	090
29820		A	Shoulder arthroscopy/surgery	7.21	NA	NA	6.21	5.82	1.00	090
29821		A	Shoulder arthroscopy/surgery	7.89	NA	NA	6.83	6.37	1.10	090
29822		A	Shoulder arthroscopy/surgery	7.60	NA	NA	6.72	6.26	1.06	090
29823		A	Shoulder arthroscopy/surgery	8.36	NA	NA	7.30	6.80	1.16	090
29824		A	Shoulder arthroscopy/surgery	8.98	NA	NA	7.90	7.29	1.24	090
29825		A	Shoulder arthroscopy/surgery	7.79	NA	NA	6.79	6.33	1.09	090
29826		A	Shoulder arthroscopy/surgery	9.16	NA	NA	7.48	6.99	1.28	090
29827		A	Arthroscop rotator cuff repr	15.59	NA	NA	11.34	10.63	2.20	090
29828		A	Arthroscopy biceps tenodesis	13.16	NA	NA	9.97	8.99	1.86	090
29830		A	Elbow arthroscopy	5.88	NA	NA	5.38	5.02	0.82	090
29834		A	Elbow arthroscopy/surgery	6.42	NA	NA	5.85	5.46	0.87	090
29835		A	Elbow arthroscopy/surgery	6.62	NA	NA	5.95	5.55	0.93	090
29836		A	Elbow arthroscopy/surgery	7.72	NA	NA	6.77	6.33	1.08	090
29837		A	Elbow arthroscopy/surgery	7.01	NA	NA	6.15	5.74	0.96	090
29838		A	Elbow arthroscopy/surgery	7.88	NA	NA	6.84	6.40	1.06	090
29840		A	Wrist arthroscopy	5.68	NA	NA	5.49	5.12	0.79	090
29843		A	Wrist arthroscopy/surgery	6.15	NA	NA	5.81	5.43	0.86	090
29844		A	Wrist arthroscopy/surgery	6.51	NA	NA	5.97	5.48	0.84	090
29845		A	Wrist arthroscopy/surgery	7.69	NA	NA	6.61	6.12	0.98	090
29846		A	Wrist arthroscopy/surgery	6.89	NA	NA	6.16	5.71	0.88	090
29847		A	Wrist arthroscopy/surgery	7.22	NA	NA	6.24	5.86	1.01	090
29848		A	Wrist endoscopy/surgery	6.39	NA	NA	6.35	5.76	0.82	090
29850		A	Knee arthroscopy/surgery	8.27	NA	NA	7.20	5.83	1.16	090
29851		A	Knee arthroscopy/surgery	13.26	NA	NA	9.96	9.28	1.88	090
29855		A	Tibial arthroscopy/surgery	10.76	NA	NA	8.84	8.23	1.52	090
29856		A	Tibial arthroscopy/surgery	14.28	NA	NA	10.56	9.90	2.03	090
29860		A	Hip arthroscopy, dx	9.00	NA	NA	7.56	6.83	1.26	090
29861		A	Hip arthroscopy/surgery	10.10	NA	NA	8.10	7.37	1.42	090
29862		A	Hip arthroscopy/surgery	11.17	NA	NA	9.21	8.46	1.56	090
29863		A	Hip arthroscopy/surgery	11.17	NA	NA	9.25	8.41	1.57	090
29866		A	Autgrft implnt, knee w/scope	14.67	NA	NA	11.45	10.61	2.08	090
29867		A	Allgrft implnt, knee w/scope	18.39	NA	NA	13.51	12.35	2.60	090
29868		A	Meniscal trnspl, knee w/scpe	25.10	NA	NA	16.80	15.44	3.55	090
29870		A	Knee arthroscopy, dx	5.19	9.05	5.68	5.02	4.66	0.72	090
29871		A	Knee arthroscopy/drainage	6.69	NA	NA	6.06	5.63	0.93	090
29873		A	Knee arthroscopy/surgery	6.24	NA	NA	6.70	6.22	0.86	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
29874		A	Knee arthroscopy/surgery	7.19	NA	NA	6.17	5.76	1.00	090
29875		A	Knee arthroscopy/surgery	6.45	NA	NA	5.85	5.47	0.90	090
29876		A	Knee arthroscopy/surgery	8.87	NA	NA	7.46	6.88	1.23	090
29877		A	Knee arthroscopy/surgery	8.30	NA	NA	7.19	6.63	1.16	090
29879		A	Knee arthroscopy/surgery	8.99	NA	NA	7.52	6.95	1.25	090
29880		A	Knee arthroscopy/surgery	9.45	NA	NA	7.75	7.17	1.32	090
29881		A	Knee arthroscopy/surgery	8.71	NA	NA	7.39	6.82	1.21	090
29882		A	Knee arthroscopy/surgery	9.60	NA	NA	7.79	7.17	1.34	090
29883		A	Knee arthroscopy/surgery	11.77	NA	NA	9.18	8.57	1.66	090
29884		A	Knee arthroscopy/surgery	8.28	NA	NA	7.19	6.62	1.15	090
29885		A	Knee arthroscopy/surgery	10.21	NA	NA	8.49	7.82	1.43	090
29886		A	Knee arthroscopy/surgery	8.49	NA	NA	7.31	6.74	1.18	090
29887		A	Knee arthroscopy/surgery	10.16	NA	NA	8.44	7.77	1.42	090
29888		A	Knee arthroscopy/surgery	14.30	NA	NA	10.48	9.70	2.02	090
29889		A	Knee arthroscopy/surgery	17.41	NA	NA	13.00	12.08	2.44	090
29891		A	Ankle arthroscopy/surgery	9.67	NA	NA	7.79	7.29	1.17	090
29892		A	Ankle arthroscopy/surgery	10.27	NA	NA	8.82	7.37	1.44	090
29893		A	Scope, plantar fasciotomy	6.32	9.28	8.44	4.84	4.59	0.36	090
29894		A	Ankle arthroscopy/surgery	7.35	NA	NA	5.63	5.24	0.88	090
29895		A	Ankle arthroscopy/surgery	7.13	NA	NA	5.29	5.02	0.79	090
29897		A	Ankle arthroscopy/surgery	7.32	NA	NA	5.71	5.41	0.88	090
29898		A	Ankle arthroscopy/surgery	8.49	NA	NA	6.06	5.75	0.93	090
29899		A	Ankle arthroscopy/surgery	15.41	NA	NA	10.90	10.18	2.06	090
29900		A	Mcp joint arthroscopy, dx	5.88	NA	NA	4.44	4.92	0.29	090
29901		A	Mcp joint arthroscopy, surg	6.59	NA	NA	6.57	5.69	0.92	090
29902		A	Mcp joint arthroscopy, surg	7.16	NA	NA	7.96	6.23	1.84	090
29904		A	Subtalar arthro w/fb rmvl	8.65	NA	NA	7.20	6.47	1.21	090
29905		A	Subtalar arthro w/exc	9.18	NA	NA	7.95	7.14	1.28	090
29906		A	Subtalar arthro w/deb	9.65	NA	NA	8.39	7.53	1.34	090
29907		A	Subtalar arthro w/fusion	12.18	NA	NA	9.63	8.66	1.72	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.48	4.37	4.19	1.59	1.46	0.14	010
30020		A	Drainage of nose lesion	1.48	4.41	4.06	1.62	1.48	0.14	010
3008F		I	Body mass index docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30100		A	Intranasal biopsy	0.94	2.66	2.51	0.85	0.81	0.09	000
30110		A	Removal of nose polyp(s)	1.68	4.18	3.89	1.72	1.58	0.15	010
30115		A	Removal of nose polyp(s)	4.44	NA	NA	6.67	6.22	0.41	090
30117		A	Removal of intranasal lesion	3.26	18.66	17.45	5.42	5.06	0.30	090
30118		A	Removal of intranasal lesion	9.92	NA	NA	9.96	9.23	0.94	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
30120		A	Revision of nose	5.39	7.71	7.35	5.78	5.64	0.61	090
30124		A	Removal of nose lesion	3.20	NA	NA	3.86	3.57	0.29	090
30125		A	Removal of nose lesion	7.30	NA	NA	8.51	7.97	0.67	090
30130		A	Excise inferior turbinate	3.47	NA	NA	6.28	5.88	0.32	090
30140		A	Resect inferior turbinate	3.57	NA	NA	7.68	7.17	0.32	090
30150		A	Partial removal of nose	9.55	NA	NA	10.34	9.88	1.01	090
3015F		I	Cerv cancer screen docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30160		A	Removal of nose	9.99	NA	NA	10.20	9.61	0.91	090
3018F		I	Pre-prxd rsk et al docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30200		A	Injection treatment of nose	0.78	2.13	1.98	0.79	0.73	0.07	000
30210		A	Nasal sinus therapy	1.13	2.70	2.52	1.46	1.35	0.10	010
30220		A	Insert nasal septal button	1.59	6.09	5.64	1.68	1.55	0.15	010
30300		A	Remove nasal foreign body	1.09	4.68	4.49	2.13	1.97	0.10	010
30310		A	Remove nasal foreign body	2.01	NA	NA	3.28	3.08	0.18	010
30320		A	Remove nasal foreign body	4.64	NA	NA	7.01	6.58	0.42	090
3038F		I	Pulm fx w/in 12 mon b/4 surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30400		R	Reconstruction of nose	10.86	NA	NA	15.20	14.78	0.98	090
30410		R	Reconstruction of nose	14.00	NA	NA	16.72	16.20	1.27	090
30420		R	Reconstruction of nose	16.90	NA	NA	18.53	17.29	1.73	090
30430		R	Revision of nose	8.24	NA	NA	13.94	14.15	1.13	090
30435		R	Revision of nose	12.73	NA	NA	16.11	16.51	1.15	090
30450		R	Revision of nose	19.66	NA	NA	19.44	19.08	1.81	090
30460		A	Revision of nose	10.32	NA	NA	10.30	8.76	1.46	090
30462		A	Revision of nose	20.28	NA	NA	16.51	16.69	2.88	090
30465		A	Repair nasal stenosis	12.36	NA	NA	13.05	12.02	1.24	090
30520		A	Repair of nasal septum	7.01	NA	NA	9.16	8.21	0.64	090
30540		A	Repair nasal defect	7.92	NA	NA	9.91	8.89	0.72	090
30545		A	Repair nasal defect	11.62	NA	NA	10.36	11.31	0.58	090
30560		A	Release of nasal adhesions	1.31	5.51	5.29	2.24	2.13	0.12	010
30580		A	Repair upper jaw fistula	6.88	9.56	8.64	6.25	5.48	0.63	090
30600		A	Repair mouth/nose fistula	6.16	8.64	8.08	5.12	4.74	0.56	090
30620		A	Intranasal reconstruction	6.16	NA	NA	9.74	9.16	0.64	090
30630		A	Repair nasal septum defect	7.29	NA	NA	8.84	8.22	0.69	090
30801		A	Ablate inf turbinate, superf	1.14	4.59	4.41	2.35	2.18	0.10	010
30802		A	Ablate inf turbinate submuc	2.08	5.31	5.05	2.84	2.61	0.19	010
30901		A	Control of nosebleed	1.21	1.46	1.36	0.42	0.35	0.13	000
30903		A	Control of nosebleed	1.54	3.56	3.26	0.59	0.50	0.16	000
30905		A	Control of nosebleed	1.97	4.33	3.99	0.70	0.63	0.21	000
30906		A	Repeat control of nosebleed	2.45	4.69	4.37	1.09	0.98	0.24	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
30915		A	Ligation, nasal sinus artery	7.44	NA	NA	7.65	6.96	0.70	090
30920		A	Ligation, upper jaw artery	11.14	NA	NA	10.68	9.61	1.03	090
30930		A	Ther fx, nasal inf turbinate	1.31	NA	NA	1.88	1.73	0.12	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.20	3.36	3.21	1.50	1.42	0.10	010
31002		A	Irrigation, sphenoid sinus	1.96	NA	NA	3.16	3.03	0.18	010
31020		A	Exploration, maxillary sinus	3.07	8.99	8.78	5.97	5.67	0.28	090
31030		A	Exploration, maxillary sinus	6.01	11.40	11.06	7.44	6.90	0.54	090
31032		A	Explore sinus, remove polyps	6.69	NA	NA	8.10	7.48	0.62	090
31040		A	Exploration behind upper jaw	9.77	NA	NA	9.69	8.83	0.99	090
31050		A	Exploration, sphenoid sinus	5.37	NA	NA	7.34	6.86	0.49	090
31051		A	Sphenoid sinus surgery	7.25	NA	NA	9.46	8.77	0.66	090
31070		A	Exploration of frontal sinus	4.40	NA	NA	6.89	6.43	0.41	090
31075		A	Exploration of frontal sinus	9.51	NA	NA	10.80	10.02	0.87	090
31080		A	Removal of frontal sinus	12.74	NA	NA	14.07	12.54	1.16	090
31081		A	Removal of frontal sinus	14.19	NA	NA	20.46	16.68	3.64	090
31084		A	Removal of frontal sinus	14.95	NA	NA	15.13	14.35	1.36	090
31085		A	Removal of frontal sinus	15.64	NA	NA	21.13	16.37	4.01	090
31086		A	Removal of frontal sinus	14.36	NA	NA	14.85	13.60	1.31	090
31087		A	Removal of frontal sinus	14.57	NA	NA	13.70	12.75	1.33	090
31090		A	Exploration of sinuses	11.17	NA	NA	15.31	13.97	1.02	090
31200		A	Removal of ethmoid sinus	5.14	NA	NA	8.95	8.33	0.52	090
31201		A	Removal of ethmoid sinus	8.60	NA	NA	10.50	9.59	0.80	090
31205		A	Removal of ethmoid sinus	10.58	NA	NA	12.16	10.97	1.13	090
31225		A	Removal of upper jaw	26.70	NA	NA	22.22	19.58	2.55	090
31230		A	Removal of upper jaw	30.82	NA	NA	23.86	20.98	2.85	090
31231		A	Nasal endoscopy, dx	1.10	3.77	3.63	0.93	0.86	0.10	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.60	4.41	1.45	1.32	0.20	000
31235		A	Nasal/sinus endoscopy, dx	2.64	5.05	4.89	1.66	1.51	0.24	000
31237		A	Nasal/sinus endoscopy, surg	2.98	5.36	5.14	1.84	1.66	0.28	000
31238		A	Nasal/sinus endoscopy, surg	3.26	5.33	5.11	1.98	1.79	0.30	000
31239		A	Nasal/sinus endoscopy, surg	9.33	NA	NA	8.47	7.49	0.89	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	NA	1.66	1.51	0.24	000
31254		A	Revision of ethmoid sinus	4.64	NA	NA	2.65	2.39	0.43	000
31255		A	Removal of ethmoid sinus	6.95	NA	NA	3.74	3.38	0.64	000
31256		A	Exploration maxillary sinus	3.29	NA	NA	1.99	1.80	0.31	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	NA	3.03	2.73	0.51	000
31276		A	Sinus endoscopy, surgical	8.84	NA	NA	4.66	4.18	0.82	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	NA	2.29	2.07	0.36	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	NA	2.61	2.36	0.43	000
31290		A	Nasal/sinus endoscopy, surg	18.61	NA	NA	11.92	10.75	1.91	010
31291		A	Nasal/sinus endoscopy, surg	19.56	NA	NA	12.40	11.21	2.26	010
31292		A	Nasal/sinus endoscopy, surg	15.90	NA	NA	10.61	9.54	1.49	010
31293		A	Nasal/sinus endoscopy, surg	17.47	NA	NA	11.37	10.25	1.62	010
31294		A	Nasal/sinus endoscopy, surg	20.31	NA	NA	12.74	11.45	1.89	010
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	15.91	NA	NA	17.25	15.74	1.46	090
31320		A	Diagnostic incision, larynx	5.73	NA	NA	11.11	10.50	0.52	090
31360		A	Removal of larynx	29.91	NA	NA	24.69	21.22	2.81	090
31365		A	Removal of larynx	38.81	NA	NA	29.01	24.84	3.64	090
31367		A	Partial removal of larynx	30.57	NA	NA	27.24	24.25	2.85	090
31368		A	Partial removal of larynx	34.19	NA	NA	29.99	26.82	3.15	090
31370		A	Partial removal of larynx	27.57	NA	NA	26.66	23.96	2.54	090
31375		A	Partial removal of larynx	26.07	NA	NA	25.39	22.74	2.40	090
31380		A	Partial removal of larynx	25.57	NA	NA	25.15	22.49	2.35	090
31382		A	Partial removal of larynx	28.57	NA	NA	27.14	24.17	2.63	090
31390		A	Removal of larynx & pharynx	42.51	NA	NA	31.96	28.10	4.21	090
31395		A	Reconstruct larynx & pharynx	43.80	NA	NA	35.37	31.10	4.04	090
31400		A	Revision of larynx	11.60	NA	NA	14.32	13.49	1.06	090
31420		A	Removal of epiglottis	11.43	NA	NA	10.48	9.57	1.05	090
31500		A	Insert emergency airway	2.33	NA	NA	0.51	0.48	0.22	000
31502		A	Change of windpipe airway	0.65	NA	NA	0.28	0.25	0.06	000
31505		A	Diagnostic laryngoscopy	0.61	1.51	1.47	0.68	0.63	0.06	000
31510		A	Laryngoscopy with biopsy	1.92	3.48	3.36	1.28	1.17	0.18	000
31511		A	Remove foreign body, larynx	2.16	3.24	3.10	1.24	1.13	0.22	000
31512		A	Removal of larynx lesion	2.07	3.30	3.14	1.40	1.26	0.19	000
31513		A	Injection into vocal cord	2.10	NA	NA	1.42	1.29	0.20	000
31515		A	Laryngoscopy for aspiration	1.80	3.51	3.42	1.11	1.01	0.18	000
31520		A	Dx laryngoscopy, newborn	2.56	NA	NA	1.64	1.41	0.24	000
31525		A	Dx laryngoscopy excl nb	2.63	3.84	3.64	1.61	1.46	0.24	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	NA	1.64	1.49	0.24	000
31527		A	Laryngoscopy for treatment	3.27	NA	NA	1.98	1.72	0.30	000
31528		A	Laryngoscopy and dilation	2.37	NA	NA	1.49	1.34	0.23	000
31529		A	Laryngoscopy and dilation	2.68	NA	NA	1.63	1.49	0.25	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	NA	1.89	1.71	0.33	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	NA	2.12	1.92	0.33	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	NA	1.92	1.73	0.30	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	NA	2.11	1.91	0.33	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	NA	2.38	2.15	0.39	000
31541		A	Larynscop w/tumr exc + scope	4.52	NA	NA	2.58	2.33	0.42	000
31545		A	Remove vc lesion w/scope	6.30	NA	NA	3.47	3.08	0.58	000
31546		A	Remove vc lesion scope/graft	9.73	NA	NA	5.13	4.44	0.90	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	NA	3.00	2.68	0.50	000
31561		A	Larynscop, remve cart + scop	5.99	NA	NA	3.23	2.89	0.56	000
31570		A	Laryngoscope w/vc inj	3.86	4.81	4.77	2.20	2.01	0.39	000
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	NA	2.46	2.21	0.40	000
31575		A	Diagnostic laryngoscopy	1.10	1.86	1.80	0.93	0.85	0.10	000
31576		A	Laryngoscopy with biopsy	1.97	3.78	3.68	1.32	1.20	0.17	000
31577		A	Remove foreign body, larynx	2.47	3.76	3.60	1.50	1.36	0.23	000
31578		A	Removal of larynx lesion	2.84	4.41	4.22	1.77	1.54	0.26	000
31579		A	Diagnostic laryngoscopy	2.26	3.21	3.18	1.49	1.35	0.21	000
31580		A	Revision of larynx	14.66	NA	NA	17.17	15.67	1.34	090
31582		A	Revision of larynx	23.22	NA	NA	26.19	24.65	2.14	090
31584		A	Treat larynx fracture	20.47	NA	NA	19.10	17.52	1.90	090
31587		A	Revision of larynx	15.27	NA	NA	11.24	9.81	1.41	090
31588		A	Revision of larynx	14.99	NA	NA	14.90	13.65	1.36	090
31590		A	Reinnervate larynx	7.85	NA	NA	15.01	14.44	0.71	090
31595		A	Larynx nerve surgery	8.84	NA	NA	11.02	10.36	0.81	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	NA	3.05	2.77	0.91	000
31601		A	Incision of windpipe	4.44	NA	NA	2.51	2.25	0.41	000
31603		A	Incision of windpipe	4.14	NA	NA	1.65	1.48	0.50	000
31605		A	Incision of windpipe	3.57	NA	NA	1.09	1.01	0.46	000
31610		A	Incision of windpipe	9.38	NA	NA	9.16	8.38	0.95	090
31611		A	Surgery/speech prosthesis	6.00	NA	NA	8.00	7.44	0.56	090
31612		A	Puncture/clear windpipe	0.91	1.17	1.11	0.35	0.31	0.09	000
31613		A	Repair windpipe opening	4.71	NA	NA	6.91	6.41	0.52	090
31614		A	Repair windpipe opening	8.63	NA	NA	10.92	9.96	0.83	090
31615		A	Visualization of windpipe	2.09	2.58	2.51	1.30	1.18	0.19	000
31620		A	Endobronchial us add-on	1.40	5.22	5.74	0.40	0.41	0.10	ZZZ
31622		A	Dx bronchoscope/wash	2.78	4.89	5.25	1.04	1.00	0.24	000
31623		A	Dx bronchoscope/brush	2.88	5.27	5.88	1.02	0.97	0.18	000
31624		A	Dx bronchoscope/lavage	2.88	4.81	5.29	1.03	0.99	0.18	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	4.96	5.42	1.17	1.12	0.23	000
31626		A	Bronchoscopy w/markers	4.16	7.33	7.33	1.46	1.46	0.23	000
31627		A	Navigational bronchoscopy	2.00	30.18	30.18	0.73	0.73	0.11	ZZZ
31628		A	Bronchoscopy/lung bx, each	3.80	5.68	6.64	1.27	1.21	0.22	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
31629		A	Bronchoscopy/needle bx, each	4.09	10.36	11.98	1.36	1.30	0.25	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	NA	1.46	1.45	0.36	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	NA	1.64	1.60	0.43	000
31632		A	Bronchoscopy/lung bx, addl	1.03	0.81	0.84	0.30	0.27	0.06	ZZZ
31633		A	Bronchoscopy/needle bx addl	1.32	0.94	0.97	0.38	0.36	0.08	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	4.85	5.31	1.30	1.27	0.29	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	NA	1.50	1.52	0.41	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	NA	0.42	0.46	0.09	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	NA	1.77	1.75	0.47	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	NA	1.79	1.77	0.46	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	NA	1.77	1.69	0.42	000
31643		A	Diag bronchoscope/catheter	3.49	NA	NA	1.15	1.13	0.21	000
31645		A	Bronchoscopy, clear airways	3.16	4.33	4.71	1.11	1.06	0.20	000
31646		A	Bronchoscopy, reclear airway	2.72	4.04	4.43	0.97	0.93	0.18	000
31656		A	Bronchoscopy, inj for x-ray	2.17	5.09	5.91	0.76	0.76	0.12	000
31715		A	Injection for bronchus x-ray	1.11	NA	NA	0.29	0.33	0.06	000
31717		A	Bronchial brush biopsy	2.12	4.15	5.33	0.74	0.75	0.12	000
31720		A	Clearance of airways	1.06	NA	NA	0.31	0.30	0.06	000
31725		A	Clearance of airways	1.96	NA	NA	0.55	0.49	0.14	000
31730		A	Intro, windpipe wire/tube	2.85	25.91	21.27	0.99	0.91	0.33	000
31750		A	Repair of windpipe	15.39	NA	NA	19.67	18.39	1.64	090
31755		A	Repair of windpipe	17.54	NA	NA	27.07	25.46	1.60	090
31760		A	Repair of windpipe	23.48	NA	NA	10.62	10.90	3.96	090
31766		A	Reconstruction of windpipe	31.67	NA	NA	14.96	13.33	5.37	090
31770		A	Repair/graft of bronchus	23.54	NA	NA	9.60	9.70	3.98	090
31775		A	Reconstruct bronchus	24.59	NA	NA	10.20	9.88	4.16	090
31780		A	Reconstruct windpipe	19.84	NA	NA	11.14	10.24	2.33	090
31781		A	Reconstruct windpipe	24.85	NA	NA	13.99	11.72	4.21	090
31785		A	Remove windpipe lesion	18.35	NA	NA	10.17	9.13	1.90	090
31786		A	Remove windpipe lesion	25.42	NA	NA	10.45	11.29	4.30	090
31800		A	Repair of windpipe injury	8.18	NA	NA	10.37	9.41	0.75	090
31805		A	Repair of windpipe injury	13.42	NA	NA	7.98	7.26	2.27	090
31820		A	Closure of windpipe lesion	4.64	6.59	6.11	3.95	3.60	0.47	090
31825		A	Repair of windpipe defect	7.07	8.55	7.94	5.55	5.09	0.70	090
31830		A	Revise windpipe scar	4.62	6.59	6.17	4.18	3.89	0.50	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
32035		A	Exploration of chest	11.29	NA	NA	6.77	6.45	1.85	090
32036		A	Exploration of chest	12.30	NA	NA	7.14	6.86	2.09	090
32095		A	Biopsy through chest wall	10.14	NA	NA	5.76	5.55	1.71	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
32100		A	Exploration/biopsy of chest	16.16	NA	NA	7.82	7.71	2.74	090
32110		A	Explore/repair chest	25.28	NA	NA	11.37	10.89	4.14	090
32120		A	Re-exploration of chest	14.39	NA	NA	7.52	7.35	2.44	090
32124		A	Explore chest free adhesions	15.45	NA	NA	7.92	7.59	2.63	090
32140		A	Removal of lung lesion(s)	16.66	NA	NA	8.43	8.03	2.81	090
32141		A	Remove/treat lung lesions	27.18	NA	NA	11.43	10.65	4.63	090
32150		A	Removal of lung lesion(s)	16.82	NA	NA	8.40	8.03	2.84	090
32151		A	Remove lung foreign body	16.94	NA	NA	8.10	8.30	2.86	090
32160		A	Open chest heart massage	13.10	NA	NA	6.60	6.17	2.16	090
32200		A	Drain, open, lung lesion	18.68	NA	NA	9.90	9.39	3.07	090
32201		A	Drain, percut, lung lesion	3.99	17.80	19.81	1.19	1.45	0.28	000
32215		A	Treat chest lining	13.05	NA	NA	7.10	6.91	2.19	090
32220		A	Release of lung	26.65	NA	NA	13.32	13.06	4.53	090
32225		A	Partial release of lung	16.75	NA	NA	8.30	8.05	2.83	090
32310		A	Removal of chest lining	15.28	NA	NA	7.84	7.57	2.61	090
32320		A	Free/remove chest lining	27.25	NA	NA	13.02	12.59	4.56	090
32400		A	Needle biopsy chest lining	1.76	1.93	2.14	0.52	0.59	0.12	000
32402		A	Open biopsy chest lining	8.97	NA	NA	5.31	5.18	1.47	090
32405		A	Biopsy, lung or mediastinum	1.93	0.57	0.71	0.57	0.70	0.13	000
32420		A	Puncture/clear lung	2.18	NA	NA	0.65	0.75	0.17	000
32421		A	Thoracentesis for aspiration	1.54	2.22	2.53	0.48	0.50	0.11	000
32422		A	Thoracentesis w/tube insert	2.19	2.65	2.95	1.00	1.08	0.15	000
32440		A	Removal of lung	27.28	NA	NA	12.21	12.19	4.60	090
32442		A	Sleeve pneumonectomy	56.47	NA	NA	16.99	18.19	3.08	090
32445		A	Removal of lung	63.84	NA	NA	24.18	22.60	10.80	090
32480		A	Partial removal of lung	25.82	NA	NA	11.51	11.44	4.38	090
32482		A	Bilobectomy	27.44	NA	NA	12.52	12.41	4.64	090
32484		A	Segmentectomy	25.38	NA	NA	10.82	10.75	4.28	090
32486		A	Sleeve lobectomy	42.88	NA	NA	16.25	15.68	7.35	090
32488		A	Completion pneumonectomy	42.99	NA	NA	17.18	16.36	7.32	090
32491		R	Lung volume reduction	25.24	NA	NA	11.55	11.98	4.25	090
32500		A	Partial removal of lung	24.64	NA	NA	11.54	11.52	4.18	090
32501		A	Repair bronchus add-on	4.68	NA	NA	1.48	1.52	0.79	ZZZ
32503		A	Resect apical lung tumor	31.74	NA	NA	13.39	13.57	5.41	090
32504		A	Resect apical lung tum/chest	36.54	NA	NA	15.04	15.39	6.15	090
32540		A	Removal of lung lesion	30.35	NA	NA	13.19	12.40	5.14	090
32550		A	Insert pleural cath	4.17	15.00	16.12	1.57	1.65	0.51	000
32551		A	Insertion of chest tube	3.29	NA	NA	1.09	1.14	0.37	000
32552		A	Remove lung catheter	2.53	2.06	2.06	1.49	1.49	0.42	010

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
32553		A	Ins mark thor for rt perq	3.80	11.67	11.67	1.29	1.29	0.64	000
32560		A	Treat pleurodesis w/agent	1.54	4.48	5.23	0.48	0.62	0.28	000
32561		A	Lyse chest fibrin init day	1.39	1.04	1.04	0.43	0.43	0.18	000
32562		A	Lyse chest fibrin subq day	1.24	0.92	0.92	0.39	0.39	0.16	000
32601		A	Thoracoscopy, diagnostic	5.45	NA	NA	2.28	2.30	0.91	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	NA	2.45	2.45	0.98	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	NA	3.00	3.06	1.42	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	NA	3.23	3.41	1.49	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	NA	2.67	2.72	1.17	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	NA	3.25	3.27	1.41	000
32650		A	Thoracoscopy, surgical	10.83	NA	NA	5.95	5.94	1.81	090
32651		A	Thoracoscopy, surgical	18.78	NA	NA	8.77	8.23	3.12	090
32652		A	Thoracoscopy, surgical	29.13	NA	NA	12.58	11.90	4.85	090
32653		A	Thoracoscopy, surgical	18.17	NA	NA	8.34	7.92	2.97	090
32654		A	Thoracoscopy, surgical	20.52	NA	NA	9.21	8.64	3.36	090
32655		A	Thoracoscopy, surgical	16.17	NA	NA	7.93	7.55	2.72	090
32656		A	Thoracoscopy, surgical	13.26	NA	NA	6.81	6.81	2.16	090
32657		A	Thoracoscopy, surgical	12.93	NA	NA	6.78	6.79	2.18	090
32658		A	Thoracoscopy, surgical	11.71	NA	NA	6.03	6.30	1.99	090
32659		A	Thoracoscopy, surgical	11.94	NA	NA	6.35	6.49	2.03	090
32660		A	Thoracoscopy, surgical	17.77	NA	NA	8.02	8.29	3.21	090
32661		A	Thoracoscopy, surgical	13.33	NA	NA	6.52	6.77	2.26	090
32662		A	Thoracoscopy, surgical	14.99	NA	NA	7.49	7.57	2.53	090
32663		A	Thoracoscopy, surgical	24.64	NA	NA	10.44	10.46	4.16	090
32664		A	Thoracoscopy, surgical	14.28	NA	NA	6.81	6.94	2.42	090
32665		A	Thoracoscopy, surgical	21.53	NA	NA	10.84	9.47	3.32	090
32800		A	Repair lung hernia	15.71	NA	NA	6.29	7.23	2.65	090
32810		A	Close chest after drainage	14.95	NA	NA	7.46	7.53	2.52	090
32815		A	Close bronchial fistula	50.03	NA	NA	20.50	18.57	8.59	090
32820		A	Reconstruct injured chest	22.51	NA	NA	10.59	11.09	3.79	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant, single	41.61	NA	NA	22.64	23.38	6.99	090
32852		A	Lung transplant with bypass	45.48	NA	NA	25.46	26.59	7.58	090
32853		A	Lung transplant, double	50.78	NA	NA	25.50	26.42	8.62	090
32854		A	Lung transplant with bypass	54.74	NA	NA	28.93	29.85	9.19	090
32855		C	Prepare donor lung, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung, double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	23.81	NA	NA	10.88	10.44	3.96	090
32905		A	Revise & repair chest wall	23.29	NA	NA	9.98	10.13	3.93	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
32906		A	Revise & repair chest wall	29.30	NA	NA	11.80	12.09	4.95	090
3293F		I	Abo rh blood typing docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32940		A	Revision of lung	21.34	NA	NA	9.39	9.36	3.60	090
3294F		I	Grp b strep screening docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32960		A	Therapeutic pneumothorax	1.84	1.86	1.77	0.73	0.74	0.31	000
32997		A	Total lung lavage	7.31	NA	NA	2.11	1.95	0.66	000
32998		A	Perq rf ablate tx, pul tumor	5.68	62.77	67.97	1.81	2.25	0.43	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	NA	0.71	0.94	0.34	000
33011		A	Repeat drainage of heart sac	2.24	NA	NA	0.75	0.89	0.35	000
33015		A	Incision of heart sac	8.52	NA	NA	4.11	5.08	1.21	090
33020		A	Incision of heart sac	14.95	NA	NA	7.12	6.99	2.53	090
33025		A	Incision of heart sac	13.70	NA	NA	6.47	6.41	2.36	090
33030		A	Partial removal of heart sac	22.39	NA	NA	10.06	9.88	3.83	090
33031		A	Partial removal of heart sac	25.38	NA	NA	10.62	10.56	4.42	090
33050		A	Removal of heart sac lesion	16.97	NA	NA	8.24	8.07	2.86	090
33120		A	Removal of heart lesion	27.45	NA	NA	11.78	11.72	4.74	090
33130		A	Removal of heart lesion	24.17	NA	NA	17.53	12.28	4.36	090
33140		A	Heart revascularize (tmr)	28.34	NA	NA	11.21	11.43	5.13	090
33141		A	Heart tmr w/other procedure	2.54	NA	NA	0.82	1.00	0.44	ZZZ
33202		A	Insert epicard eltrd, open	13.20	NA	NA	6.17	6.38	2.28	090
33203		A	Insert epicard eltrd, endo	13.97	NA	NA	6.07	6.78	2.37	090
33206		A	Insertion of heart pacemaker	7.39	NA	NA	3.76	4.75	1.16	090
33207		A	Insertion of heart pacemaker	8.05	NA	NA	3.78	4.87	1.27	090
33208		A	Insertion of heart pacemaker	8.77	NA	NA	4.01	5.19	1.39	090
33210		A	Insertion of heart electrode	3.30	NA	NA	1.09	1.48	0.51	000
33211		A	Insertion of heart electrode	3.39	NA	NA	1.10	1.42	0.54	000
33212		A	Insertion of pulse generator	5.52	NA	NA	2.72	3.47	0.87	090
33213		A	Insertion of pulse generator	6.37	NA	NA	2.99	3.89	1.01	090
33214		A	Upgrade of pacemaker system	7.84	NA	NA	3.94	4.96	1.23	090
33215		A	Reposition pacing-defib lead	4.92	NA	NA	2.48	3.22	0.77	090
33216		A	Insert 1 electrode pm-defib	5.87	NA	NA	3.23	4.23	0.92	090
33217		A	Insert 2 electrode pm-defib	5.84	NA	NA	3.23	4.17	0.92	090
33218		A	Repair lead pace-defib, one	6.07	NA	NA	3.43	4.43	0.95	090
3321F		I	AJCC cncr 0/IA melan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33220		A	Repair lead pace-defib, dual	6.15	NA	NA	3.49	4.46	0.96	090
33222		A	Revise pocket, pacemaker	5.10	NA	NA	3.33	4.12	0.80	090
33223		A	Revise pocket for defib	6.55	NA	NA	3.46	4.54	1.03	090
33224		A	Insert pacing lead & connect	9.04	NA	NA	3.32	4.45	1.45	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
33225		A	L ventric pacing lead add-on	8.33	NA	NA	2.78	3.84	1.31	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	NA	3.20	4.31	1.39	000
3322F		I	Melan >AJCC stage 0 or IA	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33233		A	Removal of pacemaker system	3.39	NA	NA	2.34	3.06	0.53	090
33234		A	Removal of pacemaker system	7.91	NA	NA	3.91	5.07	1.25	090
33235		A	Removal pacemaker electrode	10.15	NA	NA	5.29	6.77	1.60	090
33236		A	Remove electrode/thoracotomy	12.73	NA	NA	6.97	7.04	2.30	090
33237		A	Remove electrode/thoracotomy	13.84	NA	NA	6.52	7.79	2.34	090
33238		A	Remove electrode/thoracotomy	15.40	NA	NA	8.15	8.18	2.64	090
33240		A	Insert pulse generator	7.64	NA	NA	3.53	4.77	1.20	090
33241		A	Remove pulse generator	3.29	NA	NA	2.09	2.79	0.51	090
33243		A	Remove eltrd/thoracotomy	23.57	NA	NA	10.74	11.44	4.00	090
33244		A	Remove eltrd, transven	13.99	NA	NA	6.69	8.82	2.23	090
33249		A	Eltrd/insert pace-defib	15.17	NA	NA	6.79	9.11	2.38	090
3324F		I	Mri ct scan ord rvwd rqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33250		A	Ablate heart dysrhythm focus	25.90	NA	NA	10.98	11.09	4.67	090
33251		A	Ablate heart dysrhythm focus	28.92	NA	NA	12.71	12.22	5.07	090
33254		A	Ablate atria, lmtd	23.71	NA	NA	10.77	10.65	4.28	090
33255		A	Ablate atria w/o bypass, ext	29.04	NA	NA	12.39	12.86	5.25	090
33256		A	Ablate atria w/bypass, exten	34.90	NA	NA	14.26	14.86	6.30	090
33257		A	Ablate atria, lmtd, add-on	9.63	NA	NA	5.18	5.17	1.69	ZZZ
33258		A	Ablate atria, x10sv, add-on	11.00	NA	NA	5.65	5.65	1.92	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	NA	7.33	7.34	2.48	ZZZ
33261		A	Ablate heart dysrhythm focus	28.92	NA	NA	11.91	11.93	5.23	090
33265		A	Ablate atria, lmtd, endo	23.71	NA	NA	10.66	10.56	4.07	090
33266		A	Ablate atria, x10sv, endo	33.04	NA	NA	13.65	13.72	5.76	090
33282		A	Implant pat-active ht record	4.80	NA	NA	2.95	3.91	0.74	090
33284		A	Remove pat-active ht record	3.14	NA	NA	2.41	3.17	0.48	090
3328F		I	Prfrmnc docd 2 wks b/4 surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33300		A	Repair of heart wound	44.97	NA	NA	16.81	15.40	7.76	090
33305		A	Repair of heart wound	76.93	NA	NA	26.79	24.54	13.35	090
33310		A	Exploratory heart surgery	20.34	NA	NA	9.33	9.24	3.24	090
33315		A	Exploratory heart surgery	26.17	NA	NA	11.27	11.34	4.55	090
33320		A	Repair major blood vessel(s)	18.54	NA	NA	8.19	8.34	3.11	090
33321		A	Repair major vessel	20.81	NA	NA	9.09	9.17	3.51	090
33322		A	Repair major blood vessel(s)	24.42	NA	NA	10.87	10.79	4.24	090
33330		A	Insert major vessel graft	25.29	NA	NA	12.54	10.83	4.56	090
33332		A	Insert major vessel graft	24.56	NA	NA	10.42	10.70	4.44	090
33335		A	Insert major vessel graft	33.91	NA	NA	14.10	13.78	5.92	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
33400		A	Repair of aortic valve	41.50	NA	NA	16.26	16.44	7.16	090
33401		A	Valvuloplasty, open	24.63	NA	NA	10.60	12.67	3.86	090
33403		A	Valvuloplasty, w/cp bypass	25.61	NA	NA	11.74	12.36	4.60	090
33404		A	Prepare heart-aorta conduit	31.37	NA	NA	13.11	13.48	5.31	090
33405		A	Replacement of aortic valve	41.32	NA	NA	16.74	17.03	7.18	090
33406		A	Replacement of aortic valve	52.68	NA	NA	20.31	20.17	9.23	090
33410		A	Replacement of aortic valve	46.41	NA	NA	18.39	18.05	8.06	090
33411		A	Replacement of aortic valve	62.07	NA	NA	23.42	22.58	10.81	090
33412		A	Replacement of aortic valve	43.94	NA	NA	17.85	18.53	7.93	090
33413		A	Replacement of aortic valve	59.87	NA	NA	21.47	22.29	10.15	090
33414		A	Repair of aortic valve	39.37	NA	NA	15.01	15.46	7.13	090
33415		A	Revision, subvalvular tissue	37.27	NA	NA	14.60	13.95	6.16	090
33416		A	Revise ventricle muscle	36.56	NA	NA	15.22	14.67	6.35	090
33417		A	Repair of aortic valve	29.33	NA	NA	12.97	13.09	5.09	090
33420		A	Revision of mitral valve	25.79	NA	NA	11.87	10.18	2.56	090
33422		A	Revision of mitral valve	29.73	NA	NA	12.44	12.83	5.37	090
33425		A	Repair of mitral valve	49.96	NA	NA	19.26	18.18	8.68	090
33426		A	Repair of mitral valve	43.28	NA	NA	17.45	17.41	7.52	090
33427		A	Repair of mitral valve	44.83	NA	NA	17.32	17.76	7.79	090
33430		A	Replacement of mitral valve	50.93	NA	NA	20.50	19.93	8.86	090
33460		A	Revision of tricuspid valve	44.70	NA	NA	29.01	19.06	8.09	090
33463		A	Valvuloplasty, tricuspid	57.08	NA	NA	21.48	20.04	9.98	090
33464		A	Valvuloplasty, tricuspid	44.62	NA	NA	17.92	16.85	7.76	090
33465		A	Replace tricuspid valve	50.72	NA	NA	19.39	18.21	8.89	090
33468		A	Revision of tricuspid valve	32.94	NA	NA	13.19	14.42	5.95	090
33470		A	Revision of pulmonary valve	21.54	NA	NA	9.35	9.70	3.62	090
33471		A	Valvotomy, pulmonary valve	22.96	NA	NA	10.93	10.53	1.14	090
33472		A	Revision of pulmonary valve	23.06	NA	NA	10.48	10.55	1.15	090
33474		A	Revision of pulmonary valve	39.40	NA	NA	15.00	13.86	6.66	090
33475		A	Replacement, pulmonary valve	42.40	NA	NA	16.50	16.36	7.66	090
33476		A	Revision of heart chamber	26.57	NA	NA	11.65	11.29	4.79	090
33478		A	Revision of heart chamber	27.54	NA	NA	11.95	12.13	4.96	090
33496		A	Repair, prosth valve clot	29.84	NA	NA	12.73	12.65	5.05	090
33500		A	Repair heart vessel fistula	27.94	NA	NA	11.60	11.83	5.05	090
33501		A	Repair heart vessel fistula	19.51	NA	NA	8.75	8.68	3.52	090
33502		A	Coronary artery correction	21.85	NA	NA	10.19	10.24	3.93	090
33503		A	Coronary artery graft	22.51	NA	NA	9.90	12.19	3.52	090
33504		A	Coronary artery graft	25.46	NA	NA	11.35	11.23	4.59	090
33505		A	Repair artery w/tunnel	38.40	NA	NA	13.16	13.31	6.96	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
33506		A	Repair artery, translocation	37.85	NA	NA	13.49	14.06	6.42	090
33507		A	Repair art, intramural	31.40	NA	NA	11.67	12.38	5.33	090
33508		A	Endoscopic vein harvest	0.31	NA	NA	0.10	0.10	0.05	ZZZ
33510		A	CABG, vein, single	34.98	NA	NA	14.52	14.74	6.08	090
33511		A	CABG, vein, two	38.45	NA	NA	15.80	15.99	6.69	090
33512		A	CABG, vein, three	43.98	NA	NA	17.49	17.63	7.66	090
33513		A	CABG, vein, four	45.37	NA	NA	17.87	17.61	7.93	090
33514		A	CABG, vein, five	48.08	NA	NA	18.79	18.82	8.35	090
33516		A	Cabg, vein, six or more	49.76	NA	NA	18.83	19.48	9.00	090
33517		A	CABG, artery-vein, single	3.61	NA	NA	1.17	1.14	0.62	ZZZ
33518		A	CABG, artery-vein, two	7.93	NA	NA	2.57	2.44	1.37	ZZZ
33519		A	CABG, artery-vein, three	10.49	NA	NA	3.41	3.28	1.84	ZZZ
3351F		I	Neg scrn dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33521		A	CABG, artery-vein, four	12.59	NA	NA	4.10	3.99	2.20	ZZZ
33522		A	CABG, artery-vein, five	14.14	NA	NA	4.62	4.56	2.48	ZZZ
33523		A	Cabg, art-vein, six or more	16.08	NA	NA	5.19	5.18	2.81	ZZZ
3352F		I	No sig dep symp by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33530		A	Coronary artery, bypass/reop	10.13	NA	NA	3.26	3.09	1.78	ZZZ
33533		A	CABG, arterial, single	33.75	NA	NA	13.92	14.41	5.87	090
33534		A	CABG, arterial, two	39.88	NA	NA	16.23	16.56	6.94	090
33535		A	CABG, arterial, three	44.75	NA	NA	17.82	18.06	7.78	090
33536		A	Cabg, arterial, four or more	48.43	NA	NA	19.20	18.96	8.47	090
3353F		I	Mild-mod dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33542		A	Removal of heart lesion	48.21	NA	NA	18.61	17.56	8.42	090
33545		A	Repair of heart damage	57.06	NA	NA	21.07	20.31	9.90	090
33548		A	Restore/remodel, ventricle	54.14	NA	NA	21.34	21.37	9.47	090
3354F		I	Clin sig dep sym by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33572		A	Open coronary endarterectomy	4.44	NA	NA	1.43	1.46	0.77	ZZZ
33600		A	Closure of valve	30.31	NA	NA	12.60	12.74	5.13	090
33602		A	Closure of valve	29.34	NA	NA	14.58	12.63	4.51	090
33606		A	Anastomosis/artery-aorta	31.53	NA	NA	15.27	13.80	4.85	090
33608		A	Repair anomaly w/conduit	31.88	NA	NA	13.08	13.79	5.39	090
33610		A	Repair by enlargement	31.40	NA	NA	12.93	13.30	5.31	090
33611		A	Repair double ventricle	35.57	NA	NA	13.47	13.86	6.43	090
33612		A	Repair double ventricle	36.57	NA	NA	13.70	13.98	5.77	090
33615		A	Repair, modified fontan	35.89	NA	NA	13.98	14.99	6.07	090
33617		A	Repair single ventricle	39.09	NA	NA	14.95	15.07	6.61	090
33619		A	Repair single ventricle	48.76	NA	NA	19.33	18.29	8.25	090
33641		A	Repair heart septum defect	29.58	NA	NA	12.28	11.62	5.15	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
33645		A	Revision of heart veins	28.10	NA	NA	11.47	11.82	5.08	090
33647		A	Repair heart septum defects	29.53	NA	NA	21.24	15.55	5.33	090
33660		A	Repair of heart defects	31.83	NA	NA	12.32	12.47	5.76	090
33665		A	Repair of heart defects	34.85	NA	NA	23.26	16.14	6.30	090
33670		A	Repair of heart chambers	36.63	NA	NA	12.96	13.35	6.63	090
33675		A	Close mult vsd	35.95	NA	NA	13.36	13.77	6.50	090
33676		A	Close mult vsd w/resection	36.95	NA	NA	15.51	14.95	1.87	090
33677		A	Cl mult vsd w/rem pul band	38.45	NA	NA	16.06	15.48	1.94	090
33681		A	Repair heart septum defect	32.34	NA	NA	14.37	14.11	5.63	090
33684		A	Repair heart septum defect	34.37	NA	NA	22.60	15.85	6.22	090
33688		A	Repair heart septum defect	34.75	NA	NA	12.61	12.49	6.29	090
33690		A	Reinforce pulmonary artery	20.36	NA	NA	9.60	9.50	3.43	090
33692		A	Repair of heart defects	31.54	NA	NA	13.61	13.13	1.58	090
33694		A	Repair of heart defects	35.57	NA	NA	13.21	14.07	6.43	090
33697		A	Repair of heart defects	37.57	NA	NA	14.03	16.51	5.93	090
33702		A	Repair of heart defects	27.24	NA	NA	11.59	11.57	4.91	090
33710		A	Repair of heart defects	30.41	NA	NA	12.33	15.59	5.15	090
33720		A	Repair of heart defect	27.26	NA	NA	11.38	11.84	4.61	090
33722		A	Repair of heart defect	29.21	NA	NA	11.41	11.49	5.27	090
33724		A	Repair venous anomaly	27.63	NA	NA	10.85	11.78	4.68	090
33726		A	Repair pul venous stenosis	37.12	NA	NA	13.99	14.61	6.71	090
33730		A	Repair heart-vein defect(s)	36.14	NA	NA	14.23	13.47	6.53	090
33732		A	Repair heart-vein defect	28.96	NA	NA	12.43	12.65	5.23	090
33735		A	Revision of heart chamber	22.20	NA	NA	10.15	10.18	3.99	090
33736		A	Revision of heart chamber	24.32	NA	NA	11.00	11.11	4.38	090
33737		A	Revision of heart chamber	22.47	NA	NA	9.93	10.24	3.79	090
33750		A	Major vessel shunt	22.22	NA	NA	14.69	12.94	5.74	090
33755		A	Major vessel shunt	22.60	NA	NA	9.70	9.94	3.55	090
33762		A	Major vessel shunt	22.60	NA	NA	10.34	10.12	1.12	090
33764		A	Major vessel shunt & graft	22.60	NA	NA	12.10	10.24	3.47	090
33766		A	Major vessel shunt	23.57	NA	NA	9.47	11.12	3.70	090
33767		A	Major vessel shunt	25.30	NA	NA	10.23	10.22	4.56	090
33768		A	Cavopulmonary shunting	8.00	NA	NA	2.92	2.79	0.40	ZZZ
33770		A	Repair great vessels defect	39.07	NA	NA	16.55	15.20	6.62	090
33771		A	Repair great vessels defect	40.63	NA	NA	16.10	15.00	2.05	090
33774		A	Repair great vessels defect	31.73	NA	NA	13.46	13.78	5.72	090
33775		A	Repair great vessels defect	32.99	NA	NA	14.75	14.52	1.66	090
33776		A	Repair great vessels defect	34.75	NA	NA	15.68	15.41	1.75	090
33777		A	Repair great vessels defect	34.17	NA	NA	14.71	14.57	1.72	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
33778		A	Repair great vessels defect	42.75	NA	NA	18.07	17.46	2.16	090
33779		A	Repair great vessels defect	43.23	NA	NA	17.29	16.50	2.18	090
33780		A	Repair great vessels defect	43.90	NA	NA	28.12	20.20	2.22	090
33781		A	Repair great vessels defect	43.21	NA	NA	17.04	15.91	2.18	090
33782		A	Nikaidoh proc	60.08	NA	NA	20.65	20.65	10.19	090
33783		A	Nikaidoh proc w/ostia implt	65.08	NA	NA	22.16	22.16	11.04	090
33786		A	Repair arterial trunk	41.87	NA	NA	17.20	16.40	2.11	090
33788		A	Revision of pulmonary artery	27.42	NA	NA	12.10	11.83	1.37	090
33800		A	Aortic suspension	17.28	NA	NA	7.52	7.33	3.12	090
33802		A	Repair vessel defect	18.37	NA	NA	8.69	8.46	3.31	090
33803		A	Repair vessel defect	20.31	NA	NA	8.42	8.30	3.66	090
33813		A	Repair septal defect	21.36	NA	NA	9.60	11.00	3.60	090
33814		A	Repair septal defect	26.57	NA	NA	11.69	11.87	4.79	090
33820		A	Revise major vessel	16.69	NA	NA	7.65	7.94	3.01	090
33822		A	Revise major vessel	17.71	NA	NA	8.46	8.43	0.88	090
33824		A	Revise major vessel	20.23	NA	NA	10.34	9.67	3.41	090
33840		A	Remove aorta constriction	21.34	NA	NA	9.09	9.11	3.84	090
33845		A	Remove aorta constriction	22.93	NA	NA	10.57	11.51	4.12	090
33851		A	Remove aorta constriction	21.98	NA	NA	9.78	9.76	3.96	090
33852		A	Repair septal defect	24.41	NA	NA	17.89	12.68	4.40	090
33853		A	Repair septal defect	32.51	NA	NA	22.99	17.20	5.87	090
33860		A	Ascending aortic graft	59.46	NA	NA	22.07	21.27	10.31	090
33861		A	Ascending aortic graft	44.07	NA	NA	17.28	17.42	7.68	090
33863		A	Ascending aortic graft	58.79	NA	NA	21.12	21.04	10.19	090
33864		A	Ascending aortic graft	60.08	NA	NA	21.78	21.93	10.37	090
33870		A	Transverse aortic arch graft	46.06	NA	NA	17.74	18.07	7.94	090
33875		A	Thoracic aortic graft	35.78	NA	NA	13.88	14.15	6.18	090
33877		A	Thoracoabdominal graft	69.03	NA	NA	23.33	22.00	11.82	090
33880		A	Endovasc taa repr incl subcl	34.58	NA	NA	12.05	12.46	5.59	090
33881		A	Endovasc taa repr w/o subcl	29.58	NA	NA	10.47	10.84	4.77	090
33883		A	Insert endovasc prosth, taa	21.09	NA	NA	7.96	8.21	3.38	090
33884		A	Endovasc prosth, taa, add-on	8.20	NA	NA	2.41	2.42	1.32	ZZZ
33886		A	Endovasc prosth, delayed	18.09	NA	NA	6.38	6.97	3.10	090
33889		A	Artery transpose/endovas taa	15.92	NA	NA	4.28	4.53	2.74	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	NA	5.37	5.60	3.44	000
33910		A	Remove lung artery emboli	29.71	NA	NA	12.56	12.50	5.37	090
33915		A	Remove lung artery emboli	24.95	NA	NA	9.69	9.76	3.92	090
33916		A	Surgery of great vessel	28.42	NA	NA	11.53	13.31	5.14	090
33917		A	Repair pulmonary artery	25.30	NA	NA	11.09	12.39	4.27	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
33920		A	Repair pulmonary atresia	32.74	NA	NA	12.47	13.03	5.91	090
33922		A	Transect pulmonary artery	24.22	NA	NA	10.66	10.71	4.37	090
33924		A	Remove pulmonary shunt	5.49	NA	NA	1.66	1.72	0.93	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.30	NA	NA	11.64	12.73	5.31	090
33926		A	Repr pul art, unifocal w/cpb	44.73	NA	NA	18.88	15.34	8.10	090
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	62.01	NA	NA	24.73	25.38	11.18	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	89.50	NA	NA	32.81	31.19	15.42	090
33960		A	External circulation assist	19.33	NA	NA	6.07	5.94	2.77	000
33961		A	External circulation assist	10.91	NA	NA	3.29	3.49	1.20	ZZZ
33967		A	Insert ia percut device	4.84	NA	NA	1.60	2.17	0.77	000
33968		A	Remove aortic assist device	0.64	NA	NA	0.22	0.26	0.10	000
33970		A	Aortic circulation assist	6.74	NA	NA	2.18	2.55	1.13	000
33971		A	Aortic circulation assist	11.99	NA	NA	5.89	6.31	2.03	090
33973		A	Insert balloon device	9.75	NA	NA	3.12	3.73	1.65	000
33974		A	Remove intra-aortic balloon	15.03	NA	NA	7.35	8.11	2.71	090
33975		A	Implant ventricular device	20.97	NA	NA	6.72	6.93	3.61	XXX
33976		A	Implant ventricular device	22.97	NA	NA	7.09	7.93	4.17	XXX
33977		A	Remove ventricular device	20.28	NA	NA	10.30	10.40	3.45	090
33978		A	Remove ventricular device	22.72	NA	NA	11.03	10.95	4.07	090
33979		A	Insert intracorporeal device	45.93	NA	NA	14.31	15.00	7.96	XXX
33980		A	Remove intracorporeal device	65.20	NA	NA	26.17	26.25	11.35	090
33981		C	Replace vad pump ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33982		C	Replace vad intra w/o bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33983		C	Replace vad intra w/bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	17.88	NA	NA	7.63	7.15	2.93	090
34051		A	Removal of artery clot	16.99	NA	NA	8.05	7.81	3.07	090
34101		A	Removal of artery clot	10.93	NA	NA	5.02	4.85	1.79	090
34111		A	Removal of arm artery clot	10.93	NA	NA	5.08	4.86	1.77	090
34151		A	Removal of artery clot	26.52	NA	NA	10.39	9.75	4.31	090
34201		A	Removal of artery clot	19.48	NA	NA	7.78	6.93	3.23	090
34203		A	Removal of leg artery clot	17.86	NA	NA	7.46	7.26	2.96	090
34401		A	Removal of vein clot	26.52	NA	NA	10.92	11.03	4.08	090
34421		A	Removal of vein clot	13.37	NA	NA	5.98	5.81	2.13	090
34451		A	Removal of vein clot	28.52	NA	NA	9.30	10.13	4.89	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
34471		A	Removal of vein clot	21.11	NA	NA	10.38	7.98	3.25	090
34490		A	Removal of vein clot	10.91	NA	NA	5.18	4.97	1.76	090
34501		A	Repair valve, femoral vein	16.85	NA	NA	6.72	7.33	2.88	090
34502		A	Reconstruct vena cava	28.07	NA	NA	11.51	11.52	4.24	090
3450F		I	Dyspnea scrnd, no-mild dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34510		A	Transposition of vein valve	19.91	NA	NA	9.96	8.47	3.06	090
3451F		I	Dyspnea scrnd mod-high dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34520		A	Cross-over vein graft	19.18	NA	NA	6.89	7.40	3.28	090
3452F		I	Dyspnea not screened	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34530		A	Leg vein fusion	17.93	NA	NA	9.79	8.12	2.75	090
34800		A	Endovas aaa repr w/sm tube	21.54	NA	NA	7.97	8.29	3.31	090
34802		A	Endovas aaa repr w/2-p part	23.79	NA	NA	8.90	9.06	3.68	090
34803		A	Endovas aaa repr w/3-p part	24.82	NA	NA	8.98	9.06	3.85	090
34804		A	Endovas aaa repr w/1-p part	23.79	NA	NA	8.93	9.07	3.71	090
34805		A	Endovas aaa repr w/long tube	22.67	NA	NA	8.29	8.32	3.63	090
34806		A	Aneurysm press sensor add-on	2.06	NA	NA	0.61	0.64	0.33	ZZZ
34808		A	Endovas iliac a device addon	4.12	NA	NA	1.21	1.21	0.66	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	NA	2.07	1.98	1.12	000
34813		A	Femoral endovas graft add-on	4.79	NA	NA	1.42	1.37	0.80	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	NA	2.90	2.88	1.58	000
34825		A	Endovasc extend prosth, init	12.80	NA	NA	5.52	5.66	1.99	090
34826		A	Endovasc exten prosth, addl	4.12	NA	NA	1.26	1.27	0.64	ZZZ
34830		A	Open aortic tube prosth repr	35.23	NA	NA	11.19	11.90	6.04	090
34831		A	Open aortoiliac prosth repr	37.98	NA	NA	11.93	12.08	6.51	090
34832		A	Open aortofemor prosth repr	37.98	NA	NA	11.93	12.67	6.51	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	NA	3.85	3.84	2.03	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	NA	1.81	1.83	0.89	000
34900		A	Endovasc iliac repr w/graft	16.85	NA	NA	6.70	6.86	2.59	090
3491F		I	HIV unsure baby of HIV+moms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3497F		I	CD4+ cell percentage <15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3498F		I	CD4+ cell percentage >=15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35001		A	Repair defect of artery	20.81	NA	NA	8.82	8.68	3.46	090
35002		A	Repair artery rupture, neck	22.23	NA	NA	10.90	9.34	3.42	090
35005		A	Repair defect of artery	19.29	NA	NA	6.90	7.95	3.30	090
35011		A	Repair defect of artery	18.58	NA	NA	7.62	7.28	3.05	090
35013		A	Repair artery rupture, arm	23.23	NA	NA	9.40	8.94	3.80	090
35021		A	Repair defect of artery	22.17	NA	NA	9.47	9.36	3.75	090
35022		A	Repair artery rupture, chest	25.70	NA	NA	10.53	10.07	4.35	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
35045		A	Repair defect of arm artery	18.01	NA	NA	7.89	7.26	2.89	090
35081		A	Repair defect of artery	33.53	NA	NA	12.72	11.90	5.60	090
35082		A	Repair artery rupture, aorta	42.09	NA	NA	15.53	14.61	6.98	090
35091		A	Repair defect of artery	35.35	NA	NA	12.09	11.74	5.94	090
35092		A	Repair artery rupture, aorta	50.97	NA	NA	17.81	16.74	8.53	090
35102		A	Repair defect of artery	36.53	NA	NA	13.51	12.64	6.09	090
35103		A	Repair artery rupture, groin	43.62	NA	NA	15.53	14.77	7.22	090
3510F		I	Doc tb scrng-rslts interpd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35111		A	Repair defect of artery	26.28	NA	NA	12.29	10.31	4.04	090
35112		A	Repair artery rupture,spleen	32.57	NA	NA	14.74	12.35	5.02	090
35121		A	Repair defect of artery	31.52	NA	NA	11.77	11.17	5.25	090
35122		A	Repair artery rupture, belly	37.89	NA	NA	16.70	14.12	5.84	090
35131		A	Repair defect of artery	26.40	NA	NA	10.34	9.93	4.41	090
35132		A	Repair artery rupture, groin	32.57	NA	NA	12.08	11.52	5.39	090
3513F		I	Hep B scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35141		A	Repair defect of artery	20.91	NA	NA	8.25	7.96	3.48	090
35142		A	Repair artery rupture, thigh	25.16	NA	NA	9.75	9.46	4.19	090
3514F		I	Hep C scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35151		A	Repair defect of artery	23.72	NA	NA	9.19	8.87	3.95	090
35152		A	Repair artery rupture, knee	27.66	NA	NA	9.15	9.91	4.74	090
3515F		I	Pt has docd immun to hep C	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35180		A	Repair blood vessel lesion	15.10	NA	NA	6.74	7.18	2.59	090
35182		A	Repair blood vessel lesion	31.71	NA	NA	15.32	13.36	4.88	090
35184		A	Repair blood vessel lesion	18.82	NA	NA	9.35	7.88	2.90	090
35188		A	Repair blood vessel lesion	15.16	NA	NA	8.30	7.21	2.33	090
35189		A	Repair blood vessel lesion	29.98	NA	NA	11.78	11.18	5.42	090
35190		A	Repair blood vessel lesion	13.42	NA	NA	6.28	5.95	2.20	090
35201		A	Repair blood vessel lesion	16.93	NA	NA	7.78	7.31	2.71	090
35206		A	Repair blood vessel lesion	13.84	NA	NA	6.38	6.00	2.20	090
35207		A	Repair blood vessel lesion	10.94	NA	NA	8.14	7.38	1.40	090
35211		A	Repair blood vessel lesion	24.58	NA	NA	10.85	10.56	4.28	090
35216		A	Repair blood vessel lesion	36.61	NA	NA	15.33	13.83	6.23	090
35221		A	Repair blood vessel lesion	26.62	NA	NA	10.65	9.69	4.23	090
35226		A	Repair blood vessel lesion	15.30	NA	NA	6.46	6.48	2.55	090
35231		A	Repair blood vessel lesion	21.16	NA	NA	10.52	9.41	3.01	090
35236		A	Repair blood vessel lesion	18.02	NA	NA	7.72	7.29	2.88	090
35241		A	Repair blood vessel lesion	25.58	NA	NA	11.17	10.96	4.57	090
35246		A	Repair blood vessel lesion	28.23	NA	NA	9.41	10.88	4.85	090
35251		A	Repair blood vessel lesion	31.91	NA	NA	12.27	11.14	5.07	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
35256		A	Repair blood vessel lesion	19.06	NA	NA	7.70	7.43	3.15	090
35261		A	Repair blood vessel lesion	18.96	NA	NA	8.51	7.95	3.35	090
35266		A	Repair blood vessel lesion	15.83	NA	NA	6.80	6.48	2.62	090
35271		A	Repair blood vessel lesion	24.58	NA	NA	10.65	10.49	4.44	090
35276		A	Repair blood vessel lesion	25.83	NA	NA	10.81	10.82	4.37	090
35281		A	Repair blood vessel lesion	30.06	NA	NA	11.69	11.00	4.90	090
35286		A	Repair blood vessel lesion	17.19	NA	NA	7.44	7.21	2.85	090
35301		A	Rechanneling of artery	19.61	NA	NA	8.01	7.68	3.30	090
35302		A	Rechanneling of artery	21.35	NA	NA	8.34	7.67	3.55	090
35303		A	Rechanneling of artery	23.60	NA	NA	9.07	8.34	3.92	090
35304		A	Rechanneling of artery	24.60	NA	NA	9.33	8.59	4.07	090
35305		A	Rechanneling of artery	23.60	NA	NA	9.04	8.30	3.92	090
35306		A	Rechanneling of artery	9.25	NA	NA	2.49	2.47	1.59	ZZZ
35311		A	Rechanneling of artery	28.60	NA	NA	10.62	10.60	4.84	090
35321		A	Rechanneling of artery	16.59	NA	NA	7.05	6.68	2.72	090
35331		A	Rechanneling of artery	27.72	NA	NA	10.70	10.46	4.65	090
35341		A	Rechanneling of artery	26.21	NA	NA	9.77	9.59	4.38	090
35351		A	Rechanneling of artery	24.61	NA	NA	9.36	8.86	4.08	090
35355		A	Rechanneling of artery	19.86	NA	NA	7.71	7.36	3.30	090
35361		A	Rechanneling of artery	30.24	NA	NA	9.85	10.53	5.19	090
35363		A	Rechanneling of artery	32.35	NA	NA	12.29	12.40	5.48	090
35371		A	Rechanneling of artery	15.31	NA	NA	6.40	6.14	2.54	090
35372		A	Rechanneling of artery	18.58	NA	NA	7.39	7.09	3.08	090
35390		A	Reoperation, carotid add-on	3.19	NA	NA	0.99	0.96	0.54	ZZZ
35400		A	Angioscopy	3.00	NA	NA	0.90	0.91	0.50	ZZZ
35450		A	Repair arterial blockage	10.05	NA	NA	3.29	3.34	1.63	000
35452		A	Repair arterial blockage	6.90	NA	NA	2.42	2.38	1.14	000
35454		A	Repair arterial blockage	6.03	NA	NA	2.09	2.07	0.98	000
35456		A	Repair arterial blockage	7.34	NA	NA	2.55	2.49	1.20	000
35458		A	Repair arterial blockage	9.48	NA	NA	3.33	3.19	1.54	000
35459		A	Repair arterial blockage	8.62	NA	NA	2.96	2.95	1.42	000
35460		A	Repair venous blockage	6.03	NA	NA	2.23	2.07	0.96	000
35470		A	Repair arterial blockage	8.62	52.72	64.41	2.90	3.43	1.26	000
35471		A	Repair arterial blockage	10.05	52.64	69.04	3.42	4.36	1.46	000
35472		A	Repair arterial blockage	6.90	41.42	49.13	2.39	2.73	1.04	000
35473		A	Repair arterial blockage	6.03	40.09	47.50	2.11	2.48	0.89	000
35474		A	Repair arterial blockage	7.35	52.14	63.61	2.52	2.97	1.07	000
35475		R	Repair arterial blockage	9.48	46.82	49.81	3.21	3.56	1.09	000
35476		A	Repair venous blockage	6.03	36.14	38.75	2.12	2.34	0.60	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
35480		A	Atherectomy, open	11.06	NA	NA	3.18	3.45	1.91	000
35481		A	Atherectomy, open	7.60	NA	NA	2.70	2.77	1.28	000
35482		A	Atherectomy, open	6.64	NA	NA	1.99	2.38	1.14	000
35483		A	Atherectomy, open	8.09	NA	NA	2.96	2.92	1.31	000
35484		A	Atherectomy, open	10.42	NA	NA	3.00	3.28	1.80	000
35485		A	Atherectomy, open	9.48	NA	NA	3.43	3.30	1.55	000
35490		A	Atherectomy, percutaneous	11.06	NA	NA	4.17	5.09	1.74	000
35491		A	Atherectomy, percutaneous	7.60	NA	NA	3.03	3.20	1.30	000
35492		A	Atherectomy, percutaneous	6.64	NA	NA	2.65	3.20	1.04	000
35493		A	Atherectomy, percutaneous	8.09	NA	NA	3.14	3.86	1.24	000
35494		A	Atherectomy, percutaneous	10.42	NA	NA	3.94	4.81	1.58	000
35495		A	Atherectomy, percutaneous	9.48	NA	NA	3.59	4.35	1.48	000
35500		A	Harvest vein for bypass	6.44	NA	NA	2.05	1.89	1.07	ZZZ
35501		A	Artery bypass graft	29.09	NA	NA	12.43	11.59	4.84	090
35506		A	Artery bypass graft	25.33	NA	NA	9.62	9.50	4.35	090
35508		A	Artery bypass graft	26.09	NA	NA	10.89	10.21	4.71	090
35509		A	Artery bypass graft	28.09	NA	NA	10.78	10.76	4.82	090
3550F		I	Low rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35510		A	Artery bypass graft	24.39	NA	NA	8.04	8.75	4.19	090
35511		A	Artery bypass graft	22.20	NA	NA	10.35	9.04	3.80	090
35512		A	Artery bypass graft	23.89	NA	NA	7.91	8.43	4.09	090
35515		A	Artery bypass graft	26.09	NA	NA	10.68	9.15	4.48	090
35516		A	Artery bypass graft	24.21	NA	NA	7.96	7.78	4.14	090
35518		A	Artery bypass graft	22.65	NA	NA	7.46	8.34	3.88	090
3551F		I	Intrmed rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35521		A	Artery bypass graft	24.13	NA	NA	8.21	8.70	4.13	090
35522		A	Artery bypass graft	23.15	NA	NA	9.15	8.72	3.96	090
35523		A	Artery bypass graft	24.13	NA	NA	9.86	9.65	3.96	090
35525		A	Artery bypass graft	21.69	NA	NA	8.59	8.15	3.47	090
35526		A	Artery bypass graft	31.55	NA	NA	12.30	11.99	5.71	090
3552F		I	Hgh risk for thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35531		A	Artery bypass graft	39.11	NA	NA	14.30	13.59	6.44	090
35533		A	Artery bypass graft	29.92	NA	NA	13.76	11.59	5.14	090
35535		A	Artery bypass graft	38.13	NA	NA	14.31	13.99	1.92	090
35536		A	Artery bypass graft	33.73	NA	NA	10.79	11.25	5.79	090
35537		A	Artery bypass graft	41.88	NA	NA	13.05	13.82	7.19	090
35538		A	Artery bypass graft	47.03	NA	NA	14.46	15.51	8.06	090
35539		A	Artery bypass graft	44.11	NA	NA	13.65	13.95	7.57	090
35540		A	Artery bypass graft	49.33	NA	NA	17.72	16.29	8.20	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
35548		A	Artery bypass graft	22.68	NA	NA	7.81	8.40	3.88	090
35549		A	Artery bypass graft	24.45	NA	NA	8.29	9.19	3.76	090
35551		A	Artery bypass graft	27.83	NA	NA	12.97	11.39	4.29	090
35556		A	Artery bypass graft	26.75	NA	NA	10.45	9.69	4.44	090
35558		A	Artery bypass graft	23.13	NA	NA	9.38	8.93	3.83	090
3555F		I	Pt inr measurement performed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35560		A	Artery bypass graft	34.03	NA	NA	12.62	12.20	5.84	090
35563		A	Artery bypass graft	26.12	NA	NA	12.36	10.09	4.48	090
35565		A	Artery bypass graft	25.13	NA	NA	9.72	9.40	4.13	090
35566		A	Artery bypass graft	32.35	NA	NA	11.94	11.21	5.41	090
35570		A	Artery bypass graft	29.15	NA	NA	11.54	11.28	1.46	090
35571		A	Artery bypass graft	25.52	NA	NA	9.70	9.43	4.25	090
35572		A	Harvest femoropopliteal vein	6.81	NA	NA	2.17	2.18	1.15	ZZZ
35583		A	Vein bypass graft	27.75	NA	NA	10.65	9.89	4.59	090
35585		A	Vein bypass graft	32.35	NA	NA	12.25	11.46	5.36	090
35587		A	Vein bypass graft	26.21	NA	NA	10.03	9.82	4.36	090
35600		A	Harvest art for cabg add-on	4.94	NA	NA	1.67	1.68	0.86	ZZZ
35601		A	Artery bypass graft	27.09	NA	NA	12.09	10.75	4.59	090
35606		A	Artery bypass graft	22.46	NA	NA	8.54	8.29	3.78	090
35612		A	Artery bypass graft	16.82	NA	NA	6.23	7.00	2.88	090
35616		A	Artery bypass graft	21.82	NA	NA	10.21	8.38	3.36	090
35621		A	Artery bypass graft	21.03	NA	NA	8.14	7.80	3.51	090
35623		A	Bypass graft, not vein	25.92	NA	NA	8.69	9.24	4.44	090
35626		A	Artery bypass graft	29.14	NA	NA	11.40	11.35	5.06	090
35631		A	Artery bypass graft	36.03	NA	NA	12.44	12.19	6.09	090
35632		A	Artery bypass graft	36.13	NA	NA	13.67	13.36	1.82	090
35633		A	Artery bypass graft	39.11	NA	NA	14.62	14.30	1.97	090
35634		A	Artery bypass graft	35.33	NA	NA	13.41	13.12	1.78	090
35636		A	Artery bypass graft	31.75	NA	NA	10.26	10.97	5.45	090
35637		A	Artery bypass graft	33.05	NA	NA	12.56	11.58	5.53	090
35638		A	Artery bypass graft	33.60	NA	NA	12.65	11.92	5.66	090
35642		A	Artery bypass graft	18.94	NA	NA	7.09	7.93	3.24	090
35645		A	Artery bypass graft	18.43	NA	NA	7.83	7.26	3.32	090
35646		A	Artery bypass graft	32.98	NA	NA	12.42	11.93	5.50	090
35647		A	Artery bypass graft	29.73	NA	NA	11.16	10.88	4.98	090
35650		A	Artery bypass graft	20.16	NA	NA	8.07	7.69	3.32	090
35651		A	Artery bypass graft	26.08	NA	NA	12.33	10.55	4.01	090
35654		A	Artery bypass graft	26.28	NA	NA	10.03	9.63	4.38	090
35656		A	Artery bypass graft	20.47	NA	NA	8.20	7.83	3.40	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
35661		A	Artery bypass graft	20.35	NA	NA	8.46	8.10	3.37	090
35663		A	Artery bypass graft	23.93	NA	NA	9.30	9.01	3.94	090
35665		A	Artery bypass graft	22.35	NA	NA	8.76	8.46	3.69	090
35666		A	Artery bypass graft	23.66	NA	NA	10.01	9.64	3.93	090
35671		A	Artery bypass graft	20.77	NA	NA	8.95	8.60	3.44	090
35681		A	Composite bypass graft	1.60	NA	NA	0.50	0.48	0.27	ZZZ
35682		A	Composite bypass graft	7.19	NA	NA	2.12	2.06	1.20	ZZZ
35683		A	Composite bypass graft	8.49	NA	NA	2.28	2.38	1.46	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	NA	1.21	1.16	0.68	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	NA	1.01	1.01	0.55	ZZZ
35691		A	Arterial transposition	18.41	NA	NA	6.51	7.06	3.15	090
35693		A	Arterial transposition	15.73	NA	NA	6.30	6.91	2.70	090
35694		A	Arterial transposition	19.28	NA	NA	6.74	7.10	3.30	090
35695		A	Arterial transposition	20.06	NA	NA	6.95	7.42	3.44	090
35697		A	Reimplant artery each	3.00	NA	NA	0.90	0.88	0.50	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	NA	0.94	0.91	0.51	ZZZ
35701		A	Exploration, carotid artery	9.19	NA	NA	5.42	4.96	1.28	090
35721		A	Exploration, femoral artery	7.72	NA	NA	4.15	4.12	1.25	090
3572F		I	Pt consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3573F		I	Pt not consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35741		A	Exploration popliteal artery	8.69	NA	NA	4.66	4.37	1.40	090
35761		A	Exploration of artery/vein	5.93	NA	NA	4.11	3.84	0.92	090
35800		A	Explore neck vessels	8.07	NA	NA	4.74	4.44	1.22	090
35820		A	Explore chest vessels	36.89	NA	NA	14.04	12.87	6.38	090
35840		A	Explore abdominal vessels	10.96	NA	NA	5.86	5.33	1.72	090
35860		A	Explore limb vessels	6.80	NA	NA	3.94	3.77	1.10	090
35870		A	Repair vessel graft defect	24.50	NA	NA	8.30	8.77	4.20	090
35875		A	Removal of clot in graft	10.72	NA	NA	5.00	4.79	1.77	090
35876		A	Removal of clot in graft	17.82	NA	NA	7.24	6.87	2.94	090
35879		A	Revise graft w/vein	17.41	NA	NA	7.22	6.85	2.89	090
35881		A	Revise graft w/vein	19.35	NA	NA	7.63	7.50	3.24	090
35883		A	Revise graft w/nonauto graft	23.15	NA	NA	8.76	8.09	3.85	090
35884		A	Revise graft w/vein	24.65	NA	NA	8.05	8.03	4.23	090
35901		A	Excision, graft, neck	8.38	NA	NA	4.90	4.74	1.36	090
35903		A	Excision, graft, extremity	9.53	NA	NA	5.39	5.24	1.55	090
35905		A	Excision, graft, thorax	33.52	NA	NA	10.73	11.44	5.75	090
35907		A	Excision, graft, abdomen	37.27	NA	NA	13.12	12.65	6.20	090
36000		A	Place needle in vein	0.18	0.41	0.47	0.07	0.07	0.02	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.08	2.38	0.80	0.91	0.21	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
36005		A	Injection ext venography	0.95	7.26	7.99	0.30	0.36	0.11	000
36010		A	Place catheter in vein	2.43	10.29	12.57	0.74	0.83	0.26	XXX
36011		A	Place catheter in vein	3.14	18.58	21.04	1.00	1.08	0.32	XXX
36012		A	Place catheter in vein	3.51	18.24	19.57	1.09	1.27	0.37	XXX
36013		A	Place catheter in artery	2.52	16.41	18.50	0.79	0.87	0.34	XXX
36014		A	Place catheter in artery	3.02	17.33	19.09	0.94	1.13	0.24	XXX
36015		A	Place catheter in artery	3.51	18.38	20.63	1.08	1.30	0.26	XXX
36100		A	Establish access to artery	3.02	9.11	10.74	0.97	1.15	0.48	XXX
36120		A	Establish access to artery	2.01	8.95	9.66	0.57	0.64	0.24	XXX
36140		A	Establish access to artery	2.01	9.18	10.64	0.63	0.71	0.29	XXX
36147		A	Access av dial grft for eval	3.72	17.20	17.20	1.20	1.20	0.36	XXX
36148		A	Access av dial grft for proc	1.00	5.60	5.60	0.31	0.31	0.10	ZZZ
36160		A	Establish access to aorta	2.52	9.54	11.29	0.75	0.95	0.27	XXX
36200		A	Place catheter in aorta	3.02	12.39	13.99	0.92	1.04	0.43	XXX
36215		A	Place catheter in artery	4.67	22.64	25.43	1.53	1.82	0.60	XXX
36216		A	Place catheter in artery	5.27	24.71	27.65	1.73	2.05	0.67	XXX
36217		A	Place catheter in artery	6.29	42.29	47.35	2.08	2.43	0.76	XXX
36218		A	Place catheter in artery	1.01	3.47	3.99	0.33	0.38	0.12	ZZZ
36245		A	Place catheter in artery	4.67	22.75	27.84	1.52	1.96	0.64	XXX
36246		A	Place catheter in artery	5.27	23.62	27.12	1.65	1.97	0.70	XXX
36247		A	Place catheter in artery	6.29	39.15	44.68	1.96	2.33	0.85	XXX
36248		A	Place catheter in artery	1.01	2.75	3.26	0.31	0.38	0.12	ZZZ
36260		A	Insertion of infusion pump	9.91	NA	NA	6.13	5.20	1.52	090
36261		A	Revision of infusion pump	5.63	NA	NA	3.51	3.49	0.95	090
36262		A	Removal of infusion pump	4.11	NA	NA	3.33	2.96	0.62	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.37	0.31	0.14	0.10	0.05	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.37	0.32	0.11	0.10	0.05	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.30	0.28	0.07	0.06	0.02	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.35	0.32	0.07	0.05	0.02	XXX
36415		X	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	NA	0.38	0.29	0.10	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	NA	0.28	0.25	0.08	XXX
36430		A	Blood transfusion service	0.00	0.75	0.91	NA	NA	0.01	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	NA	0.39	0.31	0.18	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	NA	0.86	0.83	0.09	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	NA	0.96	0.95	0.11	XXX
36460		A	Transfusion service, fetal	6.58	NA	NA	2.43	2.08	1.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.10	2.63	2.52	0.77	0.71	0.15	010
36471		A	Injection therapy of veins	1.65	2.79	2.77	0.95	0.90	0.23	010
36475		A	Endovenous rf, 1st vein	6.72	38.31	40.25	2.37	2.28	1.02	000
36476		A	Endovenous rf, vein add-on	3.38	6.57	6.68	1.07	1.02	0.53	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	28.94	31.56	2.35	2.34	0.96	000
36479		A	Endovenous laser vein addon	3.38	6.62	7.09	1.10	1.05	0.48	ZZZ
36481		A	Insertion of catheter, vein	6.98	45.38	14.46	2.41	3.53	0.65	000
36500		A	Insertion of catheter, vein	3.51	NA	NA	1.13	1.29	0.39	000
3650F		I	Eeg ordered rvwd reqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36510		A	Insertion of catheter, vein	1.09	1.26	1.64	0.43	0.40	0.17	000
36511		A	Apheresis wbc	1.74	NA	NA	0.73	0.66	0.19	000
36512		A	Apheresis rbc	1.74	NA	NA	0.71	0.68	0.12	000
36513		A	Apheresis platelets	1.74	NA	NA	0.74	0.71	0.24	000
36514		A	Apheresis plasma	1.74	10.32	11.71	0.65	0.62	0.19	000
36515		A	Apheresis, adsorp/reinfuse	1.74	44.55	48.95	0.66	0.59	0.17	000
36516		A	Apheresis, selective	1.22	46.41	54.98	0.46	0.43	0.25	000
36522		A	Photopheresis	1.67	29.97	33.81	1.00	0.99	0.12	000
36555		A	Insert non-tunnel cv cath	2.68	3.57	4.33	0.45	0.63	0.15	000
36556		A	Insert non-tunnel cv cath	2.50	3.26	3.54	0.68	0.65	0.23	000
36557		A	Insert tunneled cv cath	5.14	19.61	17.77	3.07	2.73	0.79	010
36558		A	Insert tunneled cv cath	4.84	14.54	16.16	2.39	2.52	0.53	010
36560		A	Insert tunneled cv cath	6.29	17.83	22.78	2.64	2.87	0.42	010
36561		A	Insert tunneled cv cath	6.04	23.28	24.11	3.08	2.93	0.79	010
36563		A	Insert tunneled cv cath	6.24	25.61	24.67	3.29	2.96	0.94	010
36565		A	Insert tunneled cv cath	6.04	18.85	19.42	2.90	2.78	0.93	010
36566		A	Insert tunneled cv cath	6.54	122.41	98.72	3.20	2.96	0.91	010
36568		A	Insert picc cath	1.92	4.90	6.00	0.60	0.64	0.13	000
36569		A	Insert picc cath	1.82	4.21	5.04	0.61	0.68	0.13	000
36570		A	Insert picvad cath	5.36	20.74	24.63	2.50	2.77	0.36	010
36571		A	Insert picvad cath	5.34	26.26	26.93	2.86	2.69	0.72	010
36575		A	Repair tunneled cv cath	0.67	3.29	3.48	0.25	0.25	0.07	000
36576		A	Repair tunneled cv cath	3.24	6.24	6.28	1.78	1.73	0.41	010
36578		A	Replace tunneled cv cath	3.54	9.10	9.67	2.02	2.12	0.38	010
36580		A	Replace cvad cath	1.31	3.93	4.59	0.46	0.47	0.11	000
36581		A	Replace tunneled cv cath	3.48	15.01	16.38	1.66	1.84	0.32	010
36582		A	Replace tunneled cv cath	5.24	21.99	22.85	2.65	2.69	0.64	010
36583		A	Replace tunneled cv cath	5.29	27.77	24.29	3.12	2.78	0.81	010

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
36584		A	Replace picc cath	1.20	3.72	4.55	0.55	0.62	0.08	000
36585		A	Replace picvad cath	4.84	21.68	23.66	2.40	2.56	0.48	010
36589		A	Removal tunneled cv cath	2.28	1.97	2.02	1.33	1.34	0.27	010
36590		A	Removal tunneled cv cath	3.35	4.02	3.75	1.90	1.76	0.45	010
36591		T	Draw blood off venous device	0.00	0.51	0.59	NA	NA	0.01	XXX
36592		T	Collect blood from picc	0.00	0.58	0.65	NA	NA	0.01	XXX
36593		A	Declot vascular device	0.00	0.69	0.72	NA	NA	0.01	XXX
36595		A	Mech remov tunneled cv cath	3.59	10.00	12.03	1.27	1.47	0.30	000
36596		A	Mech remov tunneled cv cath	0.75	2.43	2.79	0.41	0.45	0.07	000
36597		A	Reposition venous catheter	1.21	1.86	2.11	0.40	0.47	0.09	000
36598		T	Inj w/fluor, eval cv device	0.74	1.96	2.24	0.22	0.73	0.05	000
36600		A	Withdrawal of arterial blood	0.32	0.45	0.48	0.09	0.08	0.02	XXX
36620		A	Insertion catheter, artery	1.15	NA	NA	0.21	0.18	0.07	000
36625		A	Insertion catheter, artery	2.11	NA	NA	0.61	0.58	0.31	000
36640		A	Insertion catheter, artery	2.10	NA	NA	1.03	0.99	0.31	000
36660		A	Insertion catheter, artery	1.40	NA	NA	0.22	0.29	0.25	000
36680		A	Insert needle, bone cavity	1.20	NA	NA	0.28	0.32	0.15	000
36800		A	Insertion of cannula	2.43	NA	NA	1.74	1.68	0.31	000
36810		A	Insertion of cannula	3.96	NA	NA	1.59	1.45	0.54	000
36815		A	Insertion of cannula	2.62	NA	NA	1.28	1.19	0.41	000
36818		A	Av fuse, uppr arm, cephalic	11.89	NA	NA	5.54	5.25	1.93	090
36819		A	Av fuse, uppr arm, basilic	14.47	NA	NA	6.28	5.89	2.35	090
36820		A	Av fusion/forearm vein	14.47	NA	NA	6.51	6.01	2.34	090
36821		A	Av fusion direct any site	12.11	NA	NA	5.94	5.29	1.95	090
36822		A	Insertion of cannula(s)	5.57	NA	NA	4.14	4.09	0.92	090
36823		A	Insertion of cannula(s)	22.98	NA	NA	10.96	9.88	3.60	090
36825		A	Artery-vein autograft	15.13	NA	NA	6.80	5.20	1.61	090
36830		A	Artery-vein nonautograft	12.03	NA	NA	5.09	4.77	1.96	090
36831		A	Open thrombect av fistula	8.04	NA	NA	3.89	3.64	1.29	090
36832		A	Av fistula revision, open	10.53	NA	NA	4.61	4.31	1.72	090
36833		A	Av fistula revision	11.98	NA	NA	5.11	4.77	1.95	090
36835		A	Artery to vein shunt	7.51	NA	NA	5.06	4.45	1.27	090
36838		A	Dist revas ligation, hemo	21.69	NA	NA	8.61	8.17	3.56	090
36860		A	External cannula declotting	2.01	3.26	3.09	0.81	0.72	0.19	000
36861		A	Cannula declotting	2.52	NA	NA	1.46	1.38	0.35	000
36870		A	Percut thrombect av fistula	5.20	39.49	43.30	2.63	2.91	0.49	090
37140		A	Revision of circulation	25.23	NA	NA	12.02	10.28	3.88	090
37145		A	Revision of circulation	26.24	NA	NA	12.30	11.14	4.13	090
37160		A	Revision of circulation	23.24	NA	NA	11.28	9.52	3.57	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
37180		A	Revision of circulation	26.24	NA	NA	12.39	10.34	4.03	090
37181		A	Splice spleen/kidney veins	28.37	NA	NA	13.17	11.22	4.37	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	NA	5.15	6.50	1.17	000
37183		A	Remove hepatic shunt (tips)	7.99	127.96	35.06	2.45	3.16	0.54	000
37184		A	Prim art mech thrombectomy	8.66	46.28	54.00	2.98	3.41	1.08	000
37185		A	Prim art m-thrombect add-on	3.28	14.88	17.41	1.02	1.16	0.44	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	29.77	36.77	1.53	1.87	0.69	ZZZ
37187		A	Venous mech thrombectomy	8.03	44.74	52.06	2.68	3.16	0.81	000
37188		A	Venous m-thrombectomy add-on	5.71	37.86	45.10	1.98	2.38	0.51	000
37195		C	Thrombolytic therapy, stroke	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37200		A	Transcatheter biopsy	4.55	NA	NA	1.33	1.68	0.31	000
37201		A	Transcatheter therapy infuse	4.99	NA	NA	2.09	2.42	0.56	000
37202		A	Transcatheter therapy infuse	5.67	NA	NA	2.73	3.21	0.85	000
37203		A	Transcatheter retrieval	5.02	27.14	30.16	1.75	2.10	0.50	000
37204		A	Transcatheter occlusion	18.11	NA	NA	5.39	6.46	1.61	000
37205		A	Transcath iv stent, percut	8.27	92.94	103.81	2.60	3.30	1.13	000
37206		A	Transcath iv stent/perc addl	4.12	56.82	63.44	1.28	1.53	0.59	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	NA	2.87	2.79	1.34	000
37208		A	Transcath iv stent/open addl	4.12	NA	NA	1.23	1.21	0.68	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	NA	0.67	0.79	0.24	000
37210		A	Embolization uterine fibroid	10.60	75.61	82.53	3.16	4.14	0.73	000
37215		R	Transcath stent, cca w/eps	19.68	NA	NA	7.63	9.47	3.02	090
37216		N	Transcath stent, cca w/o eps	18.95	NA	NA	8.42	8.33	0.94	090
37250		A	Iv us first vessel add-on	2.10	NA	NA	0.65	0.76	0.33	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	NA	0.47	0.52	0.26	ZZZ
37500		A	Endoscopy ligate perf veins	11.67	NA	NA	6.46	6.11	1.89	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
37565		A	Ligation of neck vein	12.05	NA	NA	6.61	5.83	1.86	090
37600		A	Ligation of neck artery	12.42	NA	NA	6.26	5.73	1.84	090
37605		A	Ligation of neck artery	14.28	NA	NA	6.61	6.16	2.44	090
37606		A	Ligation of neck artery	8.81	NA	NA	5.63	4.81	1.34	090
37607		A	Ligation of a-v fistula	6.25	NA	NA	3.59	3.37	0.98	090
37609		A	Temporal artery procedure	3.05	4.82	4.48	2.28	2.02	0.46	010
37615		A	Ligation of neck artery	7.80	NA	NA	5.16	4.51	1.19	090
37616		A	Ligation of chest artery	18.97	NA	NA	9.15	8.65	2.92	090
37617		A	Ligation of abdomen artery	23.79	NA	NA	10.15	9.05	3.62	090
37618		A	Ligation of extremity artery	6.03	NA	NA	3.89	3.65	0.95	090
37620		A	Revision of major vein	11.57	NA	NA	5.06	5.69	1.23	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
37650		A	Revision of major vein	8.49	NA	NA	4.36	4.47	1.34	090
37660		A	Revision of major vein	22.28	NA	NA	10.39	8.85	3.43	090
37700		A	Revise leg vein	3.82	NA	NA	2.74	2.62	0.60	090
37718		A	Ligate/strip short leg vein	7.13	NA	NA	4.22	3.94	1.12	090
37722		A	Ligate/strip long leg vein	8.16	NA	NA	4.46	4.15	1.29	090
37735		A	Removal of leg veins/lesion	10.90	NA	NA	5.29	5.14	1.74	090
37760		A	Ligate leg veins radical	10.78	NA	NA	6.36	5.33	1.65	090
37761		A	Ligate leg veins open	9.13	NA	NA	5.37	5.37	1.41	090
37765		A	Phleb veins - extrem - to 20	7.71	NA	NA	4.10	4.04	1.12	090
37766		A	Phleb veins - extrem 20+	9.66	NA	NA	4.77	4.67	1.46	090
37780		A	Revision of leg vein	3.93	NA	NA	2.84	2.72	0.62	090
37785		A	Ligate/divide/excise vein	3.93	5.29	5.13	2.89	2.74	0.61	090
37788		A	Revascularization, penis	23.33	NA	NA	11.08	11.90	3.59	090
37790		A	Penile venous occlusion	8.43	NA	NA	4.22	4.52	0.59	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen, total	19.55	NA	NA	9.18	7.62	2.94	090
38101		A	Removal of spleen, partial	19.55	NA	NA	9.39	7.72	3.01	090
38102		A	Removal of spleen, total	4.79	NA	NA	1.76	1.52	0.71	ZZZ
38115		A	Repair of ruptured spleen	21.88	NA	NA	10.04	8.34	3.09	090
38120		A	Laparoscopy, splenectomy	17.07	NA	NA	9.16	7.83	2.60	090
38129		C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	NA	1.04	1.01	0.45	000
38204		B	Bl donor search management	2.00	NA	NA	0.73	0.70	0.10	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	NA	0.66	0.63	0.07	000
38206		R	Harvest auto stem cells	1.50	NA	NA	0.65	0.62	0.08	000
38207		I	Cryopreserve stem cells	0.89	NA	NA	0.44	0.45	0.04	XXX
38208		I	Thaw preserved stem cells	0.56	NA	NA	0.28	0.28	0.03	XXX
38209		I	Wash harvest stem cells	0.24	NA	NA	0.12	0.12	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	NA	NA	0.78	0.79	0.08	XXX
38211		I	Tumor cell deplete of harvst	1.42	NA	NA	0.70	0.72	0.07	XXX
38212		I	Rbc depletion of harvest	0.94	NA	NA	0.46	0.48	0.05	XXX
38213		I	Platelet deplete of harvest	0.24	NA	NA	0.12	0.12	0.01	XXX
38214		I	Volume deplete of harvest	0.81	NA	NA	0.40	0.41	0.04	XXX
38215		I	Harvest stem cell concentrte	0.94	NA	NA	0.46	0.48	0.05	XXX
38220		A	Bone marrow aspiration	1.08	2.41	2.86	0.51	0.51	0.09	XXX
38221		A	Bone marrow biopsy	1.37	2.46	2.98	0.64	0.64	0.06	XXX
38230		R	Bone marrow collection	4.85	NA	NA	3.58	3.31	0.79	010
38240		R	Bone marrow/stem transplant	2.24	NA	NA	1.07	1.04	0.12	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	NA	1.08	1.06	0.11	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
38242		A	Lymphocyte infuse transplant	1.71	NA	NA	0.84	0.80	0.08	000
38300		A	Drainage, lymph node lesion	2.36	4.32	4.34	2.22	2.13	0.29	010
38305		A	Drainage, lymph node lesion	6.68	NA	NA	4.91	4.51	0.94	090
38308		A	Incision of lymph channels	6.81	NA	NA	4.45	3.92	1.03	090
38380		A	Thoracic duct procedure	8.46	NA	NA	6.69	5.73	0.77	090
38381		A	Thoracic duct procedure	13.38	NA	NA	6.68	6.62	2.27	090
38382		A	Thoracic duct procedure	10.65	NA	NA	7.06	6.04	1.62	090
38500		A	Biopsy/removal, lymph nodes	3.79	4.40	3.97	2.54	2.23	0.56	010
38505		A	Needle biopsy, lymph nodes	1.14	1.98	2.10	0.71	0.77	0.09	000
38510		A	Biopsy/removal, lymph nodes	6.74	6.42	5.81	4.01	3.52	0.87	010
38520		A	Biopsy/removal, lymph nodes	7.03	NA	NA	4.65	4.18	1.01	090
38525		A	Biopsy/removal, lymph nodes	6.43	NA	NA	4.38	3.77	0.97	090
38530		A	Biopsy/removal, lymph nodes	8.34	NA	NA	5.29	4.64	1.30	090
38542		A	Explore deep node(s), neck	7.95	NA	NA	5.45	4.81	0.95	090
38550		A	Removal, neck/armpit lesion	7.11	NA	NA	5.45	4.61	1.07	090
38555		A	Removal, neck/armpit lesion	15.59	NA	NA	9.06	8.36	2.39	090
38562		A	Removal, pelvic lymph nodes	11.06	NA	NA	6.50	6.17	1.42	090
38564		A	Removal, abdomen lymph nodes	11.38	NA	NA	6.31	5.66	1.63	090
38570		A	Laparoscopy, lymph node biop	9.34	NA	NA	4.42	4.35	0.99	010
38571		A	Laparoscopy, lymphadenectomy	14.76	NA	NA	5.93	6.82	1.06	010
38572		A	Laparoscopy, lymphadenectomy	16.94	NA	NA	7.43	6.84	1.75	010
38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	12.81	NA	NA	8.54	7.23	1.26	090
38720		A	Removal of lymph nodes, neck	21.95	NA	NA	13.26	11.25	2.43	090
38724		A	Removal of lymph nodes, neck	23.95	NA	NA	14.59	12.13	2.40	090
38740		A	Remove armpit lymph nodes	10.70	NA	NA	6.46	5.55	1.62	090
38745		A	Remove armpit lymph nodes	13.87	NA	NA	7.90	6.74	2.11	090
38746		A	Remove thoracic lymph nodes	4.88	NA	NA	1.56	1.59	0.82	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	NA	1.79	1.55	0.74	ZZZ
38760		A	Remove groin lymph nodes	13.62	NA	NA	7.39	6.58	2.01	090
38765		A	Remove groin lymph nodes	21.91	NA	NA	10.52	9.44	3.05	090
38770		A	Remove pelvis lymph nodes	14.06	NA	NA	6.63	6.86	1.27	090
38780		A	Remove abdomen lymph nodes	17.70	NA	NA	8.67	8.69	1.84	090
38790		A	Inject for lymphatic x-ray	1.29	NA	NA	0.81	0.79	0.17	000
38792		A	Identify sentinel node	0.52	NA	NA	0.50	0.49	0.07	000
38794		A	Access thoracic lymph duct	4.62	NA	NA	2.81	3.31	0.30	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	7.57	NA	NA	4.92	4.72	1.20	090
39010		A	Exploration of chest	13.19	NA	NA	6.69	6.76	2.26	090
39200		A	Removal chest lesion	15.09	NA	NA	6.99	6.95	2.56	090
39220		A	Removal chest lesion	19.55	NA	NA	9.19	8.99	3.20	090
39400		A	Visualization of chest	8.05	NA	NA	4.61	4.57	1.35	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.98	NA	NA	7.28	6.55	2.12	090
39502		A	Repair paraesophageal hernia	17.18	NA	NA	8.66	7.49	2.64	090
39503		A	Repair of diaphragm hernia	108.91	NA	NA	44.14	35.79	16.81	090
39520		A	Repair of diaphragm hernia	16.74	NA	NA	8.28	7.69	2.66	090
39530		A	Repair of diaphragm hernia	16.30	NA	NA	7.87	7.13	2.61	090
39531		A	Repair of diaphragm hernia	17.31	NA	NA	8.71	7.35	2.67	090
39540		A	Repair of diaphragm hernia	14.57	NA	NA	7.20	6.39	2.25	090
39541		A	Repair of diaphragm hernia	15.75	NA	NA	7.89	6.92	2.45	090
39545		A	Revision of diaphragm	14.67	NA	NA	7.71	7.50	2.46	090
39560		A	Resect diaphragm, simple	13.06	NA	NA	6.75	6.21	2.02	090
39561		A	Resect diaphragm, complex	19.99	NA	NA	11.47	10.24	3.15	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4004F		I	Pt tobacco use done rcvd tlk	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40490		A	Biopsy of lip	1.22	1.99	2.01	0.72	0.66	0.12	000
40500		A	Partial excision of lip	4.47	8.35	7.90	4.96	4.58	0.47	090
40510		A	Partial excision of lip	4.82	7.50	7.04	4.45	4.03	0.51	090
40520		A	Partial excision of lip	4.79	7.66	7.34	4.53	4.13	0.54	090
40525		A	Reconstruct lip with flap	7.72	NA	NA	6.63	6.07	0.90	090
40527		A	Reconstruct lip with flap	9.32	NA	NA	7.16	6.85	0.85	090
40530		A	Partial removal of lip	5.54	8.30	7.88	5.04	4.60	0.61	090
4063F		I	Antidepres rxthxpy not rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40650		A	Repair lip	3.78	6.71	6.38	3.65	3.37	0.46	090
40652		A	Repair lip	4.43	7.86	7.48	4.60	4.26	0.55	090
40654		A	Repair lip	5.48	8.83	8.51	5.42	5.04	0.67	090
40700		A	Repair cleft lip/nasal	14.17	NA	NA	9.98	9.16	1.29	090
40701		A	Repair cleft lip/nasal	17.23	NA	NA	11.46	11.14	1.59	090
40702		A	Repair cleft lip/nasal	14.27	NA	NA	7.65	7.67	0.71	090
40720		A	Repair cleft lip/nasal	14.72	NA	NA	11.84	9.88	2.08	090
40761		A	Repair cleft lip/nasal	15.84	NA	NA	12.22	10.59	2.25	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.23	4.05	3.78	2.13	1.96	0.12	010
40801		A	Drainage of mouth lesion	2.63	5.40	4.96	3.13	2.83	0.27	010

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
40804		A	Removal, foreign body, mouth	1.30	4.22	3.85	2.17	1.95	0.12	010
40805		A	Removal, foreign body, mouth	2.79	5.36	5.09	3.25	2.89	0.25	010
40806		A	Incision of lip fold	0.31	2.20	2.27	0.55	0.53	0.03	000
40808		A	Biopsy of mouth lesion	1.01	3.70	3.49	1.79	1.67	0.09	010
40810		A	Excision of mouth lesion	1.36	3.87	3.62	1.96	1.80	0.13	010
40812		A	Excise/repair mouth lesion	2.37	4.95	4.57	2.78	2.49	0.23	010
40814		A	Excise/repair mouth lesion	3.52	6.33	5.80	4.42	4.00	0.34	090
40816		A	Excision of mouth lesion	3.77	6.60	6.06	4.53	4.11	0.37	090
40818		A	Excise oral mucosa for graft	2.83	6.21	5.92	4.17	4.00	0.26	090
40819		A	Excise lip or cheek fold	2.51	5.36	4.95	3.61	3.30	0.23	090
40820		A	Treatment of mouth lesion	1.34	5.30	5.15	3.06	2.95	0.13	010
40830		A	Repair mouth laceration	1.82	4.64	4.19	2.36	2.14	0.22	010
40831		A	Repair mouth laceration	2.57	5.85	5.35	3.15	2.95	0.30	010
40840		R	Reconstruction of mouth	9.15	11.37	10.62	6.92	6.43	0.84	090
40842		R	Reconstruction of mouth	9.15	13.05	10.80	8.14	6.48	0.84	090
40843		R	Reconstruction of mouth	12.79	13.41	12.54	7.67	7.01	1.81	090
40844		R	Reconstruction of mouth	16.80	17.51	16.62	11.47	10.79	2.37	090
40845		R	Reconstruction of mouth	19.36	18.90	17.28	13.23	11.87	1.79	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.35	2.79	2.60	1.57	1.44	0.13	010
41005		A	Drainage of mouth lesion	1.31	4.57	4.28	2.00	1.87	0.12	010
41006		A	Drainage of mouth lesion	3.34	6.00	5.51	3.37	3.09	0.30	090
41007		A	Drainage of mouth lesion	3.20	5.97	5.65	3.30	3.06	0.29	090
41008		A	Drainage of mouth lesion	3.46	6.19	5.64	3.55	3.19	0.31	090
41009		A	Drainage of mouth lesion	3.71	6.52	5.96	3.94	3.52	0.34	090
41010		A	Incision of tongue fold	1.11	4.12	3.92	1.75	1.65	0.10	010
41015		A	Drainage of mouth lesion	4.08	6.90	6.33	4.85	4.30	0.37	090
41016		A	Drainage of mouth lesion	4.19	6.91	6.42	4.99	4.46	0.38	090
41017		A	Drainage of mouth lesion	4.19	7.16	6.55	4.99	4.49	0.38	090
41018		A	Drainage of mouth lesion	5.22	7.62	6.98	5.61	4.90	0.48	090
41019		A	Place needles h&n for rt	8.84	NA	NA	4.09	3.73	0.52	000
41100		A	Biopsy of tongue	1.42	2.90	2.73	1.42	1.32	0.13	010
41105		A	Biopsy of tongue	1.47	2.92	2.71	1.47	1.33	0.14	010
41108		A	Biopsy of floor of mouth	1.10	2.69	2.51	1.28	1.16	0.10	010
41110		A	Excision of tongue lesion	1.56	3.90	3.63	1.91	1.74	0.14	010
41112		A	Excision of tongue lesion	2.83	5.74	5.31	3.77	3.44	0.26	090
41113		A	Excision of tongue lesion	3.29	6.07	5.60	4.02	3.64	0.31	090
41114		A	Excision of tongue lesion	8.82	NA	NA	8.00	7.13	0.83	090
41115		A	Excision of tongue fold	1.79	4.42	4.20	2.16	1.93	0.16	010

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
41116		A	Excision of mouth lesion	2.52	5.96	5.50	3.25	2.97	0.24	090
41120		A	Partial removal of tongue	11.14	NA	NA	16.14	15.28	1.04	090
41130		A	Partial removal of tongue	15.74	NA	NA	18.40	16.92	1.49	090
41135		A	Tongue and neck surgery	30.14	NA	NA	26.66	23.97	2.90	090
41140		A	Removal of tongue	29.15	NA	NA	28.37	26.17	2.69	090
41145		A	Tongue removal, neck surgery	37.93	NA	NA	34.94	31.61	3.50	090
41150		A	Tongue, mouth, jaw surgery	29.86	NA	NA	27.86	25.25	2.84	090
41153		A	Tongue, mouth, neck surgery	33.59	NA	NA	29.30	26.22	3.16	090
41155		A	Tongue, jaw, & neck surgery	44.30	NA	NA	34.85	30.29	4.27	090
41250		A	Repair tongue laceration	1.96	4.44	3.77	1.92	1.61	0.23	010
41251		A	Repair tongue laceration	2.32	4.55	3.65	2.11	1.80	0.21	010
41252		A	Repair tongue laceration	3.02	5.09	4.57	2.55	2.26	0.34	010
41500		A	Fixation of tongue	3.80	NA	NA	8.09	7.49	0.35	090
41510		A	Tongue to lip surgery	3.51	NA	NA	7.95	7.03	0.32	090
41512		A	Tongue suspension	6.86	NA	NA	9.81	8.95	0.34	090
41520		A	Reconstruction, tongue fold	2.83	6.08	5.69	3.81	3.52	0.26	090
41530		A	Tongue base vol reduction	4.51	74.84	74.78	6.19	5.82	0.22	010
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41800		A	Drainage of gum lesion	1.27	5.26	4.54	2.40	2.05	0.14	010
41805		A	Removal foreign body, gum	1.34	5.45	4.66	3.29	2.88	0.12	010
41806		A	Removal foreign body, jawbone	2.79	6.15	5.60	3.91	3.53	0.39	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.41	4.95	4.61	2.38	1.99	0.22	010
41823		R	Excision of gum lesion	3.77	7.10	6.69	4.64	4.19	0.34	090
41825		A	Excision of gum lesion	1.41	3.90	3.68	1.76	1.73	0.13	010
41826		A	Excision of gum lesion	2.41	5.52	4.78	3.10	2.69	0.22	010
41827		A	Excision of gum lesion	3.83	7.43	6.77	4.25	3.77	0.34	090
41828		R	Excision of gum lesion	3.14	4.71	4.25	2.50	2.17	0.29	010
41830		R	Removal of gum tissue	3.45	6.52	5.99	3.94	3.48	0.31	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	3.01	6.24	5.92	3.81	3.52	0.41	090
41874		R	Repair tooth socket	3.19	6.26	5.77	3.47	3.09	0.29	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42000		A	Drainage mouth roof lesion	1.28	2.73	2.60	1.46	1.31	0.12	010
42100		A	Biopsy roof of mouth	1.36	2.50	2.33	1.52	1.38	0.13	010
42104		A	Excision lesion, mouth roof	1.69	3.84	3.49	1.97	1.76	0.16	010
42106		A	Excision lesion, mouth roof	2.15	4.79	4.37	2.51	2.31	0.20	010
42107		A	Excision lesion, mouth roof	4.56	7.34	6.73	4.58	4.09	0.41	090
42120		A	Remove palate/lesion	11.86	NA	NA	14.20	12.91	1.12	090
42140		A	Excision of uvula	1.70	4.84	4.52	2.38	2.21	0.15	090
42145		A	Repair palate, pharynx/uvula	17.46	NA	NA	12.63	8.97	0.89	090
42160		A	Treatment mouth roof lesion	1.85	4.12	4.04	2.02	1.95	0.17	010
42180		A	Repair palate	2.55	3.86	3.48	2.35	2.09	0.23	010
42182		A	Repair palate	3.87	4.59	4.23	2.99	2.76	0.36	010
42200		A	Reconstruct cleft palate	12.53	NA	NA	10.16	9.50	1.15	090
42205		A	Reconstruct cleft palate	13.66	NA	NA	10.08	9.55	1.26	090
42210		A	Reconstruct cleft palate	15.03	NA	NA	12.79	11.26	2.14	090
42215		A	Reconstruct cleft palate	8.99	NA	NA	8.16	8.08	1.26	090
42220		A	Reconstruct cleft palate	7.16	NA	NA	7.42	6.57	0.35	090
42225		A	Reconstruct cleft palate	9.77	NA	NA	13.31	13.56	0.89	090
42226		A	Lengthening of palate	10.35	NA	NA	13.17	12.88	0.95	090
42227		A	Lengthening of palate	9.90	NA	NA	12.18	12.48	0.91	090
42235		A	Repair palate	8.01	NA	NA	11.27	10.64	0.73	090
42260		A	Repair nose to lip fistula	10.22	11.23	10.30	7.44	6.69	0.93	090
42280		A	Preparation, palate mold	1.59	2.58	2.30	1.30	1.04	0.24	010
42281		A	Insertion, palate prosthesis	1.98	3.39	3.08	2.04	1.85	0.18	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.98	3.43	3.18	2.03	1.86	0.19	010
42305		A	Drainage of salivary gland	6.31	NA	NA	5.09	4.58	0.62	090
42310		A	Drainage of salivary gland	1.61	2.58	2.40	1.69	1.53	0.15	010
42320		A	Drainage of salivary gland	2.40	4.14	3.80	2.28	2.07	0.22	010
42330		A	Removal of salivary stone	2.26	3.78	3.51	2.12	1.90	0.21	010
42335		A	Removal of salivary stone	3.41	6.31	5.83	3.43	3.13	0.31	090
42340		A	Removal of salivary stone	4.72	7.45	6.84	4.23	3.84	0.43	090
42400		A	Biopsy of salivary gland	0.78	2.00	1.94	0.70	0.69	0.07	000
42405		A	Biopsy of salivary gland	3.34	4.37	4.16	2.62	2.40	0.31	010
42408		A	Excision of salivary cyst	4.66	7.20	6.63	4.04	3.63	0.42	090
42409		A	Drainage of salivary cyst	2.91	5.78	5.33	3.00	2.74	0.26	090
42410		A	Excise parotid gland/lesion	9.57	NA	NA	6.79	6.07	1.02	090
42415		A	Excise parotid gland/lesion	18.12	NA	NA	11.42	10.15	1.76	090
42420		A	Excise parotid gland/lesion	21.00	NA	NA	12.80	11.36	2.04	090
42425		A	Excise parotid gland/lesion	13.42	NA	NA	8.81	7.93	1.31	090
42426		A	Excise parotid gland/lesion	22.66	NA	NA	13.32	11.87	2.24	090
42440		A	Excise submaxillary gland	7.13	NA	NA	5.26	4.71	0.69	090
42450		A	Excise sublingual gland	4.74	7.08	6.54	4.76	4.34	0.46	090
42500		A	Repair salivary duct	4.42	6.89	6.35	4.62	4.22	0.42	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
42505		A	Repair salivary duct	6.32	8.27	7.60	5.76	5.21	0.58	090
42507		A	Parotid duct diversion	6.25	NA	NA	7.31	6.78	0.57	090
42508		A	Parotid duct diversion	9.33	NA	NA	9.56	8.91	0.85	090
42509		A	Parotid duct diversion	11.76	NA	NA	10.73	9.44	1.66	090
42510		A	Parotid duct diversion	8.35	NA	NA	8.32	7.64	0.76	090
42550		A	Injection for salivary x-ray	1.25	2.00	2.43	0.37	0.45	0.08	000
42600		A	Closure of salivary fistula	4.94	7.62	7.14	4.34	4.01	0.45	090
4260F		I	Wound srfc culturetech used	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4261F		I	Tech other than surfc cultr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42650		A	Dilation of salivary duct	0.77	1.40	1.29	0.78	0.72	0.07	000
4265F		I	Wet-dry dressings Rx-recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42660		A	Dilation of salivary duct	1.13	1.67	1.52	0.96	0.85	0.10	000
42665		A	Ligation of salivary duct	2.63	5.54	5.11	2.86	2.63	0.24	090
4266F		I	No wet-dry drssings Rx-recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4268F		I	Pt ed re comp thxpy rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4269F		I	Appropos mthd offloading Rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42700		A	Drainage of tonsil abscess	1.67	3.24	3.02	1.90	1.77	0.16	010
4270F		I	Pt rcvng anti r-viral thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42720		A	Drainage of throat abscess	6.31	5.69	5.14	4.16	3.70	0.60	010
42725		A	Drainage of throat abscess	12.41	NA	NA	9.08	8.16	1.14	090
4275F		I	Hep b vac inj admin/ rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4279F		I	PCP prophylaxis Rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42800		A	Biopsy of throat	1.44	2.69	2.50	1.53	1.40	0.13	010
42802		A	Biopsy of throat	1.59	4.40	4.37	1.93	1.85	0.15	010
42804		A	Biopsy of upper nose/throat	1.29	3.79	3.71	1.70	1.63	0.12	010
42806		A	Biopsy of upper nose/throat	1.63	4.09	3.99	1.87	1.78	0.15	010
42808		A	Excise pharynx lesion	2.35	3.60	3.35	1.98	1.81	0.22	010
42809		A	Remove pharynx foreign body	1.86	2.56	2.37	1.59	1.42	0.19	010
4280F		I	PCP prophylax Rxd 3mon low %	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42810		A	Excision of neck cyst	3.38	6.75	6.29	4.27	3.88	0.31	090
42815		A	Excision of neck cyst	7.31	NA	NA	7.41	6.73	0.72	090
42820		A	Remove tonsils and adenoids	4.22	NA	NA	3.52	3.19	0.39	090
42821		A	Remove tonsils and adenoids	4.36	NA	NA	3.66	3.35	0.40	090
42825		A	Removal of tonsils	3.51	NA	NA	3.45	3.16	0.32	090
42826		A	Removal of tonsils	3.45	NA	NA	3.22	2.96	0.32	090
42830		A	Removal of adenoids	2.65	NA	NA	2.85	2.61	0.24	090
42831		A	Removal of adenoids	2.81	NA	NA	3.10	2.87	0.26	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
42835		A	Removal of adenoids	2.38	NA	NA	2.72	2.39	0.22	090
42836		A	Removal of adenoids	3.26	NA	NA	3.14	2.90	0.30	090
42842		A	Extensive surgery of throat	12.23	NA	NA	14.00	12.60	1.13	090
42844		A	Extensive surgery of throat	17.78	NA	NA	18.35	16.77	1.64	090
42845		A	Extensive surgery of throat	32.56	NA	NA	26.42	23.68	3.01	090
42860		A	Excision of tonsil tags	2.30	NA	NA	2.68	2.47	0.21	090
42870		A	Excision of lingual tonsil	5.52	NA	NA	9.56	9.04	0.50	090
42890		A	Partial removal of pharynx	19.13	NA	NA	18.20	16.20	1.82	090
42892		A	Revision of pharyngeal walls	26.03	NA	NA	23.44	20.45	2.45	090
42894		A	Revision of pharyngeal walls	33.92	NA	NA	28.84	25.33	3.18	090
42900		A	Repair throat wound	5.29	NA	NA	3.78	3.40	0.49	010
42950		A	Reconstruction of throat	8.27	NA	NA	12.36	11.74	0.80	090
42953		A	Repair throat, esophagus	9.45	NA	NA	15.36	15.04	0.94	090
42955		A	Surgical opening of throat	8.01	NA	NA	11.71	10.83	0.73	090
42960		A	Control throat bleeding	2.38	NA	NA	2.13	1.92	0.22	010
42961		A	Control throat bleeding	5.77	NA	NA	5.40	4.92	0.53	090
42962		A	Control throat bleeding	7.40	NA	NA	6.39	5.80	0.68	090
42970		A	Control nose/throat bleeding	5.82	NA	NA	4.54	4.07	0.61	090
42971		A	Control nose/throat bleeding	6.60	NA	NA	5.60	5.03	0.61	090
42972		A	Control nose/throat bleeding	7.59	NA	NA	6.07	5.43	0.70	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4300F		I	Pt rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4301F		I	Pt not rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43020		A	Incision of esophagus	8.23	NA	NA	6.19	5.14	0.75	090
43030		A	Throat muscle surgery	7.99	NA	NA	5.69	5.18	0.84	090
43045		A	Incision of esophagus	21.88	NA	NA	10.51	10.48	3.68	090
4305F		I	Pt ed re ft care inspct rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4306F		I	Pt tlk psych & Rx opd addic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43100		A	Excision of esophagus lesion	9.66	NA	NA	7.10	6.15	0.88	090
43101		A	Excision of esophagus lesion	17.07	NA	NA	7.98	7.95	2.89	090
43107		A	Removal of esophagus	44.18	NA	NA	19.58	18.35	7.12	090
43108		A	Removal of esophagus	82.87	NA	NA	34.14	26.94	12.79	090
43112		A	Removal of esophagus	47.48	NA	NA	19.89	19.03	7.77	090
43113		A	Removal of esophagus	80.06	NA	NA	34.29	28.92	12.35	090
43116		A	Partial removal of esophagus	92.99	NA	NA	47.97	34.66	8.64	090
43117		A	Partial removal of esophagus	43.65	NA	NA	18.18	17.25	7.14	090
43118		A	Partial removal of esophagus	67.07	NA	NA	28.32	22.77	10.34	090
43121		A	Partial removal of esophagus	51.43	NA	NA	19.87	18.56	8.70	090
43122		A	Partial removal of esophagus	44.18	NA	NA	19.98	17.79	6.96	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
43123		A	Partial removal of esophagus	83.12	NA	NA	35.42	27.48	12.83	090
43124		A	Removal of esophagus	69.09	NA	NA	25.92	23.87	11.68	090
43130		A	Removal of esophagus pouch	12.53	NA	NA	8.10	7.33	1.43	090
43135		A	Removal of esophagus pouch	26.17	NA	NA	11.26	10.39	4.31	090
43200		A	Esophagus endoscopy	1.59	3.80	3.84	1.14	1.07	0.16	000
43201		A	Esoph scope w/submucous inj	2.09	5.13	5.35	1.20	1.22	0.22	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.06	5.23	1.08	1.04	0.21	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	NA	1.90	1.96	0.42	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	NA	1.91	1.96	0.40	000
4320F		I	Pt talk psychsoc+rx oh dpnd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43215		A	Esophagus endoscopy	2.60	NA	NA	1.37	1.33	0.30	000
43216		A	Esophagus endoscopy/lesion	2.40	3.01	2.69	1.29	1.27	0.25	000
43217		A	Esophagus endoscopy	2.90	6.31	6.57	1.46	1.41	0.36	000
43219		A	Esophagus endoscopy	2.80	NA	NA	1.53	1.56	0.34	000
43220		A	Esoph endoscopy, dilation	2.10	NA	NA	1.18	1.15	0.23	000
43226		A	Esoph endoscopy, dilation	2.34	NA	NA	1.27	1.27	0.27	000
43227		A	Esoph endoscopy, repair	3.59	NA	NA	1.79	1.78	0.40	000
43228		A	Esoph endoscopy, ablation	3.76	NA	NA	1.89	1.93	0.42	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	NA	1.64	1.69	0.35	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	NA	2.16	2.23	0.51	000
43234		A	Upper GI endoscopy, exam	2.01	4.83	5.02	1.08	1.04	0.25	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	4.72	5.14	1.29	1.32	0.27	000
43236		A	Uppr gi scope w/submuc inj	2.92	5.86	6.45	1.54	1.60	0.32	000
43237		A	Endoscopic us exam, esoph	3.98	NA	NA	1.99	2.07	0.44	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	NA	2.42	2.54	0.55	000
43239		A	Upper GI endoscopy, biopsy	2.87	5.43	5.86	1.50	1.53	0.32	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	NA	3.24	3.33	0.74	000
43241		A	Upper GI endoscopy with tube	2.59	NA	NA	1.37	1.39	0.29	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	NA	3.46	3.59	0.78	000
43243		A	Upper gi endoscopy & inject	4.56	NA	NA	2.24	2.31	0.49	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	NA	2.47	2.57	0.53	000
43245		A	Uppr gi scope dilate strictr	3.18	NA	NA	1.61	1.61	0.37	000
43246		A	Place gastrostomy tube	4.32	NA	NA	2.08	2.10	0.51	000
43247		A	Operative upper GI endoscopy	3.38	NA	NA	1.72	1.75	0.38	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	NA	1.64	1.71	0.34	000
43249		A	Esoph endoscopy, dilation	2.90	NA	NA	1.52	1.57	0.32	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	NA	1.61	1.60	0.38	000
43251		A	Operative upper GI endoscopy	3.69	NA	NA	1.86	1.89	0.41	000
43255		A	Operative upper GI endoscopy	4.81	NA	NA	2.37	2.45	0.51	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
43256		A	Uppr gi endoscopy w/stent	4.34	NA	NA	2.11	2.18	0.49	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	NA	2.74	2.60	0.58	000
43258		A	Operative upper GI endoscopy	4.54	NA	NA	2.24	2.31	0.49	000
43259		A	Endoscopic ultrasound exam	5.19	NA	NA	2.53	2.63	0.55	000
43260		A	Endo cholangiopancreatograph	5.95	NA	NA	2.86	2.98	0.63	000
43261		A	Endo cholangiopancreatograph	6.26	NA	NA	3.01	3.12	0.67	000
43262		A	Endo cholangiopancreatograph	7.38	NA	NA	3.50	3.63	0.78	000
43263		A	Endo cholangiopancreatograph	7.28	NA	NA	3.42	3.60	0.77	000
43264		A	Endo cholangiopancreatograph	8.89	NA	NA	4.16	4.33	0.94	000
43265		A	Endo cholangiopancreatograph	10.00	NA	NA	4.65	4.84	1.06	000
43267		A	Endo cholangiopancreatograph	7.38	NA	NA	3.48	3.59	0.78	000
43268		A	Endo cholangiopancreatograph	7.38	NA	NA	3.63	3.77	0.78	000
43269		A	Endo cholangiopancreatograph	8.20	NA	NA	3.86	4.01	0.88	000
43271		A	Endo cholangiopancreatograph	7.38	NA	NA	3.49	3.62	0.79	000
43272		A	Endo cholangiopancreatograph	7.38	NA	NA	3.50	3.61	0.78	000
43273		A	Endoscopic pancreatoscopy	2.24	NA	NA	0.98	1.07	0.11	ZZZ
43279		A	Lap myotomy, heller	22.10	NA	NA	10.39	8.79	1.10	090
43280		A	Laparoscopy, fundoplasty	18.10	NA	NA	8.89	7.63	2.78	090
43281		A	Lap paraesophag hern repair	26.60	NA	NA	12.03	12.03	4.08	090
43282		A	Lap paraesoph her rpr w/mesh	30.10	NA	NA	13.32	13.32	4.62	090
43289		C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43300		A	Repair of esophagus	9.33	NA	NA	7.11	6.24	0.85	090
43305		A	Repair esophagus and fistula	18.10	NA	NA	11.20	9.86	1.68	090
4330F		I	Cnslng epi spec sfty issues	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43310		A	Repair of esophagus	26.26	NA	NA	11.59	11.13	4.45	090
43312		A	Repair esophagus and fistula	29.25	NA	NA	10.57	11.46	4.96	090
43313		A	Esophagoplasty congenital	48.45	NA	NA	19.67	18.13	8.18	090
43314		A	Tracheo-esophagoplasty cong	53.43	NA	NA	29.37	23.95	4.95	090
43320		A	Fuse esophagus & stomach	23.31	NA	NA	11.22	10.12	3.58	090
43324		A	Revise esophagus & stomach	22.99	NA	NA	10.89	9.46	3.59	090
43325		A	Revise esophagus & stomach	22.60	NA	NA	11.12	9.50	3.47	090
43326		A	Revise esophagus & stomach	22.28	NA	NA	10.86	10.05	3.64	090
43330		A	Repair of esophagus	22.19	NA	NA	10.62	9.19	3.44	090
43331		A	Repair of esophagus	23.06	NA	NA	10.34	10.39	3.89	090
43340		A	Fuse esophagus & intestine	22.99	NA	NA	11.26	9.77	3.53	090
43341		A	Fuse esophagus & intestine	24.23	NA	NA	12.62	11.55	4.09	090
43350		A	Surgical opening, esophagus	19.49	NA	NA	10.53	9.07	2.99	090
43351		A	Surgical opening, esophagus	22.05	NA	NA	10.72	10.46	3.71	090
43352		A	Surgical opening, esophagus	17.81	NA	NA	8.76	8.69	3.00	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
43360		A	Gastrointestinal repair	40.11	NA	NA	16.10	16.05	6.77	090
43361		A	Gastrointestinal repair	45.68	NA	NA	21.28	18.57	7.04	090
43400		A	Ligate esophagus veins	25.60	NA	NA	13.76	14.03	2.71	090
43401		A	Esophagus surgery for veins	26.49	NA	NA	12.55	10.75	4.07	090
43405		A	Ligate/staple esophagus	24.73	NA	NA	13.56	11.61	3.79	090
4340F		I	Cnslng chldbrng+ women epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43410		A	Repair esophagus wound	16.41	NA	NA	8.34	8.23	2.77	090
43415		A	Repair esophagus wound	28.91	NA	NA	14.12	12.93	4.75	090
43420		A	Repair esophagus opening	16.78	NA	NA	10.54	8.67	1.55	090
43425		A	Repair esophagus opening	25.04	NA	NA	12.92	11.77	3.85	090
43450		A	Dilate esophagus	1.38	2.37	2.60	0.86	0.89	0.15	000
43453		A	Dilate esophagus	1.51	5.43	6.02	0.92	0.96	0.16	000
43456		A	Dilate esophagus	2.57	11.44	12.68	1.38	1.40	0.28	000
43458		A	Dilate esophagus	3.06	6.32	6.74	1.59	1.59	0.34	000
43460		A	Pressure treatment esophagus	3.79	NA	NA	1.93	1.86	0.40	000
43496		C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	12.79	NA	NA	6.76	5.78	1.96	090
43501		A	Surgical repair of stomach	22.60	NA	NA	10.89	9.19	3.44	090
43502		A	Surgical repair of stomach	25.69	NA	NA	12.21	10.23	3.95	090
43510		A	Surgical opening of stomach	15.14	NA	NA	9.08	8.04	1.60	090
43520		A	Incision of pyloric muscle	11.29	NA	NA	5.87	5.36	1.81	090
43600		A	Biopsy of stomach	1.91	NA	NA	0.79	0.81	0.21	000
43605		A	Biopsy of stomach	13.72	NA	NA	7.08	5.97	2.08	090
43610		A	Excision of stomach lesion	16.34	NA	NA	8.10	6.83	2.49	090
43611		A	Excision of stomach lesion	20.38	NA	NA	10.10	8.52	3.10	090
43620		A	Removal of stomach	34.04	NA	NA	15.02	12.76	5.25	090
43621		A	Removal of stomach	39.53	NA	NA	17.09	14.13	6.08	090
43622		A	Removal of stomach	40.03	NA	NA	17.31	14.30	6.17	090
43631		A	Removal of stomach, partial	24.51	NA	NA	11.65	9.85	3.74	090
43632		A	Removal of stomach, partial	35.14	NA	NA	15.56	12.49	5.38	090
43633		A	Removal of stomach, partial	33.14	NA	NA	14.75	12.00	5.06	090
43634		A	Removal of stomach, partial	36.64	NA	NA	16.25	13.23	5.65	090
43635		A	Removal of stomach, partial	2.06	NA	NA	0.76	0.64	0.32	ZZZ
43640		A	Vagotomy & pylorus repair	19.56	NA	NA	9.87	8.26	2.97	090
43641		A	Vagotomy & pylorus repair	19.81	NA	NA	10.04	8.30	3.04	090
43644		A	Lap gastric bypass/roux-en-y	29.40	NA	NA	13.87	11.75	4.49	090
43645		A	Lap gastr bypass incl smll i	31.53	NA	NA	14.75	12.41	4.85	090
43647		C	Lap impl electrode, antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
43648		C	Lap revise/remv eltrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43651		A	Laparoscopy, vagus nerve	10.13	NA	NA	6.10	5.23	1.57	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	NA	6.84	5.83	1.88	090
43653		A	Laparoscopy, gastrostomy	8.48	NA	NA	5.71	4.86	1.28	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43752		A	Nasal/orogastric w/stent	0.81	NA	NA	0.26	0.28	0.06	000
43760		A	Change gastrostomy tube	0.90	10.23	8.45	0.34	0.37	0.11	000
43761		A	Reposition gastrostomy tube	2.01	1.00	1.12	0.68	0.74	0.17	000
43770		A	Lap place gastr adj device	18.00	NA	NA	9.86	8.39	2.74	090
43771		A	Lap revise gastr adj device	20.79	NA	NA	10.94	9.25	3.19	090
43772		A	Lap rmvl gastr adj device	15.70	NA	NA	8.05	6.93	2.42	090
43773		A	Lap replace gastr adj device	20.79	NA	NA	10.94	9.26	3.19	090
43774		A	Lap rmvl gastr adj all parts	15.76	NA	NA	8.16	6.98	2.41	090
43775		A	Lap sleeve gastrectomy	21.56	NA	NA	10.99	10.99	3.31	090
43800		A	Reconstruction of pylorus	15.43	NA	NA	7.76	6.58	2.38	090
43810		A	Fusion of stomach and bowel	16.88	NA	NA	8.40	7.02	2.60	090
43820		A	Fusion of stomach and bowel	22.53	NA	NA	10.91	8.83	3.43	090
43825		A	Fusion of stomach and bowel	21.76	NA	NA	10.65	8.95	3.34	090
43830		A	Place gastrostomy tube	10.85	NA	NA	6.56	5.64	1.61	090
43831		A	Place gastrostomy tube	8.49	NA	NA	6.24	5.39	1.29	090
43832		A	Place gastrostomy tube	17.34	NA	NA	8.89	7.79	2.59	090
43840		A	Repair of stomach lesion	22.83	NA	NA	11.01	8.97	3.46	090
43842		N	V-band gastroplasty	21.03	NA	NA	9.74	9.19	1.05	090
43843		A	Gastroplasty w/o v-band	21.21	NA	NA	10.21	8.70	3.26	090
43845		A	Gastroplasty duodenal switch	33.30	NA	NA	15.77	12.95	5.11	090
43846		A	Gastric bypass for obesity	27.41	NA	NA	13.44	11.24	4.19	090
43847		A	Gastric bypass incl small i	30.28	NA	NA	14.52	11.93	4.65	090
43848		A	Revision gastroplasty	32.75	NA	NA	15.37	12.91	5.00	090
43850		A	Revise stomach-bowel fusion	27.58	NA	NA	12.91	10.67	4.25	090
43855		A	Revise stomach-bowel fusion	28.69	NA	NA	12.50	10.98	4.42	090
43860		A	Revise stomach-bowel fusion	27.89	NA	NA	13.02	10.91	4.25	090
43865		A	Revise stomach-bowel fusion	29.05	NA	NA	13.45	11.26	4.47	090
43870		A	Repair stomach opening	11.44	NA	NA	6.31	5.36	1.72	090
43880		A	Repair stomach-bowel fistula	27.18	NA	NA	12.68	10.69	4.11	090
43881		C	Impl/redo electrd, antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43882		C	Revise/remove electrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43886		A	Revise gastric port, open	4.64	NA	NA	4.32	3.69	0.70	090
43887		A	Remove gastric port, open	4.32	NA	NA	3.77	3.27	0.65	090
43888		A	Change gastric port, open	6.44	NA	NA	4.98	4.26	0.97	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	18.46	NA	NA	8.85	7.47	2.77	090
44010		A	Incision of small bowel	14.26	NA	NA	7.27	6.20	2.16	090
44015		A	Insert needle cath bowel	2.62	NA	NA	0.94	0.83	0.40	ZZZ
44020		A	Explore small intestine	16.22	NA	NA	7.99	6.75	2.44	090
44021		A	Decompress small bowel	16.31	NA	NA	8.05	6.90	2.48	090
44025		A	Incision of large bowel	16.51	NA	NA	8.17	6.88	2.47	090
44050		A	Reduce bowel obstruction	15.52	NA	NA	7.81	6.59	2.35	090
44055		A	Correct malrotation of bowel	25.63	NA	NA	11.61	9.74	3.91	090
44100		A	Biopsy of bowel	2.01	NA	NA	0.87	0.91	0.22	000
44110		A	Excise intestine lesion(s)	14.04	NA	NA	7.21	6.08	2.08	090
44111		A	Excision of bowel lesion(s)	16.52	NA	NA	8.15	6.84	2.48	090
44120		A	Removal of small intestine	20.82	NA	NA	9.73	8.12	3.13	090
44121		A	Removal of small intestine	4.44	NA	NA	1.63	1.39	0.66	ZZZ
44125		A	Removal of small intestine	20.03	NA	NA	9.57	8.03	2.94	090
44126		A	Enterectomy w/o taper, cong	42.23	NA	NA	19.12	15.74	6.50	090
44127		A	Enterectomy w/taper, cong	49.30	NA	NA	21.64	17.88	7.59	090
44128		A	Enterectomy cong, add-on	4.44	NA	NA	1.64	1.40	0.68	ZZZ
44130		A	Bowel to bowel fusion	22.11	NA	NA	10.71	8.67	3.29	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	NA	0.82	0.70	0.33	ZZZ
44140		A	Partial removal of colon	22.59	NA	NA	10.97	9.27	3.35	090
44141		A	Partial removal of colon	29.91	NA	NA	15.71	12.93	4.46	090
44143		A	Partial removal of colon	27.79	NA	NA	13.84	11.69	4.14	090
44144		A	Partial removal of colon	29.91	NA	NA	14.39	11.85	4.46	090
44145		A	Partial removal of colon	28.58	NA	NA	13.18	11.11	4.08	090
44146		A	Partial removal of colon	35.30	NA	NA	18.06	15.00	4.95	090
44147		A	Partial removal of colon	33.69	NA	NA	15.01	11.98	4.89	090
44150		A	Removal of colon	30.18	NA	NA	16.73	14.00	4.42	090
44151		A	Removal of colon/ileostomy	34.92	NA	NA	18.33	15.45	5.38	090
44155		A	Removal of colon/ileostomy	34.42	NA	NA	18.19	15.11	4.67	090
44156		A	Removal of colon/ileostomy	37.42	NA	NA	20.08	16.75	5.76	090
44157		A	Colectomy w/ileoanal anast	35.70	NA	NA	18.83	15.66	5.49	090
44158		A	Colectomy w/neo-rectum pouch	36.70	NA	NA	18.97	15.86	5.65	090
44160		A	Removal of colon	20.89	NA	NA	10.23	8.57	3.08	090
44180		A	Lap, enterolysis	15.27	NA	NA	7.69	6.60	2.28	090
44186		A	Lap, jejunostomy	10.38	NA	NA	5.84	5.11	1.60	090
44187		A	Lap, ileo/jejuno-stomy	17.40	NA	NA	10.54	8.95	2.38	090
44188		A	Lap, colostomy	19.35	NA	NA	11.44	9.73	2.76	090
44202		A	Lap, enterectomy	23.39	NA	NA	11.34	9.55	3.49	090
44203		A	Lap resect s/intestine, addl	4.44	NA	NA	1.64	1.38	0.68	ZZZ
44204		A	Laparo partial colectomy	26.42	NA	NA	12.39	10.38	3.76	090
44205		A	Lap colectomy part w/ileum	22.95	NA	NA	10.86	9.14	3.26	090
44206		A	Lap part colectomy w/stoma	29.79	NA	NA	14.30	12.04	4.37	090
44207		A	L colectomy/coloproctostomy	31.92	NA	NA	14.33	11.93	4.46	090
44208		A	L colectomy/coloproctostomy	33.99	NA	NA	16.56	13.83	4.62	090
44210		A	Laparo total proctocolectomy	30.09	NA	NA	15.31	12.82	4.19	090
44211		A	Lap colectomy w/proctectomy	37.08	NA	NA	19.07	15.68	5.70	090
44212		A	Laparo total proctocolectomy	34.58	NA	NA	17.82	14.92	4.59	090
44213		A	Lap, mobil splenic fl add-on	3.50	NA	NA	1.29	1.09	0.49	ZZZ
44227		A	Lap, close enterostomy	28.62	NA	NA	13.35	11.20	4.23	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	13.75	NA	NA	7.26	6.19	2.10	090
44310		A	Ileostomy/jejunostomy	17.59	NA	NA	8.68	7.32	2.49	090
44312		A	Revision of ileostomy	9.43	NA	NA	5.48	4.89	1.24	090
44314		A	Revision of ileostomy	16.74	NA	NA	8.69	7.50	2.27	090
44316		A	Devise bowel pouch	23.59	NA	NA	11.55	9.62	3.62	090
44320		A	Colostomy	19.91	NA	NA	10.17	8.57	2.92	090
44322		A	Colostomy with biopsies	13.32	NA	NA	11.47	9.80	2.04	090
44340		A	Revision of colostomy	9.28	NA	NA	6.31	5.30	1.33	090
44345		A	Revision of colostomy	17.22	NA	NA	9.19	7.76	2.47	090
44346		A	Revision of colostomy	19.63	NA	NA	10.15	8.46	2.80	090
44360		A	Small bowel endoscopy	2.59	NA	NA	1.40	1.45	0.28	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	NA	1.53	1.58	0.30	000
44363		A	Small bowel endoscopy	3.49	NA	NA	1.76	1.78	0.37	000
44364		A	Small bowel endoscopy	3.73	NA	NA	1.89	1.95	0.40	000
44365		A	Small bowel endoscopy	3.31	NA	NA	1.71	1.75	0.36	000
44366		A	Small bowel endoscopy	4.40	NA	NA	2.20	2.29	0.47	000
44369		A	Small bowel endoscopy	4.51	NA	NA	2.25	2.33	0.48	000
44370		A	Small bowel endoscopy/stent	4.79	NA	NA	2.52	2.58	0.51	000
44372		A	Small bowel endoscopy	4.40	NA	NA	2.11	2.11	0.51	000
44373		A	Small bowel endoscopy	3.49	NA	NA	1.74	1.78	0.39	000
44376		A	Small bowel endoscopy	5.25	NA	NA	2.49	2.52	0.59	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	NA	2.67	2.74	0.59	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
44378		A	Small bowel endoscopy	7.12	NA	NA	3.37	3.47	0.76	000
44379		A	S bowel endoscope w/stent	7.46	NA	NA	3.71	3.75	0.79	000
44380		A	Small bowel endoscopy	1.05	NA	NA	0.69	0.72	0.11	000
44382		A	Small bowel endoscopy	1.27	NA	NA	0.81	0.84	0.14	000
44383		A	Ileoscopy w/stent	2.94	NA	NA	1.35	1.56	0.23	000
44385		A	Endoscopy of bowel pouch	1.82	4.55	4.51	0.93	0.89	0.19	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.40	6.61	1.13	1.06	0.24	000
44388		A	Colonoscopy	2.82	5.83	5.87	1.43	1.38	0.34	000
44389		A	Colonoscopy with biopsy	3.13	6.56	6.90	1.59	1.57	0.35	000
44390		A	Colonoscopy for foreign body	3.82	7.59	7.81	1.96	1.85	0.40	000
44391		A	Colonoscopy for bleeding	4.31	7.86	8.57	2.08	2.12	0.48	000
44392		A	Colonoscopy & polypectomy	3.81	7.04	7.11	1.82	1.74	0.45	000
44393		A	Colonoscopy, lesion removal	4.83	7.62	7.80	2.28	2.23	0.55	000
44394		A	Colonoscopy w/snare	4.42	7.88	8.27	2.13	2.11	0.50	000
44397		A	Colonoscopy w/stent	4.70	NA	NA	2.33	2.35	0.50	000
44500		A	Intro, gastrointestinal tube	0.49	NA	NA	0.16	0.18	0.03	000
44602		A	Suture, small intestine	24.72	NA	NA	10.58	8.45	3.69	090
44603		A	Suture, small intestine	28.16	NA	NA	12.40	9.93	4.16	090
44604		A	Suture, large intestine	18.16	NA	NA	8.28	6.98	2.68	090
44605		A	Repair of bowel lesion	22.08	NA	NA	10.68	8.98	3.30	090
44615		A	Intestinal stricturoplasty	18.16	NA	NA	8.78	7.43	2.69	090
44620		A	Repair bowel opening	14.43	NA	NA	7.41	6.18	2.04	090
44625		A	Repair bowel opening	17.28	NA	NA	8.47	7.04	2.42	090
44626		A	Repair bowel opening	27.90	NA	NA	12.40	10.40	4.12	090
44640		A	Repair bowel-skin fistula	24.20	NA	NA	10.98	9.26	3.52	090
44650		A	Repair bowel fistula	25.12	NA	NA	11.28	9.62	3.65	090
44660		A	Repair bowel-bladder fistula	23.91	NA	NA	10.25	9.87	2.79	090
44661		A	Repair bowel-bladder fistula	27.35	NA	NA	11.95	10.53	3.69	090
44680		A	Surgical revision, intestine	17.96	NA	NA	8.83	7.38	2.77	090
44700		A	Suspend bowel w/prosthesis	17.48	NA	NA	8.47	7.11	2.18	090
44701		A	Intraop colon lavage add-on	3.10	NA	NA	1.14	0.96	0.42	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	NA	1.83	1.75	0.25	XXX
44721		A	Prep donor intestine/artery	7.00	NA	NA	2.58	2.24	1.08	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	12.05	NA	NA	7.00	6.03	1.77	090
44820		A	Excision of mesentery lesion	13.73	NA	NA	7.23	6.21	2.04	090
44850		A	Repair of mesentery	12.11	NA	NA	6.42	5.49	1.82	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
44900		A	Drain app abscess, open	12.57	NA	NA	6.70	5.62	1.91	090
44901		A	Drain app abscess, percut	3.37	18.21	21.29	1.02	1.21	0.26	000
44950		A	Appendectomy	10.60	NA	NA	5.40	4.61	1.61	090
44955		A	Appendectomy add-on	1.53	NA	NA	0.57	0.50	0.22	ZZZ
44960		A	Appendectomy	14.50	NA	NA	7.27	6.09	2.21	090
44970		A	Laparoscopy, appendectomy	9.45	NA	NA	5.49	4.65	1.43	090
44979		C	Laparoscope proc, app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	6.30	NA	NA	4.34	3.78	0.77	090
45005		A	Drainage of rectal abscess	2.02	4.48	4.14	1.91	1.69	0.27	010
45020		A	Drainage of rectal abscess	8.56	NA	NA	5.63	4.73	1.15	090
45100		A	Biopsy of rectum	4.04	NA	NA	3.45	2.97	0.52	090
45108		A	Removal of anorectal lesion	5.12	NA	NA	4.01	3.36	0.77	090
45110		A	Removal of rectum	30.76	NA	NA	16.08	13.50	4.21	090
45111		A	Partial removal of rectum	18.01	NA	NA	9.40	7.92	2.56	090
45112		A	Removal of rectum	33.18	NA	NA	14.76	12.27	4.40	090
45113		A	Partial proctectomy	33.22	NA	NA	16.54	13.58	5.12	090
45114		A	Partial removal of rectum	30.79	NA	NA	14.40	11.81	4.74	090
45116		A	Partial removal of rectum	27.72	NA	NA	12.88	10.64	2.86	090
45119		A	Remove rectum w/reservoir	33.48	NA	NA	16.42	13.46	4.24	090
45120		A	Removal of rectum	26.40	NA	NA	13.13	10.96	4.05	090
45121		A	Removal of rectum and colon	29.08	NA	NA	14.12	11.73	4.47	090
45123		A	Partial proctectomy	18.86	NA	NA	9.74	7.92	2.28	090
45126		A	Pelvic exenteration	49.10	NA	NA	22.11	19.98	7.56	090
45130		A	Excision of rectal prolapse	18.50	NA	NA	9.43	7.67	2.25	090
45135		A	Excision of rectal prolapse	22.36	NA	NA	11.85	9.65	3.42	090
45136		A	Excise ileoanal reservior	30.82	NA	NA	16.13	13.55	3.17	090
45150		A	Excision of rectal stricture	5.85	NA	NA	4.18	3.73	0.59	090
45160		A	Excision of rectal lesion	16.33	NA	NA	8.89	7.46	2.50	090
45171		A	Exc rect tum transanal part	8.13	NA	NA	6.90	6.90	1.06	090
45172		A	Exc rect tum transanal full	12.13	NA	NA	8.37	8.37	1.61	090
45190		A	Destruction, rectal tumor	10.42	NA	NA	7.07	5.89	1.35	090
45300		A	Proctosigmoidoscopy dx	0.80	2.21	1.97	0.58	0.47	0.09	000
45303		A	Proctosigmoidoscopy dilate	1.50	21.14	20.03	0.84	0.66	0.18	000
45305		A	Proctosigmoidoscopy w/bx	1.25	3.47	3.18	0.75	0.64	0.16	000
45307		A	Proctosigmoidoscopy fb	1.70	3.71	3.28	0.91	0.72	0.23	000
45308		A	Proctosigmoidoscopy removal	1.40	3.75	3.22	0.81	0.66	0.18	000
45309		A	Proctosigmoidoscopy removal	1.50	3.82	3.52	0.85	0.78	0.19	000
45315		A	Proctosigmoidoscopy removal	1.80	3.87	3.63	0.96	0.86	0.24	000
45317		A	Proctosigmoidoscopy bleed	2.00	3.77	3.32	1.03	0.83	0.24	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
45320		A	Proctosigmoidoscopy ablate	1.78	3.62	3.47	0.96	0.88	0.23	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	NA	0.96	0.85	0.24	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	NA	1.15	1.03	0.31	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.44	2.47	0.65	0.62	0.11	000
45331		A	Sigmoidoscopy and biopsy	1.15	2.94	3.17	0.76	0.77	0.13	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.18	5.36	1.02	1.00	0.20	000
45333		A	Sigmoidoscopy & polypectomy	1.79	5.30	5.43	1.01	0.99	0.21	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	NA	1.44	1.48	0.29	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	4.84	4.78	0.88	0.87	0.16	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	NA	1.26	1.24	0.28	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.35	5.64	1.26	1.27	0.26	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	5.17	5.17	1.61	1.62	0.35	000
45340		A	Sig w/balloon dilation	1.89	9.47	9.32	1.05	1.04	0.22	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	NA	1.39	1.42	0.28	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	NA	2.03	2.09	0.43	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	NA	1.51	1.54	0.32	000
45355		A	Surgical colonoscopy	3.51	NA	NA	1.70	1.59	0.42	000
45378		A	Diagnostic colonoscopy	3.69	5.90	6.26	1.83	1.82	0.42	000
45378	53	A	Diagnostic colonoscopy	0.96	2.44	2.47	0.65	0.62	0.11	000
45379		A	Colonoscopy w/fb removal	4.68	7.61	7.97	2.25	2.22	0.53	000
45380		A	Colonoscopy and biopsy	4.43	6.99	7.50	2.17	2.21	0.49	000
45381		A	Colonoscopy, submucous inj	4.19	6.89	7.43	2.07	2.11	0.45	000
45382		A	Colonoscopy/control bleeding	5.68	9.14	10.01	2.73	2.81	0.61	000
45383		A	Lesion removal colonoscopy	5.86	8.08	8.37	2.71	2.67	0.67	000
45384		A	Lesion remove colonoscopy	4.69	6.76	7.06	2.23	2.21	0.54	000
45385		A	Lesion removal colonoscopy	5.30	7.60	8.13	2.54	2.58	0.58	000
45386		A	Colonoscopy dilate stricture	4.57	11.26	12.10	2.19	2.19	0.52	000
45387		A	Colonoscopy w/stent	5.90	NA	NA	2.91	2.93	0.65	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	NA	2.46	2.52	0.54	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	NA	3.08	3.15	0.73	000
45395		A	Lap, removal of rectum	33.00	NA	NA	17.69	14.87	4.31	090
45397		A	Lap, remove rectum w/pouch	36.50	NA	NA	18.73	15.53	4.34	090
45400		A	Laparoscopic proc	19.44	NA	NA	9.84	8.22	2.57	090
45402		A	Lap proctopexy w/sig resect	26.51	NA	NA	12.50	10.35	3.46	090
45499		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45500		A	Repair of rectum	7.73	NA	NA	5.60	4.68	0.86	090
45505		A	Repair of rectum	8.36	NA	NA	6.47	5.33	1.07	090
45520		A	Treatment of rectal prolapse	0.55	3.21	2.74	0.48	0.41	0.06	000
45540		A	Correct rectal prolapse	18.12	NA	NA	8.87	7.39	2.25	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
45541		A	Correct rectal prolapse	14.85	NA	NA	8.73	7.25	1.87	090
45550		A	Repair rectum/remove sigmoid	24.80	NA	NA	12.51	10.29	3.22	090
45560		A	Repair of rectocele	11.50	NA	NA	6.33	5.82	1.28	090
45562		A	Exploration/repair of rectum	17.98	NA	NA	10.04	8.71	2.42	090
45563		A	Exploration/repair of rectum	26.38	NA	NA	14.49	12.05	4.05	090
45800		A	Repair rect/bladder fistula	20.31	NA	NA	9.97	9.42	2.44	090
45805		A	Repair fistula w/colostomy	23.32	NA	NA	12.94	10.80	3.58	090
45820		A	Repair rectourethral fistula	20.37	NA	NA	9.05	9.12	1.43	090
45825		A	Repair fistula w/colostomy	24.17	NA	NA	13.68	11.74	2.49	090
45900		A	Reduction of rectal prolapse	2.99	NA	NA	2.08	1.78	0.40	010
45905		A	Dilation of anal sphincter	2.35	NA	NA	1.89	1.69	0.30	010
45910		A	Dilation of rectal narrowing	2.85	NA	NA	2.05	1.90	0.34	010
45915		A	Remove rectal obstruction	3.19	4.76	4.41	2.43	2.18	0.38	010
45990		A	Surg dx exam, anorectal	1.80	NA	NA	0.94	0.83	0.23	000
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	3.00	3.84	3.23	2.87	2.41	0.39	010
46030		A	Removal of rectal marker	1.26	2.17	1.88	1.01	0.86	0.16	010
46040		A	Incision of rectal abscess	5.37	7.68	6.72	4.88	4.22	0.74	090
46045		A	Incision of rectal abscess	5.87	NA	NA	4.90	4.07	0.82	090
46050		A	Incision of anal abscess	1.24	3.66	3.20	1.20	1.02	0.16	010
46060		A	Incision of rectal abscess	6.37	NA	NA	5.50	4.58	0.83	090
46070		A	Incision of anal septum	2.79	NA	NA	2.84	2.68	0.14	090
46080		A	Incision of anal sphincter	2.52	3.60	3.11	1.48	1.25	0.35	010
46083		A	Incise external hemorrhoid	1.45	2.80	2.78	1.23	1.13	0.18	010
46200		A	Removal of anal fissure	3.59	7.27	6.14	4.48	3.81	0.44	090
46220		A	Excise anal ext tag/papilla	1.61	3.44	3.03	1.37	1.17	0.21	010
46221		A	Ligation of hemorrhoid(s)	2.36	4.26	3.71	2.40	2.09	0.29	010
46230		A	Removal of anal tags	2.62	4.13	3.63	1.73	1.47	0.34	010
46250		A	Remove ext hem groups = 2	4.25	7.02	6.21	3.55	3.05	0.58	090
46255		A	Remove int/ext hem 1 group	4.96	7.43	6.62	3.85	3.30	0.68	090
46257		A	Remove in/ex hem grp & fiss	5.76	NA	NA	4.81	3.98	0.76	090
46258		A	Remove in/ex hem grp w/fistu	6.41	NA	NA	5.20	4.30	0.96	090
46260		A	Remove in/ex hem groups = 2	6.73	NA	NA	5.13	4.27	0.90	090
46261		A	Remove in/ex hem grps & fiss	7.76	NA	NA	5.54	4.60	0.99	090
46262		A	Remove in/ex hem grps w/fist	7.91	NA	NA	5.97	4.98	1.01	090
46270		A	Remove anal fist subq	4.92	7.50	6.48	4.79	4.01	0.68	090
46275		A	Remove anal fist inter	5.42	7.83	6.65	4.93	4.11	0.68	090
46280		A	Remove anal fist complex	6.39	NA	NA	5.36	4.45	0.79	090
46285		A	Remove anal fist 2 stage	5.42	7.76	6.42	4.94	4.06	0.65	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
46288		A	Repair anal fistula	7.81	NA	NA	5.98	4.97	0.96	090
46320		A	Removal of hemorrhoid clot	1.64	2.86	2.50	1.15	0.97	0.21	010
46500		A	Injection into hemorrhoid(s)	1.69	4.13	3.50	1.57	1.34	0.19	010
46505		A	Chemodenervation anal musc	3.18	3.93	3.46	2.83	2.42	0.41	010
46600		A	Diagnostic anoscopy	0.55	1.58	1.48	0.48	0.40	0.06	000
46604		A	Anoscopy and dilation	1.03	13.61	12.10	0.66	0.58	0.12	000
46606		A	Anoscopy and biopsy	1.20	4.24	4.01	0.73	0.61	0.16	000
46608		A	Anoscopy, remove for body	1.30	4.34	4.05	0.70	0.64	0.17	000
46610		A	Anoscopy, remove lesion	1.28	4.22	3.99	0.77	0.66	0.18	000
46611		A	Anoscopy	1.30	2.93	2.79	0.76	0.67	0.16	000
46612		A	Anoscopy, remove lesions	1.50	4.92	4.73	0.86	0.79	0.23	000
46614		A	Anoscopy, control bleeding	1.00	2.14	2.08	0.65	0.63	0.11	000
46615		A	Anoscopy	1.50	2.00	1.97	0.84	0.79	0.21	000
46700		A	Repair of anal stricture	9.81	NA	NA	6.74	5.53	1.17	090
46705		A	Repair of anal stricture	7.43	NA	NA	5.23	4.93	0.37	090
46706		A	Repr of anal fistula w/glue	2.44	NA	NA	1.79	1.57	0.31	010
46707		A	Repair anorectal fist w/plug	6.39	NA	NA	5.27	5.27	0.65	090
46710		A	Repr per/vag pouch sngl proc	17.14	NA	NA	10.23	8.81	2.63	090
46712		A	Repr per/vag pouch dbl proc	36.45	NA	NA	17.32	15.38	1.84	090
46715		A	Rep perf anoper fistu	7.62	NA	NA	4.92	4.56	0.38	090
46716		A	Rep perf anoper/vestib fistu	17.54	NA	NA	10.72	12.18	0.86	090
46730		A	Construction of absent anus	30.65	NA	NA	24.85	17.31	1.52	090
46735		A	Construction of absent anus	36.14	NA	NA	18.11	16.95	1.81	090
46740		A	Construction of absent anus	33.90	NA	NA	19.21	15.99	5.17	090
46742		A	Repair of imperforated anus	40.14	NA	NA	21.43	18.27	6.13	090
46744		A	Repair of cloacal anomaly	58.94	NA	NA	27.63	22.92	6.06	090
46746		A	Repair of cloacal anomaly	65.44	NA	NA	28.92	27.60	3.27	090
46748		A	Repair of cloacal anomaly	71.42	NA	NA	31.10	29.01	3.57	090
46750		A	Repair of anal sphincter	12.15	NA	NA	7.29	6.25	1.42	090
46751		A	Repair of anal sphincter	9.30	NA	NA	5.72	5.71	1.12	090
46753		A	Reconstruction of anus	8.89	NA	NA	5.90	4.97	1.07	090
46754		A	Removal of suture from anus	3.01	4.33	3.92	2.81	2.35	0.30	010
46760		A	Repair of anal sphincter	17.45	NA	NA	10.64	8.74	1.79	090
46761		A	Repair of anal sphincter	15.29	NA	NA	8.64	7.17	1.75	090
46762		A	Implant artificial sphincter	14.82	NA	NA	8.89	7.48	1.52	090
46900		A	Destruction, anal lesion(s)	1.91	4.04	3.62	1.60	1.42	0.22	010
46910		A	Destruction, anal lesion(s)	1.91	4.34	3.89	1.49	1.29	0.24	010
46916		A	Cryosurgery, anal lesion(s)	1.91	3.79	3.75	1.77	1.66	0.19	010
46917		A	Laser surgery, anal lesions	1.91	9.14	9.03	1.44	1.29	0.23	010
46922		A	Excision of anal lesion(s)	1.91	4.62	4.13	1.49	1.28	0.25	010
46924		A	Destruction, anal lesion(s)	2.81	10.27	9.69	1.90	1.64	0.33	010
46930		A	Destroy internal hemorrhoids	1.61	3.30	3.54	2.00	2.10	0.08	090
46940		A	Treatment of anal fissure	2.35	3.34	2.85	1.40	1.18	0.27	010
46942		A	Treatment of anal fissure	2.07	3.31	2.79	1.30	1.08	0.23	010
46945		A	Remove by ligat int hem grp	2.21	5.26	4.65	3.35	3.00	0.27	090
46946		A	Remove by ligat int hem grps	2.63	4.93	4.58	2.92	2.71	0.32	090
46947		A	Hemorrhoidopexy by stapling	5.57	NA	NA	3.98	3.35	0.77	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	6.90	6.69	0.60	0.71	0.14	000
47001		A	Needle biopsy, liver add-on	1.90	NA	NA	0.69	0.60	0.28	ZZZ
47010		A	Open drainage, liver lesion	19.40	NA	NA	10.41	9.16	2.85	090
47011		A	Percut drain, liver lesion	3.69	NA	NA	1.11	1.36	0.26	000
47015		A	Inject/aspirate liver cyst	18.50	NA	NA	10.35	8.68	2.84	090
47100		A	Wedge biopsy of liver	12.91	NA	NA	8.08	6.92	1.94	090
47120		A	Partial removal of liver	39.01	NA	NA	18.94	16.12	5.96	090
47122		A	Extensive removal of liver	59.48	NA	NA	23.96	22.05	9.15	090
47125		A	Partial removal of liver	53.04	NA	NA	23.55	20.01	8.11	090
47130		A	Partial removal of liver	57.19	NA	NA	24.91	21.28	8.73	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	83.64	NA	NA	38.04	32.35	12.80	090
47136		R	Transplantation of liver	70.74	NA	NA	33.52	28.39	10.88	090
47140		A	Partial removal, donor liver	59.40	NA	NA	29.23	24.60	9.16	090
47141		A	Partial removal, donor liver	71.50	NA	NA	32.09	28.46	3.59	090
47142		A	Partial removal, donor liver	79.44	NA	NA	37.37	31.54	12.25	090
47143		C	Prep donor liver, whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47146		A	Prep donor liver/venous	6.00	NA	NA	2.21	1.89	0.92	XXX
47147		A	Prep donor liver/arterial	7.00	NA	NA	2.58	2.20	1.06	XXX
47300		A	Surgery for liver lesion	18.14	NA	NA	10.12	8.48	2.76	090
47350		A	Repair liver wound	22.49	NA	NA	11.65	9.94	3.38	090
47360		A	Repair liver wound	31.31	NA	NA	14.85	12.76	4.82	090
47361		A	Repair liver wound	52.60	NA	NA	22.68	19.43	7.73	090
47362		A	Repair liver wound	23.54	NA	NA	12.30	10.29	3.55	090
47370		A	Laparo ablate liver tumor rf	20.80	NA	NA	10.10	8.68	3.05	090
47371		A	Laparo ablate liver cryosurg	20.80	NA	NA	10.40	9.16	3.20	090
47379		C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	24.56	NA	NA	11.36	9.89	3.56	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
47381		A	Open ablate liver tumor cryo	24.88	NA	NA	11.90	10.35	3.82	090
47382		A	Percut ablate liver rf	15.22	102.11	31.02	5.05	6.35	1.06	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.36	NA	NA	17.18	14.50	5.61	090
47420		A	Incision of bile duct	22.03	NA	NA	11.34	9.65	3.37	090
47425		A	Incision of bile duct	22.31	NA	NA	11.62	9.76	3.43	090
47460		A	Incise bile duct sphincter	20.52	NA	NA	11.11	9.81	3.16	090
47480		A	Incision of gallbladder	13.25	NA	NA	8.38	7.17	1.98	090
47490		A	Incision of gallbladder	8.13	NA	NA	4.58	5.43	0.55	090
47500		A	Injection for liver x-rays	1.96	NA	NA	0.58	0.72	0.14	000
47505		A	Injection for liver x-rays	0.76	NA	NA	0.23	0.28	0.05	000
47510		A	Insert catheter, bile duct	8.03	NA	NA	4.01	4.79	0.57	090
47511		A	Insert bile duct drain	10.77	NA	NA	4.23	5.19	0.73	090
47525		A	Change bile duct catheter	1.54	10.47	11.80	0.67	1.20	0.10	000
47530		A	Revise/reinsert bile tube	6.05	28.06	31.11	2.99	3.58	0.43	090
47550		A	Bile duct endoscopy add-on	3.02	NA	NA	1.12	0.97	0.45	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	NA	2.16	2.59	0.45	000
47553		A	Biliary endoscopy thru skin	6.34	NA	NA	1.91	2.31	0.45	000
47554		A	Biliary endoscopy thru skin	9.05	NA	NA	3.40	3.50	1.09	000
47555		A	Biliary endoscopy thru skin	7.55	NA	NA	2.19	2.78	0.52	000
47556		A	Biliary endoscopy thru skin	8.55	NA	NA	2.52	3.16	0.58	000
47560		A	Laparoscopy w/cholangio	4.88	NA	NA	1.80	1.56	0.75	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	NA	2.16	1.87	0.79	000
47562		A	Laparoscopic cholecystectomy	11.76	NA	NA	6.89	5.81	1.79	090
47563		A	Laparo cholecystectomy/graph	12.11	NA	NA	6.71	5.72	1.86	090
47564		A	Laparo cholecystectomy/explr	14.24	NA	NA	7.24	6.20	2.19	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	NA	6.68	5.71	1.95	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	17.48	NA	NA	9.52	7.86	2.66	090
47605		A	Removal of gallbladder	15.98	NA	NA	8.45	7.17	2.45	090
47610		A	Removal of gallbladder	20.92	NA	NA	10.32	8.71	3.21	090
47612		A	Removal of gallbladder	21.21	NA	NA	10.32	8.73	3.26	090
47620		A	Removal of gallbladder	23.07	NA	NA	11.04	9.37	3.55	090
47630		A	Remove bile duct stone	9.65	NA	NA	4.37	4.94	0.86	090
47700		A	Exploration of bile ducts	16.50	NA	NA	9.60	8.25	2.54	090
47701		A	Bile duct revision	28.73	NA	NA	14.35	13.26	4.43	090
47711		A	Excision of bile duct tumor	25.90	NA	NA	12.81	10.91	3.96	090
47712		A	Excision of bile duct tumor	33.72	NA	NA	15.96	13.39	5.20	090
47715		A	Excision of bile duct cyst	21.55	NA	NA	11.47	9.57	3.31	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
47720		A	Fuse gallbladder & bowel	18.34	NA	NA	10.30	8.62	2.80	090
47721		A	Fuse upper gi structures	21.99	NA	NA	11.63	9.73	3.38	090
47740		A	Fuse gallbladder & bowel	21.23	NA	NA	11.35	9.46	3.26	090
47741		A	Fuse gallbladder & bowel	24.21	NA	NA	12.45	10.43	3.72	090
47760		A	Fuse bile ducts and bowel	38.32	NA	NA	17.81	14.43	5.85	090
47765		A	Fuse liver ducts & bowel	52.19	NA	NA	23.39	18.34	8.04	090
47780		A	Fuse bile ducts and bowel	42.32	NA	NA	19.30	15.52	6.49	090
47785		A	Fuse bile ducts and bowel	56.19	NA	NA	24.70	19.52	8.68	090
47800		A	Reconstruction of bile ducts	26.17	NA	NA	13.07	11.04	4.02	090
47801		A	Placement, bile duct support	17.60	NA	NA	8.15	8.78	1.77	090
47802		A	Fuse liver duct & intestine	24.93	NA	NA	12.97	10.91	3.83	090
47900		A	Suture bile duct injury	22.44	NA	NA	11.65	9.82	3.40	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	31.95	NA	NA	14.26	12.53	4.47	090
48001		A	Placement of drain, pancreas	39.69	NA	NA	17.73	14.90	6.12	090
48020		A	Removal of pancreatic stone	19.09	NA	NA	10.14	8.59	2.93	090
48100		A	Biopsy of pancreas, open	14.46	NA	NA	7.59	6.50	2.16	090
48102		A	Needle biopsy, pancreas	4.70	8.55	9.25	1.60	1.98	0.32	010
48105		A	Resect/debride pancreas	49.26	NA	NA	21.87	18.26	7.43	090
48120		A	Removal of pancreas lesion	18.41	NA	NA	9.15	7.72	2.82	090
48140		A	Partial removal of pancreas	26.32	NA	NA	12.58	10.62	4.02	090
48145		A	Partial removal of pancreas	27.39	NA	NA	13.20	10.99	4.22	090
48146		A	Pancreatectomy	30.60	NA	NA	15.70	13.31	4.70	090
48148		A	Removal of pancreatic duct	20.39	NA	NA	10.61	8.85	3.13	090
48150		A	Partial removal of pancreas	52.84	NA	NA	24.45	20.75	8.12	090
48152		A	Pancreatectomy	48.65	NA	NA	23.09	19.48	7.50	090
48153		A	Pancreatectomy	52.79	NA	NA	24.37	20.67	8.11	090
48154		A	Pancreatectomy	48.88	NA	NA	23.18	19.44	7.53	090
48155		A	Removal of pancreas	29.45	NA	NA	15.57	13.24	4.53	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48400		A	Injection, intraop add-on	1.95	NA	NA	0.87	0.76	0.21	ZZZ
48500		A	Surgery of pancreatic cyst	18.16	NA	NA	10.40	8.71	2.79	090
48510		A	Drain pancreatic pseudocyst	17.19	NA	NA	9.79	8.35	2.59	090
48511		A	Drain pancreatic pseudocyst	3.99	18.32	20.24	1.19	1.47	0.28	000
48520		A	Fuse pancreas cyst and bowel	18.15	NA	NA	9.07	7.68	2.78	090
48540		A	Fuse pancreas cyst and bowel	21.94	NA	NA	10.63	8.85	3.38	090
48545		A	Pancreatorrhaphy	22.23	NA	NA	11.19	9.23	3.42	090
48547		A	Duodenal exclusion	30.38	NA	NA	14.19	11.77	4.68	090
48548		A	Fuse pancreas and bowel	28.09	NA	NA	13.19	11.25	4.31	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	NA	1.59	1.39	0.66	XXX
48554		R	Transpl allograft pancreas	37.80	NA	NA	25.75	22.09	5.61	090
48556		A	Removal, allograft pancreas	19.47	NA	NA	12.13	10.23	2.98	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	12.54	NA	NA	6.69	5.83	1.86	090
49002		A	Reopening of abdomen	17.63	NA	NA	8.49	6.93	2.63	090
49010		A	Exploration behind abdomen	16.06	NA	NA	7.48	6.77	2.31	090
49020		A	Drain abdominal abscess	26.67	NA	NA	13.05	11.17	3.89	090
49021		A	Drain abdominal abscess	3.37	17.80	19.77	1.01	1.24	0.23	000
49040		A	Drain, open, abdom abscess	16.52	NA	NA	8.47	7.26	2.43	090
49041		A	Drain, percut, abdom abscess	3.99	17.94	19.68	1.19	1.46	0.27	000
49060		A	Drain, open, retrop abscess	18.53	NA	NA	8.93	8.02	2.65	090
49061		A	Drain, percut, retroper absc	3.69	17.85	19.58	1.10	1.35	0.25	000
49062		A	Drain to peritoneal cavity	12.22	NA	NA	6.13	5.68	1.80	090
49080		A	Puncture, peritoneal cavity	1.35	2.51	2.96	0.44	0.50	0.10	000
49081		A	Removal of abdominal fluid	1.26	2.79	2.87	0.46	0.48	0.12	000
49180		A	Biopsy, abdominal mass	1.73	2.21	2.60	0.52	0.64	0.12	000
49203		A	Exc abd tum 5 cm or less	20.13	NA	NA	9.81	8.62	2.84	090
49204		A	Exc abd tum over 5 cm	26.13	NA	NA	12.02	10.50	3.66	090
49205		A	Exc abd tum over 10 cm	30.13	NA	NA	13.57	11.78	4.35	090
49215		A	Excise sacral spine tumor	37.81	NA	NA	16.99	14.67	5.45	090
49220		A	Multiple surgery, abdomen	15.79	NA	NA	8.30	7.15	2.43	090
49250		A	Excision of umbilicus	9.01	NA	NA	5.44	4.77	1.31	090
49255		A	Removal of omentum	12.56	NA	NA	7.13	6.20	1.82	090
49320		A	Diag laparo separate proc	5.14	NA	NA	3.03	2.71	0.73	010
49321		A	Laparoscopy, biopsy	5.44	NA	NA	3.21	2.83	0.79	010
49322		A	Laparoscopy, aspiration	6.01	NA	NA	3.28	2.97	0.82	010
49323		A	Laparo drain lymphocele	10.23	NA	NA	5.61	5.05	1.53	090
49324		A	Lap insertion perm ip cath	6.32	NA	NA	3.54	3.07	0.96	010
49325		A	Lap revision perm ip cath	6.82	NA	NA	3.70	3.21	1.05	010
49326		A	Lap w/omentopexy add-on	3.50	NA	NA	1.26	1.05	0.54	ZZZ
49329		C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	2.36	2.64	0.59	0.67	0.17	000
49402		A	Remove foreign body, adbomen	14.09	NA	NA	7.21	6.19	2.09	090
49411		A	Ins mark abd/pel for rt perq	3.82	9.91	9.91	1.42	1.42	0.26	000
49419		A	Insrt abdom cath for chemotx	7.08	NA	NA	4.00	3.75	0.88	090
49420		A	Insert abdom drain, temp	2.22	NA	NA	1.18	1.20	0.25	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
49421		A	Insert abdom drain, perm	5.90	NA	NA	3.67	3.37	0.84	090
49422		A	Remove perm cannula/catheter	6.29	NA	NA	3.28	2.95	0.94	010
49423		A	Exchange drainage catheter	1.46	11.97	13.22	0.46	0.57	0.10	000
49424		A	Assess cyst, contrast inject	0.76	2.81	3.19	0.25	0.31	0.05	000
49425		A	Insert abdomen-venous drain	12.22	NA	NA	6.44	5.88	1.93	090
49426		A	Revise abdomen-venous shunt	10.41	NA	NA	5.41	5.00	1.50	090
49427		A	Injection, abdominal shunt	0.89	NA	NA	0.28	0.33	0.08	000
49428		A	Ligation of shunt	6.87	NA	NA	3.85	3.58	1.04	010
49429		A	Removal of shunt	7.44	NA	NA	3.60	3.39	1.15	010
49435		A	Insert subq exten to ip cath	2.25	NA	NA	0.76	0.65	0.34	ZZZ
49436		A	Embedded ip cath exit-site	2.72	NA	NA	1.93	1.72	0.41	010
49440		A	Place gastrostomy tube perc	4.18	21.33	24.04	1.66	1.88	0.34	010
49441		A	Place duod/jej tube perc	4.77	22.91	25.99	1.84	2.08	0.40	010
49442		A	Place cecostomy tube perc	4.00	18.28	22.94	1.64	1.71	0.27	010
49446		A	Change g-tube to g-j perc	3.31	20.47	22.64	0.99	1.23	0.23	000
49450		A	Replace g/c tube perc	1.36	14.56	17.63	0.42	0.47	0.10	000
49451		A	Replace duod/jej tube perc	1.84	15.46	16.76	0.57	0.69	0.14	000
49452		A	Replace g-j tube perc	2.86	18.51	20.42	0.86	1.07	0.20	000
49460		A	Fix g/colon tube w/device	0.96	16.40	19.87	0.30	0.34	0.08	000
49465		A	Fluoro exam of g/colon tube	0.62	3.49	3.84	0.19	0.23	0.04	000
49491		A	Rpr hern preemie reduc	12.53	NA	NA	7.13	5.98	1.93	090
49492		A	Rpr ing hern premie, blocked	15.43	NA	NA	6.60	6.60	2.37	090
49495		A	Rpr ing hernia baby, reduc	6.20	NA	NA	3.95	3.24	0.94	090
49496		A	Rpr ing hernia baby, blocked	9.42	NA	NA	5.78	4.89	1.58	090
49500		A	Rpr ing hernia, init, reduce	5.84	NA	NA	4.33	3.62	0.88	090
49501		A	Rpr ing hernia, init blocked	9.36	NA	NA	5.63	4.78	1.44	090
49505		A	Prp i/hern init reduc >5 yr	7.96	NA	NA	4.97	4.26	1.19	090
49507		A	Prp i/hern init block >5 yr	10.05	NA	NA	5.79	4.95	1.52	090
49520		A	Rerepair ing hernia, reduce	9.99	NA	NA	5.70	4.88	1.52	090
49521		A	Rerepair ing hernia, blocked	12.44	NA	NA	6.57	5.63	1.89	090
49525		A	Repair ing hernia, sliding	8.93	NA	NA	5.31	4.55	1.34	090
49540		A	Repair lumbar hernia	10.74	NA	NA	6.06	5.16	1.63	090
49550		A	Rpr rem hernia, init, reduce	8.99	NA	NA	5.32	4.55	1.36	090
49553		A	Rpr fem hernia, init blocked	9.92	NA	NA	5.76	4.90	1.51	090
49555		A	Rerepair fem hernia, reduce	9.39	NA	NA	5.52	4.70	1.43	090
49557		A	Rerepair fem hernia, blocked	11.62	NA	NA	6.39	5.45	1.78	090
49560		A	Rpr ventral hern init, reduc	11.92	NA	NA	6.43	5.50	1.81	090
49561		A	Rpr ventral hern init, block	15.38	NA	NA	7.76	6.58	2.34	090
49565		A	Rerepair ventrl hern, reduce	12.37	NA	NA	6.73	5.74	1.88	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
49566		A	Rerepair ventrl hern, block	15.53	NA	NA	7.84	6.65	2.37	090
49568		A	Hernia repair w/mesh	4.88	NA	NA	1.80	1.54	0.74	ZZZ
49570		A	Rpr epigastric hern, reduce	6.05	NA	NA	4.26	3.65	0.91	090
49572		A	Rpr epigastric hern, blocked	7.87	NA	NA	4.91	4.15	1.19	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.47	NA	NA	4.79	3.44	0.67	090
49582		A	Rpr umbil hern, block < 5 yr	7.13	NA	NA	4.81	4.07	1.08	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.59	NA	NA	4.44	3.81	0.98	090
49587		A	Rpr umbil hern, block > 5 yr	8.04	NA	NA	4.98	4.25	1.21	090
49590		A	Repair spigelian hernia	8.90	NA	NA	5.30	4.53	1.34	090
49600		A	Repair umbilical lesion	11.55	NA	NA	6.55	5.78	1.78	090
49605		A	Repair umbilical lesion	87.09	NA	NA	35.71	31.44	13.43	090
49606		A	Repair umbilical lesion	19.00	NA	NA	9.12	7.79	2.93	090
49610		A	Repair umbilical lesion	10.91	NA	NA	6.13	5.34	1.68	090
49611		A	Repair umbilical lesion	9.34	NA	NA	5.05	5.17	0.46	090
49650		A	Lap ing hernia repair init	6.36	NA	NA	4.27	3.66	0.96	090
49651		A	Lap ing hernia repair recur	8.38	NA	NA	5.45	4.63	1.26	090
49652		A	Lap vent/abd hernia repair	12.88	NA	NA	6.96	5.91	0.64	090
49653		A	Lap vent/abd hern proc comp	16.21	NA	NA	8.62	7.31	0.81	090
49654		A	Lap inc hernia repair	15.03	NA	NA	7.75	6.56	0.75	090
49655		A	Lap inc hern repair comp	18.11	NA	NA	9.32	7.88	0.90	090
49656		A	Lap inc hernia repair recur	15.08	NA	NA	7.77	6.57	0.75	090
49657		A	Lap inc hern recur comp	22.11	NA	NA	10.79	9.09	1.10	090
49659		C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.41	NA	NA	7.93	6.90	1.83	090
49904		A	Omental flap, extra-abdom	22.35	NA	NA	13.49	13.24	3.41	090
49905		A	Omental flap, intra-abdom	6.54	NA	NA	2.37	2.08	0.89	ZZZ
49906		C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	12.28	NA	NA	6.37	6.64	1.28	090
50020		A	Renal abscess, open drain	18.08	NA	NA	8.93	8.98	1.75	090
50021		A	Renal abscess, percut drain	3.37	19.02	21.02	1.00	1.23	0.23	000
50040		A	Drainage of kidney	16.68	NA	NA	7.38	8.61	1.21	090
50045		A	Exploration of kidney	16.82	NA	NA	7.49	8.58	1.17	090
50060		A	Removal of kidney stone	20.95	NA	NA	8.85	10.34	1.47	090
50065		A	Incision of kidney	22.32	NA	NA	9.30	10.55	1.56	090
50070		A	Incision of kidney	21.85	NA	NA	9.15	10.80	1.53	090
50075		A	Removal of kidney stone	27.09	NA	NA	11.06	13.02	1.90	090
50080		A	Removal of kidney stone	15.74	NA	NA	6.95	8.16	1.11	090
50081		A	Removal of kidney stone	23.50	NA	NA	9.90	11.60	1.68	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
50100		A	Revise kidney blood vessels	17.45	NA	NA	9.30	8.25	2.68	090
50120		A	Exploration of kidney	17.21	NA	NA	7.57	8.70	1.19	090
50125		A	Explore and drain kidney	17.82	NA	NA	9.44	9.29	1.24	090
50130		A	Removal of kidney stone	18.82	NA	NA	8.15	9.54	1.31	090
50135		A	Exploration of kidney	20.59	NA	NA	8.73	10.14	1.44	090
50200		A	Renal biopsy perq	2.63	12.11	4.05	1.08	1.24	0.22	000
50205		A	Renal biopsy open	12.29	NA	NA	6.48	5.87	1.74	090
5020F		I	Txmnts 2 main Dr by 1 mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50220		A	Remove kidney, open	18.68	NA	NA	8.32	9.28	1.62	090
50225		A	Removal kidney open, complex	21.88	NA	NA	9.36	10.50	1.73	090
50230		A	Removal kidney open, radical	23.81	NA	NA	9.68	11.21	1.79	090
50234		A	Removal of kidney & ureter	24.05	NA	NA	9.96	11.52	1.78	090
50236		A	Removal of kidney & ureter	26.94	NA	NA	11.40	13.33	1.91	090
50240		A	Partial removal of kidney	24.21	NA	NA	10.38	12.03	1.76	090
50250		A	Cryoablate renal mass open	22.22	NA	NA	9.70	11.38	1.57	090
50280		A	Removal of kidney lesion	17.09	NA	NA	7.70	8.75	1.34	090
50290		A	Removal of kidney lesion	16.15	NA	NA	7.27	7.67	1.12	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney, living donor	22.43	NA	NA	13.41	12.90	2.80	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	NA	1.44	1.30	0.57	XXX
50328		A	Prep renal graft/arterial	3.50	NA	NA	1.25	1.15	0.48	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	NA	1.15	1.21	0.34	XXX
50340		A	Removal of kidney	14.04	NA	NA	9.42	8.05	2.15	090
50360		A	Transplantation of kidney	40.90	NA	NA	23.12	19.86	5.95	090
50365		A	Transplantation of kidney	46.13	NA	NA	24.79	21.90	7.07	090
50370		A	Remove transplanted kidney	18.88	NA	NA	10.95	9.55	2.69	090
50380		A	Reimplantation of kidney	30.11	NA	NA	19.46	18.08	4.59	090
50382		A	Change ureter stent, percut	5.50	23.62	28.17	1.70	2.10	0.38	000
50384		A	Remove ureter stent, percut	5.00	18.68	23.60	1.55	1.92	0.34	000
50385		A	Change stent via transureth	4.44	24.05	28.56	1.61	2.05	0.31	000
50386		A	Remove stent via transureth	3.30	15.47	18.15	1.29	1.61	0.23	000
50387		A	Change ext/int ureter stent	2.00	11.39	13.59	0.59	0.75	0.14	000
50389		A	Remove renal tube w/fluoro	1.10	5.99	7.77	0.33	0.41	0.07	000
50390		A	Drainage of kidney lesion	1.96	NA	NA	0.58	0.72	0.13	000
50391		A	Instll rx agnt into rnal tub	1.96	1.26	1.49	0.70	0.78	0.14	000
50392		A	Insert kidney drain	3.37	NA	NA	1.27	1.56	0.23	000
50393		A	Insert ureteral tube	4.15	NA	NA	1.50	1.85	0.28	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
50394		A	Injection for kidney x-ray	0.76	1.67	2.02	0.50	0.60	0.05	000
50395		A	Create passage to kidney	3.37	NA	NA	1.30	1.59	0.23	000
50396		A	Measure kidney pressure	2.09	NA	NA	0.88	1.11	0.14	000
50398		A	Change kidney tube	1.46	10.76	12.60	0.47	0.58	0.10	000
50400		A	Revision of kidney/ureter	21.27	NA	NA	8.98	10.36	1.52	090
50405		A	Revision of kidney/ureter	25.86	NA	NA	10.66	12.40	1.82	090
50500		A	Repair of kidney wound	21.22	NA	NA	10.26	9.59	3.26	090
50520		A	Close kidney-skin fistula	18.88	NA	NA	8.17	9.35	1.31	090
50525		A	Repair renal-abdomen fistula	24.39	NA	NA	12.05	11.54	3.74	090
50526		A	Repair renal-abdomen fistula	26.31	NA	NA	11.88	11.26	1.31	090
50540		A	Revision of horseshoe kidney	21.10	NA	NA	8.90	9.96	1.48	090
50541		A	Laparo ablate renal cyst	16.86	NA	NA	7.21	8.35	1.23	090
50542		A	Laparo ablate renal mass	21.36	NA	NA	9.18	10.68	1.52	090
50543		A	Laparo partial nephrectomy	27.41	NA	NA	11.58	13.46	1.97	090
50544		A	Laparoscopy, pyeloplasty	23.37	NA	NA	9.32	10.92	1.70	090
50545		A	Laparo radical nephrectomy	25.06	NA	NA	10.09	11.78	1.84	090
50546		A	Laparoscopic nephrectomy	21.87	NA	NA	9.47	10.87	1.66	090
50547		A	Laparo removal donor kidney	26.34	NA	NA	13.92	13.09	3.48	090
50548		A	Laparo remove w/ureter	25.36	NA	NA	10.00	11.73	1.82	090
50549		C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	3.62	4.42	2.16	2.55	0.40	000
50553		A	Kidney endoscopy	5.98	3.83	4.53	2.22	2.63	0.47	000
50555		A	Kidney endoscopy & biopsy	6.52	4.03	4.89	2.46	2.90	0.46	000
50557		A	Kidney endoscopy & treatment	6.61	4.13	5.02	2.49	2.94	0.46	000
50561		A	Kidney endoscopy & treatment	7.58	4.62	5.61	2.81	3.33	0.54	000
50562		A	Renal scope w/tumor resect	10.90	NA	NA	4.34	5.19	0.76	090
50570		A	Kidney endoscopy	9.53	NA	NA	3.42	4.08	0.67	000
50572		A	Kidney endoscopy	10.33	NA	NA	3.68	4.41	0.72	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	NA	3.90	4.65	0.77	000
50575		A	Kidney endoscopy	13.96	NA	NA	4.88	5.82	0.98	000
50576		A	Kidney endoscopy & treatment	10.97	NA	NA	3.89	4.65	0.77	000
50580		A	Kidney endoscopy & treatment	11.84	NA	NA	4.18	4.91	0.83	000
50590		A	Fragmenting of kidney stone	9.77	13.09	15.51	4.91	5.71	0.68	090
50592		A	Perc rf ablate renal tumor	6.80	64.70	86.46	2.58	3.13	0.47	010
50593		A	Perc cryo ablate renal tum	9.13	98.27	115.07	3.49	3.63	0.62	010
50600		A	Exploration of ureter	17.17	NA	NA	7.36	8.47	1.19	090
50605		A	Insert ureteral support	16.79	NA	NA	7.84	7.97	1.92	090
50610		A	Removal of ureter stone	17.25	NA	NA	7.44	8.69	1.20	090
50620		A	Removal of ureter stone	16.43	NA	NA	7.17	8.37	1.14	090
50630		A	Removal of ureter stone	16.21	NA	NA	7.10	8.02	1.13	090
50650		A	Removal of ureter	18.82	NA	NA	8.21	9.48	1.35	090
50660		A	Removal of ureter	21.02	NA	NA	8.87	10.25	1.47	090
50684		A	Injection for ureter x-ray	0.76	3.32	4.04	0.52	0.60	0.05	000
50686		A	Measure ureter pressure	1.51	2.29	1.33	0.88	0.97	0.15	000
50688		A	Change of ureter tube/stent	1.20	NA	NA	0.83	0.98	0.08	010
50690		A	Injection for ureter x-ray	1.16	1.24	1.52	0.63	0.75	0.08	000
50700		A	Revision of ureter	16.69	NA	NA	7.67	8.63	1.16	090
50715		A	Release of ureter	20.64	NA	NA	9.68	9.28	2.17	090
50722		A	Release of ureter	17.95	NA	NA	8.76	8.15	2.19	090
50725		A	Release/revise ureter	20.20	NA	NA	8.60	9.55	1.41	090
50727		A	Revise ureter	8.28	NA	NA	4.73	5.43	0.60	090
50728		A	Revise ureter	12.18	NA	NA	5.97	6.68	0.84	090
50740		A	Fusion of ureter & kidney	20.07	NA	NA	10.27	9.46	3.08	090
50750		A	Fusion of ureter & kidney	21.22	NA	NA	8.94	10.55	1.49	090
50760		A	Fusion of ureters	20.07	NA	NA	8.96	9.65	1.93	090
50770		A	Splicing of ureters	21.22	NA	NA	8.94	9.70	1.49	090
50780		A	Reimplant ureter in bladder	19.95	NA	NA	8.78	9.79	1.68	090
50782		A	Reimplant ureter in bladder	19.66	NA	NA	8.43	9.44	3.02	090
50783		A	Reimplant ureter in bladder	20.70	NA	NA	10.50	9.85	1.45	090
50785		A	Reimplant ureter in bladder	22.23	NA	NA	9.40	10.81	1.63	090
50800		A	Implant ureter in bowel	16.41	NA	NA	7.59	8.70	1.25	090
50810		A	Fusion of ureter & bowel	22.61	NA	NA	12.04	10.77	3.46	090
50815		A	Urine shunt to intestine	22.26	NA	NA	9.66	11.19	1.56	090
50820		A	Construct bowel bladder	24.07	NA	NA	10.30	11.47	1.92	090
50825		A	Construct bowel bladder	30.68	NA	NA	12.55	14.47	2.29	090
50830		A	Revise urine flow	33.77	NA	NA	13.45	15.22	2.37	090
50840		A	Replace ureter by bowel	22.39	NA	NA	9.71	11.31	1.56	090
50845		A	Appendico-vesicostomy	22.46	NA	NA	10.11	11.73	1.57	090
50860		A	Transplant ureter to skin	17.08	NA	NA	7.58	8.73	1.19	090
50900		A	Repair of ureter	15.04	NA	NA	7.21	7.82	1.04	090
50920		A	Closure ureter/skin fistula	15.81	NA	NA	7.16	8.32	1.10	090
50930		A	Closure ureter/bowel fistula	20.19	NA	NA	8.60	9.17	3.10	090
50940		A	Release of ureter	15.93	NA	NA	7.20	8.22	1.11	090
50945		A	Laparoscopy ureterolithotomy	17.97	NA	NA	7.49	8.74	1.25	090
50947		A	Laparo new ureter/bladder	25.78	NA	NA	10.44	11.99	1.82	090
50948		A	Laparo new ureter/bladder	23.82	NA	NA	9.58	11.33	1.68	090
50949		C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	3.79	4.63	2.25	2.66	0.41	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
50953		A	Endoscopy of ureter	6.23	3.96	4.82	2.65	3.13	0.44	000
50955		A	Ureter endoscopy & biopsy	6.74	4.16	5.39	2.83	3.36	0.47	000
50957		A	Ureter endoscopy & treatment	6.78	4.23	5.11	2.56	3.01	0.47	000
50961		A	Ureter endoscopy & treatment	6.04	3.85	4.69	2.30	2.74	0.42	000
50970		A	Ureter endoscopy	7.13	NA	NA	2.63	3.13	0.50	000
50972		A	Ureter endoscopy & catheter	6.88	NA	NA	2.55	3.01	0.48	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	NA	3.30	3.93	0.64	000
50976		A	Ureter endoscopy & treatment	9.03	NA	NA	3.25	3.85	0.63	000
50980		A	Ureter endoscopy & treatment	6.84	NA	NA	2.54	3.02	0.48	000
5100F		I	Rsk fx ref w/n 24 hrs x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
51020		A	Incise & treat bladder	7.69	NA	NA	4.42	5.10	0.56	090
51030		A	Incise & treat bladder	7.81	NA	NA	4.04	4.76	0.54	090
51040		A	Incise & drain bladder	4.49	NA	NA	2.95	3.46	0.32	090
51045		A	Incise bladder/drain ureter	7.81	NA	NA	4.66	5.01	0.75	090
51050		A	Removal of bladder stone	7.97	NA	NA	4.27	4.97	0.56	090
51060		A	Removal of ureter stone	9.95	NA	NA	5.12	5.98	0.69	090
51065		A	Remove ureter calculus	9.95	NA	NA	5.06	5.87	0.69	090
51080		A	Drainage of bladder abscess	6.71	NA	NA	3.84	4.40	0.46	090
51100		A	Drain bladder by needle	0.78	0.80	0.88	0.25	0.28	0.06	000
51101		A	Drain bladder by trocar/cath	1.02	2.10	2.37	0.36	0.38	0.10	000
51102		A	Drain bl w/cath insertion	2.70	2.98	3.59	1.10	1.33	0.21	000
51500		A	Removal of bladder cyst	11.05	NA	NA	5.48	5.88	0.76	090
51520		A	Removal of bladder lesion	10.21	NA	NA	5.21	5.85	0.71	090
51525		A	Removal of bladder lesion	15.42	NA	NA	7.00	8.09	1.12	090
51530		A	Removal of bladder lesion	13.71	NA	NA	6.58	7.25	1.19	090
51535		A	Repair of ureter lesion	13.90	NA	NA	6.40	7.23	0.96	090
51550		A	Partial removal of bladder	17.23	NA	NA	7.80	8.59	1.54	090
51555		A	Partial removal of bladder	23.18	NA	NA	9.88	11.09	1.88	090
51565		A	Revise bladder & ureter(s)	23.68	NA	NA	10.13	11.44	1.76	090
51570		A	Removal of bladder	27.46	NA	NA	11.24	12.68	2.03	090
51575		A	Removal of bladder & nodes	34.18	NA	NA	13.61	15.84	2.41	090
51580		A	Remove bladder/revise tract	35.37	NA	NA	14.27	16.77	2.48	090
51585		A	Removal of bladder & nodes	39.64	NA	NA	15.67	18.42	2.78	090
51590		A	Remove bladder/revise tract	36.33	NA	NA	14.29	16.58	2.65	090
51595		A	Remove bladder/revise tract	41.32	NA	NA	16.11	18.78	2.97	090
51596		A	Remove bladder/create pouch	44.26	NA	NA	17.43	20.38	3.13	090
51597		A	Removal of pelvic structures	42.86	NA	NA	17.16	19.54	3.28	090
51600		A	Injection for bladder x-ray	0.88	3.57	4.29	0.28	0.33	0.06	000
51605		A	Preparation for bladder xray	0.64	NA	NA	0.35	0.41	0.04	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
51610		A	Injection for bladder x-ray	1.05	1.60	1.94	0.59	0.68	0.07	000
51700		A	Irrigation of bladder	0.88	1.19	1.46	0.30	0.34	0.07	000
51701		A	Insert bladder catheter	0.50	0.85	1.11	0.22	0.24	0.04	000
51702		A	Insert temp bladder cath	0.50	1.23	1.58	0.28	0.32	0.04	000
51703		A	Insert bladder cath, complex	1.47	1.78	2.28	0.66	0.76	0.11	000
51705		A	Change of bladder tube	1.05	1.58	2.00	0.69	0.79	0.07	010
51710		A	Change of bladder tube	1.52	2.11	2.74	0.94	1.09	0.11	010
51715		A	Endoscopic injection/implant	3.73	3.54	4.20	1.50	1.69	0.30	000
51720		A	Treatment of bladder lesion	1.50	1.27	1.60	0.61	0.74	0.11	000
51725		A	Simple cystometrogram	1.51	3.35	4.32	NA	NA	0.10	000
51725	TC	A	Simple cystometrogram	0.00	2.83	3.75	NA	NA	0.01	000
51725	26	A	Simple cystometrogram	1.51	0.52	0.57	0.52	0.57	0.09	000
51726		A	Complex cystometrogram	1.71	5.56	6.85	NA	NA	0.15	000
51726	TC	A	Complex cystometrogram	0.00	4.97	6.20	NA	NA	0.05	000
51726	26	A	Complex cystometrogram	1.71	0.59	0.65	0.59	0.65	0.10	000
51727		A	Cystometrogram w/up	2.11	5.81	5.81	NA	NA	0.15	000
51727	TC	A	Cystometrogram w/up	0.00	5.06	5.06	NA	NA	0.01	000
51727	26	A	Cystometrogram w/up	2.11	0.75	0.75	0.75	0.75	0.14	000
51728		A	Cystometrogram w/vp	2.11	5.82	5.82	NA	NA	0.13	000
51728	TC	A	Cystometrogram w/vp	0.00	5.09	5.09	NA	NA	0.01	000
51728	26	A	Cystometrogram w/vp	2.11	0.73	0.73	0.73	0.73	0.12	000
51729		A	Cystometrogram w/vp&up	2.11	5.89	5.89	NA	NA	0.14	000
51729	TC	A	Cystometrogram w/vp&up	0.00	5.15	5.15	NA	NA	0.01	000
51729	26	A	Cystometrogram w/vp&up	2.11	0.74	0.74	0.74	0.74	0.13	000
51736		A	Urine flow measurement	0.61	0.73	0.84	NA	NA	0.04	000
51736	TC	A	Urine flow measurement	0.00	0.52	0.60	NA	NA	0.01	000
51736	26	A	Urine flow measurement	0.61	0.21	0.24	0.21	0.24	0.03	000
51741		A	Electro-uroflowmetry, first	1.14	0.99	1.14	NA	NA	0.06	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.61	0.70	NA	NA	0.01	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.38	0.44	0.38	0.44	0.05	000
51784		A	Anal/urinary muscle study	1.53	3.31	3.90	NA	NA	0.10	000
51784	TC	A	Anal/urinary muscle study	0.00	2.78	3.33	NA	NA	0.01	000
51784	26	A	Anal/urinary muscle study	1.53	0.53	0.57	0.53	0.57	0.09	000
51785		A	Anal/urinary muscle study	1.53	3.78	4.39	NA	NA	0.10	000
51785	TC	A	Anal/urinary muscle study	0.00	3.25	3.81	NA	NA	0.01	000
51785	26	A	Anal/urinary muscle study	1.53	0.53	0.58	0.53	0.58	0.09	000
51792		A	Urinary reflex study	1.10	4.03	4.99	NA	NA	0.08	000
51792	TC	A	Urinary reflex study	0.00	3.65	4.57	NA	NA	0.01	000
51792	26	A	Urinary reflex study	1.10	0.38	0.42	0.38	0.42	0.07	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
51797		A	Intraabdominal pressure test	0.80	1.94	2.98	NA	NA	0.05	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	1.67	2.63	NA	NA	0.01	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.27	0.35	0.27	0.35	0.04	ZZZ
51798		A	Us urine capacity measure	0.00	0.44	0.51	NA	NA	0.01	XXX
51800		A	Revision of bladder/urethra	18.89	NA	NA	8.35	9.61	1.40	090
51820		A	Revision of urinary tract	19.59	NA	NA	8.68	9.38	1.36	090
51840		A	Attach bladder/urethra	11.36	NA	NA	5.75	5.98	1.07	090
51841		A	Attach bladder/urethra	13.68	NA	NA	6.61	6.89	1.32	090
51845		A	Repair bladder neck	10.15	NA	NA	5.10	5.67	0.86	090
51860		A	Repair of bladder wound	12.60	NA	NA	6.49	6.76	1.33	090
51865		A	Repair of bladder wound	15.80	NA	NA	7.39	8.15	1.39	090
51880		A	Repair of bladder opening	7.87	NA	NA	4.22	4.63	0.70	090
51900		A	Repair bladder/vagina lesion	14.63	NA	NA	7.11	7.64	1.01	090
51920		A	Close bladder-uterus fistula	13.41	NA	NA	6.44	7.10	0.93	090
51925		A	Hysterectomy/bladder repair	17.53	NA	NA	9.00	9.10	2.13	090
51940		A	Correction of bladder defect	30.66	NA	NA	12.33	13.33	2.15	090
51960		A	Revision of bladder & bowel	25.40	NA	NA	10.85	12.55	1.92	090
51980		A	Construct bladder opening	12.57	NA	NA	5.98	6.89	0.87	090
51990		A	Laparo urethral suspension	13.36	NA	NA	6.42	6.52	1.26	090
51992		A	Laparo sling operation	14.87	NA	NA	7.06	6.94	1.61	090
51999		C	Laparoscope proc, bla	0.00	0.00	0.00	0.00	0.00	0.00	YYY
52000		A	Cystoscopy	2.23	2.81	3.45	1.05	1.21	0.16	000
52001		A	Cystoscopy, removal of clots	5.44	3.99	4.96	2.12	2.47	0.38	000
52005		A	Cystoscopy & ureter catheter	2.37	4.35	5.44	1.10	1.28	0.17	000
52007		A	Cystoscopy and biopsy	3.02	8.15	11.31	1.31	1.54	0.21	000
5200F		I	Eval appros surg thxpy epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
52010		A	Cystoscopy & duct catheter	3.02	6.15	7.83	1.31	1.43	0.21	000
52204		A	Cystoscopy w/biopsy(s)	2.59	6.29	9.09	1.11	1.29	0.18	000
52214		A	Cystoscopy and treatment	3.70	11.86	12.61	1.48	2.17	0.26	000
52224		A	Cystoscopy and treatment	3.14	11.26	18.28	1.29	1.53	0.22	000
52234		A	Cystoscopy and treatment	4.62	NA	NA	1.84	2.17	0.33	000
52235		A	Cystoscopy and treatment	5.44	NA	NA	2.13	2.53	0.38	000
52240		A	Cystoscopy and treatment	9.71	NA	NA	3.54	4.21	0.69	000
52250		A	Cystoscopy and radiotracer	4.49	NA	NA	1.88	2.19	0.33	000
52260		A	Cystoscopy and treatment	3.91	NA	NA	1.60	1.86	0.29	000
52265		A	Cystoscopy and treatment	2.94	6.00	8.30	1.33	1.43	0.25	000
52270		A	Cystoscopy & revise urethra	3.36	5.34	7.48	1.40	1.65	0.24	000
52275		A	Cystoscopy & revise urethra	4.69	7.08	10.10	1.84	2.18	0.33	000
52276		A	Cystoscopy and treatment	4.99	NA	NA	1.98	2.34	0.35	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
52277		A	Cystoscopy and treatment	6.16	NA	NA	2.68	2.87	0.43	000
52281		A	Cystoscopy and treatment	2.80	4.03	5.41	1.24	1.45	0.20	000
52282		A	Cystoscopy, implant stent	6.39	NA	NA	2.46	2.86	0.48	000
52283		A	Cystoscopy and treatment	3.73	3.24	3.95	1.56	1.80	0.27	000
52285		A	Cystoscopy and treatment	3.60	3.39	4.13	1.52	1.75	0.27	000
52290		A	Cystoscopy and treatment	4.58	NA	NA	1.83	2.17	0.33	000
52300		A	Cystoscopy and treatment	5.30	NA	NA	2.15	2.46	0.41	000
52301		A	Cystoscopy and treatment	5.50	NA	NA	2.18	2.59	0.39	000
52305		A	Cystoscopy and treatment	5.30	NA	NA	2.03	2.39	0.37	000
52310		A	Cystoscopy and treatment	2.81	3.09	3.99	1.16	1.36	0.20	000
52315		A	Cystoscopy and treatment	5.20	5.11	6.80	2.00	2.38	0.37	000
52317		A	Remove bladder stone	6.71	12.93	18.55	2.44	2.90	0.47	000
52318		A	Remove bladder stone	9.18	NA	NA	3.29	3.92	0.65	000
52320		A	Cystoscopy and treatment	4.69	NA	NA	1.79	2.12	0.34	000
52325		A	Cystoscopy, stone removal	6.15	NA	NA	2.28	2.70	0.43	000
52327		A	Cystoscopy, inject material	5.18	NA	NA	1.72	2.05	0.38	000
52330		A	Cystoscopy and treatment	5.03	7.12	14.57	1.91	2.25	0.36	000
52332		A	Cystoscopy and treatment	2.83	9.36	10.50	1.25	1.46	0.20	000
52334		A	Create passage to kidney	4.82	NA	NA	1.90	2.25	0.34	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.22	2.66	0.38	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	2.38	2.86	0.41	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	2.61	3.14	0.46	000
52344		A	Cysto/uretero, stricture tx	7.05	NA	NA	2.90	3.47	0.50	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	3.07	3.67	0.53	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	3.40	4.08	0.60	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	NA	2.38	2.82	0.41	000
52352		A	Cystouretero w/stone remove	6.87	NA	NA	2.80	3.30	0.48	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	NA	3.15	3.74	0.56	000
52354		A	Cystouretero w/biopsy	7.33	NA	NA	2.95	3.49	0.52	000
52355		A	Cystouretero w/excise tumor	8.81	NA	NA	3.43	4.08	0.62	000
52400		A	Cystouretero w/congen repr	8.69	NA	NA	2.81	4.29	0.61	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	NA	1.77	2.12	0.37	000
52450		A	Incision of prostate	7.78	NA	NA	4.37	5.07	0.54	090
52500		A	Revision of bladder neck	8.14	NA	NA	4.49	5.24	0.56	090
52601		A	Prostatectomy (TURP)	15.26	NA	NA	6.80	7.55	1.07	090
52630		A	Remove prostate regrowth	7.73	NA	NA	3.84	4.42	0.54	090
52640		A	Relieve bladder contracture	4.79	NA	NA	2.81	3.39	0.33	090
52647		A	Laser surgery of prostate	11.30	31.63	45.95	5.53	6.41	0.78	090
52648		A	Laser surgery of prostate	12.15	32.13	46.39	5.81	6.74	0.85	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
52649		A	Prostate laser enucleation	17.29	NA	NA	7.52	9.44	1.20	090
52700		A	Drainage of prostate abscess	7.49	NA	NA	3.94	4.44	0.52	090
53000		A	Incision of urethra	2.33	NA	NA	1.50	1.74	0.17	010
53010		A	Incision of urethra	4.45	NA	NA	3.10	3.61	0.31	090
53020		A	Incision of urethra	1.77	NA	NA	0.77	0.90	0.13	000
53025		A	Incision of urethra	1.13	NA	NA	0.70	0.67	0.06	000
53040		A	Drainage of urethra abscess	6.55	NA	NA	3.61	4.16	0.45	090
53060		A	Drainage of urethra abscess	2.68	2.01	2.06	1.58	1.52	0.32	010
53080		A	Drainage of urinary leakage	6.92	NA	NA	3.94	4.88	0.48	090
53085		A	Drainage of urinary leakage	11.18	NA	NA	5.42	5.70	1.03	090
53200		A	Biopsy of urethra	2.59	1.42	1.63	1.11	1.25	0.19	000
53210		A	Removal of urethra	13.72	NA	NA	6.43	7.38	0.95	090
53215		A	Removal of urethra	16.85	NA	NA	7.39	8.68	1.18	090
53220		A	Treatment of urethra lesion	7.63	NA	NA	4.15	4.74	0.53	090
53230		A	Removal of urethra lesion	10.44	NA	NA	5.31	6.01	0.83	090
53235		A	Removal of urethra lesion	10.99	NA	NA	5.44	6.45	0.76	090
53240		A	Surgery for urethra pouch	7.08	NA	NA	3.90	4.62	0.49	090
53250		A	Removal of urethra gland	6.52	NA	NA	3.50	4.30	1.01	090
53260		A	Treatment of urethra lesion	3.03	2.12	2.38	1.64	1.77	0.26	010
53265		A	Treatment of urethra lesion	3.17	2.37	2.82	1.65	1.86	0.25	010
53270		A	Removal of urethra gland	3.14	2.23	2.38	1.76	1.80	0.38	010
53275		A	Repair of urethra defect	4.57	NA	NA	2.24	2.66	0.33	010
53400		A	Revise urethra, stage 1	14.13	NA	NA	6.75	7.78	1.01	090
53405		A	Revise urethra, stage 2	15.66	NA	NA	7.11	8.39	1.09	090
53410		A	Reconstruction of urethra	17.68	NA	NA	7.88	9.21	1.24	090
53415		A	Reconstruction of urethra	20.70	NA	NA	8.89	10.30	1.49	090
53420		A	Reconstruct urethra, stage 1	15.17	NA	NA	6.77	7.10	1.05	090
53425		A	Reconstruct urethra, stage 2	17.07	NA	NA	7.39	8.77	1.19	090
53430		A	Reconstruction of urethra	17.43	NA	NA	7.78	8.53	1.43	090
53431		A	Reconstruct urethra/bladder	21.18	NA	NA	8.99	10.47	1.48	090
53440		A	Male sling procedure	15.54	NA	NA	7.49	8.61	1.08	090
53442		A	Remove/revise male sling	13.49	NA	NA	6.84	7.82	0.94	090
53444		A	Insert tandem cuff	14.19	NA	NA	6.51	7.63	0.98	090
53445		A	Insert uro/ves nck sphincter	15.39	NA	NA	7.43	8.76	1.07	090
53446		A	Remove uro sphincter	11.02	NA	NA	5.66	6.64	0.78	090
53447		A	Remove/replace ur sphincter	14.28	NA	NA	6.79	7.99	1.01	090
53448		A	Remov/replc ur sphinctr comp	23.44	NA	NA	10.01	11.76	1.64	090
53449		A	Repair uro sphincter	10.56	NA	NA	5.33	6.24	0.74	090
53450		A	Revision of urethra	6.77	NA	NA	3.81	4.44	0.47	090
53460		A	Revision of urethra	7.75	NA	NA	4.11	4.81	0.54	090
53500		A	Urethrlys, transvag w/ scope	13.00	NA	NA	6.44	7.20	1.06	090
53502		A	Repair of urethra injury	8.26	NA	NA	4.35	4.99	0.57	090
53505		A	Repair of urethra injury	8.26	NA	NA	4.34	5.08	0.57	090
53510		A	Repair of urethra injury	10.96	NA	NA	5.44	6.37	0.76	090
53515		A	Repair of urethra injury	14.22	NA	NA	6.51	7.55	0.99	090
53520		A	Repair of urethra defect	9.48	NA	NA	4.95	5.77	0.65	090
53600		A	Dilate urethra stricture	1.21	0.91	1.12	0.47	0.55	0.09	000
53601		A	Dilate urethra stricture	0.98	1.05	1.30	0.42	0.50	0.07	000
53605		A	Dilate urethra stricture	1.28	NA	NA	0.42	0.50	0.09	000
53620		A	Dilate urethra stricture	1.62	1.32	1.71	0.67	0.79	0.11	000
53621		A	Dilate urethra stricture	1.35	1.39	1.80	0.54	0.64	0.09	000
53660		A	Dilation of urethra	0.71	1.03	1.27	0.37	0.42	0.05	000
53661		A	Dilation of urethra	0.72	1.00	1.24	0.34	0.39	0.05	000
53665		A	Dilation of urethra	0.76	NA	NA	0.26	0.28	0.07	000
53850		A	Prostatic microwave thermotx	10.08	37.08	55.23	4.72	5.49	0.70	090
53852		A	Prostatic rf thermotx	10.83	34.95	52.10	5.34	6.19	0.75	090
53855		A	Insert prost urethral stent	1.64	16.31	16.31	0.54	0.54	0.11	000
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.59	2.08	2.65	1.17	1.35	0.11	010
54001		A	Slitting of prepuce	2.24	2.39	2.98	1.34	1.54	0.16	010
54015		A	Drain penis lesion	5.36	NA	NA	2.69	3.10	0.40	010
54050		A	Destruction, penis lesion(s)	1.29	2.01	2.04	1.39	1.37	0.12	010
54055		A	Destruction, penis lesion(s)	1.25	1.71	1.88	1.11	1.16	0.10	010
54056		A	Cryosurgery, penis lesion(s)	1.29	2.25	2.23	1.54	1.48	0.13	010
54057		A	Laser surg, penis lesion(s)	1.29	2.11	2.44	1.13	1.23	0.10	010
54060		A	Excision of penis lesion(s)	1.98	2.51	3.02	1.38	1.52	0.15	010
54065		A	Destruction, penis lesion(s)	2.47	3.06	3.16	1.98	1.90	0.22	010
54100		A	Biopsy of penis	1.90	2.99	3.22	1.37	1.32	0.17	000
54105		A	Biopsy of penis	3.54	3.14	3.94	1.97	2.33	0.25	010
54110		A	Treatment of penis lesion	10.92	NA	NA	5.31	6.18	0.76	090
54111		A	Treat penis lesion, graft	14.42	NA	NA	6.46	7.60	1.00	090
54112		A	Treat penis lesion, graft	16.98	NA	NA	7.49	8.86	1.18	090
54115		A	Treatment of penis lesion	6.95	4.62	5.43	4.00	4.63	0.48	090
54120		A	Partial removal of penis	11.01	NA	NA	5.42	6.31	0.78	090
54125		A	Removal of penis	14.56	NA	NA	6.64	7.70	1.06	090
54130		A	Remove penis & nodes	21.84	NA	NA	9.34	10.97	1.53	090
54135		A	Remove penis & nodes	28.17	NA	NA	11.41	13.46	1.98	090
54150		A	Circumcision w/regionl block	1.90	2.02	2.59	0.68	0.74	0.16	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
54160		A	Circumcision, neonate	2.53	2.96	3.76	1.22	1.43	0.18	010
54161		A	Circum 28 days or older	3.32	NA	NA	1.78	2.07	0.24	010
54162		A	Lysis penil circumic lesion	3.32	3.16	4.01	1.84	2.08	0.24	010
54163		A	Repair of circumcision	3.32	NA	NA	2.28	2.65	0.23	010
54164		A	Frenulotomy of penis	2.82	NA	NA	2.12	2.45	0.20	010
54200		A	Treatment of penis lesion	1.11	1.57	1.90	1.03	1.21	0.08	010
54205		A	Treatment of penis lesion	8.97	NA	NA	4.82	5.74	0.62	090
54220		A	Treatment of penis lesion	2.42	2.60	3.31	1.10	1.26	0.18	000
54230		A	Prepare penis study	1.34	1.11	1.32	0.73	0.85	0.09	000
54231		A	Dynamic cavernosometry	2.04	1.53	1.80	0.99	1.17	0.14	000
54235		A	Penile injection	1.19	1.11	1.28	0.72	0.82	0.08	000
54240		A	Penis study	1.31	1.22	1.42	NA	NA	0.07	000
54240	TC	A	Penis study	0.00	0.79	0.91	NA	NA	0.01	000
54240	26	A	Penis study	1.31	0.43	0.51	0.43	0.51	0.06	000
54250		A	Penis study	2.22	1.02	1.19	NA	NA	0.11	000
54250	TC	A	Penis study	0.00	0.28	0.32	NA	NA	0.01	000
54250	26	A	Penis study	2.22	0.74	0.87	0.74	0.87	0.10	000
54300		A	Revision of penis	11.20	NA	NA	5.50	6.56	0.78	090
54304		A	Revision of penis	13.28	NA	NA	6.25	7.50	0.92	090
54308		A	Reconstruction of urethra	12.62	NA	NA	5.99	7.17	0.87	090
54312		A	Reconstruction of urethra	14.51	NA	NA	6.80	8.18	1.01	090
54316		A	Reconstruction of urethra	18.05	NA	NA	7.99	9.57	1.25	090
54318		A	Reconstruction of urethra	12.43	NA	NA	6.67	7.35	0.62	090
54322		A	Reconstruction of urethra	13.98	NA	NA	6.37	7.65	0.97	090
54324		A	Reconstruction of urethra	17.55	NA	NA	7.74	9.32	1.22	090
54326		A	Reconstruction of urethra	17.02	NA	NA	7.65	8.43	1.18	090
54328		A	Revise penis/urethra	16.89	NA	NA	7.61	8.87	1.17	090
54332		A	Revise penis/urethra	18.37	NA	NA	8.10	9.64	1.28	090
54336		A	Revise penis/urethra	21.62	NA	NA	9.44	9.97	1.51	090
54340		A	Secondary urethral surgery	9.71	NA	NA	5.07	5.81	0.67	090
54344		A	Secondary urethral surgery	17.06	NA	NA	7.66	9.20	1.18	090
54348		A	Secondary urethral surgery	18.32	NA	NA	8.98	10.01	0.91	090
54352		A	Reconstruct urethra/penis	26.13	NA	NA	10.92	13.15	1.84	090
54360		A	Penis plastic surgery	12.78	NA	NA	6.00	7.18	0.89	090
54380		A	Repair penis	14.18	NA	NA	6.63	7.94	0.98	090
54385		A	Repair penis	16.56	NA	NA	10.09	10.71	1.75	090
54390		A	Repair penis and bladder	22.77	NA	NA	9.66	9.98	1.59	090
54400		A	Insert semi-rigid prosthesis	9.17	NA	NA	4.59	5.43	0.64	090
54401		A	Insert self-contd prosthesis	10.44	NA	NA	6.44	7.55	0.73	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
54405		A	Insert multi-comp penis pros	14.52	NA	NA	6.59	7.72	1.01	090
54406		A	Remove muti-comp penis pros	12.89	NA	NA	6.12	7.17	0.90	090
54408		A	Repair multi-comp penis pros	13.91	NA	NA	6.68	7.76	0.98	090
54410		A	Remove/replace penis prosth	15.18	NA	NA	7.22	8.49	1.06	090
54411		A	Remov/reple penis pros, comp	18.35	NA	NA	8.46	9.80	1.27	090
54415		A	Remove self-contd penis pros	8.88	NA	NA	4.81	5.60	0.62	090
54416		A	Remv/repl penis contain pros	12.08	NA	NA	6.34	7.37	0.83	090
54417		A	Remv/reple penis pros, compl	16.10	NA	NA	7.33	8.55	1.12	090
54420		A	Revision of penis	12.39	NA	NA	5.94	7.05	0.86	090
54430		A	Revision of penis	11.06	NA	NA	5.56	6.58	0.77	090
54435		A	Revision of penis	6.81	NA	NA	3.95	4.65	0.47	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.68	0.86	0.40	0.48	0.08	000
54500		A	Biopsy of testis	1.31	NA	NA	0.63	0.75	0.09	000
54505		A	Biopsy of testis	3.50	NA	NA	1.93	2.31	0.24	010
54512		A	Excise lesion testis	9.33	NA	NA	4.66	5.34	0.67	090
54520		A	Removal of testis	5.30	NA	NA	3.10	3.52	0.44	090
54522		A	Orchiectomy, partial	10.25	NA	NA	5.08	5.62	0.71	090
54530		A	Removal of testis	8.46	NA	NA	4.63	5.39	0.62	090
54535		A	Extensive testis surgery	13.19	NA	NA	6.18	6.96	0.91	090
54550		A	Exploration for testis	8.41	NA	NA	4.35	4.99	0.58	090
54560		A	Exploration for testis	12.10	NA	NA	5.77	6.21	0.84	090
54600		A	Reduce testis torsion	7.64	NA	NA	4.10	4.76	0.53	090
54620		A	Suspension of testis	5.21	NA	NA	2.58	3.07	0.36	010
54640		A	Suspension of testis	7.73	NA	NA	4.57	5.07	0.62	090
54650		A	Orchiopexy (Fowler-Stephens)	12.39	NA	NA	6.10	6.93	0.86	090
54660		A	Revision of testis	5.74	NA	NA	3.47	3.99	0.40	090
54670		A	Repair testis injury	6.65	NA	NA	3.82	4.42	0.46	090
54680		A	Relocation of testis(es)	14.04	NA	NA	6.47	7.33	0.97	090
54690		A	Laparoscopy, orchiectomy	11.70	NA	NA	6.62	5.94	1.80	090
54692		A	Laparoscopy, orchiopexy	13.74	NA	NA	6.07	7.16	0.96	090
54699		C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.47	NA	NA	2.05	2.29	0.29	010
54800		A	Biopsy of epididymis	2.33	NA	NA	1.66	1.39	0.24	000
54830		A	Remove epididymis lesion	6.01	NA	NA	3.62	4.12	0.45	090
54840		A	Remove epididymis lesion	5.27	NA	NA	3.02	3.55	0.37	090
54860		A	Removal of epididymis	6.95	NA	NA	3.88	4.51	0.49	090
54861		A	Removal of epididymis	9.70	NA	NA	4.98	5.78	0.67	090
54865		A	Explore epididymis	5.77	NA	NA	3.48	4.00	0.40	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
54900		A	Fusion of spermatic ducts	14.20	NA	NA	7.32	6.92	0.70	090
54901		A	Fusion of spermatic ducts	19.10	NA	NA	9.33	10.18	0.95	090
55000		A	Drainage of hydrocele	1.43	1.52	1.85	0.78	0.87	0.11	000
55040		A	Removal of hydrocele	5.45	NA	NA	3.27	3.73	0.44	090
55041		A	Removal of hydroceles	8.54	NA	NA	4.66	5.33	0.64	090
55060		A	Repair of hydrocele	6.15	NA	NA	3.67	4.17	0.48	090
55100		A	Drainage of scrotum abscess	2.45	2.92	3.44	1.80	1.98	0.21	010
55110		A	Explore scrotum	6.33	NA	NA	3.67	4.18	0.48	090
55120		A	Removal of scrotum lesion	5.72	NA	NA	3.50	3.95	0.43	090
55150		A	Removal of scrotum	8.14	NA	NA	4.54	5.17	0.61	090
55175		A	Revision of scrotum	5.87	NA	NA	3.50	4.04	0.42	090
55180		A	Revision of scrotum	11.78	NA	NA	6.07	6.92	0.92	090
55200		A	Incision of sperm duct	4.55	6.24	8.51	2.64	3.00	0.32	090
55250		A	Removal of sperm duct(s)	3.37	6.04	8.17	2.44	2.82	0.23	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	NA	1.41	1.46	0.25	000
55400		A	Repair of sperm duct	8.61	NA	NA	4.33	5.14	0.60	090
55450		A	Ligation of sperm duct	4.43	4.57	5.87	2.25	2.56	0.31	010
55500		A	Removal of hydrocele	6.22	NA	NA	3.89	4.05	0.64	090
55520		A	Removal of sperm cord lesion	6.66	NA	NA	4.60	4.02	0.96	090
55530		A	Revise spermatic cord veins	5.75	NA	NA	3.35	3.86	0.44	090
55535		A	Revise spermatic cord veins	7.19	NA	NA	3.95	4.52	0.50	090
55540		A	Revise hernia & sperm veins	8.30	NA	NA	5.13	4.55	1.17	090
55550		A	Laparo ligate spermatic vein	7.20	NA	NA	3.90	4.35	0.50	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	7.01	NA	NA	3.89	4.55	0.48	090
55605		A	Incise sperm duct pouch	8.76	NA	NA	4.73	5.09	0.60	090
55650		A	Remove sperm duct pouch	12.65	NA	NA	6.07	6.89	0.88	090
55680		A	Remove sperm pouch lesion	5.67	NA	NA	3.27	3.61	0.39	090
55700		A	Biopsy of prostate	2.58	2.86	3.67	1.07	1.20	0.18	000
55705		A	Biopsy of prostate	4.61	NA	NA	2.30	2.74	0.33	010
55706		A	Prostate saturation sampling	6.28	NA	NA	3.42	4.22	0.31	010
55720		A	Drainage of prostate abscess	7.73	NA	NA	4.00	4.64	0.54	090
55725		A	Drainage of prostate abscess	10.05	NA	NA	5.33	6.08	0.69	090
55801		A	Removal of prostate	19.80	NA	NA	8.74	10.04	1.37	090
55810		A	Extensive prostate surgery	24.29	NA	NA	10.18	11.74	1.81	090
55812		A	Extensive prostate surgery	29.89	NA	NA	12.23	14.30	2.10	090
55815		A	Extensive prostate surgery	32.95	NA	NA	13.24	15.53	2.31	090
55821		A	Removal of prostate	15.76	NA	NA	7.06	8.24	1.11	090
55831		A	Removal of prostate	17.19	NA	NA	7.54	8.80	1.20	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
55840		A	Extensive prostate surgery	24.63	NA	NA	10.38	12.13	1.75	090
55842		A	Extensive prostate surgery	26.49	NA	NA	10.98	12.88	1.88	090
55845		A	Extensive prostate surgery	30.67	NA	NA	12.23	14.29	2.19	090
55860		A	Surgical exposure, prostate	15.84	NA	NA	6.97	8.21	1.09	090
55862		A	Extensive prostate surgery	20.04	NA	NA	8.62	10.19	1.40	090
55865		A	Extensive prostate surgery	24.57	NA	NA	10.32	12.18	1.73	090
55866		A	Laparo radical prostatectomy	32.46	NA	NA	13.19	15.37	2.30	090
55870		A	Electroejaculation	2.58	1.89	2.22	1.14	1.36	0.18	000
55873		A	Cryoablate prostate	13.60	147.06	45.92	6.30	10.14	1.46	090
55875		A	Transperi needle place, pros	13.46	NA	NA	6.46	7.47	0.93	090
55876		A	Place rt device/marker, pros	1.73	1.71	2.03	0.90	1.07	0.12	000
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55920		A	Place needles pelvic for rt	8.31	NA	NA	3.70	3.55	0.58	000
55970		N	Sex transformation, M to F	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation, F to M	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & D of vulva/perineum	1.49	1.27	1.25	1.25	1.20	0.18	010
56420		A	Drainage of gland abscess	1.44	1.60	1.71	0.90	0.88	0.17	010
56440		A	Surgery for vulva lesion	2.89	NA	NA	1.79	1.70	0.35	010
56441		A	Lysis of labial lesion(s)	2.02	1.61	1.74	1.49	1.55	0.20	010
56442		A	Hymenotomy	0.68	NA	NA	0.53	0.54	0.08	000
56501		A	Destroy, vulva lesions, sim	1.58	1.68	1.71	1.31	1.28	0.19	010
56515		A	Destroy vulva lesion/s compl	3.08	2.56	2.53	1.99	1.88	0.36	010
56605		A	Biopsy of vulva/perineum	1.10	0.97	0.99	0.46	0.41	0.13	000
56606		A	Biopsy of vulva/perineum	0.55	0.40	0.41	0.21	0.19	0.07	ZZZ
56620		A	Partial removal of vulva	7.53	NA	NA	5.23	4.94	0.89	090
56625		A	Complete removal of vulva	9.68	NA	NA	5.73	5.29	1.16	090
56630		A	Extensive vulva surgery	14.80	NA	NA	7.84	7.05	1.84	090
56631		A	Extensive vulva surgery	18.99	NA	NA	9.84	8.80	2.31	090
56632		A	Extensive vulva surgery	21.86	NA	NA	11.69	10.34	2.65	090
56633		A	Extensive vulva surgery	19.62	NA	NA	9.98	8.87	2.39	090
56634		A	Extensive vulva surgery	20.66	NA	NA	10.58	9.41	2.51	090
56637		A	Extensive vulva surgery	24.75	NA	NA	11.89	10.66	3.01	090
56640		A	Extensive vulva surgery	24.78	NA	NA	11.83	10.36	3.02	090
56700		A	Partial removal of hymen	2.84	NA	NA	1.92	1.85	0.34	010
56740		A	Remove vagina gland lesion	4.88	NA	NA	2.73	2.55	0.60	010
56800		A	Repair of vagina	3.93	NA	NA	2.22	2.16	0.46	010
56805		A	Repair clitoris	19.88	NA	NA	9.57	8.83	2.42	090
56810		A	Repair of perineum	4.29	NA	NA	2.36	2.25	0.50	010
56820		A	Exam of vulva w/scope	1.50	1.27	1.27	0.68	0.62	0.18	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
56821		A	Exam/biopsy of vulva w/scope	2.05	1.63	1.64	0.90	0.81	0.25	000
57000		A	Exploration of vagina	3.02	NA	NA	1.81	1.77	0.36	010
57010		A	Drainage of pelvic abscess	6.84	NA	NA	4.23	4.00	0.82	090
57020		A	Drainage of pelvic fluid	1.50	0.88	0.85	0.60	0.53	0.18	000
57022		A	I & d vaginal hematoma, pp	2.73	NA	NA	1.57	1.47	0.33	010
57023		A	I & d vag hematoma, non-ob	5.18	NA	NA	2.78	2.62	0.62	010
57061		A	Destroy vag lesions, simple	1.30	1.53	1.57	1.17	1.15	0.15	010
57065		A	Destroy vag lesions, complex	2.66	2.16	2.16	1.69	1.62	0.32	010
57100		A	Biopsy of vagina	1.20	1.01	1.01	0.50	0.44	0.14	000
57105		A	Biopsy of vagina	1.74	1.63	1.67	1.40	1.40	0.20	010
57106		A	Remove vagina wall, partial	7.50	NA	NA	4.82	4.54	0.85	090
57107		A	Remove vagina tissue, part	24.56	NA	NA	11.55	10.41	2.99	090
57109		A	Vaginectomy partial w/nodes	28.40	NA	NA	13.48	11.66	3.46	090
57110		A	Remove vagina wall, complete	15.48	NA	NA	7.57	7.01	1.86	090
57111		A	Remove vagina tissue, compl	28.40	NA	NA	13.48	12.02	3.46	090
57112		A	Vaginectomy w/nodes, compl	30.52	NA	NA	14.33	12.62	1.76	090
57120		A	Closure of vagina	8.28	NA	NA	4.77	4.57	0.97	090
57130		A	Remove vagina lesion	2.46	2.01	2.06	1.59	1.56	0.30	010
57135		A	Remove vagina lesion	2.70	2.12	2.15	1.69	1.64	0.32	010
57150		A	Treat vagina infection	0.55	0.58	0.70	0.21	0.19	0.07	000
57155		A	Insert uteri tandems/ovoids	6.87	NA	NA	4.09	3.97	0.42	090
57160		A	Insert pessary/other device	0.89	1.02	1.05	0.34	0.31	0.10	000
57170		A	Fitting of diaphragm/cap	0.91	0.63	0.78	0.35	0.30	0.11	000
57180		A	Treat vaginal bleeding	1.63	1.87	1.96	1.06	1.05	0.19	010
57200		A	Repair of vagina	4.42	NA	NA	3.14	3.07	0.51	090
57210		A	Repair vagina/perineum	5.71	NA	NA	3.62	3.52	0.66	090
57220		A	Revision of urethra	4.85	NA	NA	3.29	3.21	0.57	090
57230		A	Repair of urethral lesion	6.30	NA	NA	3.79	3.78	0.76	090
57240		A	Repair bladder & vagina	11.50	NA	NA	5.77	5.47	1.18	090
57250		A	Repair rectum & vagina	11.50	NA	NA	5.90	5.20	1.34	090
57260		A	Repair of vagina	14.44	NA	NA	7.03	6.22	1.71	090
57265		A	Extensive repair of vagina	15.94	NA	NA	7.57	6.90	1.86	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	NA	1.81	1.76	0.52	ZZZ
57268		A	Repair of bowel bulge	7.57	NA	NA	4.74	4.55	0.87	090
57270		A	Repair of bowel pouch	13.67	NA	NA	6.89	6.36	1.62	090
57280		A	Suspension of vagina	16.72	NA	NA	7.87	7.54	1.88	090
57282		A	Colpopexy, extraperitoneal	7.97	NA	NA	4.86	4.76	0.88	090
57283		A	Colpopexy, intraperitoneal	11.66	NA	NA	6.06	5.71	1.39	090
57284		A	Repair paravag defect, open	14.33	NA	NA	6.72	6.65	1.56	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
57285		A	Repair paravag defect, vag	11.60	NA	NA	5.76	5.55	1.28	090
57287		A	Revise/remove sling repair	11.15	NA	NA	6.33	6.69	1.04	090
57288		A	Repair bladder defect	12.13	NA	NA	6.01	6.42	1.14	090
57289		A	Repair bladder & vagina	12.80	NA	NA	6.15	6.62	0.89	090
57291		A	Construction of vagina	8.64	NA	NA	4.92	4.93	1.04	090
57292		A	Construct vagina with graft	14.01	NA	NA	7.26	6.75	1.71	090
57295		A	Revise vag graft via vagina	7.82	NA	NA	4.45	4.47	0.85	090
57296		A	Revise vag graft, open abd	16.56	NA	NA	7.91	7.26	2.02	090
57300		A	Repair rectum-vagina fistula	8.71	NA	NA	5.50	4.84	1.08	090
57305		A	Repair rectum-vagina fistula	15.35	NA	NA	8.14	6.97	2.14	090
57307		A	Fistula repair & colostomy	17.17	NA	NA	9.38	7.85	2.63	090
57308		A	Fistula repair, transperine	10.59	NA	NA	5.80	5.34	1.27	090
57310		A	Repair urethrovaginal lesion	7.65	NA	NA	4.26	4.79	0.53	090
57311		A	Repair urethrovaginal lesion	8.91	NA	NA	4.67	5.25	0.62	090
57320		A	Repair bladder-vagina lesion	8.88	NA	NA	4.83	5.25	0.75	090
57330		A	Repair bladder-vagina lesion	13.21	NA	NA	6.05	6.71	0.92	090
57335		A	Repair vagina	20.02	NA	NA	9.72	9.24	2.44	090
57400		A	Dilation of vagina	2.27	NA	NA	1.14	1.10	0.28	000
57410		A	Pelvic examination	1.75	NA	NA	0.99	0.93	0.21	000
57415		A	Remove vaginal foreign body	2.49	NA	NA	1.59	1.56	0.26	010
57420		A	Exam of vagina w/scope	1.60	1.31	1.31	0.72	0.65	0.19	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.71	1.71	0.96	0.86	0.27	000
57423		A	Repair paravag defect, lap	16.08	NA	NA	7.45	7.09	1.97	090
57425		A	Laparoscopy, surg, colpopexy	17.03	NA	NA	8.05	7.47	1.94	090
57426		A	Revise prosth vag graft lap	14.30	NA	NA	7.61	7.61	1.74	090
57452		A	Exam of cervix w/scope	1.50	1.23	1.24	0.85	0.80	0.17	000
57454		A	Bx/curett of cervix w/scope	2.33	1.56	1.53	1.17	1.08	0.28	000
57455		A	Biopsy of cervix w/scope	1.99	1.60	1.60	0.87	0.78	0.24	000
57456		A	Endocerv curettage w/scope	1.85	1.54	1.55	0.81	0.74	0.22	000
57460		A	Bx of cervix w/scope, leep	2.83	4.15	4.61	1.36	1.26	0.34	000
57461		A	Conz of cervix w/scope, leep	3.43	4.47	4.92	1.42	1.28	0.42	000
57500		A	Biopsy of cervix	1.20	1.94	2.12	0.74	0.68	0.14	000
57505		A	Endocervical curettage	1.19	1.34	1.38	1.11	1.11	0.14	010
57510		A	Cauterization of cervix	1.90	1.41	1.41	1.06	0.99	0.23	010
57511		A	Cryocautery of cervix	1.95	1.70	1.71	1.41	1.36	0.23	010
57513		A	Laser surgery of cervix	1.95	1.66	1.66	1.40	1.37	0.23	010
57520		A	Conization of cervix	4.11	3.55	3.60	2.80	2.72	0.49	090
57522		A	Conization of cervix	3.67	2.94	2.95	2.49	2.42	0.44	090
57530		A	Removal of cervix	5.27	NA	NA	3.48	3.37	0.63	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
57531		A	Removal of cervix, radical	29.95	NA	NA	14.27	12.59	3.64	090
57540		A	Removal of residual cervix	13.29	NA	NA	6.71	6.18	1.61	090
57545		A	Remove cervix/repair pelvis	14.10	NA	NA	7.03	6.46	1.72	090
57550		A	Removal of residual cervix	6.34	NA	NA	4.04	3.89	0.76	090
57555		A	Remove cervix/repair vagina	9.94	NA	NA	5.45	5.08	1.20	090
57556		A	Remove cervix, repair bowel	9.36	NA	NA	5.18	5.02	1.03	090
57558		A	D&c of cervical stump	1.72	1.42	1.43	1.17	1.13	0.21	010
57700		A	Revision of cervix	4.35	NA	NA	3.51	3.46	0.51	090
57720		A	Revision of cervix	4.61	NA	NA	3.20	3.11	0.55	090
57800		A	Dilation of cervical canal	0.77	0.74	0.74	0.47	0.45	0.09	000
58100		A	Biopsy of uterus lining	1.53	1.22	1.23	0.73	0.66	0.18	000
58110		A	Bx done w/colposcopy add-on	0.77	0.46	0.45	0.30	0.27	0.09	ZZZ
58120		A	Dilation and curettage	3.59	2.88	2.74	1.98	1.84	0.43	010
58140		A	Myomectomy abdom method	15.79	NA	NA	7.73	6.99	2.03	090
58145		A	Myomectomy vag method	8.91	NA	NA	4.99	4.68	1.07	090
58146		A	Myomectomy abdom complex	20.34	NA	NA	9.36	8.58	2.48	090
58150		A	Total hysterectomy	17.31	NA	NA	8.28	7.45	2.12	090
58152		A	Total hysterectomy	21.86	NA	NA	10.18	9.26	2.69	090
58180		A	Partial hysterectomy	16.60	NA	NA	7.99	7.25	2.03	090
58200		A	Extensive hysterectomy	23.10	NA	NA	10.69	9.54	2.82	090
58210		A	Extensive hysterectomy	30.91	NA	NA	14.27	12.63	3.79	090
58240		A	Removal of pelvis contents	49.33	NA	NA	22.33	19.87	6.00	090
58260		A	Vaginal hysterectomy	14.15	NA	NA	7.09	6.53	1.72	090
58262		A	Vag hyst including t/o	15.94	NA	NA	7.76	7.12	1.94	090
58263		A	Vag hyst w/t/o & vag repair	17.23	NA	NA	8.28	7.60	2.10	090
58267		A	Vag hyst w/urinary repair	18.36	NA	NA	8.78	8.02	2.24	090
58270		A	Vag hyst w/enterocele repair	15.30	NA	NA	7.36	6.77	1.86	090
58275		A	Hysterectomy/revise vagina	17.03	NA	NA	8.26	7.57	2.08	090
58280		A	Hysterectomy/revise vagina	18.33	NA	NA	8.80	7.99	2.21	090
58285		A	Extensive hysterectomy	23.38	NA	NA	10.41	9.44	2.85	090
58290		A	Vag hyst complex	20.27	NA	NA	9.33	8.53	2.47	090
58291		A	Vag hyst incl t/o, complex	22.06	NA	NA	10.02	9.20	2.69	090
58292		A	Vag hyst t/o & repair, compl	23.35	NA	NA	10.52	9.59	2.85	090
58293		A	Vag hyst w/uro repair, compl	24.33	NA	NA	10.89	9.88	2.97	090
58294		A	Vag hyst w/enterocele, compl	21.55	NA	NA	9.82	8.91	2.63	090
58300		N	Insert intrauterine device	1.01	0.79	0.92	0.37	0.36	0.05	XXX
58301		A	Remove intrauterine device	1.27	1.12	1.14	0.49	0.43	0.15	000
58321		A	Artificial insemination	0.92	1.06	1.07	0.34	0.32	0.05	000
58322		A	Artificial insemination	1.10	1.05	1.09	0.42	0.37	0.13	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
58323		A	Sperm washing	0.23	0.16	0.23	0.09	0.08	0.03	000
58340		A	Catheter for hysterography	0.88	1.98	2.33	0.60	0.61	0.10	000
58345		A	Reopen fallopian tube	4.70	NA	NA	2.46	2.33	0.57	010
58346		A	Insert heyman uteri capsule	7.56	NA	NA	4.49	4.10	0.44	090
58350		A	Reopen fallopian tube	1.06	1.33	1.39	0.92	0.92	0.13	010
58353		A	Endometr ablate, thermal	3.60	20.25	24.78	2.01	1.91	0.43	010
58356		A	Endometrial cryoablation	6.41	38.38	45.86	2.54	2.29	0.77	010
58400		A	Suspension of uterus	7.14	NA	NA	4.16	4.08	0.77	090
58410		A	Suspension of uterus	13.80	NA	NA	6.86	6.29	1.69	090
58520		A	Repair of ruptured uterus	13.48	NA	NA	7.37	6.28	2.08	090
58540		A	Revision of uterus	15.71	NA	NA	7.65	6.96	1.92	090
58541		A	Lsh, uterus 250 g or less	14.70	NA	NA	7.49	6.76	1.79	090
58542		A	Lsh w/t/o ut 250 g or less	16.56	NA	NA	8.21	7.38	2.02	090
58543		A	Lsh uterus above 250 g	16.87	NA	NA	8.37	7.47	2.06	090
58544		A	Lsh w/t/o uterus above 250 g	18.37	NA	NA	8.91	7.92	2.24	090
58545		A	Laparoscopic myomectomy	15.55	NA	NA	7.42	6.76	1.93	090
58546		A	Laparo-myomectomy, complex	19.94	NA	NA	9.05	8.25	2.43	090
58548		A	Lap radical hyst	31.63	NA	NA	14.82	12.69	3.83	090
58550		A	Laparo-asst vag hysterectomy	15.10	NA	NA	7.55	6.97	1.84	090
58552		A	Laparo-vag hyst incl t/o	16.91	NA	NA	8.25	7.56	2.06	090
58553		A	Laparo-vag hyst, complex	20.06	NA	NA	9.12	8.29	2.45	090
58554		A	Laparo-vag hyst w/t/o, compl	23.11	NA	NA	10.65	9.65	2.84	090
58555		A	Hysteroscopy, dx, sep proc	3.33	4.18	3.07	1.55	1.42	0.40	000
58558		A	Hysteroscopy, biopsy	4.74	5.12	3.81	2.12	1.95	0.58	000
58559		A	Hysteroscopy, lysis	6.16	NA	NA	2.67	2.44	0.75	000
58560		A	Hysteroscopy, resect septum	6.99	NA	NA	2.99	2.73	0.85	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	NA	4.14	3.75	1.21	000
58562		A	Hysteroscopy, remove fb	5.20	5.06	3.78	2.27	2.09	0.63	000
58563		A	Hysteroscopy, ablation	6.16	33.31	40.14	2.66	2.44	0.75	000
58565		A	Hysteroscopy, sterilization	7.12	37.25	42.55	3.97	3.75	0.86	090
58570		A	Tlh, uterus 250 g or less	15.88	NA	NA	7.99	7.15	1.94	090
58571		A	Tlh w/t/o 250 g or less	17.69	NA	NA	8.83	7.77	2.17	090
58572		A	Tlh, uterus over 250 g	20.09	NA	NA	9.55	8.48	2.45	090
58573		A	Tlh w/t/o uterus over 250 g	23.11	NA	NA	10.94	9.51	2.82	090
58578		C	Laparo proc, uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58600		A	Division of fallopian tube	5.91	NA	NA	3.40	3.18	0.71	090
58605		A	Division of fallopian tube	5.28	NA	NA	3.13	2.97	0.64	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	NA	0.56	0.49	0.18	ZZZ

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
58615		A	Occlude fallopian tube(s)	3.94	NA	NA	2.29	2.26	0.48	010
58660		A	Laparoscopy, lysis	11.59	NA	NA	5.63	5.12	1.49	090
58661		A	Laparoscopy, remove adnexa	11.35	NA	NA	5.17	4.70	1.40	010
58662		A	Laparoscopy, excise lesions	12.15	NA	NA	5.93	5.45	1.50	090
58670		A	Laparoscopy, tubal cautery	5.91	NA	NA	3.43	3.24	0.72	090
58671		A	Laparoscopy, tubal block	5.91	NA	NA	3.42	3.22	0.72	090
58672		A	Laparoscopy, fimbrioplasty	12.91	NA	NA	6.02	5.50	1.58	090
58673		A	Laparoscopy, salpingostomy	14.04	NA	NA	6.54	6.02	1.72	090
58679		C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.95	NA	NA	6.84	6.13	1.75	090
58720		A	Removal of ovary/tube(s)	12.16	NA	NA	6.29	5.73	1.55	090
58740		A	Adhesiolysis tube, ovary	14.90	NA	NA	7.51	6.89	1.90	090
58750		A	Repair oviduct	15.64	NA	NA	7.53	6.94	1.91	090
58752		A	Revise ovarian tube(s)	15.64	NA	NA	7.39	7.06	0.78	090
58760		A	Fimbrioplasty	13.93	NA	NA	6.87	6.41	1.70	090
58770		A	Create new tubal opening	14.77	NA	NA	7.14	6.28	1.81	090
58800		A	Drainage of ovarian cyst(s)	4.62	3.43	3.46	2.98	2.91	0.55	090
58805		A	Drainage of ovarian cyst(s)	6.42	NA	NA	3.90	3.74	0.77	090
58820		A	Drain ovary abscess, open	4.70	NA	NA	3.24	3.16	0.56	090
58822		A	Drain ovary abscess, percut	11.81	NA	NA	6.84	6.04	1.82	090
58823		A	Drain pelvic abscess, percut	3.37	18.40	20.11	1.04	1.22	0.27	000
58825		A	Transposition, ovary(s)	11.78	NA	NA	6.05	5.60	1.43	090
58900		A	Biopsy of ovary(s)	6.59	NA	NA	4.64	3.96	1.00	090
58920		A	Partial removal of ovary(s)	11.95	NA	NA	6.03	5.50	1.45	090
58925		A	Removal of ovarian cyst(s)	12.43	NA	NA	6.47	5.86	1.61	090
58940		A	Removal of ovary(s)	8.22	NA	NA	4.86	4.40	1.09	090
58943		A	Removal of ovary(s)	19.52	NA	NA	9.33	8.33	2.54	090
58950		A	Resect ovarian malignancy	18.37	NA	NA	9.23	8.29	2.35	090
58951		A	Resect ovarian malignancy	24.26	NA	NA	11.31	10.06	3.02	090
58952		A	Resect ovarian malignancy	27.29	NA	NA	12.87	11.42	3.41	090
58953		A	Tah, rad dissect for debulk	34.13	NA	NA	15.64	13.81	4.25	090
58954		A	Tah rad debulk/lymph remove	37.13	NA	NA	16.84	14.88	4.59	090
58956		A	Bso, omentectomy w/tah	22.80	NA	NA	11.08	9.94	2.87	090
58957		A	Resect recurrent gyn mal	26.22	NA	NA	12.51	10.82	3.45	090
58958		A	Resect recur gyn mal w/lym	29.22	NA	NA	13.77	11.91	3.55	090
58960		A	Exploration of abdomen	15.79	NA	NA	7.97	7.21	2.00	090
58970		A	Retrieval of oocyte	3.52	2.20	2.08	1.63	1.46	0.18	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	2.52	2.56	1.74	1.72	0.19	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis, diagnostic	1.30	1.70	1.83	0.66	0.62	0.27	000
59001		A	Amniocentesis, therapeutic	3.00	NA	NA	1.36	1.35	0.62	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	NA	1.49	1.36	0.71	000
59015		A	Chorion biopsy	2.20	1.55	1.52	1.01	0.94	0.46	000
59020		A	Fetal contract stress test	0.66	1.03	1.01	NA	NA	0.13	000
59020	TC	A	Fetal contract stress test	0.00	0.78	0.79	NA	NA	0.01	000
59020	26	A	Fetal contract stress test	0.66	0.25	0.22	0.25	0.22	0.12	000
59025		A	Fetal non-stress test	0.53	0.62	0.60	NA	NA	0.10	000
59025	TC	A	Fetal non-stress test	0.00	0.42	0.42	NA	NA	0.01	000
59025	26	A	Fetal non-stress test	0.53	0.20	0.18	0.20	0.18	0.09	000
59030		A	Fetal scalp blood sample	1.99	NA	NA	0.73	0.67	0.10	000
59050		A	Fetal monitor w/report	0.89	NA	NA	0.34	0.30	0.18	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	NA	0.28	0.25	0.15	XXX
59070		A	Transabdom amnioinfus w/us	5.24	4.64	4.84	2.29	2.19	1.09	000
59072		A	Umbilical cord occlud w/us	8.99	NA	NA	3.76	3.48	1.88	000
59074		A	Fetal fluid drainage w/us	5.24	4.88	4.49	2.45	2.18	1.09	000
59076		A	Fetal shunt placement, w/us	8.99	NA	NA	3.76	3.27	1.88	000
59100		A	Remove uterus lesion	13.37	NA	NA	6.82	6.22	2.77	090
59120		A	Treat ectopic pregnancy	12.67	NA	NA	6.55	6.08	2.62	090
59121		A	Treat ectopic pregnancy	12.74	NA	NA	6.50	6.05	2.64	090
59130		A	Treat ectopic pregnancy	15.08	NA	NA	7.35	6.75	0.75	090
59135		A	Treat ectopic pregnancy	14.92	NA	NA	7.23	7.11	0.74	090
59136		A	Treat ectopic pregnancy	14.25	NA	NA	7.03	6.45	2.95	090
59140		A	Treat ectopic pregnancy	5.94	NA	NA	3.84	3.51	0.29	090
59150		A	Treat ectopic pregnancy	12.29	NA	NA	6.34	5.85	2.54	090
59151		A	Treat ectopic pregnancy	12.11	NA	NA	6.01	5.58	2.51	090
59160		A	D & c after delivery	2.76	2.14	2.33	1.43	1.48	0.56	010
59200		A	Insert cervical dilator	0.79	0.93	1.00	0.30	0.27	0.16	000
59300		A	Episiotomy or vaginal repair	2.41	2.23	2.21	1.20	1.06	0.50	000
59320		A	Revision of cervix	2.48	NA	NA	1.22	1.14	0.51	000
59325		A	Revision of cervix	4.06	NA	NA	1.79	1.68	0.20	000
59350		A	Repair of uterus	4.94	NA	NA	1.87	1.59	1.02	000
59400		A	Obstetrical care	27.48	NA	NA	16.54	15.42	5.41	MMM
59409		A	Obstetrical care	13.48	NA	NA	5.21	4.60	2.70	MMM
59410		A	Obstetrical care	15.37	NA	NA	6.56	5.85	3.08	MMM
59412		A	Antepartum manipulation	1.71	NA	NA	0.80	0.74	0.35	MMM
59414		A	Deliver placenta	1.61	NA	NA	0.62	0.55	0.33	MMM
59425		A	Antepartum care only	6.50	4.78	4.49	2.49	2.02	1.23	MMM

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
59426		A	Antepartum care only	11.57	8.75	8.18	4.42	3.57	2.17	MMM
59430		A	Care after delivery	2.13	1.26	1.19	0.93	0.84	0.42	MMM
59510		A	Cesarean delivery	31.07	NA	NA	18.56	17.41	6.27	MMM
59514		A	Cesarean delivery only	15.95	NA	NA	6.20	5.46	3.29	MMM
59515		A	Cesarean delivery	18.39	NA	NA	8.06	7.26	3.74	MMM
59525		A	Remove uterus after cesarean	8.53	NA	NA	3.28	2.91	1.79	ZZZ
59610		A	Vbac delivery	28.86	NA	NA	17.32	16.18	5.88	MMM
59612		A	Vbac delivery only	15.04	NA	NA	5.84	5.21	3.13	MMM
59614		A	Vbac care after delivery	16.64	NA	NA	6.86	6.18	3.46	MMM
59618		A	Attempted vbac delivery	32.51	NA	NA	19.20	18.09	6.62	MMM
59620		A	Attempted vbac delivery only	17.50	NA	NA	6.79	6.00	3.64	MMM
59622		A	Attempted vbac after care	19.83	NA	NA	8.75	7.94	4.10	MMM
59812		A	Treatment of miscarriage	4.44	3.34	3.14	2.70	2.55	0.90	090
59820		A	Care of miscarriage	4.84	4.27	4.28	3.74	3.63	0.97	090
59821		A	Treatment of miscarriage	5.09	4.09	4.08	3.52	3.40	1.03	090
59830		A	Treat uterus infection	6.59	NA	NA	3.95	3.79	1.35	090
59840		R	Abortion	3.01	2.24	2.16	2.03	1.96	0.58	010
59841		R	Abortion	5.65	3.57	3.40	3.07	2.86	1.15	010
59850		R	Abortion	5.90	NA	NA	3.32	3.28	0.30	090
59851		R	Abortion	5.92	NA	NA	3.70	3.57	1.23	090
59852		R	Abortion	8.23	NA	NA	5.05	5.03	0.41	090
59855		R	Abortion	6.43	NA	NA	3.60	3.41	1.32	090
59856		R	Abortion	7.79	NA	NA	4.01	3.76	1.61	090
59857		R	Abortion	9.33	NA	NA	4.47	4.45	0.47	090
59866		R	Abortion (mpr)	3.99	NA	NA	1.80	1.69	0.20	000
59870		A	Evacuate mole of uterus	6.57	NA	NA	4.80	4.75	1.33	090
59871		A	Remove cerclage suture	2.13	NA	NA	1.12	1.05	0.44	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.81	2.37	2.23	1.96	1.86	0.16	010
60100		A	Biopsy of thyroid	1.56	1.23	1.36	0.49	0.55	0.12	000
60200		A	Remove thyroid lesion	10.02	NA	NA	6.90	6.14	1.23	090
60210		A	Partial thyroid excision	11.23	NA	NA	6.79	5.91	1.49	090
60212		A	Partial thyroid excision	16.43	NA	NA	9.33	8.05	2.20	090
60220		A	Partial removal of thyroid	12.37	NA	NA	7.44	6.44	1.55	090
60225		A	Partial removal of thyroid	14.79	NA	NA	8.99	7.81	1.90	090
60240		A	Removal of thyroid	16.22	NA	NA	8.64	7.48	2.14	090
60252		A	Removal of thyroid	22.01	NA	NA	11.89	10.24	2.80	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
60254		A	Extensive thyroid surgery	28.42	NA	NA	15.19	13.28	3.28	090
60260		A	Repeat thyroid surgery	18.26	NA	NA	9.97	8.63	2.26	090
60270		A	Removal of thyroid	23.20	NA	NA	11.88	10.63	3.16	090
60271		A	Removal of thyroid	17.62	NA	NA	9.65	8.42	2.18	090
60280		A	Remove thyroid duct lesion	6.16	NA	NA	5.46	4.89	0.60	090
60281		A	Remove thyroid duct lesion	8.82	NA	NA	6.79	5.91	0.81	090
60300		A	Aspir/inj thyroid cyst	0.97	1.81	1.83	0.31	0.33	0.08	000
60500		A	Explore parathyroid glands	16.78	NA	NA	9.15	7.83	2.34	090
60502		A	Re-explore parathyroids	21.15	NA	NA	11.31	9.73	2.99	090
60505		A	Explore parathyroid glands	23.06	NA	NA	12.52	10.91	3.12	090
60512		A	Autotransplant parathyroid	4.44	NA	NA	1.76	1.50	0.60	ZZZ
60520		A	Removal of thymus gland	17.16	NA	NA	8.85	7.95	2.50	090
60521		A	Removal of thymus gland	19.18	NA	NA	9.16	9.11	3.28	090
60522		A	Removal of thymus gland	23.48	NA	NA	10.95	10.77	3.94	090
60540		A	Explore adrenal gland	18.02	NA	NA	8.71	8.60	2.18	090
60545		A	Explore adrenal gland	20.93	NA	NA	9.89	9.38	2.66	090
60600		A	Remove carotid body lesion	25.09	NA	NA	10.83	10.23	3.82	090
60605		A	Remove carotid body lesion	31.96	NA	NA	19.07	14.05	2.97	090
60650		A	Laparoscopy adrenalectomy	20.73	NA	NA	9.48	8.82	2.70	090
60659		C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
6070F		I	Pt asked/cnsld aed effects	0.00	0.00	0.00	0.00	0.00	0.00	XXX
61000		A	Remove cranial cavity fluid	1.58	NA	NA	1.31	1.20	0.11	000
61001		A	Remove cranial cavity fluid	1.49	NA	NA	1.99	1.37	0.39	000
61020		A	Remove brain cavity fluid	1.51	NA	NA	1.69	1.60	0.36	000
61026		A	Injection into brain canal	1.69	NA	NA	1.43	1.39	0.28	000
61050		A	Remove brain canal fluid	1.51	NA	NA	1.16	1.21	0.10	000
61055		A	Injection into brain canal	2.10	NA	NA	1.31	1.38	0.21	000
61070		A	Brain canal shunt procedure	0.89	NA	NA	1.19	1.12	0.14	000
61105		A	Twist drill hole	5.45	NA	NA	5.15	4.70	1.37	090
61107		A	Drill skull for implantation	4.99	NA	NA	2.31	2.18	1.27	000
61108		A	Drill skull for drainage	11.64	NA	NA	9.39	8.51	2.96	090
61120		A	Burr hole for puncture	9.60	NA	NA	7.74	6.95	2.48	090
61140		A	Pierce skull for biopsy	17.23	NA	NA	11.92	10.98	4.40	090
61150		A	Pierce skull for drainage	18.90	NA	NA	12.47	11.34	4.89	090
61151		A	Pierce skull for drainage	13.49	NA	NA	9.55	8.56	3.49	090
61154		A	Pierce skull & remove clot	17.07	NA	NA	12.36	11.23	4.39	090
61156		A	Pierce skull for drainage	17.45	NA	NA	11.30	10.53	4.52	090
61210		A	Pierce skull, implant device	5.83	NA	NA	2.69	2.54	1.51	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
61215		A	Insert brain-fluid device	5.85	NA	NA	5.90	5.36	1.49	090
61250		A	Pierce skull & explore	11.49	NA	NA	8.62	7.66	2.97	090
61253		A	Pierce skull & explore	13.49	NA	NA	8.37	7.72	1.24	090
61304		A	Open skull for exploration	23.41	NA	NA	14.76	13.53	5.89	090
61305		A	Open skull for exploration	28.64	NA	NA	17.87	16.38	7.42	090
61312		A	Open skull for drainage	30.17	NA	NA	17.99	16.45	7.80	090
61313		A	Open skull for drainage	28.09	NA	NA	17.85	16.33	7.24	090
61314		A	Open skull for drainage	25.90	NA	NA	16.49	15.01	6.68	090
61315		A	Open skull for drainage	29.65	NA	NA	18.24	16.81	7.69	090
61316		A	Implt cran bone flap to abdo	1.39	NA	NA	0.64	0.59	0.36	ZZZ
61320		A	Open skull for drainage	27.42	NA	NA	16.69	15.48	7.00	090
61321		A	Open skull for drainage	30.53	NA	NA	18.75	16.79	7.91	090
61322		A	Decompressive craniotomy	34.26	NA	NA	20.71	18.51	8.82	090
61323		A	Decompressive lobectomy	35.06	NA	NA	20.16	18.26	9.01	090
61330		A	Decompress eye socket	25.30	NA	NA	14.76	13.45	6.55	090
61332		A	Explore/biopsy eye socket	28.60	NA	NA	17.32	15.06	7.42	090
61333		A	Explore orbit/remove lesion	29.27	NA	NA	19.51	15.92	7.59	090
61334		A	Explore orbit/remove object	19.60	NA	NA	13.13	10.42	5.08	090
61340		A	Subtemporal decompression	20.11	NA	NA	13.37	12.08	5.21	090
61343		A	Incise skull (press relief)	31.86	NA	NA	19.09	17.55	8.19	090
61345		A	Relieve cranial pressure	29.23	NA	NA	17.97	16.54	7.58	090
61440		A	Incise skull for surgery	28.66	NA	NA	17.70	16.18	7.43	090
61450		A	Incise skull for surgery	27.69	NA	NA	16.80	15.28	7.18	090
61458		A	Incise skull for brain wound	28.84	NA	NA	17.62	16.33	7.40	090
61460		A	Incise skull for surgery	30.24	NA	NA	18.44	16.48	7.84	090
61470		A	Incise skull for surgery	27.62	NA	NA	16.76	15.38	7.17	090
61480		A	Incise skull for surgery	28.05	NA	NA	12.06	12.42	1.41	090
61490		A	Incise skull for surgery	27.22	NA	NA	16.58	15.33	7.06	090
61500		A	Removal of skull lesion	19.18	NA	NA	12.80	11.61	4.18	090
61501		A	Remove infected skull bone	16.35	NA	NA	11.51	10.33	3.36	090
61510		A	Removal of brain lesion	30.83	NA	NA	19.76	18.18	7.93	090
61512		A	Remove brain lining lesion	37.14	NA	NA	21.91	20.26	9.59	090
61514		A	Removal of brain abscess	27.23	NA	NA	16.89	15.57	7.01	090
61516		A	Removal of brain lesion	26.58	NA	NA	16.28	15.15	6.65	090
61517		A	Implt brain chemotx add-on	1.38	NA	NA	0.64	0.60	0.35	ZZZ
61518		A	Removal of brain lesion	39.89	NA	NA	24.04	22.06	10.32	090
61519		A	Remove brain lining lesion	43.43	NA	NA	24.77	22.93	11.20	090
61520		A	Removal of brain lesion	57.09	NA	NA	31.41	29.27	12.98	090
61521		A	Removal of brain lesion	46.99	NA	NA	26.63	24.41	12.19	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
61522		A	Removal of brain abscess	31.54	NA	NA	19.05	17.60	8.17	090
61524		A	Removal of brain lesion	29.89	NA	NA	18.28	16.63	7.75	090
61526		A	Removal of brain lesion	54.08	NA	NA	28.99	26.55	14.03	090
61530		A	Removal of brain lesion	45.56	NA	NA	25.57	22.99	11.83	090
61531		A	Implant brain electrodes	16.41	NA	NA	11.91	10.91	4.24	090
61533		A	Implant brain electrodes	21.46	NA	NA	13.77	12.65	5.55	090
61534		A	Removal of brain lesion	23.01	NA	NA	15.07	13.83	5.96	090
61535		A	Remove brain electrodes	13.15	NA	NA	10.03	9.15	3.39	090
61536		A	Removal of brain lesion	37.72	NA	NA	21.92	20.37	9.79	090
61537		A	Removal of brain tissue	36.45	NA	NA	20.40	18.27	9.41	090
61538		A	Removal of brain tissue	39.45	NA	NA	21.55	19.47	10.25	090
61539		A	Removal of brain tissue	34.28	NA	NA	20.32	18.48	8.89	090
61540		A	Removal of brain tissue	31.43	NA	NA	19.08	17.64	8.14	090
61541		A	Incision of brain tissue	30.94	NA	NA	18.77	17.18	8.02	090
61542		A	Removal of brain tissue	33.16	NA	NA	19.67	18.32	8.60	090
61543		A	Removal of brain tissue	31.31	NA	NA	18.94	16.98	8.11	090
61544		A	Remove & treat brain lesion	27.36	NA	NA	16.64	13.22	7.10	090
61545		A	Excision of brain tumor	46.43	NA	NA	27.22	24.87	12.04	090
61546		A	Removal of pituitary gland	33.44	NA	NA	19.93	18.24	8.67	090
61548		A	Removal of pituitary gland	23.37	NA	NA	14.11	12.92	4.81	090
61550		A	Release of skull seams	15.59	NA	NA	7.92	8.64	0.77	090
61552		A	Release of skull seams	20.40	NA	NA	9.55	11.26	1.02	090
61556		A	Incise skull/sutures	24.09	NA	NA	15.34	13.53	6.25	090
61557		A	Incise skull/sutures	23.31	NA	NA	15.61	14.54	6.03	090
61558		A	Excision of skull/sutures	26.50	NA	NA	16.96	15.64	6.85	090
61559		A	Excision of skull/sutures	34.02	NA	NA	15.05	18.32	1.71	090
61563		A	Excision of skull tumor	28.44	NA	NA	17.36	16.03	7.38	090
61564		A	Excision of skull tumor	34.74	NA	NA	20.93	19.38	9.01	090
61566		A	Removal of brain tissue	32.45	NA	NA	19.55	18.24	8.42	090
61567		A	Incision of brain tissue	37.00	NA	NA	22.29	20.87	9.59	090
61570		A	Remove foreign body, brain	26.51	NA	NA	16.70	15.04	6.86	090
61571		A	Incise skull for brain wound	28.42	NA	NA	17.59	16.28	7.37	090
61575		A	Skull base/brainstem surgery	36.56	NA	NA	21.38	18.81	9.48	090
61576		A	Skull base/brainstem surgery	55.31	NA	NA	36.00	34.47	5.14	090
61580		A	Craniofacial approach, skull	34.51	NA	NA	27.89	25.34	4.26	090
61581		A	Craniofacial approach, skull	39.13	NA	NA	31.93	28.28	3.62	090
61582		A	Craniofacial approach, skull	35.14	NA	NA	35.92	31.98	9.09	090
61583		A	Craniofacial approach, skull	38.50	NA	NA	29.12	27.16	9.36	090
61584		A	Orbitocranial approach/skull	37.70	NA	NA	28.50	26.74	9.18	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
61585		A	Orbitocranial approach/skull	42.57	NA	NA	32.61	27.79	11.05	090
61586		A	Resect nasopharynx, skull	27.48	NA	NA	29.62	24.48	7.10	090
61590		A	Infratemporal approach/skull	47.04	NA	NA	31.59	28.31	6.09	090
61591		A	Infratemporal approach/skull	47.02	NA	NA	31.43	28.50	6.94	090
61592		A	Orbitocranial approach/skull	43.08	NA	NA	30.88	28.85	10.48	090
61595		A	Transtemporal approach/skull	33.74	NA	NA	25.63	23.33	5.16	090
61596		A	Transcochlear approach/skull	39.43	NA	NA	26.02	23.75	3.66	090
61597		A	Transcondylar approach/skull	40.82	NA	NA	28.02	24.96	10.60	090
61598		A	Transpetrosal approach/skull	36.53	NA	NA	29.28	24.15	9.48	090
61600		A	Resect/excise cranial lesion	30.01	NA	NA	24.16	21.48	4.49	090
61601		A	Resect/excise cranial lesion	31.14	NA	NA	24.91	22.99	7.36	090
61605		A	Resect/excise cranial lesion	32.57	NA	NA	24.50	21.97	3.56	090
61606		A	Resect/excise cranial lesion	42.05	NA	NA	28.76	26.81	9.89	090
61607		A	Resect/excise cranial lesion	40.93	NA	NA	26.99	24.19	10.63	090
61608		A	Resect/excise cranial lesion	45.54	NA	NA	30.00	27.94	11.13	090
61609		A	Transect artery, sinus	9.88	NA	NA	4.76	4.03	2.58	ZZZ
61610		A	Transect artery, sinus	29.63	NA	NA	13.79	12.74	7.71	ZZZ
61611		A	Transect artery, sinus	7.41	NA	NA	2.71	3.10	0.37	ZZZ
61612		A	Transect artery, sinus	27.84	NA	NA	10.16	10.93	1.41	ZZZ
61613		A	Remove aneurysm, sinus	45.03	NA	NA	31.03	28.08	11.69	090
61615		A	Resect/excise lesion, skull	35.77	NA	NA	24.39	23.11	3.32	090
61616		A	Resect/excise lesion, skull	46.74	NA	NA	32.02	29.42	10.42	090
61618		A	Repair dura	18.69	NA	NA	12.31	11.17	4.16	090
61619		A	Repair dura	22.10	NA	NA	13.72	12.49	4.58	090
61623		A	Endovasc tempory vessel occl	9.95	NA	NA	3.72	4.00	1.33	000
61624		A	Transcath occlusion, cns	20.12	NA	NA	7.07	7.69	2.73	000
61626		A	Transcath occlusion, non-cns	16.60	NA	NA	5.20	6.15	1.55	000
61630		R	Intracranial angioplasty	22.07	NA	NA	9.07	9.78	3.03	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	NA	9.67	10.56	2.94	XXX
61640		N	Dilate ic vasospasm, init	12.32	NA	NA	4.50	4.29	0.62	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	NA	1.58	1.51	0.22	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	NA	3.16	3.02	0.43	ZZZ
61680		A	Intracranial vessel surgery	32.55	NA	NA	19.78	18.32	8.44	090
61682		A	Intracranial vessel surgery	63.41	NA	NA	33.11	31.03	16.48	090
61684		A	Intracranial vessel surgery	41.64	NA	NA	24.14	21.84	10.80	090
61686		A	Intracranial vessel surgery	67.50	NA	NA	36.55	34.02	17.52	090
61690		A	Intracranial vessel surgery	31.34	NA	NA	19.23	17.59	8.11	090
61692		A	Intracranial vessel surgery	54.59	NA	NA	30.06	27.60	14.17	090
61697		A	Brain aneurysm repr, complx	63.40	NA	NA	34.18	31.18	16.30	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
61698		A	Brain aneurysm repr, complx	69.63	NA	NA	37.54	33.33	18.08	090
61700		A	Brain aneurysm repr, simple	50.62	NA	NA	28.52	26.73	13.04	090
61702		A	Inner skull vessel surgery	60.04	NA	NA	33.08	29.61	15.59	090
61703		A	Clamp neck artery	18.80	NA	NA	12.66	11.69	4.87	090
61705		A	Revise circulation to head	38.10	NA	NA	22.10	19.69	9.89	090
61708		A	Revise circulation to head	37.20	NA	NA	17.70	16.10	2.22	090
61710		A	Revise circulation to head	31.29	NA	NA	13.48	14.76	4.71	090
61711		A	Fusion of skull arteries	38.23	NA	NA	21.67	20.11	9.92	090
61720		A	Incise skull/brain surgery	17.62	NA	NA	11.78	9.85	4.56	090
61735		A	Incise skull/brain surgery	22.35	NA	NA	14.44	11.91	5.79	090
61750		A	Incise skull/brain biopsy	19.83	NA	NA	12.70	11.71	5.11	090
61751		A	Brain biopsy w/ct/mr guide	18.79	NA	NA	13.00	12.04	4.82	090
61760		A	Implant brain electrodes	22.39	NA	NA	14.18	12.41	5.79	090
61770		A	Incise skull for treatment	23.19	NA	NA	13.88	12.27	5.92	090
61790		A	Treat trigeminal nerve	11.60	NA	NA	8.70	7.71	2.92	090
61791		A	Treat trigeminal tract	15.41	NA	NA	10.02	9.47	3.74	090
61795		A	Brain surgery using computer	4.03	NA	NA	1.89	1.74	0.76	ZZZ
61796		A	Srs, cranial lesion simple	13.93	NA	NA	8.99	7.51	0.54	090
61797		A	Srs, cran les simple, addl	3.48	NA	NA	1.55	1.42	0.17	ZZZ
61798		A	Srs, cranial lesion complex	19.85	NA	NA	11.62	8.18	0.54	090
61799		A	Srs, cran les complex, addl	4.81	NA	NA	2.14	1.95	0.24	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	NA	1.25	1.16	0.11	ZZZ
61850		A	Implant neuroelectrodes	13.34	NA	NA	9.40	8.69	3.45	090
61860		A	Implant neuroelectrodes	22.26	NA	NA	13.94	12.88	5.77	090
61863		A	Implant neuroelectrode	20.71	NA	NA	14.08	13.04	5.34	090
61864		A	Implant neuroelectrde, addl	4.49	NA	NA	2.09	1.98	1.16	ZZZ
61867		A	Implant neuroelectrode	33.03	NA	NA	19.80	18.33	8.55	090
61868		A	Implant neuroelectrde, addl	7.91	NA	NA	3.69	3.48	2.06	ZZZ
61870		A	Implant neuroelectrodes	16.34	NA	NA	11.06	10.32	4.23	090
61875		A	Implant neuroelectrodes	16.46	NA	NA	7.67	9.27	0.82	090
61880		A	Revise/remove neuroelectrode	6.95	NA	NA	6.30	5.60	1.78	090
61885		A	Insrt/redo neurostim 1 array	7.57	NA	NA	8.23	7.33	1.83	090
61886		A	Implant neurostim arrays	9.93	NA	NA	9.72	8.76	2.50	090
61888		A	Revise/remove neuroreceiver	5.23	NA	NA	3.89	3.71	1.24	010
62000		A	Treat skull fracture	13.93	NA	NA	9.94	7.68	3.60	090
62005		A	Treat skull fracture	17.63	NA	NA	11.79	10.55	4.56	090
62010		A	Treatment of head injury	21.43	NA	NA	13.63	12.57	5.55	090
62100		A	Repair brain fluid leakage	23.53	NA	NA	14.49	13.15	5.42	090
62115		A	Reduction of skull defect	22.91	NA	NA	10.84	9.08	1.14	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
62116		A	Reduction of skull defect	25.02	NA	NA	16.02	14.77	6.48	090
62117		A	Reduction of skull defect	28.35	NA	NA	15.86	15.58	2.63	090
62120		A	Repair skull cavity lesion	24.59	NA	NA	19.63	18.57	2.28	090
62121		A	Incise skull repair	23.03	NA	NA	19.58	16.13	5.97	090
62140		A	Repair of skull defect	14.55	NA	NA	9.94	9.10	3.42	090
62141		A	Repair of skull defect	16.07	NA	NA	10.81	9.91	3.82	090
62142		A	Remove skull plate/flap	11.83	NA	NA	8.89	8.13	2.93	090
62143		A	Replace skull plate/flap	14.15	NA	NA	10.00	9.09	3.60	090
62145		A	Repair of skull & brain	20.09	NA	NA	12.52	11.65	5.21	090
62146		A	Repair of skull with graft	17.28	NA	NA	11.63	10.33	4.47	090
62147		A	Repair of skull with graft	20.67	NA	NA	13.20	11.97	5.36	090
62148		A	Retr bone flap to fix skull	2.00	NA	NA	0.93	0.85	0.52	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	NA	1.39	1.32	0.77	ZZZ
62161		A	Dissect brain w/scope	21.23	NA	NA	14.02	12.81	5.50	090
62162		A	Remove colloid cyst w/scope	26.80	NA	NA	16.94	15.74	6.95	090
62163		A	Neuroendoscopy w/fb removal	16.53	NA	NA	11.83	10.99	4.27	090
62164		A	Remove brain tumor w/scope	29.43	NA	NA	18.93	16.84	7.62	090
62165		A	Remove pituit tumor w/scope	23.23	NA	NA	14.47	13.31	4.60	090
62180		A	Establish brain cavity shunt	22.58	NA	NA	14.46	13.33	5.85	090
62190		A	Establish brain cavity shunt	12.17	NA	NA	9.25	8.40	3.14	090
62192		A	Establish brain cavity shunt	13.35	NA	NA	9.53	8.56	3.32	090
62194		A	Replace/irrigate catheter	5.78	NA	NA	5.20	3.78	0.32	010
62200		A	Establish brain cavity shunt	19.29	NA	NA	12.56	11.54	4.99	090
62201		A	Brain cavity shunt w/scope	16.04	NA	NA	11.86	10.79	4.12	090
62220		A	Establish brain cavity shunt	14.10	NA	NA	9.65	8.75	3.47	090
62223		A	Establish brain cavity shunt	14.05	NA	NA	10.61	9.68	3.46	090
62225		A	Replace/irrigate catheter	6.19	NA	NA	5.93	5.30	1.58	090
62230		A	Replace/revise brain shunt	11.43	NA	NA	8.21	7.49	2.86	090
62252		A	Csf shunt reprogram	0.74	1.78	1.71	NA	NA	0.18	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.44	1.39	NA	NA	0.01	XXX
62252	26	A	Csf shunt reprogram	0.74	0.34	0.32	0.34	0.32	0.17	XXX
62256		A	Remove brain cavity shunt	7.38	NA	NA	6.50	5.94	1.89	090
62258		A	Replace brain cavity shunt	15.64	NA	NA	10.59	9.70	3.91	090
62263		A	Epidural lysis mult sessions	6.54	12.48	10.60	4.37	3.37	0.37	010
62264		A	Epidural lysis on single day	4.42	6.69	5.86	2.08	1.51	0.26	010
62267		A	Interdiscal perq aspir, dx	3.00	4.18	3.64	1.49	1.26	0.15	000
62268		A	Drain spinal cord cyst	4.73	5.68	6.70	1.89	1.96	0.34	000
62269		A	Needle biopsy, spinal cord	5.01	5.45	7.23	1.66	1.81	0.41	000
62270		A	Spinal fluid tap, diagnostic	1.37	2.41	2.54	0.59	0.60	0.16	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
62272		A	Drain cerebro spinal fluid	1.35	3.47	3.32	0.70	0.68	0.23	000
62273		A	Inject epidural patch	2.15	2.21	2.06	0.83	0.69	0.14	000
62280		A	Treat spinal cord lesion	2.63	5.25	5.10	1.44	1.21	0.36	010
62281		A	Treat spinal cord lesion	2.66	5.10	4.66	1.47	1.14	0.20	010
62282		A	Treat spinal canal lesion	2.33	4.92	5.08	1.44	1.17	0.21	010
62284		A	Injection for myelogram	1.54	3.52	4.00	0.66	0.73	0.13	000
62287		A	Percutaneous diskectomy	9.03	NA	NA	5.29	4.93	0.59	090
62290		A	Inject for spine disk x-ray	3.00	5.51	5.33	1.55	1.35	0.21	000
62291		A	Inject for spine disk x-ray	2.91	5.25	4.91	1.52	1.28	0.19	000
62292		A	Injection into disk lesion	9.24	NA	NA	4.26	3.27	0.54	090
62294		A	Injection into spinal artery	12.87	NA	NA	3.30	5.86	0.73	090
62310		A	Inject spine c/t	1.91	4.21	3.73	0.95	0.71	0.12	000
62311		A	Inject spine l/s (cd)	1.54	3.57	3.38	0.79	0.63	0.10	000
62318		A	Inject spine w/cath, c/t	2.04	3.91	3.85	0.62	0.53	0.12	000
62319		A	Inject spine w/cath l/s (cd)	1.87	3.70	3.50	0.67	0.55	0.12	000
62350		A	Implant spinal canal cath	6.05	NA	NA	4.07	3.39	0.75	010
62351		A	Implant spinal canal cath	11.66	NA	NA	9.35	8.14	2.43	090
62355		A	Remove spinal canal catheter	4.35	NA	NA	3.35	2.80	0.53	010
62360		A	Insert spine infusion device	4.33	NA	NA	3.44	2.82	0.63	010
62361		A	Implant spine infusion pump	5.65	NA	NA	4.23	3.82	0.79	010
62362		A	Implant spine infusion pump	6.10	NA	NA	4.26	3.70	0.88	010
62365		A	Remove spine infusion device	4.65	NA	NA	3.64	3.17	0.64	010
62367		A	Analyze spine infusion pump	0.48	0.61	0.52	0.19	0.14	0.04	XXX
62368		A	Analyze spine infusion pump	0.75	0.84	0.68	0.31	0.22	0.06	XXX
63001		A	Removal of spinal lamina	17.61	NA	NA	11.49	10.48	4.10	090
63003		A	Removal of spinal lamina	17.74	NA	NA	11.55	10.56	4.05	090
63005		A	Removal of spinal lamina	16.43	NA	NA	11.70	10.67	3.64	090
63011		A	Removal of spinal lamina	15.91	NA	NA	10.84	9.62	2.89	090
63012		A	Removal of spinal lamina	16.85	NA	NA	11.49	10.59	3.67	090
63015		A	Removal of spinal lamina	20.85	NA	NA	13.92	12.76	5.05	090
63016		A	Removal of spinal lamina	22.03	NA	NA	13.90	12.71	4.89	090
63017		A	Removal of spinal lamina	17.33	NA	NA	12.17	11.15	3.99	090
63020		A	Neck spine disk surgery	16.20	NA	NA	11.59	10.59	3.63	090
63030		A	Low back disk surgery	13.18	NA	NA	10.07	9.19	2.78	090
63035		A	Spinal disk surgery add-on	3.15	NA	NA	1.51	1.42	0.64	ZZZ
63040		A	Laminotomy, single cervical	20.31	NA	NA	13.15	12.01	4.53	090
63042		A	Laminotomy, single lumbar	18.76	NA	NA	12.68	11.63	3.73	090
63043		C	Laminotomy, addl cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy, addl lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
63045		A	Removal of spinal lamina	17.95	NA	NA	12.12	11.11	4.12	090
63046		A	Removal of spinal lamina	17.25	NA	NA	11.70	10.71	3.70	090
63047		A	Removal of spinal lamina	15.37	NA	NA	11.09	10.20	3.16	090
63048		A	Remove spinal lamina add-on	3.47	NA	NA	1.66	1.54	0.72	ZZZ
63050		A	Cervical laminoplasty	22.01	NA	NA	14.03	12.92	5.70	090
63051		A	C-laminoplasty w/graft/plate	25.51	NA	NA	15.74	14.36	5.23	090
63055		A	Decompress spinal cord	23.55	NA	NA	14.77	13.63	5.53	090
63056		A	Decompress spinal cord	21.86	NA	NA	13.77	12.60	4.46	090
63057		A	Decompress spine cord add-on	5.25	NA	NA	2.51	2.35	1.09	ZZZ
63064		A	Decompress spinal cord	26.22	NA	NA	15.96	14.53	5.73	090
63066		A	Decompress spine cord add-on	3.26	NA	NA	1.52	1.45	0.84	ZZZ
63075		A	Neck spine disk surgery	19.60	NA	NA	13.03	12.09	4.41	090
63076		A	Neck spine disk surgery	4.04	NA	NA	1.92	1.81	0.90	ZZZ
63077		A	Spine disk surgery, thorax	22.88	NA	NA	13.59	12.56	4.23	090
63078		A	Spine disk surgery, thorax	3.28	NA	NA	1.56	1.45	0.55	ZZZ
63081		A	Removal of vertebral body	26.10	NA	NA	16.16	14.84	5.69	090
63082		A	Remove vertebral body add-on	4.36	NA	NA	2.08	1.96	0.95	ZZZ
63085		A	Removal of vertebral body	29.47	NA	NA	16.62	15.23	5.72	090
63086		A	Remove vertebral body add-on	3.19	NA	NA	1.47	1.39	0.64	ZZZ
63087		A	Removal of vertebral body	37.53	NA	NA	20.70	19.13	7.04	090
63088		A	Remove vertebral body add-on	4.32	NA	NA	2.05	1.94	0.76	ZZZ
63090		A	Removal of vertebral body	30.93	NA	NA	17.68	16.14	5.19	090
63091		A	Remove vertebral body add-on	3.03	NA	NA	1.42	1.33	0.49	ZZZ
63101		A	Removal of vertebral body	34.10	NA	NA	20.89	19.23	7.66	090
63102		A	Removal of vertebral body	34.10	NA	NA	20.71	19.00	6.20	090
63103		A	Remove vertebral body add-on	4.82	NA	NA	2.29	2.18	0.93	ZZZ
63170		A	Incise spinal cord tract(s)	22.21	NA	NA	14.66	13.01	5.75	090
63172		A	Drainage of spinal cyst	19.76	NA	NA	12.66	11.69	5.12	090
63173		A	Drainage of spinal cyst	24.31	NA	NA	15.64	14.38	6.29	090
63180		A	Revise spinal cord ligaments	20.53	NA	NA	10.37	10.93	5.32	090
63182		A	Revise spinal cord ligaments	22.82	NA	NA	14.94	11.48	5.91	090
63185		A	Incise spinal column/nerves	16.49	NA	NA	11.87	10.18	4.26	090
63190		A	Incise spinal column/nerves	18.89	NA	NA	12.59	11.45	3.09	090
63191		A	Incise spinal column/nerves	18.92	NA	NA	13.93	9.03	2.69	090
63194		A	Incise spinal column & cord	22.10	NA	NA	13.28	12.47	2.05	090
63195		A	Incise spinal column & cord	21.64	NA	NA	13.94	12.48	5.61	090
63196		A	Incise spinal column & cord	25.27	NA	NA	11.24	13.51	1.26	090
63197		A	Incise spinal column & cord	24.08	NA	NA	15.53	14.18	6.23	090
63198		A	Incise spinal column & cord	29.90	NA	NA	13.12	11.96	1.50	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
63199		A	Incise spinal column & cord	31.47	NA	NA	13.69	15.60	1.58	090
63200		A	Release of spinal cord	21.44	NA	NA	14.05	12.73	5.48	090
63250		A	Revise spinal cord vessels	43.86	NA	NA	24.78	22.52	11.38	090
63251		A	Revise spinal cord vessels	44.64	NA	NA	25.54	23.47	11.58	090
63252		A	Revise spinal cord vessels	44.63	NA	NA	25.53	23.40	11.57	090
63265		A	Excise intraspinal lesion	23.82	NA	NA	15.24	13.97	5.83	090
63266		A	Excise intraspinal lesion	24.68	NA	NA	15.63	14.22	6.05	090
63267		A	Excise intraspinal lesion	19.45	NA	NA	13.08	11.99	4.51	090
63268		A	Excise intraspinal lesion	20.02	NA	NA	13.68	12.15	5.18	090
63270		A	Excise intraspinal lesion	29.80	NA	NA	18.24	16.59	7.72	090
63271		A	Excise intraspinal lesion	29.92	NA	NA	18.17	16.67	7.63	090
63272		A	Excise intraspinal lesion	27.50	NA	NA	16.98	15.57	6.83	090
63273		A	Excise intraspinal lesion	26.47	NA	NA	16.69	14.54	6.85	090
63275		A	Biopsy/excise spinal tumor	25.86	NA	NA	16.16	14.75	6.35	090
63276		A	Biopsy/excise spinal tumor	25.69	NA	NA	16.02	14.70	6.28	090
63277		A	Biopsy/excise spinal tumor	22.39	NA	NA	14.41	13.19	5.05	090
63278		A	Biopsy/excise spinal tumor	22.12	NA	NA	14.66	13.08	5.73	090
63280		A	Biopsy/excise spinal tumor	30.29	NA	NA	18.75	17.35	7.81	090
63281		A	Biopsy/excise spinal tumor	29.99	NA	NA	18.49	17.12	7.69	090
63282		A	Biopsy/excise spinal tumor	28.15	NA	NA	17.69	16.35	7.19	090
63283		A	Biopsy/excise spinal tumor	26.76	NA	NA	17.21	15.61	6.93	090
63285		A	Biopsy/excise spinal tumor	38.05	NA	NA	22.39	20.30	9.87	090
63286		A	Biopsy/excise spinal tumor	37.62	NA	NA	22.15	20.39	9.53	090
63287		A	Biopsy/excise spinal tumor	40.08	NA	NA	23.41	21.39	10.40	090
63290		A	Biopsy/excise spinal tumor	40.82	NA	NA	23.76	21.69	10.59	090
63295		A	Repair of laminectomy defect	5.25	NA	NA	2.44	2.19	1.36	ZZZ
63300		A	Removal of vertebral body	26.80	NA	NA	16.41	15.04	6.26	090
63301		A	Removal of vertebral body	31.57	NA	NA	19.45	16.63	8.18	090
63302		A	Removal of vertebral body	31.15	NA	NA	19.26	16.59	8.07	090
63303		A	Removal of vertebral body	33.55	NA	NA	18.21	16.64	8.70	090
63304		A	Removal of vertebral body	33.85	NA	NA	20.51	18.60	8.77	090
63305		A	Removal of vertebral body	36.24	NA	NA	21.63	18.27	9.39	090
63306		A	Removal of vertebral body	35.55	NA	NA	21.30	19.56	9.21	090
63307		A	Removal of vertebral body	34.96	NA	NA	15.77	17.24	9.06	090
63308		A	Remove vertebral body add-on	5.24	NA	NA	2.40	2.30	1.13	ZZZ
63600		A	Remove spinal cord lesion	15.12	NA	NA	6.70	5.34	1.13	090
63610		A	Stimulation of spinal cord	8.72	13.78	22.32	1.66	1.82	0.50	000
63615		A	Remove lesion of spinal cord	17.32	NA	NA	8.50	8.95	4.48	090
63620		A	Srs, spinal lesion	15.60	NA	NA	9.73	7.70	0.54	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
63621		A	Srs, spinal lesion, addl	4.00	NA	NA	1.78	1.63	0.20	ZZZ
63650		A	Implant neuroelectrodes	7.20	NA	NA	4.29	3.25	0.46	010
63655		A	Implant neuroelectrodes	11.56	NA	NA	9.09	8.09	2.60	090
63661		A	Remove spine eltrd perq aray	5.08	9.73	9.73	3.19	3.19	0.01	010
63662		A	Remove spine eltrd plate	11.00	NA	NA	6.94	6.94	1.10	090
63663		A	Revise spine eltrd perq aray	7.75	13.43	13.43	4.27	4.27	0.78	010
63664		A	Revise spine eltrd plate	11.52	NA	NA	7.15	7.15	1.15	090
63685		A	Insrt/redo spine n generator	6.05	NA	NA	4.13	3.51	0.79	010
63688		A	Revise/remove neuroreceiver	5.30	NA	NA	3.93	3.33	0.72	010
63700		A	Repair of spinal herniation	17.47	NA	NA	12.61	11.05	4.51	090
63702		A	Repair of spinal herniation	19.41	NA	NA	13.51	12.35	5.02	090
63704		A	Repair of spinal herniation	22.43	NA	NA	15.77	13.35	5.79	090
63706		A	Repair of spinal herniation	25.35	NA	NA	17.12	15.35	6.54	090
63707		A	Repair spinal fluid leakage	12.65	NA	NA	9.32	8.42	2.51	090
63709		A	Repair spinal fluid leakage	15.65	NA	NA	10.82	9.85	3.24	090
63710		A	Graft repair of spine defect	15.40	NA	NA	10.85	9.87	3.49	090
63740		A	Install spinal shunt	12.63	NA	NA	9.52	8.79	3.07	090
63741		A	Install spinal shunt	9.12	NA	NA	5.68	5.01	1.57	090
63744		A	Revision of spinal shunt	8.94	NA	NA	6.85	5.88	2.19	090
63746		A	Removal of spinal shunt	7.33	NA	NA	6.60	5.73	1.89	090
64400		A	N block inj, trigeminal	1.11	1.82	1.64	0.65	0.51	0.12	000
64402		A	N block inj, facial	1.25	1.76	1.55	0.72	0.58	0.13	000
64405		A	N block inj, occipital	1.32	1.61	1.35	0.73	0.57	0.18	000
64408		A	N block inj, vagus	1.41	1.78	1.62	0.97	0.85	0.12	000
64410		A	N block inj, phrenic	1.43	2.37	2.14	0.65	0.56	0.24	000
64412		A	N block inj, spinal accessor	1.18	2.83	2.43	0.78	0.62	0.13	000
64413		A	N block inj, cervical plexus	1.40	1.61	1.51	0.65	0.55	0.14	000
64415		A	N block inj, brachial plexus	1.48	1.73	1.77	0.41	0.37	0.09	000
64416		A	N block cont infuse, b plex	1.81	NA	NA	0.30	0.35	0.11	000
64417		A	N block inj, axillary	1.44	1.74	1.82	0.41	0.38	0.09	000
64418		A	N block inj, suprascapular	1.32	2.24	2.11	0.68	0.55	0.10	000
64420		A	N block inj, intercost, sng	1.18	3.02	2.90	0.63	0.50	0.09	000
64421		A	N block inj, intercost, mlt	1.68	4.50	4.35	0.78	0.62	0.14	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.72	1.50	0.78	0.62	0.14	000
64430		A	N block inj, pudendal	1.46	1.92	2.34	0.66	0.73	0.11	000
64435		A	N block inj, paracervical	1.45	1.91	2.10	0.70	0.64	0.18	000
64445		A	N block inj, sciatic, sng	1.48	1.92	1.91	0.63	0.55	0.12	000
64446		A	N blk inj, sciatic, cont inf	1.81	NA	NA	0.32	0.41	0.11	000
64447		A	N block inj fem, single	1.50	NA	NA	0.25	0.25	0.09	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
64448		A	N block inj fem, cont inf	1.63	NA	NA	0.27	0.34	0.10	000
64449		A	N block inj, lumbar plexus	1.81	NA	NA	0.37	0.43	0.11	000
64450		A	N block, other peripheral	1.27	1.42	1.32	0.55	0.51	0.08	000
64455		A	N block inj, plantar digit	0.75	0.59	0.55	0.27	0.25	0.04	000
64479		A	Inj foramen epidural c/t	2.20	5.00	4.86	1.22	0.97	0.18	000
64480		A	Inj foramen epidural add-on	1.54	2.15	2.00	0.65	0.50	0.17	ZZZ
64483		A	Inj foramen epidural l/s	1.90	5.03	4.96	1.10	0.88	0.12	000
64484		A	Inj foramen epidural add-on	1.33	2.27	2.15	0.56	0.42	0.09	ZZZ
64490		A	Inj paravert f jnt c/t 1 lev	1.82	2.57	2.57	1.02	1.02	0.14	000
64491		A	Inj paravert f jnt c/t 2 lev	1.16	0.98	0.98	0.46	0.46	0.09	ZZZ
64492		A	Inj paravert f jnt c/t 3 lev	1.16	1.01	1.01	0.49	0.49	0.09	ZZZ
64493		A	Inj paravert f jnt l/s 1 lev	1.52	2.47	2.47	0.90	0.90	0.11	000
64494		A	Inj paravert f jnt l/s 2 lev	1.00	0.93	0.93	0.39	0.39	0.07	ZZZ
64495		A	Inj paravert f jnt l/s 3 lev	1.00	0.96	0.96	0.42	0.42	0.07	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.15	1.16	0.80	0.75	0.07	000
64508		A	N block, carotid sinus s/p	1.12	3.10	2.63	0.85	0.68	0.17	000
64510		A	N block, stellate ganglion	1.22	2.01	2.26	0.71	0.53	0.07	000
64517		A	N block inj, hypogas plxs	2.20	2.55	2.18	1.16	0.87	0.13	000
64520		A	N block, lumbar/thoracic	1.35	3.55	3.39	0.80	0.62	0.08	000
64530		A	N block inj, celiac pelus	1.58	3.41	3.29	0.89	0.73	0.11	000
64550		A	Apply neurostimulator	0.18	0.24	0.22	0.06	0.05	0.01	000
64553		A	Implant neuroelectrodes	2.36	3.06	2.81	1.79	1.65	0.27	010
64555		A	Implant neuroelectrodes	2.32	2.54	2.94	1.43	1.53	0.18	010
64560		A	Implant neuroelectrodes	2.41	2.61	2.84	1.51	1.56	0.12	010
64561		A	Implant neuroelectrodes	7.15	15.30	20.70	3.25	3.60	0.57	010
64565		A	Implant neuroelectrodes	1.81	2.84	2.57	1.52	1.26	0.17	010
64573		A	Implant neuroelectrodes	8.25	NA	NA	6.31	5.65	1.76	090
64575		A	Implant neuroelectrodes	4.42	NA	NA	3.20	2.63	0.32	090
64577		A	Implant neuroelectrodes	4.69	NA	NA	5.09	3.99	1.20	090
64580		A	Implant neuroelectrodes	4.19	NA	NA	3.35	3.16	0.64	090
64581		A	Implant neuroelectrodes	14.23	NA	NA	5.78	6.49	1.14	090
64585		A	Revise/remove neuroelectrode	2.11	4.02	5.83	1.59	1.84	0.20	010
64590		A	Insrt/redo pn/gastr stimul	2.45	4.02	5.17	1.65	1.97	0.21	010
64595		A	Revise/rmv pn/gastr stimul	1.78	4.22	5.94	1.44	1.69	0.15	010
64600		A	Injection treatment of nerve	3.49	6.72	6.62	2.28	1.88	0.39	010
64605		A	Injection treatment of nerve	5.65	13.53	9.62	4.06	2.89	0.32	010
64610		A	Injection treatment of nerve	7.20	10.84	9.69	4.36	4.04	1.55	010
64612		A	Destroy nerve, face muscle	2.01	2.11	1.93	1.83	1.50	0.47	010
64613		A	Destroy nerve, neck muscle	2.01	1.89	1.83	1.58	1.29	0.42	010

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
64614		A	Destroy nerve, extrem musc	2.20	2.13	2.08	1.71	1.44	0.31	010
64620		A	Injection treatment of nerve	2.89	4.68	4.10	1.78	1.38	0.20	010
64622		A	Destr paravertebrl nerve l/s	3.05	5.80	5.30	2.06	1.54	0.18	010
64623		A	Destr paravertebral n add-on	0.99	2.31	2.11	0.41	0.28	0.06	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.92	6.77	5.95	3.00	2.25	0.24	010
64627		A	Destr paravertebral n add-on	1.16	3.30	3.07	0.48	0.33	0.07	ZZZ
64630		A	Injection treatment of nerve	3.05	2.54	2.73	1.72	1.76	0.25	010
64632		A	N block inj, common digit	1.23	1.08	1.00	0.71	0.66	0.06	010
64640		A	Injection treatment of nerve	2.81	2.69	2.84	1.58	1.56	0.17	010
64650		A	Chemodenerv eccrine glands	0.70	1.12	1.01	0.35	0.29	0.09	000
64653		A	Chemodenerv eccrine glands	0.88	1.30	1.11	0.39	0.35	0.18	000
64680		A	Injection treatment of nerve	2.67	5.31	5.13	1.63	1.43	0.21	010
64681		A	Injection treatment of nerve	3.78	4.85	5.81	1.18	1.47	0.22	010
64702		A	Revise finger/toe nerve	6.26	NA	NA	6.30	5.35	0.74	090
64704		A	Revise hand/foot nerve	4.69	NA	NA	3.65	3.51	0.40	090
64708		A	Revise arm/leg nerve	6.36	NA	NA	5.98	5.33	0.81	090
64712		A	Revision of sciatic nerve	8.07	NA	NA	5.76	5.28	0.95	090
64713		A	Revision of arm nerve(s)	11.40	NA	NA	7.77	6.96	1.71	090
64714		A	Revise low back nerve(s)	10.55	NA	NA	7.18	5.66	1.24	090
64716		A	Revision of cranial nerve	6.99	NA	NA	6.67	6.03	0.80	090
64718		A	Revise ulnar nerve at elbow	7.26	NA	NA	7.40	6.63	1.03	090
64719		A	Revise ulnar nerve at wrist	4.97	NA	NA	4.95	4.54	0.67	090
64721		A	Carpal tunnel surgery	4.97	5.60	5.18	5.54	5.13	0.68	090
64722		A	Relieve pressure on nerve(s)	4.82	NA	NA	3.97	3.48	0.61	090
64726		A	Release foot/toe nerve	4.27	NA	NA	2.94	2.84	0.29	090
64727		A	Internal nerve revision	3.10	NA	NA	1.53	1.41	0.43	ZZZ
64732		A	Incision of brow nerve	4.89	NA	NA	5.34	4.43	1.24	090
64734		A	Incision of cheek nerve	5.55	NA	NA	6.04	4.74	0.50	090
64736		A	Incision of chin nerve	5.23	NA	NA	5.89	4.71	1.33	090
64738		A	Incision of jaw nerve	6.36	NA	NA	6.41	5.03	1.63	090
64740		A	Incision of tongue nerve	6.22	NA	NA	5.82	5.17	0.57	090
64742		A	Incision of facial nerve	6.85	NA	NA	5.98	4.91	0.62	090
64744		A	Incise nerve, back of head	5.72	NA	NA	5.72	4.38	1.47	090
64746		A	Incise diaphragm nerve	6.56	NA	NA	5.21	4.41	1.09	090
64752		A	Incision of vagus nerve	7.69	NA	NA	4.45	4.41	1.28	090
64755		A	Incision of stomach nerves	15.05	NA	NA	7.75	6.57	2.32	090
64760		A	Incision of vagus nerve	7.59	NA	NA	5.12	4.18	1.15	090
64761		A	Incision of pelvis nerve	7.04	NA	NA	4.62	4.14	0.71	090
64763		A	Incise hip/thigh nerve	7.56	NA	NA	5.03	5.45	1.15	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
64766		A	Incise hip/thigh nerve	9.47	NA	NA	6.03	5.77	0.65	090
64771		A	Sever cranial nerve	8.15	NA	NA	6.24	6.02	0.74	090
64772		A	Incision of spinal nerve	7.84	NA	NA	6.39	5.76	1.28	090
64774		A	Remove skin nerve lesion	5.80	NA	NA	4.70	4.23	0.74	090
64776		A	Remove digit nerve lesion	5.60	NA	NA	4.37	3.97	0.60	090
64778		A	Digit nerve surgery add-on	3.11	NA	NA	1.53	1.39	0.44	ZZZ
64782		A	Remove limb nerve lesion	6.86	NA	NA	4.90	4.43	0.66	090
64783		A	Limb nerve surgery add-on	3.71	NA	NA	2.09	1.75	0.33	ZZZ
64784		A	Remove nerve lesion	10.62	NA	NA	7.86	6.96	1.45	090
64786		A	Remove sciatic nerve lesion	16.25	NA	NA	10.79	9.63	2.31	090
64787		A	Implant nerve end	4.29	NA	NA	1.94	1.87	0.49	ZZZ
64788		A	Remove skin nerve lesion	5.24	NA	NA	4.64	4.18	0.76	090
64790		A	Removal of nerve lesion	12.10	NA	NA	8.45	7.58	1.98	090
64792		A	Removal of nerve lesion	15.86	NA	NA	11.68	9.99	4.08	090
64795		A	Biopsy of nerve	3.01	NA	NA	1.79	1.60	0.59	000
64802		A	Remove sympathetic nerves	10.37	NA	NA	7.31	4.88	0.59	090
64804		A	Remove sympathetic nerves	15.91	NA	NA	4.15	5.42	0.90	090
64809		A	Remove sympathetic nerves	14.71	NA	NA	3.77	5.49	0.84	090
64818		A	Remove sympathetic nerves	11.34	NA	NA	5.44	4.89	1.49	090
64820		A	Remove sympathetic nerves	10.74	NA	NA	8.40	7.58	1.36	090
64821		A	Remove sympathetic nerves	9.33	NA	NA	7.84	7.28	1.31	090
64822		A	Remove sympathetic nerves	9.33	NA	NA	7.84	7.09	1.31	090
64823		A	Remove sympathetic nerves	10.94	NA	NA	8.63	7.65	1.54	090
64831		A	Repair of digit nerve	9.16	NA	NA	8.04	7.28	1.17	090
64832		A	Repair nerve add-on	5.65	NA	NA	3.01	2.72	0.72	ZZZ
64834		A	Repair of hand or foot nerve	10.81	NA	NA	7.96	7.23	1.33	090
64835		A	Repair of hand or foot nerve	11.73	NA	NA	8.57	7.80	1.66	090
64836		A	Repair of hand or foot nerve	11.73	NA	NA	8.57	7.82	1.66	090
64837		A	Repair nerve add-on	6.25	NA	NA	3.53	3.08	0.56	ZZZ
64840		A	Repair of leg nerve	14.02	NA	NA	5.55	7.59	0.77	090
64856		A	Repair/transpose nerve	15.07	NA	NA	10.59	9.52	2.04	090
64857		A	Repair arm/leg nerve	15.82	NA	NA	11.05	9.89	2.09	090
64858		A	Repair sciatic nerve	17.82	NA	NA	11.65	11.04	2.53	090
64859		A	Nerve surgery	4.25	NA	NA	2.08	1.99	0.60	ZZZ
64861		A	Repair of arm nerves	20.89	NA	NA	13.44	11.76	2.97	090
64862		A	Repair of low back nerves	21.09	NA	NA	14.12	11.12	5.46	090
64864		A	Repair of facial nerve	13.41	NA	NA	9.19	8.27	1.23	090
64865		A	Repair of facial nerve	16.09	NA	NA	13.34	12.60	1.49	090
64866		A	Fusion of facial/other nerve	16.83	NA	NA	13.70	12.72	1.56	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
64868		A	Fusion of facial/other nerve	14.90	NA	NA	12.07	11.19	1.37	090
64870		A	Fusion of facial/other nerve	17.08	NA	NA	10.47	8.70	2.88	090
64872		A	Subsequent repair of nerve	1.99	NA	NA	1.12	0.99	0.18	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	NA	1.39	1.34	0.27	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	NA	1.98	1.49	0.48	ZZZ
64885		A	Nerve graft, head or neck	17.60	NA	NA	11.45	10.51	1.63	090
64886		A	Nerve graft, head or neck	20.82	NA	NA	13.89	12.50	1.94	090
64890		A	Nerve graft, hand or foot	16.24	NA	NA	10.78	10.08	2.31	090
64891		A	Nerve graft, hand or foot	17.35	NA	NA	11.42	10.39	2.47	090
64892		A	Nerve graft, arm or leg	15.74	NA	NA	10.54	9.74	2.24	090
64893		A	Nerve graft, arm or leg	16.87	NA	NA	11.19	10.03	2.40	090
64895		A	Nerve graft, hand or foot	20.39	NA	NA	12.91	11.48	2.90	090
64896		A	Nerve graft, hand or foot	21.96	NA	NA	15.44	13.23	5.68	090
64897		A	Nerve graft, arm or leg	19.38	NA	NA	12.42	11.35	2.75	090
64898		A	Nerve graft, arm or leg	20.97	NA	NA	13.48	12.49	2.98	090
64901		A	Nerve graft add-on	10.20	NA	NA	5.99	4.88	1.46	ZZZ
64902		A	Nerve graft add-on	11.81	NA	NA	6.94	5.56	1.70	ZZZ
64905		A	Nerve pedicle transfer	15.11	NA	NA	11.34	9.78	2.15	090
64907		A	Nerve pedicle transfer	20.03	NA	NA	9.19	10.96	1.00	090
64910		A	Nerve repair w/allograft	11.39	NA	NA	9.62	8.58	1.42	090
64911		A	Neurorraphy w/vein autograft	14.39	NA	NA	11.73	9.94	2.04	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	7.26	NA	NA	8.83	7.78	1.01	090
65093		A	Revise eye with implant	7.04	NA	NA	8.83	7.90	0.98	090
65101		A	Removal of eye	8.30	NA	NA	10.38	9.12	1.15	090
65103		A	Remove eye/insert implant	8.84	NA	NA	10.66	9.34	1.23	090
65105		A	Remove eye/attach implant	9.93	NA	NA	11.65	10.14	1.39	090
65110		A	Removal of eye	15.70	NA	NA	15.38	13.28	1.44	090
65112		A	Remove eye/revise socket	18.51	NA	NA	17.93	15.40	1.70	090
65114		A	Remove eye/revise socket	19.65	NA	NA	18.60	15.85	1.81	090
65125		A	Revise ocular implant	3.27	7.88	7.49	4.14	3.59	0.45	090
65130		A	Insert ocular implant	8.42	NA	NA	10.14	8.83	1.17	090
65135		A	Insert ocular implant	8.60	NA	NA	10.25	8.95	1.19	090
65140		A	Attach ocular implant	9.46	NA	NA	11.06	9.66	0.86	090
65150		A	Revise ocular implant	6.43	NA	NA	8.17	7.31	0.32	090
65155		A	Reinsert ocular implant	10.10	NA	NA	11.44	9.99	1.41	090
65175		A	Removal of ocular implant	7.40	NA	NA	9.20	8.12	0.68	090
65205		A	Remove foreign body from eye	0.71	0.71	0.63	0.44	0.36	0.08	000
65210		A	Remove foreign body from eye	0.84	0.92	0.81	0.57	0.45	0.09	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
65220		A	Remove foreign body from eye	0.71	0.75	0.66	0.39	0.32	0.08	000
65222		A	Remove foreign body from eye	0.93	1.00	0.88	0.60	0.48	0.11	000
65235		A	Remove foreign body from eye	9.01	NA	NA	9.22	7.65	0.87	090
65260		A	Remove foreign body from eye	12.54	NA	NA	12.13	10.14	0.62	090
65265		A	Remove foreign body from eye	14.34	NA	NA	13.49	11.21	2.18	090
65270		A	Repair of eye wound	1.95	4.55	4.34	1.70	1.41	0.19	010
65272		A	Repair of eye wound	4.62	7.87	7.14	4.44	3.65	0.22	090
65273		A	Repair of eye wound	5.16	NA	NA	4.70	3.89	0.25	090
65275		A	Repair of eye wound	6.29	8.32	7.00	5.68	4.52	0.61	090
65280		A	Repair of eye wound	9.10	NA	NA	8.26	6.79	1.26	090
65285		A	Repair of eye wound	14.71	NA	NA	12.18	9.93	1.85	090
65286		A	Repair of eye wound	6.63	10.91	9.97	6.18	5.08	0.64	090
65290		A	Repair of eye socket wound	6.53	NA	NA	6.14	5.11	0.90	090
65400		A	Removal of eye lesion	7.50	9.70	8.42	7.96	6.66	0.72	090
65410		A	Biopsy of cornea	1.47	2.10	1.91	1.23	1.01	0.23	000
65420		A	Removal of eye lesion	4.36	8.40	7.79	5.24	4.51	0.40	090
65426		A	Removal of eye lesion	6.05	10.17	9.28	6.23	5.24	0.59	090
65430		A	Corneal smear	1.47	1.46	1.26	1.21	1.01	0.15	000
65435		A	Curette/treat cornea	0.92	1.10	0.97	0.87	0.74	0.12	000
65436		A	Curette/treat cornea	4.82	5.10	4.31	4.74	3.95	0.60	090
65450		A	Treatment of corneal lesion	3.47	4.74	4.13	4.66	4.04	0.33	090
65600		A	Revision of cornea	4.20	5.73	5.01	4.59	3.82	0.41	090
65710		A	Corneal transplant	14.45	NA	NA	14.09	11.77	1.40	090
65730		A	Corneal transplant	16.35	NA	NA	15.36	12.76	1.59	090
65750		A	Corneal transplant	16.90	NA	NA	15.06	12.49	1.55	090
65755		A	Corneal transplant	16.79	NA	NA	15.00	12.44	1.64	090
65756		A	Corneal trnspl, endothelial	16.84	NA	NA	13.93	11.27	0.83	090
65757		C	Prep corneal endo allograft	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	19.74	NA	NA	16.73	13.81	5.06	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	5.09	6.35	5.52	5.33	4.47	0.46	090
65775		A	Correction of astigmatism	6.91	NA	NA	7.23	6.13	0.34	090
65780		A	Ocular reconst, transplant	10.73	NA	NA	11.93	10.27	0.98	090
65781		A	Ocular reconst, transplant	18.14	NA	NA	16.38	13.73	0.89	090
65782		A	Ocular reconst, transplant	15.43	NA	NA	14.31	12.03	2.17	090
65800		A	Drainage of eye	1.91	1.90	1.66	1.49	1.22	0.19	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
65805		A	Drainage of eye	1.91	2.23	1.99	1.50	1.23	0.24	000
65810		A	Drainage of eye	5.82	NA	NA	6.29	5.27	0.60	090
65815		A	Drainage of eye	6.00	9.89	9.03	6.25	5.23	0.74	090
65820		A	Relieve inner eye pressure	8.91	NA	NA	10.19	8.81	0.44	090
65850		A	Incision of eye	11.39	NA	NA	10.30	8.63	1.44	090
65855		A	Laser surgery of eye	3.99	4.63	4.06	3.69	3.10	0.44	010
65860		A	Incise inner eye adhesions	3.59	4.28	3.78	2.99	2.49	0.95	090
65865		A	Incise inner eye adhesions	5.77	NA	NA	6.31	5.46	0.28	090
65870		A	Incise inner eye adhesions	7.39	NA	NA	7.75	6.58	0.92	090
65875		A	Incise inner eye adhesions	7.81	NA	NA	8.33	7.05	0.75	090
65880		A	Incise inner eye adhesions	8.36	NA	NA	8.63	7.28	0.41	090
65900		A	Remove eye lesion	12.51	NA	NA	12.30	10.36	0.61	090
65920		A	Remove implant of eye	9.99	NA	NA	10.23	8.60	0.91	090
65930		A	Remove blood clot from eye	8.39	NA	NA	8.01	6.79	1.05	090
66020		A	Injection treatment of eye	1.64	2.98	2.75	1.73	1.47	0.08	010
66030		A	Injection treatment of eye	1.30	2.77	2.60	1.52	1.31	0.13	010
66130		A	Remove eye lesion	7.83	9.80	8.75	6.91	5.76	1.19	090
66150		A	Glaucoma surgery	10.53	NA	NA	11.86	10.02	0.51	090
66155		A	Glaucoma surgery	10.52	NA	NA	11.85	10.01	0.51	090
66160		A	Glaucoma surgery	12.39	NA	NA	12.96	10.87	0.60	090
66165		A	Glaucoma surgery	10.24	NA	NA	11.69	9.88	0.50	090
66170		A	Glaucoma surgery	15.02	NA	NA	15.76	13.19	1.35	090
66172		A	Incision of eye	18.86	NA	NA	19.96	16.66	1.71	090
66180		A	Implant eye shunt	16.30	NA	NA	13.91	11.44	1.51	090
66185		A	Revise eye shunt	9.58	NA	NA	9.68	8.07	1.19	090
66220		A	Repair eye lesion	9.21	NA	NA	9.85	8.09	0.89	090
66225		A	Repair/graft eye lesion	12.63	NA	NA	11.48	9.45	1.78	090
66250		A	Follow-up surgery of eye	7.10	11.56	10.55	7.21	6.00	0.98	090
66500		A	Incision of iris	3.83	NA	NA	5.11	4.49	0.19	090
66505		A	Incision of iris	4.22	NA	NA	5.58	4.89	0.21	090
66600		A	Remove iris and lesion	10.12	NA	NA	11.15	9.31	0.55	090
66605		A	Removal of iris	14.22	NA	NA	13.10	10.76	0.70	090
66625		A	Removal of iris	5.30	NA	NA	5.69	4.84	0.51	090
66630		A	Removal of iris	7.28	NA	NA	7.36	6.14	0.86	090
66635		A	Removal of iris	7.37	NA	NA	7.41	6.18	0.36	090
66680		A	Repair iris & ciliary body	6.39	NA	NA	6.84	5.74	0.96	090
66682		A	Repair iris & ciliary body	7.33	NA	NA	8.85	7.47	1.02	090
66700		A	Destruction, ciliary body	5.14	6.30	5.43	4.99	4.17	0.35	090
66710		A	Ciliary transsleral therapy	5.14	6.07	5.24	4.98	4.15	0.72	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
66711		A	Ciliary endoscopic ablation	7.93	NA	NA	8.55	7.14	0.39	090
66720		A	Destruction, ciliary body	5.00	6.89	5.97	5.72	4.88	0.48	090
66740		A	Destruction, ciliary body	5.14	6.00	5.17	4.99	4.18	0.25	090
66761		A	Revision of iris	5.02	6.53	5.67	5.63	4.73	0.54	090
66762		A	Revision of iris	5.38	6.69	5.78	5.56	4.65	0.49	090
66770		A	Removal of inner eye lesion	6.13	7.32	6.28	6.30	5.25	0.30	090
66820		A	Incision, secondary cataract	4.01	NA	NA	5.88	5.31	0.48	090
66821		A	After cataract laser surgery	3.42	4.89	4.26	4.45	3.83	0.37	090
66825		A	Reposition intraocular lens	9.01	NA	NA	10.33	8.95	0.83	090
66830		A	Removal of lens lesion	9.47	NA	NA	8.94	7.41	0.46	090
66840		A	Removal of lens material	9.18	NA	NA	8.78	7.26	1.28	090
66850		A	Removal of lens material	10.55	NA	NA	9.91	8.21	1.02	090
66852		A	Removal of lens material	11.41	NA	NA	10.41	8.63	1.43	090
66920		A	Extraction of lens	10.13	NA	NA	9.36	7.75	0.50	090
66930		A	Extraction of lens	11.61	NA	NA	10.53	8.71	0.57	090
66940		A	Extraction of lens	10.37	NA	NA	9.81	8.13	1.23	090
66982		A	Cataract surgery, complex	15.02	NA	NA	12.38	10 21	1.69	090
66983		A	Cataract surg w/iol, 1 stage	10.43	NA	NA	8.73	7.26	0.58	090
66984		A	Cataract surg w/iol, 1 stage	10.52	NA	NA	9.16	7.64	1.17	090
66985		A	Insert lens prosthesis	9.98	NA	NA	9.85	8.17	0.91	090
66986		A	Exchange lens prosthesis	12.26	NA	NA	11.22	9.43	1.13	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	NA	0.89	0.70	0.08	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.89	NA	NA	6.21	5.22	0.89	090
67010		A	Partial removal of eye fluid	7.06	NA	NA	6.89	5.76	0.69	090
67015		A	Release of eye fluid	7.14	NA	NA	7.69	6.56	0.69	090
67025		A	Replace eye fluid	8.11	10.25	8.99	8.13	6.77	1.00	090
67027		A	Implant eye drug system	11.62	NA	NA	10.41	8.59	1.46	090
67028		A	Injection eye drug	2.52	2.85	2.52	1.86	1.51	0.27	000
67030		A	Incise inner eye strands	6.11	NA	NA	7.42	6.30	0.30	090
67031		A	Laser surgery, eye strands	4.47	5.40	4.66	4.68	3.92	0.41	090
67036		A	Removal of inner eye fluid	13.32	NA	NA	11.53	9.53	1.29	090
67039		A	Laser treatment of retina	16.74	NA	NA	15.17	12.61	2.10	090
67040		A	Laser treatment of retina	19.61	NA	NA	17.15	14.20	1.92	090
67041		A	Vit for macular pucker	19.25	NA	NA	15.25	12.26	1.90	090
67042		A	Vit for macular hole	22.38	NA	NA	17.10	13.66	2.21	090
67043		A	Vit for membrane dissect	23.24	NA	NA	18.26	14.63	2.93	090
67101		A	Repair detached retina	8.80	11.08	9.55	8.56	7.10	1.09	090
67105		A	Repair detached retina	8.53	9.85	8.42	8.08	6.69	0.83	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
67107		A	Repair detached retina	16.71	NA	NA	14.76	12.13	2.10	090
67108		A	Repair detached retina	22.89	NA	NA	18.85	15.37	2.24	090
67110		A	Repair detached retina	10.25	11.86	10.24	9.72	8.05	0.93	090
67112		A	Rerepair detached retina	18.75	NA	NA	15.68	12.80	1.84	090
67113		A	Repair retinal detach, cplx	25.35	NA	NA	20.09	16.14	2.49	090
67115		A	Release encircling material	6.11	NA	NA	6.67	5.59	0.55	090
67120		A	Remove eye implant material	7.10	9.48	8.36	7.22	6.04	0.98	090
67121		A	Remove eye implant material	12.25	NA	NA	11.23	9.25	1.53	090
67141		A	Treatment of retina	6.15	7.19	6.14	6.36	5.31	0.76	090
67145		A	Treatment of retina	6.32	7.14	6.06	6.46	5.39	0.61	090
67208		A	Treatment of retinal lesion	7.65	7.74	6.50	7.26	6.01	0.38	090
67210		A	Treatment of retinal lesion	9.45	8.38	6.94	7.86	6.41	1.00	090
67218		A	Treatment of retinal lesion	20.36	NA	NA	15.73	12.78	1.01	090
67220		A	Treatment of choroid lesion	14.39	13.01	10.83	11.85	9.67	1.82	090
67221		R	Ocular photodynamic ther	3.45	3.87	3.54	2.19	1.76	0.34	000
67225		A	Eye photodynamic ther add-on	0.47	0.31	0.26	0.28	0.22	0.02	ZZZ
67227		A	Treatment of retinal lesion	7.53	8.10	6.87	7.19	5.96	0.37	090
67228		A	Treatment of retinal lesion	13.82	17.64	14.66	13.93	11.24	1.51	090
67229		A	Tr retinal les preterm inf	16.30	NA	NA	13.51	11.06	0.80	090
67250		A	Reinforce eye wall	9.61	NA	NA	10.35	8.93	1.15	090
67255		A	Reinforce/graft eye wall	10.17	NA	NA	11.29	9.75	1.43	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	7.77	NA	NA	7.62	6.37	0.92	090
67312		A	Revise two eye muscles	9.66	NA	NA	8.74	7.22	1.35	090
67314		A	Revise eye muscle	8.79	NA	NA	8.53	7.10	1.04	090
67316		A	Revise two eye muscles	10.93	NA	NA	9.71	8.01	1.53	090
67318		A	Revise eye muscle(s)	9.12	NA	NA	9.04	7.51	0.45	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	NA	3.17	2.39	0.27	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	NA	2.99	2.25	0.62	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	NA	3.26	2.46	0.68	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	NA	2.98	2.24	0.25	ZZZ
67335		A	Eye suture during surgery	2.49	NA	NA	1.45	1.14	0.30	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	NA	3.54	2.67	0.30	ZZZ
67343		A	Release eye tissue	8.47	NA	NA	8.29	6.94	1.18	090
67345		A	Destroy nerve of eye muscle	3.01	2.92	2.52	2.40	2.01	0.57	010
67346		A	Biopsy, eye muscle	2.87	NA	NA	2.35	1.94	0.44	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	11.20	NA	NA	12.52	10.89	1.47	090
67405		A	Explore/drain eye socket	9.20	NA	NA	10.92	9.62	0.83	090
67412		A	Explore/treat eye socket	10.30	NA	NA	11.38	10.04	1.32	090
67413		A	Explore/treat eye socket	10.24	NA	NA	11.56	10.14	1.44	090
67414		A	Explr/decompress eye socket	17.94	NA	NA	16.27	13.43	1.66	090
67415		A	Aspiration, orbital contents	1.76	NA	NA	1.04	0.79	0.17	000
67420		A	Explore/treat eye socket	21.87	NA	NA	19.76	16.86	3.09	090
67430		A	Explore/treat eye socket	15.29	NA	NA	16.57	14.33	0.75	090
67440		A	Explore/drain eye socket	14.84	NA	NA	15.98	13.80	1.35	090
67445		A	Explr/decompress eye socket	19.12	NA	NA	17.02	14.29	2.71	090
67450		A	Explore/biopsy eye socket	15.41	NA	NA	16.64	14.36	1.41	090
67500		A	Inject/treat eye socket	1.44	0.84	0.69	0.68	0.50	0.08	000
67505		A	Inject/treat eye socket	1.27	1.05	0.84	0.87	0.63	0.18	000
67515		A	Inject/treat eye socket	1.40	1.12	0.86	0.95	0.69	0.18	000
67550		A	Insert eye socket implant	11.77	NA	NA	12.87	11.17	1.65	090
67560		A	Revise eye socket implant	12.18	NA	NA	13.03	11.27	1.10	090
67570		A	Decompress optic nerve	14.40	NA	NA	14.75	12.96	3.69	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67700		A	Drainage of eyelid abscess	1.40	4.98	4.88	1.55	1.32	0.15	010
67710		A	Incision of eyelid	1.07	4.25	4.22	1.39	1.22	0.15	010
67715		A	Incision of eyelid fold	1.27	4.39	4.31	1.50	1.30	0.18	010
67800		A	Remove eyelid lesion	1.41	1.80	1.59	1.27	1.06	0.17	010
67801		A	Remove eyelid lesions	1.91	2.22	1.93	1.57	1.29	0.27	010
67805		A	Remove eyelid lesions	2.27	2.85	2.49	2.00	1.67	0.32	010
67808		A	Remove eyelid lesion(s)	4.60	NA	NA	4.84	4.07	0.63	090
67810		A	Biopsy of eyelid	1.48	3.77	3.83	0.88	0.77	0.15	000
67820		A	Revise eyelashes	0.71	0.59	0.52	0.67	0.57	0.08	000
67825		A	Revise eyelashes	1.43	1.81	1.61	1.66	1.44	0.19	010
67830		A	Revise eyelashes	1.75	4.69	4.54	1.79	1.52	0.24	010
67835		A	Revise eyelashes	5.70	NA	NA	5.60	4.72	0.80	090
67840		A	Remove eyelid lesion	2.09	4.64	4.47	1.99	1.69	0.24	010
67850		A	Treat eyelid lesion	1.74	3.56	3.52	1.74	1.62	0.17	010
67875		A	Closure of eyelid by suture	1.35	2.85	2.73	1.17	0.98	0.18	000
67880		A	Revision of eyelid	4.60	6.87	6.18	4.84	4.07	0.57	090
67882		A	Revision of eyelid	6.02	8.18	7.26	6.11	5.13	0.83	090
67900		A	Repair brow defect	6.82	9.29	8.39	6.31	5.35	0.87	090
67901		A	Repair eyelid defect	7.59	11.26	9.11	7.24	6.01	1.06	090
67902		A	Repair eyelid defect	9.82	NA	NA	8.83	7.11	1.37	090
67903		A	Repair eyelid defect	6.51	8.46	7.84	5.98	5.15	0.90	090
67904		A	Repair eyelid defect	7.97	10.49	9.28	7.44	6.10	1.07	090
67906		A	Repair eyelid defect	6.93	NA	NA	6.23	5.21	0.34	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
67908		A	Repair eyelid defect	5.30	7.15	6.34	5.59	4.89	0.73	090
67909		A	Revise eyelid defect	5.57	7.87	7.15	5.67	4.87	0.77	090
67911		A	Revise eyelid defect	7.50	NA	NA	7.01	5.71	0.99	090
67912		A	Correction eyelid w/implant	6.36	15.26	15.01	6.27	5.44	0.67	090
67914		A	Repair eyelid defect	3.75	5.90	5.47	3.65	3.11	0.49	090
67915		A	Repair eyelid defect	3.26	5.32	5.00	3.25	2.80	0.32	090
67916		A	Repair eyelid defect	5.48	8.01	7.28	5.60	4.79	0.68	090
67917		A	Repair eyelid defect	6.19	8.54	7.71	6.03	5.12	0.82	090
67921		A	Repair eyelid defect	3.47	5.73	5.32	3.49	2.96	0.49	090
67922		A	Repair eyelid defect	3.14	5.17	4.86	3.14	2.70	0.31	090
67923		A	Repair eyelid defect	6.05	8.25	7.41	5.95	5.03	0.80	090
67924		A	Repair eyelid defect	5.93	8.73	7.96	5.63	4.76	0.79	090
67930		A	Repair eyelid wound	3.65	5.47	5.04	2.65	2.18	0.51	010
67935		A	Repair eyelid wound	6.36	8.56	7.75	5.12	4.31	0.89	090
67938		A	Remove eyelid foreign body	1.38	4.46	4.36	1.57	1.36	0.15	010
67950		A	Revision of eyelid	5.99	8.38	7.66	5.91	5.09	0.79	090
67961		A	Revision of eyelid	5.86	8.56	7.80	5.84	5.00	0.78	090
67966		A	Revision of eyelid	8.97	10.54	9.16	8.03	6.54	1.21	090
67971		A	Reconstruction of eyelid	10.01	NA	NA	8.73	7.32	1.41	090
67973		A	Reconstruction of eyelid	13.13	NA	NA	11.06	9.25	1.86	090
67974		A	Reconstruction of eyelid	13.10	NA	NA	11.04	9.20	1.86	090
67975		A	Reconstruction of eyelid	9.35	NA	NA	8.37	7.03	1.31	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.42	1.61	1.41	1.41	1.21	0.14	010
68040		A	Treatment of eyelid lesions	0.85	0.81	0.70	0.54	0.43	0.12	000
68100		A	Biopsy of eyelid lining	1.35	2.80	2.69	1.19	1.00	0.14	000
68110		A	Remove eyelid lining lesion	1.82	3.72	3.50	1.98	1.69	0.25	010
68115		A	Remove eyelid lining lesion	2.41	5.21	4.95	2.33	1.96	0.22	010
68130		A	Remove eyelid lining lesion	5.10	8.32	7.65	5.46	4.66	0.25	090
68135		A	Remove eyelid lining lesion	1.89	2.11	1.82	1.98	1.69	0.18	010
68200		A	Treat eyelid by injection	0.49	0.59	0.51	0.41	0.34	0.07	000
68320		A	Revise/graft eyelid lining	6.64	11.38	10.37	7.17	6.02	0.91	090
68325		A	Revise/graft eyelid lining	8.63	NA	NA	8.32	6.96	1.20	090
68326		A	Revise/graft eyelid lining	8.42	NA	NA	8.20	6.83	1.17	090
68328		A	Revise/graft eyelid lining	9.45	NA	NA	8.86	7.43	1.31	090
68330		A	Revise eyelid lining	5.78	9.30	8.47	6.06	5.08	0.80	090
68335		A	Revise/graft eyelid lining	8.46	NA	NA	8.24	6.85	1.17	090
68340		A	Separate eyelid adhesions	4.97	8.56	7.86	5.27	4.41	0.69	090
68360		A	Revise eyelid lining	5.17	8.08	7.34	5.38	4.52	0.72	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
68362		A	Revise eyelid lining	8.61	NA	NA	8.28	6.89	1.19	090
68371		A	Harvest eye tissue, alograft	5.09	NA	NA	5.49	4.71	0.25	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.74	5.09	4.91	1.66	1.48	0.24	010
68420		A	Incise/drain tear sac	2.35	5.46	5.22	2.01	1.77	0.21	010
68440		A	Incise tear duct opening	0.99	1.57	1.52	1.50	1.31	0.13	010
68500		A	Removal of tear gland	12.77	NA	NA	12.37	10.30	2.13	090
68505		A	Partial removal, tear gland	12.69	NA	NA	12.32	10.46	1.78	090
68510		A	Biopsy of tear gland	4.60	6.55	6.10	3.09	2.43	0.65	000
68520		A	Removal of tear sac	8.78	NA	NA	8.87	7.54	0.79	090
68525		A	Biopsy of tear sac	4.42	NA	NA	2.60	2.03	0.63	000
68530		A	Clearance of tear duct	3.70	6.83	6.54	2.99	2.52	0.52	010
68540		A	Remove tear gland lesion	12.18	NA	NA	11.77	9.85	1.10	090
68550		A	Remove tear gland lesion	15.16	NA	NA	12.69	11.43	1.37	090
68700		A	Repair tear ducts	7.87	NA	NA	7.70	6.42	1.08	090
68705		A	Revise tear duct opening	2.11	3.74	3.50	2.16	1.83	0.30	010
68720		A	Create tear sac drain	9.96	NA	NA	9.49	8.03	1.19	090
68745		A	Create tear duct drain	9.90	NA	NA	9.67	8.15	1.39	090
68750		A	Create tear duct drain	10.10	NA	NA	10.13	8.55	1.41	090
68760		A	Close tear duct opening	1.78	3.18	2.98	1.95	1.67	0.25	010
68761		A	Close tear duct opening	1.41	2.26	2.08	1.62	1.40	0.15	010
68770		A	Close tear system fistula	8.29	NA	NA	7.94	6.02	1.15	090
68801		A	Dilate tear duct opening	1.00	2.11	1.92	1.72	1.54	0.12	010
68810		A	Probe nasolacrimal duct	2.15	3.85	3.49	2.61	2.34	0.28	010
68811		A	Probe nasolacrimal duct	2.45	NA	NA	2.82	2.43	0.34	010
68815		A	Probe nasolacrimal duct	3.30	7.64	7.21	3.31	2.82	0.41	010
68816		A	Probe nl duct w/balloon	3.06	14.53	13.35	3.36	2.84	0.43	010
68840		A	Explore/irrigate tear ducts	1.30	1.91	1.67	1.66	1.38	0.17	010
68850		A	Injection for tear sac x-ray	0.80	0.76	0.79	0.64	0.65	0.06	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.50	3.21	3.00	1.60	1.44	0.14	010
69005		A	Drain external ear lesion	2.16	3.35	3.13	1.95	1.79	0.20	010
69020		A	Drain outer ear canal lesion	1.53	4.44	4.22	2.20	2.05	0.14	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	1.68	1.80	0.48	0.43	0.08	000
69105		A	Biopsy of external ear canal	0.85	2.73	2.64	0.83	0.77	0.08	000
69110		A	Remove external ear, partial	3.53	7.98	7.78	4.78	4.64	0.38	090
69120		A	Removal of external ear	4.14	NA	NA	6.27	5.86	0.42	090
69140		A	Remove ear canal lesion(s)	8.14	NA	NA	14.52	13.78	0.75	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
69145		A	Remove ear canal lesion(s)	2.70	7.45	6.96	3.81	3.53	0.25	090
69150		A	Extensive ear canal surgery	13.61	NA	NA	13.62	12.73	1.40	090
69155		A	Extensive ear/neck surgery	23.35	NA	NA	20.71	19.07	2.15	090
69200		A	Clear outer ear canal	0.77	2.36	2.27	0.74	0.64	0.08	000
69205		A	Clear outer ear canal	1.21	NA	NA	1.43	1.33	0.11	010
69210		A	Remove impacted ear wax	0.61	0.71	0.63	0.26	0.21	0.06	000
69220		A	Clean out mastoid cavity	0.83	2.70	2.58	0.81	0.74	0.08	000
69222		A	Clean out mastoid cavity	1.45	4.19	4.04	2.13	2.02	0.13	010
69300		R	Revise external ear	6.69	11.25	9.67	5.88	5.28	0.62	YYY
69310		A	Rebuild outer ear canal	10.97	NA	NA	17.12	16.29	1.02	090
69320		A	Rebuild outer ear canal	17.18	NA	NA	22.70	21.51	1.59	090
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	2.94	2.74	0.81	0.73	0.08	000
69401		A	Inflate middle ear canal	0.63	1.59	1.46	0.66	0.62	0.06	000
69405		A	Catheterize middle ear canal	2.68	4.11	3.81	2.40	2.20	0.25	010
69420		A	Incision of eardrum	1.38	3.54	3.38	1.78	1.65	0.13	010
69421		A	Incision of eardrum	1.78	NA	NA	2.13	2.02	0.16	010
69424		A	Remove ventilating tube	0.85	2.44	2.36	0.79	0.72	0.08	000
69433		A	Create eardrum opening	1.57	3.57	3.38	1.84	1.70	0.14	010
69436		A	Create eardrum opening	2.01	NA	NA	2.22	2.10	0.18	010
69440		A	Exploration of middle ear	7.71	NA	NA	10.31	9.51	0.71	090
69450		A	Eardrum revision	5.69	NA	NA	8.51	7.88	0.52	090
69501		A	Mastoidectomy	9.21	NA	NA	10.05	9.20	0.84	090
69502		A	Mastoidectomy	12.56	NA	NA	12.87	11.86	1.21	090
69505		A	Remove mastoid structures	13.17	NA	NA	18.17	17.12	1.23	090
69511		A	Extensive mastoid surgery	13.70	NA	NA	18.46	17.41	1.26	090
69530		A	Extensive mastoid surgery	20.38	NA	NA	22.97	21.43	1.89	090
69535		A	Remove part of temporal bone	37.42	NA	NA	32.63	30.06	3.77	090
69540		A	Remove ear lesion	1.25	4.09	3.95	2.06	1.96	0.11	010
69550		A	Remove ear lesion	11.15	NA	NA	15.97	15.05	1.02	090
69552		A	Remove ear lesion	19.81	NA	NA	21.41	19.91	1.84	090
69554		A	Remove ear lesion	35.97	NA	NA	28.48	26.55	3.32	090
69601		A	Mastoid surgery revision	13.45	NA	NA	14.12	12.93	1.23	090
69602		A	Mastoid surgery revision	13.76	NA	NA	14.89	13.67	1.26	090
69603		A	Mastoid surgery revision	14.20	NA	NA	18.71	17.74	1.30	090
69604		A	Mastoid surgery revision	14.20	NA	NA	15.10	14.03	1.30	090
69605		A	Mastoid surgery revision	18.69	NA	NA	22.16	20.75	1.74	090
69610		A	Repair of eardrum	4.47	5.59	5.31	3.27	2.99	0.41	010
69620		A	Repair of eardrum	6.03	11.83	11.33	6.76	6.29	0.55	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
69631		A	Repair eardrum structures	10.05	NA	NA	13.09	12.09	0.92	090
69632		A	Rebuild eardrum structures	12.96	NA	NA	15.32	14.15	1.19	090
69633		A	Rebuild eardrum structures	12.31	NA	NA	15.01	13.84	1.14	090
69635		A	Repair eardrum structures	13.51	NA	NA	18.14	17.16	1.25	090
69636		A	Rebuild eardrum structures	15.43	NA	NA	20.59	19.36	1.42	090
69637		A	Rebuild eardrum structures	15.32	NA	NA	20.54	19.32	1.45	090
69641		A	Revise middle ear & mastoid	12.89	NA	NA	14.45	13.32	1.20	090
69642		A	Revise middle ear & mastoid	17.06	NA	NA	18.13	16.70	1.58	090
69643		A	Revise middle ear & mastoid	15.59	NA	NA	16.57	15.25	1.45	090
69644		A	Revise middle ear & mastoid	17.23	NA	NA	21.41	20.14	1.60	090
69645		A	Revise middle ear & mastoid	16.71	NA	NA	21.16	19.91	1.56	090
69646		A	Revise middle ear & mastoid	18.37	NA	NA	21.98	20.54	1.71	090
69650		A	Release middle ear bone	9.80	NA	NA	11.32	10.24	0.90	090
69660		A	Revise middle ear bone	12.03	NA	NA	12.36	11.38	1.11	090
69661		A	Revise middle ear bone	15.92	NA	NA	15.86	14.65	1.45	090
69662		A	Revise middle ear bone	15.60	NA	NA	14.88	13.68	1.46	090
69666		A	Repair middle ear structures	9.89	NA	NA	11.30	10.38	0.91	090
69667		A	Repair middle ear structures	9.90	NA	NA	11.30	10.43	0.91	090
69670		A	Remove mastoid air cells	11.73	NA	NA	13.09	12.00	1.08	090
69676		A	Remove middle ear nerve	9.69	NA	NA	12.11	11.24	0.89	090
69700		A	Close mastoid fistula	8.37	NA	NA	9.64	9.03	0.77	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.62	NA	NA	12.05	11.19	0.97	090
69714		A	Implant temple bone w/stimul	14.45	NA	NA	13.92	12.76	1.33	090
69715		A	Temple bne implnt w/stimulat	18.96	NA	NA	16.26	14.80	1.76	090
69717		A	Temple bone implant revision	15.43	NA	NA	14.43	13.44	1.42	090
69718		A	Revise temple bone implant	19.21	NA	NA	16.38	14.94	1.78	090
69720		A	Release facial nerve	14.71	NA	NA	16.18	14.89	1.35	090
69725		A	Release facial nerve	27.64	NA	NA	22.29	20.10	2.56	090
69740		A	Repair facial nerve	16.27	NA	NA	14.63	13.36	1.51	090
69745		A	Repair facial nerve	17.02	NA	NA	15.82	14.58	1.57	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	8.70	NA	NA	10.97	10.13	0.80	090
69802		A	Incise inner ear	13.50	NA	NA	13.94	12.78	1.24	090
69805		A	Explore inner ear	14.71	NA	NA	13.20	11.95	1.35	090
69806		A	Explore inner ear	12.63	NA	NA	12.31	11.27	1.17	090
69820		A	Establish inner ear window	10.52	NA	NA	12.01	11.18	0.96	090
69840		A	Revise inner ear window	10.44	NA	NA	14.29	12.72	0.52	090
69905		A	Remove inner ear	11.26	NA	NA	12.86	11.91	1.03	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
69910		A	Remove inner ear & mastoid	13.91	NA	NA	13.08	11.93	1.28	090
69915		A	Incise inner ear nerve	22.77	NA	NA	14.30	15.29	2.14	090
69930		A	Implant cochlear device	17.73	NA	NA	14.67	13.57	1.65	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	27.63	NA	NA	19.85	18.24	2.56	090
69955		A	Release facial nerve	29.42	NA	NA	23.16	20.93	2.72	090
69960		A	Release inner ear canal	29.42	NA	NA	21.82	19.56	2.72	090
69970		A	Remove inner ear lesion	32.41	NA	NA	24.59	22.23	3.00	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	NA	1.61	1.52	0.83	ZZZ
70010		A	Contrast x-ray of brain	1.19	2.43	3.12	NA	NA	0.15	XXX
70010	TC	A	Contrast x-ray of brain	0.00	2.07	2.70	NA	NA	0.01	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.36	0.42	0.36	0.42	0.14	XXX
70015		A	Contrast x-ray of brain	1.19	2.59	2.63	NA	NA	0.06	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.21	2.19	NA	NA	0.01	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.38	0.44	0.38	0.44	0.05	XXX
70030		A	X-ray eye for foreign body	0.17	0.53	0.57	NA	NA	0.02	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.48	0.51	NA	NA	0.01	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.61	0.63	NA	NA	0.02	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.55	0.57	NA	NA	0.01	XXX
70100	26	A	X-ray exam of jaw	0.18	0.06	0.06	0.06	0.06	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.72	0.78	NA	NA	0.02	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.64	0.69	NA	NA	0.01	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.09	0.08	0.09	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.75	0.70	NA	NA	0.02	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.68	0.64	NA	NA	0.01	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.07	0.06	0.07	0.06	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.07	1.10	NA	NA	0.02	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.96	0.98	NA	NA	0.01	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.12	0.11	0.12	0.01	XXX
70134		A	X-ray exam of middle ear	0.34	0.79	0.87	NA	NA	0.02	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.69	0.75	NA	NA	0.01	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.10	0.12	0.10	0.12	0.01	XXX
70140		A	X-ray exam of facial bones	0.19	0.54	0.58	NA	NA	0.02	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.47	0.52	NA	NA	0.01	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.07	0.06	0.07	0.06	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.79	0.85	NA	NA	0.02	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.70	0.76	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
70150	26	A	X-ray exam of facial bones	0.26	0.09	0.09	0.09	0.09	0.01	XXX
70160		A	X-ray exam of nasal bones	0.17	0.63	0.67	NA	NA	0.02	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.58	0.61	NA	NA	0.01	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70170		C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	TC	C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.09	0.11	0.09	0.11	0.02	XXX
70190		A	X-ray exam of eye sockets	0.21	0.66	0.71	NA	NA	0.02	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.59	0.64	NA	NA	0.01	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.07	0.07	0.01	XXX
70200		A	X-ray exam of eye sockets	0.28	0.79	0.87	NA	NA	0.02	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.70	0.77	NA	NA	0.01	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.09	0.10	0.09	0.10	0.01	XXX
70210		A	X-ray exam of sinuses	0.17	0.59	0.61	NA	NA	0.02	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.53	0.55	NA	NA	0.01	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.06	0.06	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.71	0.76	NA	NA	0.02	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.62	0.68	NA	NA	0.01	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.09	0.08	0.09	0.08	0.01	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.52	0.58	NA	NA	0.02	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.46	0.51	NA	NA	0.01	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.07	0.06	0.07	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.68	0.70	NA	NA	0.02	XXX
70250	TC	A	X-ray exam of skull	0.00	0.59	0.62	NA	NA	0.01	XXX
70250	26	A	X-ray exam of skull	0.24	0.09	0.08	0.09	0.08	0.01	XXX
70260		A	X-ray exam of skull	0.34	0.83	0.89	NA	NA	0.02	XXX
70260	TC	A	X-ray exam of skull	0.00	0.71	0.78	NA	NA	0.01	XXX
70260	26	A	X-ray exam of skull	0.34	0.12	0.11	0.12	0.11	0.01	XXX
70300		A	X-ray exam of teeth	0.10	0.25	0.26	NA	NA	0.02	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.20	0.22	NA	NA	0.01	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.04	0.05	0.04	0.01	XXX
70310		A	X-ray exam of teeth	0.16	0.83	0.77	NA	NA	0.02	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.74	0.70	NA	NA	0.01	XXX
70310	26	A	X-ray exam of teeth	0.16	0.09	0.07	0.09	0.07	0.01	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.07	1.05	NA	NA	0.02	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.96	0.96	NA	NA	0.01	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.11	0.09	0.11	0.09	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.59	0.61	NA	NA	0.02	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.53	0.55	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.06	0.06	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	0.95	0.99	NA	NA	0.02	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.86	0.90	NA	NA	0.01	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.09	0.09	0.09	0.09	0.01	XXX
70332		A	X-ray exam of jaw joint	0.54	1.57	1.66	NA	NA	0.03	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.33	1.46	NA	NA	0.01	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.24	0.20	0.24	0.20	0.02	XXX
70336		A	Magnetic image, jaw joint	1.48	6.32	10.76	NA	NA	0.07	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	5.87	10.23	NA	NA	0.01	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.45	0.53	0.45	0.53	0.06	XXX
70350		A	X-ray head for orthodontia	0.17	0.37	0.37	NA	NA	0.02	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.27	0.30	NA	NA	0.01	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.10	0.07	0.10	0.07	0.01	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.32	0.37	NA	NA	0.02	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.22	0.29	NA	NA	0.01	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.10	0.08	0.10	0.08	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.50	0.54	NA	NA	0.02	XXX
70360	TC	A	X-ray exam of neck	0.00	0.45	0.48	NA	NA	0.01	XXX
70360	26	A	X-ray exam of neck	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.76	1.69	NA	NA	0.02	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.65	1.58	NA	NA	0.01	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.11	0.11	0.11	0.11	0.01	XXX
70371		A	Speech evaluation, complex	0.84	1.48	1.67	NA	NA	0.02	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.19	1.39	NA	NA	0.01	XXX
70371	26	A	Speech evaluation, complex	0.84	0.29	0.28	0.29	0.28	0.01	XXX
70373		A	Contrast x-ray of larynx	0.44	1.65	1.67	NA	NA	0.02	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.49	1.54	NA	NA	0.01	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.16	0.13	0.16	0.13	0.01	XXX
70380		A	X-ray exam of salivary gland	0.17	0.83	0.81	NA	NA	0.02	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.74	0.74	NA	NA	0.01	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.09	0.07	0.09	0.07	0.01	XXX
70390		A	X-ray exam of salivary duct	0.38	2.06	2.22	NA	NA	0.03	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.94	2.08	NA	NA	0.01	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.12	0.14	0.12	0.14	0.02	XXX
70450		A	Ct head/brain w/o dye	0.85	2.74	4.45	NA	NA	0.04	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	2.49	4.14	NA	NA	0.01	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.25	0.31	0.25	0.31	0.03	XXX
70460		A	Ct head/brain w/dye	1.13	3.64	5.77	NA	NA	0.05	XXX
70460	TC	A	Ct head/brain w/dye	0.00	3.29	5.36	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
70460	26	A	Ct head/brain w/dye	1.13	0.35	0.41	0.35	0.41	0.04	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	4.42	7.06	NA	NA	0.06	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	4.03	6.60	NA	NA	0.01	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.39	0.46	0.39	0.46	0.05	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	4.76	7.01	NA	NA	0.06	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.36	6.55	NA	NA	0.01	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.40	0.46	0.40	0.46	0.05	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	5.57	8.24	NA	NA	0.07	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.15	7.74	NA	NA	0.01	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.42	0.50	0.42	0.50	0.06	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	6.29	9.51	NA	NA	0.07	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	5.85	8.99	NA	NA	0.01	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.44	0.52	0.44	0.52	0.06	XXX
70486		A	Ct maxillofacial w/o dye	1.14	3.85	5.81	NA	NA	0.05	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	3.49	5.40	NA	NA	0.01	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.36	0.41	0.36	0.41	0.04	XXX
70487		A	Ct maxillofacial w/dye	1.30	4.66	7.09	NA	NA	0.06	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	4.27	6.62	NA	NA	0.01	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.39	0.47	0.39	0.47	0.05	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	5.73	8.78	NA	NA	0.07	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	5.30	8.27	NA	NA	0.01	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.43	0.51	0.43	0.51	0.06	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	3.63	5.59	NA	NA	0.06	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	3.24	5.12	NA	NA	0.01	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.39	0.47	0.39	0.47	0.05	XXX
70491		A	Ct soft tissue neck w/dye	1.38	4.50	6.87	NA	NA	0.06	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	4.07	6.37	NA	NA	0.01	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.43	0.50	0.43	0.50	0.05	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	5.52	8.54	NA	NA	0.07	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	5.08	8.02	NA	NA	0.01	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.44	0.52	0.44	0.52	0.06	XXX
70496		A	Ct angiography, head	1.75	15.01	15.63	NA	NA	0.08	XXX
70496	TC	A	Ct angiography, head	0.00	14.48	14.99	NA	NA	0.01	XXX
70496	26	A	Ct angiography, head	1.75	0.53	0.64	0.53	0.64	0.07	XXX
70498		A	Ct angiography, neck	1.75	14.91	15.67	NA	NA	0.08	XXX
70498	TC	A	Ct angiography, neck	0.00	14.38	15.02	NA	NA	0.01	XXX
70498	26	A	Ct angiography, neck	1.75	0.53	0.65	0.53	0.65	0.07	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	7.28	12.10	NA	NA	0.07	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	6.87	11.62	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.41	0.48	0.41	0.48	0.06	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	8.09	13.32	NA	NA	0.08	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	7.60	12.75	NA	NA	0.01	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.49	0.57	0.49	0.57	0.07	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	9.87	18.00	NA	NA	0.11	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	9.22	17.24	NA	NA	0.02	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.65	0.76	0.65	0.76	0.09	XXX
70544		A	Mr angiography head w/o dye	1.20	13.98	14.73	NA	NA	0.06	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	13.62	14.30	NA	NA	0.01	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.36	0.43	0.36	0.43	0.05	XXX
70545		A	Mr angiography head w/dye	1.20	13.83	14.64	NA	NA	0.06	XXX
70545	TC	A	Mr angiography head w/dye	0.00	13.47	14.21	NA	NA	0.01	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.36	0.43	0.36	0.43	0.05	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	21.23	23.37	NA	NA	0.10	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	20.68	22.73	NA	NA	0.02	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.55	0.64	0.55	0.64	0.08	XXX
70547		A	Mr angiography neck w/o dye	1.20	13.94	14.69	NA	NA	0.06	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	13.57	14.26	NA	NA	0.01	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.37	0.43	0.37	0.43	0.05	XXX
70548		A	Mr angiography neck w/dye	1.20	14.80	15.39	NA	NA	0.06	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	14.44	14.96	NA	NA	0.01	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.36	0.43	0.36	0.43	0.05	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	21.17	23.37	NA	NA	0.09	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	20.63	22.73	NA	NA	0.02	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.54	0.64	0.54	0.64	0.07	XXX
70551		A	Mri brain w/o dye	1.48	7.59	12.35	NA	NA	0.07	XXX
70551	TC	A	Mri brain w/o dye	0.00	7.14	11.82	NA	NA	0.01	XXX
70551	26	A	Mri brain w/o dye	1.48	0.45	0.53	0.45	0.53	0.06	XXX
70552		A	Mri brain w/dye	1.78	8.43	13.67	NA	NA	0.09	XXX
70552	TC	A	Mri brain w/dye	0.00	7.89	13.03	NA	NA	0.01	XXX
70552	26	A	Mri brain w/dye	1.78	0.54	0.64	0.54	0.64	0.08	XXX
70553		A	Mri brain w/o & w/dye	2.36	9.71	17.62	NA	NA	0.12	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	8.99	16.77	NA	NA	0.02	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.72	0.85	0.72	0.85	0.10	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
70554		A	Fmri brain by tech	2.11	9.00	13.07	NA	NA	0.11	XXX
70554	TC	A	Fmri brain by tech	0.00	8.33	12.29	NA	NA	0.02	XXX
70554	26	A	Fmri brain by tech	2.11	0.67	0.78	0.67	0.78	0.09	XXX
70555		C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	TC	C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	26	A	Fmri brain by phys/psych	2.54	0.76	0.94	0.76	0.94	0.17	XXX
70557		C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	26	A	Mri brain w/o dye	2.90	1.35	1.20	1.35	1.20	0.75	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	0.97	1.15	0.97	1.15	0.21	XXX
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.08	1.23	1.08	1.23	0.21	XXX
71010		A	Chest x-ray	0.18	0.39	0.44	NA	NA	0.02	XXX
71010	TC	A	Chest x-ray	0.00	0.33	0.38	NA	NA	0.01	XXX
71010	26	A	Chest x-ray	0.18	0.06	0.06	0.06	0.06	0.01	XXX
71015		A	Chest x-ray	0.21	0.54	0.57	NA	NA	0.02	XXX
71015	TC	A	Chest x-ray	0.00	0.47	0.50	NA	NA	0.01	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.07	0.07	0.01	XXX
71020		A	Chest x-ray	0.22	0.52	0.60	NA	NA	0.02	XXX
71020	TC	A	Chest x-ray	0.00	0.45	0.52	NA	NA	0.01	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.08	0.07	0.08	0.01	XXX
71021		A	Chest x-ray	0.27	0.66	0.72	NA	NA	0.02	XXX
71021	TC	A	Chest x-ray	0.00	0.57	0.63	NA	NA	0.01	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71022		A	Chest x-ray	0.31	0.84	0.90	NA	NA	0.02	XXX
71022	TC	A	Chest x-ray	0.00	0.74	0.79	NA	NA	0.01	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.11	0.10	0.11	0.01	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.37	1.41	NA	NA	0.02	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.24	1.26	NA	NA	0.01	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.15	0.13	0.15	0.01	XXX
71030		A	Chest x-ray	0.31	0.81	0.90	NA	NA	0.02	XXX
71030	TC	A	Chest x-ray	0.00	0.71	0.79	NA	NA	0.01	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.11	0.10	0.11	0.01	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.63	1.91	NA	NA	0.02	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.48	1.71	NA	NA	0.01	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.15	0.20	0.15	0.20	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
71035		A	Chest x-ray	0.18	0.67	0.73	NA	NA	0.02	XXX
71035	TC	A	Chest x-ray	0.00	0.62	0.66	NA	NA	0.01	XXX
71035	26	A	Chest x-ray	0.18	0.05	0.07	0.05	0.07	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.81	1.94	NA	NA	0.02	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.64	1.74	NA	NA	0.01	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.17	0.20	0.17	0.20	0.01	XXX
71060		A	Contrast x-ray of bronchi	0.74	2.81	2.95	NA	NA	0.04	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.58	2.68	NA	NA	0.01	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.23	0.27	0.23	0.27	0.03	XXX
71090		C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	TC	C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.18	0.24	0.18	0.24	0.03	XXX
71100		A	X-ray exam of ribs	0.22	0.57	0.63	NA	NA	0.02	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.50	0.55	NA	NA	0.01	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.08	0.07	0.08	0.01	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.70	0.76	NA	NA	0.02	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.61	0.67	NA	NA	0.01	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71110		A	X-ray exam of ribs	0.27	0.73	0.79	NA	NA	0.02	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.64	0.70	NA	NA	0.01	XXX
71110	26	A	X-ray exam of ribs	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71111		A	X-ray exam of ribs/chest	0.32	0.99	1.04	NA	NA	0.02	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.88	0.93	NA	NA	0.01	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.11	0.11	0.11	0.11	0.01	XXX
71120		A	X-ray exam of breastbone	0.20	0.56	0.64	NA	NA	0.02	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.50	0.57	NA	NA	0.01	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.06	0.07	0.06	0.07	0.01	XXX
71130		A	X-ray exam of breastbone	0.22	0.69	0.76	NA	NA	0.02	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.62	0.68	NA	NA	0.01	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.08	0.07	0.08	0.01	XXX
71250		A	Ct thorax w/o dye	1.16	3.59	5.78	NA	NA	0.06	XXX
71250	TC	A	Ct thorax w/o dye	0.00	3.24	5.36	NA	NA	0.01	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
71260		A	Ct thorax w/dye	1.24	4.46	7.10	NA	NA	0.06	XXX
71260	TC	A	Ct thorax w/dye	0.00	4.08	6.65	NA	NA	0.01	XXX
71260	26	A	Ct thorax w/dye	1.24	0.38	0.45	0.38	0.45	0.05	XXX
71270		A	Ct thorax w/o & w/dye	1.38	5.54	8.89	NA	NA	0.06	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	5.12	8.39	NA	NA	0.01	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.42	0.50	0.42	0.50	0.05	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
71275		A	Ct angiography, chest	1.92	10.26	11.75	NA	NA	0.10	XXX
71275	TC	A	Ct angiography, chest	0.00	9.68	11.05	NA	NA	0.02	XXX
71275	26	A	Ct angiography, chest	1.92	0.58	0.70	0.58	0.70	0.08	XXX
71550		A	Mri chest w/o dye	1.46	8.41	13.62	NA	NA	0.07	XXX
71550	TC	A	Mri chest w/o dye	0.00	7.97	13.10	NA	NA	0.01	XXX
71550	26	A	Mri chest w/o dye	1.46	0.44	0.52	0.44	0.52	0.06	XXX
71551		A	Mri chest w/dye	1.73	9.49	15.20	NA	NA	0.09	XXX
71551	TC	A	Mri chest w/dye	0.00	8.96	14.59	NA	NA	0.02	XXX
71551	26	A	Mri chest w/dye	1.73	0.53	0.61	0.53	0.61	0.07	XXX
71552		A	Mri chest w/o & w/dye	2.26	11.71	20.63	NA	NA	0.11	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	11.03	19.81	NA	NA	0.02	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.68	0.82	0.68	0.82	0.09	XXX
71555		R	Mri angio chest w or w/o dye	1.81	13.13	14.25	NA	NA	0.09	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	12.58	13.58	NA	NA	0.02	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.55	0.67	0.55	0.67	0.07	XXX
72010		A	X-ray exam of spine	0.45	1.48	1.41	NA	NA	0.03	XXX
72010	TC	A	X-ray exam of spine	0.00	1.31	1.26	NA	NA	0.01	XXX
72010	26	A	X-ray exam of spine	0.45	0.17	0.15	0.17	0.15	0.02	XXX
72020		A	X-ray exam of spine	0.15	0.42	0.47	NA	NA	0.02	XXX
72020	TC	A	X-ray exam of spine	0.00	0.37	0.41	NA	NA	0.01	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.06	0.05	0.06	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.74	0.75	NA	NA	0.03	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.66	0.67	NA	NA	0.01	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.08	0.08	0.08	0.08	0.02	XXX
72050		A	X-ray exam of neck spine	0.31	0.97	1.05	NA	NA	0.03	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.87	0.94	NA	NA	0.01	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.11	0.10	0.11	0.02	XXX
72052		A	X-ray exam of neck spine	0.36	1.29	1.36	NA	NA	0.03	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.17	1.23	NA	NA	0.01	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.13	0.12	0.13	0.02	XXX
72069		A	X-ray exam of trunk spine	0.22	0.71	0.71	NA	NA	0.03	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.63	0.63	NA	NA	0.01	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.08	0.08	0.02	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.61	0.66	NA	NA	0.02	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.53	0.58	NA	NA	0.01	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.68	0.77	NA	NA	0.02	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.61	0.69	NA	NA	0.01	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.08	0.07	0.08	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
72074		A	X-ray exam of thoracic spine	0.22	0.85	0.94	NA	NA	0.02	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.78	0.86	NA	NA	0.01	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.08	0.07	0.08	0.01	XXX
72080		A	X-ray exam of trunk spine	0.22	0.68	0.70	NA	NA	0.03	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.60	0.62	NA	NA	0.01	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.08	0.08	0.02	XXX
72090		A	X-ray exam of trunk spine	0.28	0.96	0.96	NA	NA	0.04	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.86	0.85	NA	NA	0.01	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.10	0.11	0.10	0.11	0.03	XXX
72100		A	X-ray exam of lower spine	0.22	0.79	0.80	NA	NA	0.03	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.71	0.72	NA	NA	0.01	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.08	0.08	0.08	0.08	0.02	XXX
72110		A	X-ray exam of lower spine	0.31	1.04	1.11	NA	NA	0.03	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.94	1.00	NA	NA	0.01	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.11	0.10	0.11	0.02	XXX
72114		A	X-ray exam of lower spine	0.36	1.51	1.52	NA	NA	0.04	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.38	1.39	NA	NA	0.01	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.13	0.13	0.13	0.13	0.03	XXX
72120		A	X-ray exam of lower spine	0.22	1.08	1.06	NA	NA	0.03	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.99	0.98	NA	NA	0.01	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.09	0.08	0.09	0.08	0.02	XXX
72125		A	Ct neck spine w/o dye	1.16	3.62	5.80	NA	NA	0.06	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	3.27	5.38	NA	NA	0.01	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
72126		A	Ct neck spine w/dye	1.22	4.47	7.10	NA	NA	0.06	XXX
72126	TC	A	Ct neck spine w/dye	0.00	4.10	6.66	NA	NA	0.01	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	5.52	8.83	NA	NA	0.06	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	5.14	8.38	NA	NA	0.01	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.38	0.45	0.38	0.45	0.05	XXX
72128		A	Ct chest spine w/o dye	1.16	3.61	5.79	NA	NA	0.06	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	3.26	5.37	NA	NA	0.01	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
72129		A	Ct chest spine w/dye	1.22	4.48	7.10	NA	NA	0.06	XXX
72129	TC	A	Ct chest spine w/dye	0.00	4.11	6.66	NA	NA	0.01	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	5.57	8.87	NA	NA	0.06	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	5.18	8.41	NA	NA	0.01	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.39	0.46	0.39	0.46	0.05	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
72131		A	Ct lumbar spine w/o dye	1.16	3.60	5.78	NA	NA	0.06	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	3.25	5.36	NA	NA	0.01	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
72132		A	Ct lumbar spine w/dye	1.22	4.46	7.09	NA	NA	0.06	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	4.09	6.65	NA	NA	0.01	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	5.53	8.85	NA	NA	0.06	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	5.14	8.39	NA	NA	0.01	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.39	0.46	0.39	0.46	0.05	XXX
72141		A	Mri neck spine w/o dye	1.60	6.59	10.98	NA	NA	0.08	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	6.09	10.41	NA	NA	0.01	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.50	0.57	0.50	0.57	0.07	XXX
72142		A	Mri neck spine w/dye	1.92	8.54	13.71	NA	NA	0.09	XXX
72142	TC	A	Mri neck spine w/dye	0.00	7.94	13.02	NA	NA	0.01	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.60	0.69	0.60	0.69	0.08	XXX
72146		A	Mri chest spine w/o dye	1.60	6.60	11.24	NA	NA	0.08	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	6.11	10.66	NA	NA	0.01	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.49	0.58	0.49	0.58	0.07	XXX
72147		A	Mri chest spine w/dye	1.92	7.42	12.27	NA	NA	0.09	XXX
72147	TC	A	Mri chest spine w/dye	0.00	6.83	11.58	NA	NA	0.01	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.59	0.69	0.59	0.69	0.08	XXX
72148		A	Mri lumbar spine w/o dye	1.48	6.56	11.18	NA	NA	0.08	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	6.10	10.65	NA	NA	0.01	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.46	0.53	0.46	0.53	0.07	XXX
72149		A	Mri lumbar spine w/dye	1.78	8.38	13.63	NA	NA	0.09	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	7.83	12.99	NA	NA	0.01	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.55	0.64	0.55	0.64	0.08	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	9.60	17.43	NA	NA	0.12	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	8.81	16.51	NA	NA	0.01	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.79	0.92	0.79	0.92	0.11	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	8.78	16.34	NA	NA	0.12	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	8.00	15.42	NA	NA	0.01	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.78	0.92	0.78	0.92	0.11	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	9.49	17.33	NA	NA	0.12	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	8.76	16.49	NA	NA	0.01	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.73	0.84	0.73	0.84	0.11	XXX
72159		N	Mr angio spine w/o&w/dye	1.80	15.76	15.80	NA	NA	0.06	XXX
72159	TC	N	Mr angio spine w/o&w/dye	0.00	15.10	15.15	NA	NA	0.02	XXX
72159	26	N	Mr angio spine w/o&w/dye	1.80	0.66	0.65	0.66	0.65	0.04	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
72170		A	X-ray exam of pelvis	0.17	0.47	0.51	NA	NA	0.03	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.41	0.45	NA	NA	0.01	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.06	0.06	0.02	XXX
72190		A	X-ray exam of pelvis	0.21	0.82	0.83	NA	NA	0.03	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.74	0.75	NA	NA	0.01	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.08	0.08	0.08	0.08	0.02	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	9.88	11.35	NA	NA	0.11	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	9.34	10.69	NA	NA	0.02	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.54	0.66	0.54	0.66	0.09	XXX
72192		A	Ct pelvis w/o dye	1.09	3.34	5.48	NA	NA	0.05	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	3.01	5.08	NA	NA	0.01	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.33	0.40	0.33	0.40	0.04	XXX
72193		A	Ct pelvis w/dye	1.16	4.19	6.73	NA	NA	0.06	XXX
72193	TC	A	Ct pelvis w/dye	0.00	3.84	6.31	NA	NA	0.01	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	5.56	8.87	NA	NA	0.06	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	5.19	8.43	NA	NA	0.01	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
72195		A	Mri pelvis w/o dye	1.46	7.54	12.31	NA	NA	0.08	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	7.09	11.79	NA	NA	0.01	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.45	0.52	0.45	0.52	0.07	XXX
72196		A	Mri pelvis w/dye	1.73	8.34	13.53	NA	NA	0.08	XXX
72196	TC	A	Mri pelvis w/dye	0.00	7.81	12.91	NA	NA	0.01	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.53	0.62	0.53	0.62	0.07	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	10.01	18.17	NA	NA	0.11	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	9.33	17.36	NA	NA	0.02	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.68	0.81	0.68	0.81	0.09	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	13.15	14.18	NA	NA	0.09	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	12.61	13.53	NA	NA	0.02	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.54	0.65	0.54	0.65	0.07	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.55	0.59	NA	NA	0.02	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.49	0.53	NA	NA	0.01	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.06	0.06	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.65	0.71	NA	NA	0.02	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.59	0.64	NA	NA	0.01	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.07	0.06	0.07	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.54	0.59	NA	NA	0.02	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.48	0.53	NA	NA	0.01	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.06	0.06	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
72240		A	Contrast x-ray of neck spine	0.91	2.30	3.01	NA	NA	0.05	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.02	2.69	NA	NA	0.01	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.28	0.32	0.28	0.32	0.04	XXX
72255		A	Contrast x-ray, thorax spine	0.91	2.25	2.74	NA	NA	0.04	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	1.95	2.43	NA	NA	0.01	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.30	0.31	0.30	0.31	0.03	XXX
72265		A	Contrast x-ray, lower spine	0.83	2.31	2.87	NA	NA	0.04	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	2.05	2.57	NA	NA	0.01	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.26	0.30	0.26	0.30	0.03	XXX
72270		A	Contrast x-ray, spine	1.33	3.56	4.44	NA	NA	0.06	XXX
72270	TC	A	Contrast x-ray, spine	0.00	3.14	3.96	NA	NA	0.01	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.42	0.48	0.42	0.48	0.05	XXX
72275		A	Epidurography	0.76	2.20	2.00	NA	NA	0.04	XXX
72275	TC	A	Epidurography	0.00	1.90	1.76	NA	NA	0.01	XXX
72275	26	A	Epidurography	0.76	0.30	0.24	0.30	0.24	0.03	XXX
72285		A	X-ray c/t spine disk	1.16	1.89	2.99	NA	NA	0.05	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.40	2.61	NA	NA	0.01	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.49	0.38	0.49	0.38	0.04	XXX
72291		C	Perq verte/sacroplsty, fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	TC	C	Perq verte/sacroplsty, fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	26	A	Perq verte/sacroplsty, fluor	1.31	0.49	0.51	0.49	0.51	0.15	XXX
72292		C	Perq verte/sacroplsty, ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	TC	C	Perq verte/sacroplsty, ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	26	A	Perq verte/sacroplsty, ct	1.38	0.49	0.54	0.49	0.54	0.14	XXX
72295		A	X-ray of lower spine disk	0.83	1.76	2.83	NA	NA	0.04	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.42	2.55	NA	NA	0.01	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.34	0.28	0.34	0.28	0.03	XXX
73000		A	X-ray exam of collar bone	0.16	0.55	0.57	NA	NA	0.02	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.49	0.51	NA	NA	0.01	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.06	0.06	0.06	0.06	0.01	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.60	0.58	NA	NA	0.03	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.53	0.52	NA	NA	0.01	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.07	0.06	0.07	0.06	0.02	XXX
73020		A	X-ray exam of shoulder	0.15	0.44	0.46	NA	NA	0.02	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.38	0.41	NA	NA	0.01	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.06	0.05	0.06	0.05	0.01	XXX
73030		A	X-ray exam of shoulder	0.18	0.57	0.59	NA	NA	0.03	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.50	0.52	NA	NA	0.01	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.07	0.07	0.07	0.07	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
73040		A	Contrast x-ray of shoulder	0.54	2.08	2.25	NA	NA	0.04	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	1.90	2.05	NA	NA	0.01	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.20	0.18	0.20	0.03	XXX
73050		A	X-ray exam of shoulders	0.20	0.76	0.75	NA	NA	0.03	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.68	0.67	NA	NA	0.01	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.08	0.08	0.08	0.08	0.02	XXX
73060		A	X-ray exam of humerus	0.17	0.54	0.58	NA	NA	0.03	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.48	0.52	NA	NA	0.01	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.06	0.06	0.02	XXX
73070		A	X-ray exam of elbow	0.15	0.55	0.56	NA	NA	0.02	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.49	0.51	NA	NA	0.01	XXX
73070	26	A	X-ray exam of elbow	0.15	0.06	0.05	0.06	0.05	0.01	XXX
73080		A	X-ray exam of elbow	0.17	0.71	0.73	NA	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.65	0.67	NA	NA	0.01	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73085		A	Contrast x-ray of elbow	0.54	1.84	1.97	NA	NA	0.03	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.65	1.78	NA	NA	0.01	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.19	0.19	0.19	0.19	0.02	XXX
73090		A	X-ray exam of forearm	0.16	0.52	0.55	NA	NA	0.02	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.46	0.50	NA	NA	0.01	XXX
73090	26	A	X-ray exam of forearm	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73092		A	X-ray exam of arm, infant	0.16	0.58	0.58	NA	NA	0.02	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.53	0.53	NA	NA	0.01	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73100		A	X-ray exam of wrist	0.16	0.62	0.60	NA	NA	0.03	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.55	0.54	NA	NA	0.01	XXX
73100	26	A	X-ray exam of wrist	0.16	0.07	0.06	0.07	0.06	0.02	XXX
73110		A	X-ray exam of wrist	0.17	0.75	0.74	NA	NA	0.02	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.69	0.68	NA	NA	0.01	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73115		A	Contrast x-ray of wrist	0.54	2.21	2.19	NA	NA	0.04	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.01	1.99	NA	NA	0.01	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.20	0.20	0.20	0.20	0.03	XXX
73120		A	X-ray exam of hand	0.16	0.52	0.54	NA	NA	0.02	XXX
73120	TC	A	X-ray exam of hand	0.00	0.46	0.49	NA	NA	0.01	XXX
73120	26	A	X-ray exam of hand	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.62	0.65	NA	NA	0.02	XXX
73130	TC	A	X-ray exam of hand	0.00	0.56	0.59	NA	NA	0.01	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.06	0.06	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
73140		A	X-ray exam of finger(s)	0.13	0.68	0.65	NA	NA	0.02	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.63	0.60	NA	NA	0.01	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.05	0.05	0.05	0.05	0.01	XXX
73200		A	Ct upper extremity w/o dye	1.09	3.56	5.55	NA	NA	0.06	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	3.23	5.16	NA	NA	0.01	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.33	0.39	0.33	0.39	0.05	XXX
73201		A	Ct upper extremity w/dye	1.16	4.41	6.81	NA	NA	0.06	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	4.06	6.39	NA	NA	0.01	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	5.82	8.98	NA	NA	0.06	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	5.45	8.54	NA	NA	0.01	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	9.36	10.77	NA	NA	0.08	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	8.81	10.10	NA	NA	0.02	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.55	0.67	0.55	0.67	0.06	XXX
73218		A	Mri upper extremity w/o dye	1.35	7.54	12.43	NA	NA	0.06	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	7.11	11.96	NA	NA	0.01	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.43	0.47	0.43	0.47	0.05	XXX
73219		A	Mri upper extremity w/dye	1.62	8.30	13.53	NA	NA	0.08	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	7.80	12.95	NA	NA	0.01	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.50	0.58	0.50	0.58	0.07	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	10.10	18.22	NA	NA	0.11	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	9.44	17.45	NA	NA	0.02	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.66	0.77	0.66	0.77	0.09	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	7.14	11.69	NA	NA	0.08	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	6.70	11.21	NA	NA	0.01	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.44	0.48	0.44	0.48	0.07	XXX
73222		A	Mri joint upr extrem w/dye	1.62	7.69	12.73	NA	NA	0.08	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	7.18	12.15	NA	NA	0.01	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.51	0.58	0.51	0.58	0.07	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	9.44	17.27	NA	NA	0.10	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	8.77	16.51	NA	NA	0.01	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.67	0.76	0.67	0.76	0.09	XXX
73225		N	Mr angio upr extr w/o&w/dye	1.73	15.73	15.53	NA	NA	0.06	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	0.00	15.10	14.91	NA	NA	0.02	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	1.73	0.63	0.62	0.63	0.62	0.04	XXX
73500		A	X-ray exam of hip	0.17	0.49	0.49	NA	NA	0.03	XXX
73500	TC	A	X-ray exam of hip	0.00	0.42	0.43	NA	NA	0.01	XXX
73500	26	A	X-ray exam of hip	0.17	0.07	0.06	0.07	0.06	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
73510		A	X-ray exam of hip	0.21	0.75	0.75	NA	NA	0.03	XXX
73510	TC	A	X-ray exam of hip	0.00	0.67	0.67	NA	NA	0.01	XXX
73510	26	A	X-ray exam of hip	0.21	0.08	0.08	0.08	0.08	0.02	XXX
73520		A	X-ray exam of hips	0.26	0.75	0.77	NA	NA	0.03	XXX
73520	TC	A	X-ray exam of hips	0.00	0.65	0.68	NA	NA	0.01	XXX
73520	26	A	X-ray exam of hips	0.26	0.10	0.09	0.10	0.09	0.02	XXX
73525		A	Contrast x-ray of hip	0.54	1.97	2.00	NA	NA	0.04	XXX
73525	TC	A	Contrast x-ray of hip	0.00	1.76	1.79	NA	NA	0.01	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.21	0.21	0.21	0.21	0.03	XXX
73530		C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	TC	C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	26	A	X-ray exam of hip	0.29	0.09	0.11	0.09	0.11	0.02	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.89	0.80	NA	NA	0.03	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.80	0.72	NA	NA	0.01	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.09	0.08	0.09	0.08	0.02	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	1.57	1.49	NA	NA	0.03	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	1.32	1.31	NA	NA	0.01	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.25	0.18	0.25	0.18	0.02	XXX
73550		A	X-ray exam of thigh	0.17	0.51	0.56	NA	NA	0.03	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.45	0.50	NA	NA	0.01	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.06	0.06	0.02	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.59	0.58	NA	NA	0.03	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	0.52	NA	NA	0.01	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.07	0.06	0.07	0.06	0.02	XXX
73562		A	X-ray exam of knee, 3	0.18	0.73	0.72	NA	NA	0.03	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.66	0.65	NA	NA	0.01	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.07	0.07	0.07	0.07	0.02	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.85	0.83	NA	NA	0.03	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.76	0.75	NA	NA	0.01	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.09	0.08	0.09	0.08	0.02	XXX
73565		A	X-ray exam of knees	0.17	0.70	0.65	NA	NA	0.03	XXX
73565	TC	A	X-ray exam of knees	0.00	0.62	0.58	NA	NA	0.01	XXX
73565	26	A	X-ray exam of knees	0.17	0.08	0.07	0.08	0.07	0.02	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.88	2.71	NA	NA	0.05	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.63	2.49	NA	NA	0.01	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.25	0.22	0.25	0.22	0.04	XXX
73590		A	X-ray exam of lower leg	0.17	0.51	0.54	NA	NA	0.02	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.45	0.48	NA	NA	0.01	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.06	0.06	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
73592		A	X-ray exam of leg, infant	0.16	0.62	0.59	NA	NA	0.02	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.56	0.54	NA	NA	0.01	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73600		A	X-ray exam of ankle	0.16	0.56	0.55	NA	NA	0.02	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.50	0.50	NA	NA	0.01	XXX
73600	26	A	X-ray exam of ankle	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73610		A	X-ray exam of ankle	0.17	0.65	0.65	NA	NA	0.02	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.59	0.59	NA	NA	0.01	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73615		A	Contrast x-ray of ankle	0.54	2.13	2.09	NA	NA	0.04	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	1.91	1.89	NA	NA	0.01	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.22	0.20	0.22	0.20	0.03	XXX
73620		A	X-ray exam of foot	0.16	0.53	0.53	NA	NA	0.02	XXX
73620	TC	A	X-ray exam of foot	0.00	0.48	0.48	NA	NA	0.01	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.63	0.64	NA	NA	0.02	XXX
73630	TC	A	X-ray exam of foot	0.00	0.58	0.58	NA	NA	0.01	XXX
73630	26	A	X-ray exam of foot	0.17	0.05	0.06	0.05	0.06	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.55	0.54	NA	NA	0.02	XXX
73650	TC	A	X-ray exam of heel	0.00	0.49	0.49	NA	NA	0.01	XXX
73650	26	A	X-ray exam of heel	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73660		A	X-ray exam of toe(s)	0.13	0.62	0.60	NA	NA	0.02	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.57	0.56	NA	NA	0.01	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.05	0.04	0.05	0.04	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.09	3.57	5.56	NA	NA	0.05	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	3.24	5.17	NA	NA	0.01	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.33	0.39	0.33	0.39	0.04	XXX
73701		A	Ct lower extremity w/dye	1.16	4.46	6.86	NA	NA	0.06	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	4.11	6.44	NA	NA	0.01	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	5.86	9.00	NA	NA	0.06	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	5.49	8.56	NA	NA	0.01	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	10.51	11.87	NA	NA	0.10	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	9.93	11.16	NA	NA	0.02	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.58	0.71	0.58	0.71	0.08	XXX
73718		A	Mri lower extremity w/o dye	1.35	7.43	12.20	NA	NA	0.07	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	7.01	11.72	NA	NA	0.01	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.42	0.48	0.42	0.48	0.06	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
73719		A	Mri lower extremity w/dye	1.62	8.21	13.36	NA	NA	0.08	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	7.72	12.79	NA	NA	0.01	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.49	0.57	0.49	0.57	0.07	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	10.11	18.22	NA	NA	0.11	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	9.46	17.45	NA	NA	0.02	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.65	0.77	0.65	0.77	0.09	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	7.33	11.93	NA	NA	0.08	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	6.89	11.45	NA	NA	0.01	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.44	0.48	0.44	0.48	0.07	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	7.86	12.87	NA	NA	0.09	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	7.35	12.28	NA	NA	0.01	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.51	0.59	0.51	0.59	0.08	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	9.42	17.23	NA	NA	0.10	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	8.76	16.46	NA	NA	0.01	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.66	0.77	0.66	0.77	0.09	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	13.18	14.19	NA	NA	0.09	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	12.63	13.53	NA	NA	0.02	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.55	0.66	0.55	0.66	0.07	XXX
74000		A	X-ray exam of abdomen	0.18	0.41	0.48	NA	NA	0.02	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.35	0.42	NA	NA	0.01	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.06	0.06	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.70	0.75	NA	NA	0.02	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.63	0.67	NA	NA	0.01	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.07	0.08	0.07	0.08	0.01	XXX
74020		A	X-ray exam of abdomen	0.27	0.71	0.78	NA	NA	0.02	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.63	0.68	NA	NA	0.01	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.08	0.10	0.08	0.10	0.01	XXX
74022		A	X-ray exam series, abdomen	0.32	0.86	0.95	NA	NA	0.02	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.76	0.83	NA	NA	0.01	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.10	0.12	0.10	0.12	0.01	XXX
74150		A	Ct abdomen w/o dye	1.19	3.38	5.47	NA	NA	0.06	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	3.02	5.04	NA	NA	0.01	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.36	0.43	0.36	0.43	0.05	XXX
74160		A	Ct abdomen w/dye	1.27	4.89	7.64	NA	NA	0.06	XXX
74160	TC	A	Ct abdomen w/dye	0.00	4.50	7.18	NA	NA	0.01	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.39	0.46	0.39	0.46	0.05	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	6.71	10.33	NA	NA	0.07	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	6.28	9.82	NA	NA	0.01	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.43	0.51	0.43	0.51	0.06	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
74175		A	Ct angio abdom w/o & w/dye	1.90	10.68	12.09	NA	NA	0.11	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	10.11	11.40	NA	NA	0.02	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.57	0.69	0.57	0.69	0.09	XXX
74181		A	Mri abdomen w/o dye	1.46	6.54	10.95	NA	NA	0.07	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	6.10	10.43	NA	NA	0.01	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.44	0.52	0.44	0.52	0.06	XXX
74182		A	Mri abdomen w/dye	1.73	9.25	14.88	NA	NA	0.08	XXX
74182	TC	A	Mri abdomen w/dye	0.00	8.73	14.26	NA	NA	0.01	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.52	0.62	0.52	0.62	0.07	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	10.05	18.20	NA	NA	0.11	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	9.37	17.39	NA	NA	0.02	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.68	0.81	0.68	0.81	0.09	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	13.08	14.13	NA	NA	0.09	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	12.54	13.48	NA	NA	0.02	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.54	0.65	0.54	0.65	0.07	XXX
74190		C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	TC	C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.14	0.17	0.14	0.17	0.03	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.55	1.65	NA	NA	0.02	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.44	1.52	NA	NA	0.01	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.11	0.13	0.11	0.13	0.01	XXX
74220		A	Contrast x-ray, esophagus	0.46	1.78	1.86	NA	NA	0.03	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.64	1.69	NA	NA	0.01	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.14	0.17	0.14	0.17	0.02	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.71	1.83	NA	NA	0.03	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.55	1.64	NA	NA	0.01	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.16	0.19	0.16	0.19	0.02	XXX
74235		C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	TC	C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.36	0.46	0.36	0.46	0.08	XXX
74240		A	X-ray exam, upper gi tract	0.69	2.04	2.16	NA	NA	0.04	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.83	1.91	NA	NA	0.01	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74241		A	X-ray exam, upper gi tract	0.69	2.27	2.36	NA	NA	0.03	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	2.06	2.12	NA	NA	0.01	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.21	0.24	0.21	0.24	0.02	XXX
74245		A	X-ray exam, upper gi tract	0.91	3.45	3.65	NA	NA	0.05	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	3.18	3.32	NA	NA	0.01	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.27	0.33	0.27	0.33	0.04	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
74246		A	Contrst x-ray uppr gi tract	0.69	2.44	2.57	NA	NA	0.04	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	2.23	2.32	NA	NA	0.01	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	2.82	2.91	NA	NA	0.04	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	2.61	2.66	NA	NA	0.01	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	3.81	3.99	NA	NA	0.05	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	3.54	3.66	NA	NA	0.01	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.27	0.33	0.27	0.33	0.04	XXX
74250		A	X-ray exam of small bowel	0.47	2.17	2.24	NA	NA	0.03	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.03	2.07	NA	NA	0.01	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.14	0.17	0.14	0.17	0.02	XXX
74251		A	X-ray exam of small bowel	0.69	8.84	8.21	NA	NA	0.04	XXX
74251	TC	A	X-ray exam of small bowel	0.00	8.63	7.96	NA	NA	0.01	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74260		A	X-ray exam of small bowel	0.50	7.38	6.90	NA	NA	0.03	XXX
74260	TC	A	X-ray exam of small bowel	0.00	7.23	6.72	NA	NA	0.01	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.15	0.18	0.15	0.18	0.02	XXX
74261		A	Ct colonography, w/o dye	2.28	14.44	14.44	NA	NA	0.10	XXX
74261	TC	A	Ct colonography, w/o dye	0.00	13.75	13.75	NA	NA	0.01	XXX
74261	26	A	Ct colonography, w/o dye	2.28	0.69	0.69	0.69	0.69	0.09	XXX
74262		A	Ct colonography, w/dye	2.50	16.22	16.22	NA	NA	0.11	XXX
74262	TC	A	Ct colonography, w/dye	0.00	15.46	15.46	NA	NA	0.01	XXX
74262	26	A	Ct colonography, w/dye	2.50	0.76	0.76	0.76	0.76	0.10	XXX
74263		N	Ct colonography, screen	2.28	17.17	17.17	NA	NA	0.10	XXX
74263	TC	N	Ct colonography, screen	0.00	16.34	16.34	NA	NA	0.01	XXX
74263	26	N	Ct colonography, screen	2.28	0.83	0.83	0.83	0.83	0.09	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.14	3.20	NA	NA	0.04	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	2.93	2.95	NA	NA	0.01	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74280		A	Contrast x-ray exam of colon	0.99	4.34	4.41	NA	NA	0.05	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.04	4.05	NA	NA	0.01	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.30	0.36	0.30	0.36	0.04	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.14	3.42	NA	NA	0.05	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.51	2.70	NA	NA	0.01	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.63	0.72	0.63	0.72	0.04	XXX
74290		A	Contrast x-ray, gallbladder	0.32	1.42	1.42	NA	NA	0.02	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	1.32	1.30	NA	NA	0.01	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.10	0.12	0.10	0.12	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
74291		A	Contrast x-rays, gallbladder	0.20	1.48	1.36	NA	NA	0.02	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	1.41	1.29	NA	NA	0.01	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.07	0.07	0.01	XXX
74300		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.11	0.13	0.11	0.13	0.03	XXX
74301		C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.08	0.07	0.08	0.02	ZZZ
74305		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.12	0.15	0.12	0.15	0.03	XXX
74320		A	Contrast x-ray of bile ducts	0.54	1.90	2.34	NA	NA	0.03	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	1.74	2.14	NA	NA	0.01	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.16	0.20	0.16	0.20	0.02	XXX
74327		A	X-ray bile stone removal	0.70	2.63	2.76	NA	NA	0.10	XXX
74327	TC	A	X-ray bile stone removal	0.00	2.42	2.50	NA	NA	0.01	XXX
74327	26	A	X-ray bile stone removal	0.70	0.21	0.26	0.21	0.26	0.09	XXX
74328		C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	TC	C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.26	0.23	0.26	0.05	XXX
74329		C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.26	0.23	0.26	0.04	XXX
74330		C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	TC	C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.28	0.33	0.28	0.33	0.06	XXX
74340		C	X-ray guide for GI tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	TC	C	X-ray guide for GI tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.17	0.20	0.17	0.20	0.04	XXX
74355		C	X-ray guide, intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	TC	C	X-ray guide, intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.24	0.28	0.24	0.28	0.05	XXX
74360		C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	TC	C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.22	0.23	0.22	0.23	0.04	XXX
74363		C	X-ray, bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	TC	C	X-ray, bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.26	0.32	0.26	0.32	0.06	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
74400		A	Contrst x-ray, urinary tract	0.49	2.23	2.38	NA	NA	0.03	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	2.08	2.21	NA	NA	0.01	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.17	0.15	0.17	0.02	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.25	2.51	NA	NA	0.03	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	2.10	2.33	NA	NA	0.01	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.18	0.15	0.18	0.02	XXX
74415		A	Contrst x-ray, urinary tract	0.49	2.82	3.01	NA	NA	0.03	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.67	2.83	NA	NA	0.01	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.18	0.15	0.18	0.02	XXX
74420		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.11	0.14	0.11	0.14	0.02	XXX
74425		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.11	0.13	0.11	0.13	0.02	XXX
74430		A	Contrast x-ray, bladder	0.32	1.67	1.76	NA	NA	0.02	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.57	1.64	NA	NA	0.01	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.10	0.12	0.10	0.12	0.01	XXX
74440		A	X-ray, male genital tract	0.38	1.73	1.85	NA	NA	0.03	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.60	1.71	NA	NA	0.01	XXX
74440	26	A	X-ray, male genital tract	0.38	0.13	0.14	0.13	0.14	0.02	XXX
74445		C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	TC	C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.44	0.37	0.44	0.08	XXX
74450		C	X-ray, urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	TC	C	X-ray, urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.10	0.13	0.10	0.13	0.02	XXX
74455		A	X-ray, urethra/bladder	0.33	1.78	2.02	NA	NA	0.02	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.68	1.89	NA	NA	0.01	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.10	0.13	0.10	0.13	0.01	XXX
74470		C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	TC	C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.16	0.20	0.16	0.20	0.04	XXX
74475		A	X-ray control, cath insert	0.54	1.88	2.50	NA	NA	0.03	XXX
74475	TC	A	X-ray control, cath insert	0.00	1.72	2.30	NA	NA	0.01	XXX
74475	26	A	X-ray control, cath insert	0.54	0.16	0.20	0.16	0.20	0.02	XXX
74480		A	X-ray control, cath insert	0.54	1.88	2.51	NA	NA	0.03	XXX
74480	TC	A	X-ray control, cath insert	0.00	1.72	2.31	NA	NA	0.01	XXX
74480	26	A	X-ray control, cath insert	0.54	0.16	0.20	0.16	0.20	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
74485		A	X-ray guide, GU dilation	0.54	1.93	2.42	NA	NA	0.03	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	1.76	2.22	NA	NA	0.01	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.17	0.20	0.17	0.20	0.02	XXX
74710		A	X-ray measurement of pelvis	0.34	0.56	0.75	NA	NA	0.02	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.46	0.62	NA	NA	0.01	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.10	0.13	0.10	0.13	0.01	XXX
74740		A	X-ray, female genital tract	0.38	1.56	1.67	NA	NA	0.02	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.44	1.53	NA	NA	0.01	XXX
74740	26	A	X-ray, female genital tract	0.38	0.12	0.14	0.12	0.14	0.01	XXX
74742		C	X-ray, fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	TC	C	X-ray, fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.19	0.22	0.19	0.22	0.04	XXX
74775		C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	TC	C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.19	0.22	0.19	0.22	0.04	XXX
75557		A	Cardiac mri for morph	2.35	5.84	9.90	NA	NA	0.08	XXX
75557	TC	A	Cardiac mri for morph	0.00	5.10	8.95	NA	NA	0.01	XXX
75557	26	A	Cardiac mri for morph	2.35	0.74	0.95	0.74	0.95	0.07	XXX
75559		A	Cardiac mri w/stress img	2.95	8.75	15.05	NA	NA	0.10	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	7.81	13.78	NA	NA	0.01	XXX
75559	26	A	Cardiac mri w/stress img	2.95	0.94	1.27	0.94	1.27	0.09	XXX
75561		A	Cardiac mri for morph w/dye	2.60	8.23	14.01	NA	NA	0.09	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	7.41	12.96	NA	NA	0.01	XXX
75561	26	A	Cardiac mri for morph w/dye	2.60	0.82	1.05	0.82	1.05	0.08	XXX
75563		A	Card mri w/stress img & dye	3.00	9.95	17.46	NA	NA	0.09	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	8.98	16.12	NA	NA	0.01	XXX
75563	26	A	Card mri w/stress img & dye	3.00	0.97	1.34	0.97	1.34	0.08	XXX
75565		A	Card mri vel flw map add-on	0.25	2.27	2.27	NA	NA	0.02	XXX
75565	TC	A	Card mri vel flw map add-on	0.00	2.18	2.18	NA	NA	0.01	XXX
75565	26	A	Card mri vel flw map add-on	0.25	0.09	0.09	0.09	0.09	0.01	XXX
75571		A	Ct hrt w/o dye w/ca test	0.58	2.73	2.73	NA	NA	0.02	XXX
75571	TC	A	Ct hrt w/o dye w/ca test	0.00	2.55	2.55	NA	NA	0.01	XXX
75571	26	A	Ct hrt w/o dye w/ca test	0.58	0.18	0.18	0.18	0.18	0.01	XXX
75572		A	Ct hrt w/3d image	1.75	2.00	2.00	NA	NA	0.05	XXX
75572	TC	A	Ct hrt w/3d image	0.00	1.43	1.43	NA	NA	0.01	XXX
75572	26	A	Ct hrt w/3d image	1.75	0.57	0.57	0.57	0.57	0.04	XXX
75573		A	Ct hrt w/3d image, congen	2.55	2.48	2.48	NA	NA	0.07	XXX
75573	TC	A	Ct hrt w/3d image, congen	0.00	1.71	1.71	NA	NA	0.01	XXX
75573	26	A	Ct hrt w/3d image, congen	2.55	0.77	0.77	0.77	0.77	0.06	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
75574		A	Ct angio hrt w/3d image	2.40	13.62	13.62	NA	NA	0.06	XXX
75574	TC	A	Ct angio hrt w/3d image	0.00	12.85	12.85	NA	NA	0.01	XXX
75574	26	A	Ct angio hrt w/3d image	2.40	0.77	0.77	0.77	0.77	0.05	XXX
75600		A	Contrast x-ray exam of aorta	0.49	4.79	7.16	NA	NA	0.03	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	4.63	6.94	NA	NA	0.01	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.16	0.22	0.16	0.22	0.02	XXX
75605		A	Contrast x-ray exam of aorta	1.14	2.75	5.15	NA	NA	0.06	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	2.39	4.69	NA	NA	0.01	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.36	0.46	0.36	0.46	0.05	XXX
75625		A	Contrast x-ray exam of aorta	1.14	2.83	5.09	NA	NA	0.08	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	2.48	4.67	NA	NA	0.01	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.35	0.42	0.35	0.42	0.07	XXX
75630		A	X-ray aorta, leg arteries	1.79	3.04	5.51	NA	NA	0.08	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	2.47	4.82	NA	NA	0.01	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.57	0.69	0.57	0.69	0.07	XXX
75635		A	Ct angio abdominal arteries	2.40	10.93	13.29	NA	NA	0.11	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	10.20	12.38	NA	NA	0.02	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.73	0.91	0.73	0.91	0.09	XXX
75650		A	Artery x-rays, head & neck	1.49	2.94	5.26	NA	NA	0.08	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	2.48	4.70	NA	NA	0.01	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.46	0.56	0.46	0.56	0.07	XXX
75658		A	Artery x-rays, arm	1.31	3.51	5.47	NA	NA	0.07	XXX
75658	TC	A	Artery x-rays, arm	0.00	3.11	5.02	NA	NA	0.01	XXX
75658	26	A	Artery x-rays, arm	1.31	0.40	0.45	0.40	0.45	0.06	XXX
75660		A	Artery x-rays, head & neck	1.31	3.46	5.57	NA	NA	0.04	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	3.03	5.07	NA	NA	0.01	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.43	0.50	0.43	0.50	0.03	XXX
75662		A	Artery x-rays, head & neck	1.66	4.10	6.37	NA	NA	0.07	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	3.55	5.70	NA	NA	0.02	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.55	0.67	0.55	0.67	0.05	XXX
75665		A	Artery x-rays, head & neck	1.31	3.67	5.77	NA	NA	0.10	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	3.24	5.28	NA	NA	0.02	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.43	0.49	0.43	0.49	0.08	XXX
75671		A	Artery x-rays, head & neck	1.66	4.38	6.52	NA	NA	0.09	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	3.85	5.89	NA	NA	0.02	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.53	0.63	0.53	0.63	0.07	XXX
75676		A	Artery x-rays, neck	1.31	3.39	5.55	NA	NA	0.09	XXX
75676	TC	A	Artery x-rays, neck	0.00	2.97	5.06	NA	NA	0.01	XXX
75676	26	A	Artery x-rays, neck	1.31	0.42	0.49	0.42	0.49	0.08	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
75680		A	Artery x-rays, neck	1.66	3.85	6.10	NA	NA	0.09	XXX
75680	TC	A	Artery x-rays, neck	0.00	3.32	5.46	NA	NA	0.02	XXX
75680	26	A	Artery x-rays, neck	1.66	0.53	0.64	0.53	0.64	0.07	XXX
75685		A	Artery x-rays, spine	1.31	3.43	5.58	NA	NA	0.07	XXX
75685	TC	A	Artery x-rays, spine	0.00	3.00	5.08	NA	NA	0.01	XXX
75685	26	A	Artery x-rays, spine	1.31	0.43	0.50	0.43	0.50	0.06	XXX
75705		A	Artery x-rays, spine	2.18	3.77	5.89	NA	NA	0.06	XXX
75705	TC	A	Artery x-rays, spine	0.00	3.07	5.07	NA	NA	0.01	XXX
75705	26	A	Artery x-rays, spine	2.18	0.70	0.82	0.70	0.82	0.05	XXX
75710		A	Artery x-rays, arm/leg	1.14	3.38	5.55	NA	NA	0.05	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	3.02	5.13	NA	NA	0.01	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.36	0.42	0.36	0.42	0.04	XXX
75716		A	Artery x-rays, arms/legs	1.31	4.08	6.28	NA	NA	0.09	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	3.67	5.80	NA	NA	0.02	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.41	0.48	0.41	0.48	0.07	XXX
75722		A	Artery x-rays, kidney	1.14	3.05	5.40	NA	NA	0.06	XXX
75722	TC	A	Artery x-rays, kidney	0.00	2.69	4.95	NA	NA	0.01	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.36	0.45	0.36	0.45	0.05	XXX
75724		A	Artery x-rays, kidneys	1.49	3.63	6.26	NA	NA	0.06	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	3.14	5.59	NA	NA	0.02	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.49	0.67	0.49	0.67	0.04	XXX
75726		A	Artery x-rays, abdomen	1.14	3.25	5.46	NA	NA	0.07	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	2.91	5.04	NA	NA	0.01	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.34	0.42	0.34	0.42	0.06	XXX
75731		A	Artery x-rays, adrenal gland	1.14	3.05	5.61	NA	NA	0.04	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	2.67	5.12	NA	NA	0.01	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.38	0.49	0.38	0.49	0.03	XXX
75733		A	Artery x-rays, adrenals	1.31	3.85	6.49	NA	NA	0.05	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	3.41	5.90	NA	NA	0.02	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.44	0.59	0.44	0.59	0.03	XXX
75736		A	Artery x-rays, pelvis	1.14	3.22	5.50	NA	NA	0.05	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	2.87	5.07	NA	NA	0.01	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.35	0.43	0.35	0.43	0.04	XXX
75741		A	Artery x-rays, lung	1.31	2.74	5.02	NA	NA	0.07	XXX
75741	TC	A	Artery x-rays, lung	0.00	2.35	4.53	NA	NA	0.01	XXX
75741	26	A	Artery x-rays, lung	1.31	0.39	0.49	0.39	0.49	0.06	XXX
75743		A	Artery x-rays, lungs	1.66	3.12	5.37	NA	NA	0.08	XXX
75743	TC	A	Artery x-rays, lungs	0.00	2.61	4.74	NA	NA	0.01	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.51	0.63	0.51	0.63	0.07	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
75746		A	Artery x-rays, lung	1.14	3.06	5.29	NA	NA	0.06	XXX
75746	TC	A	Artery x-rays, lung	0.00	2.71	4.87	NA	NA	0.01	XXX
75746	26	A	Artery x-rays, lung	1.14	0.35	0.42	0.35	0.42	0.05	XXX
75756		A	Artery x-rays, chest	1.14	3.23	5.69	NA	NA	0.16	XXX
75756	TC	A	Artery x-rays, chest	0.00	2.88	5.18	NA	NA	0.01	XXX
75756	26	A	Artery x-rays, chest	1.14	0.35	0.51	0.35	0.51	0.15	XXX
75774		A	Artery x-ray, each vessel	0.36	2.14	4.37	NA	NA	0.03	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	2.03	4.24	NA	NA	0.01	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.11	0.13	0.11	0.13	0.02	ZZZ
75791		A	Av dialysis shunt imaging	1.71	6.69	6.69	NA	NA	0.08	XXX
75791	TC	A	Av dialysis shunt imaging	0.00	6.16	6.16	NA	NA	0.01	XXX
75791	26	A	Av dialysis shunt imaging	1.71	0.53	0.53	0.53	0.53	0.07	XXX
75801		C	Lymph vessel x-ray, arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	TC	C	Lymph vessel x-ray, arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.30	0.27	0.30	0.27	0.12	XXX
75803		C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.35	0.43	0.35	0.43	0.08	XXX
75805		C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.24	0.30	0.24	0.30	0.05	XXX
75807		C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.36	0.43	0.36	0.43	0.08	XXX
75809		A	Nonvascular shunt, x-ray	0.47	2.03	1.93	NA	NA	0.03	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	1.88	1.76	NA	NA	0.01	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.15	0.17	0.15	0.17	0.02	XXX
75810		C	Vein x-ray, spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	TC	C	Vein x-ray, spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.34	0.43	0.34	0.43	0.08	XXX
75820		A	Vein x-ray, arm/leg	0.70	2.48	2.53	NA	NA	0.04	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	2.26	2.26	NA	NA	0.01	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.22	0.27	0.22	0.27	0.03	XXX
75822		A	Vein x-ray, arms/legs	1.06	2.85	2.88	NA	NA	0.06	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	2.53	2.50	NA	NA	0.01	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.32	0.38	0.32	0.38	0.05	XXX
75825		A	Vein x-ray, trunk	1.14	2.65	4.84	NA	NA	0.07	XXX
75825	TC	A	Vein x-ray, trunk	0.00	2.31	4.44	NA	NA	0.01	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.34	0.40	0.34	0.40	0.06	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
75827		A	Vein x-ray, chest	1.14	2.80	4.87	NA	NA	0.06	XXX
75827	TC	A	Vein x-ray, chest	0.00	2.46	4.49	NA	NA	0.01	XXX
75827	26	A	Vein x-ray, chest	1.14	0.34	0.38	0.34	0.38	0.05	XXX
75831		A	Vein x-ray, kidney	1.14	2.76	4.94	NA	NA	0.18	XXX
75831	TC	A	Vein x-ray, kidney	0.00	2.43	4.53	NA	NA	0.01	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.33	0.41	0.33	0.41	0.17	XXX
75833		A	Vein x-ray, kidneys	1.49	3.30	5.43	NA	NA	0.07	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	2.87	4.92	NA	NA	0.01	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.43	0.51	0.43	0.51	0.06	XXX
75840		A	Vein x-ray, adrenal gland	1.14	2.60	4.84	NA	NA	0.18	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	2.29	4.46	NA	NA	0.01	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.31	0.38	0.31	0.38	0.17	XXX
75842		A	Vein x-ray, adrenal glands	1.49	3.23	5.45	NA	NA	0.07	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	2.77	4.91	NA	NA	0.01	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.46	0.54	0.46	0.54	0.06	XXX
75860		A	Vein x-ray, neck	1.14	2.72	5.04	NA	NA	0.07	XXX
75860	TC	A	Vein x-ray, neck	0.00	2.36	4.59	NA	NA	0.01	XXX
75860	26	A	Vein x-ray, neck	1.14	0.36	0.45	0.36	0.45	0.06	XXX
75870		A	Vein x-ray, skull	1.14	2.90	5.04	NA	NA	0.06	XXX
75870	TC	A	Vein x-ray, skull	0.00	2.52	4.62	NA	NA	0.01	XXX
75870	26	A	Vein x-ray, skull	1.14	0.38	0.42	0.38	0.42	0.05	XXX
75872		A	Vein x-ray, skull	1.14	5.87	6.25	NA	NA	0.06	XXX
75872	TC	A	Vein x-ray, skull	0.00	5.34	5.77	NA	NA	0.01	XXX
75872	26	A	Vein x-ray, skull	1.14	0.53	0.48	0.53	0.48	0.05	XXX
75880		A	Vein x-ray, eye socket	0.70	2.57	2.58	NA	NA	0.04	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	2.35	2.34	NA	NA	0.01	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.22	0.24	0.22	0.24	0.03	XXX
75885		A	Vein x-ray, liver	1.44	2.79	5.07	NA	NA	0.07	XXX
75885	TC	A	Vein x-ray, liver	0.00	2.37	4.53	NA	NA	0.01	XXX
75885	26	A	Vein x-ray, liver	1.44	0.42	0.54	0.42	0.54	0.06	XXX
75887		A	Vein x-ray, liver	1.44	2.94	5.14	NA	NA	0.05	XXX
75887	TC	A	Vein x-ray, liver	0.00	2.49	4.60	NA	NA	0.01	XXX
75887	26	A	Vein x-ray, liver	1.44	0.45	0.54	0.45	0.54	0.04	XXX
75889		A	Vein x-ray, liver	1.14	2.72	4.94	NA	NA	0.06	XXX
75889	TC	A	Vein x-ray, liver	0.00	2.38	4.52	NA	NA	0.01	XXX
75889	26	A	Vein x-ray, liver	1.14	0.34	0.42	0.34	0.42	0.05	XXX
75891		A	Vein x-ray, liver	1.14	2.71	4.94	NA	NA	0.06	XXX
75891	TC	A	Vein x-ray, liver	0.00	2.38	4.52	NA	NA	0.01	XXX
75891	26	A	Vein x-ray, liver	1.14	0.33	0.42	0.33	0.42	0.05	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
75893		A	Venous sampling by catheter	0.54	2.48	4.69	NA	NA	0.02	XXX
75893	TC	A	Venous sampling by catheter	0.00	2.32	4.50	NA	NA	0.01	XXX
75893	26	A	Venous sampling by catheter	0.54	0.16	0.19	0.16	0.19	0.01	XXX
75894		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	TC	C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.40	0.47	0.40	0.47	0.12	XXX
75896		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	TC	C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.41	0.50	0.41	0.50	0.11	XXX
75898		C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	TC	C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	26	A	Follow-up angiography	1.65	0.51	0.63	0.51	0.63	0.14	XXX
75900		C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	TC	C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	26	A	Intravascular cath exchange	0.49	0.15	0.17	0.15	0.17	0.05	XXX
75901		A	Remove cva device obstruct	0.49	3.81	3.63	NA	NA	0.03	XXX
75901	TC	A	Remove cva device obstruct	0.00	3.66	3.45	NA	NA	0.01	XXX
75901	26	A	Remove cva device obstruct	0.49	0.15	0.18	0.15	0.18	0.02	XXX
75902		A	Remove cva lumen obstruct	0.39	1.52	1.59	NA	NA	0.04	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.40	1.45	NA	NA	0.01	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.12	0.14	0.12	0.14	0.03	XXX
75940		C	X-ray placement, vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	TC	C	X-ray placement, vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.16	0.19	0.16	0.19	0.05	XXX
75945		C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	TC	C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	26	A	Intravascular us	0.40	0.12	0.15	0.12	0.15	0.05	XXX
75946		C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	TC	C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.12	0.13	0.12	0.13	0.06	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.34	1.42	1.34	1.42	0.63	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.41	0.43	0.41	0.43	0.19	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.67	0.71	0.67	0.71	0.31	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
75956		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	26	A	Xray, endovasc thor ao repr	7.00	2.05	2.24	2.05	2.24	1.04	XXX
75957		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	1.76	1.91	1.76	1.91	0.88	XXX
75958		C	Xray, place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	TC	C	Xray, place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	26	A	Xray, place prox ext thor ao	4.00	1.16	1.23	1.16	1.23	0.59	XXX
75959		C	Xray, place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	TC	C	Xray, place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	26	A	Xray, place dist ext thor ao	3.50	0.95	1.08	0.95	1.08	0.60	XXX
75960		A	Transcath iv stent rs&i	0.82	2.27	5.00	NA	NA	0.05	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	2.02	4.69	NA	NA	0.01	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.25	0.31	0.25	0.31	0.04	XXX
75961		A	Retrieval, broken catheter	4.24	4.06	6.04	NA	NA	0.18	XXX
75961	TC	A	Retrieval, broken catheter	0.00	2.79	4.51	NA	NA	0.01	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.27	1.53	1.27	1.53	0.17	XXX
75962		A	Repair arterial blockage	0.54	2.99	5.75	NA	NA	0.03	XXX
75962	TC	A	Repair arterial blockage	0.00	2.82	5.55	NA	NA	0.01	XXX
75962	26	A	Repair arterial blockage	0.54	0.17	0.20	0.17	0.20	0.02	XXX
75964		A	Repair artery blockage, each	0.36	2.04	3.46	NA	NA	0.04	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	1.93	3.33	NA	NA	0.01	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.11	0.13	0.11	0.13	0.03	ZZZ
75966		A	Repair arterial blockage	1.31	3.19	6.21	NA	NA	0.07	XXX
75966	TC	A	Repair arterial blockage	0.00	2.78	5.69	NA	NA	0.02	XXX
75966	26	A	Repair arterial blockage	1.31	0.41	0.52	0.41	0.52	0.05	XXX
75968		A	Repair artery blockage, each	0.36	1.89	3.43	NA	NA	0.02	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	1.78	3.29	NA	NA	0.01	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.11	0.14	0.11	0.14	0.01	ZZZ
75970		C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	TC	C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	26	A	Vascular biopsy	0.83	0.25	0.31	0.25	0.31	0.06	XXX
75978		A	Repair venous blockage	0.54	3.11	5.69	NA	NA	0.03	XXX
75978	TC	A	Repair venous blockage	0.00	2.94	5.50	NA	NA	0.01	XXX
75978	26	A	Repair venous blockage	0.54	0.17	0.19	0.17	0.19	0.02	XXX
75980		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.42	0.53	0.42	0.53	0.10	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
75982		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.42	0.53	0.42	0.53	0.10	XXX
75984		A	Xray control catheter change	0.72	2.07	2.28	NA	NA	0.04	XXX
75984	TC	A	Xray control catheter change	0.00	1.86	2.01	NA	NA	0.01	XXX
75984	26	A	Xray control catheter change	0.72	0.21	0.27	0.21	0.27	0.03	XXX
75989		A	Abscess drainage under x-ray	1.19	2.00	2.48	NA	NA	0.05	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.64	2.05	NA	NA	0.01	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.36	0.43	0.36	0.43	0.04	XXX
75992		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.17	0.21	0.17	0.21	0.05	XXX
75993		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75993	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.11	0.14	0.11	0.14	0.04	ZZZ
75994		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75994	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.31	0.35	0.31	0.35	0.09	XXX
75995		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75995	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.44	0.48	0.44	0.48	0.06	XXX
75996		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75996	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.10	0.12	0.10	0.12	0.06	ZZZ
76000		A	Fluoroscope examination	0.17	2.66	2.50	NA	NA	0.02	XXX
76000	TC	A	Fluoroscope examination	0.00	2.60	2.44	NA	NA	0.01	XXX
76000	26	A	Fluoroscope examination	0.17	0.06	0.06	0.06	0.06	0.01	XXX
76001		C	Fluoroscope exam, extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	TC	C	Fluoroscope exam, extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.24	0.25	0.24	0.25	0.07	XXX
76010		A	X-ray, nose to rectum	0.18	0.46	0.55	NA	NA	0.02	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.41	0.48	NA	NA	0.01	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.05	0.07	0.05	0.07	0.01	XXX
76080		A	X-ray exam of fistula	0.54	0.96	1.11	NA	NA	0.03	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.80	0.91	NA	NA	0.01	XXX
76080	26	A	X-ray exam of fistula	0.54	0.16	0.20	0.16	0.20	0.02	XXX
76098		A	X-ray exam, breast specimen	0.16	0.28	0.35	NA	NA	0.02	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.23	0.29	NA	NA	0.01	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.06	0.05	0.06	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
76100		A	X-ray exam of body section	0.58	1.99	2.80	NA	NA	0.05	XXX
76100	TC	A	X-ray exam of body section	0.00	1.74	2.58	NA	NA	0.01	XXX
76100	26	A	X-ray exam of body section	0.58	0.25	0.22	0.25	0.22	0.04	XXX
76101		A	Complex body section x-ray	0.58	3.10	4.15	NA	NA	0.08	XXX
76101	TC	A	Complex body section x-ray	0.00	2.77	3.91	NA	NA	0.01	XXX
76101	26	A	Complex body section x-ray	0.58	0.33	0.24	0.33	0.24	0.07	XXX
76102		A	Complex body section x-rays	0.58	4.35	5.77	NA	NA	0.09	XXX
76102	TC	A	Complex body section x-rays	0.00	4.01	5.54	NA	NA	0.02	XXX
76102	26	A	Complex body section x-rays	0.58	0.34	0.23	0.34	0.23	0.07	XXX
76120		A	Cine/video x-rays	0.38	1.50	1.61	NA	NA	0.03	XXX
76120	TC	A	Cine/video x-rays	0.00	1.37	1.48	NA	NA	0.01	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.13	0.13	0.02	XXX
76125		C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.11	0.09	0.11	0.02	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.55	0.51	NA	NA	0.01	XXX
76350		C	Special x-ray contrast study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76376		A	3d render w/o postprocess	0.20	1.23	1.78	NA	NA	0.02	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.17	1.70	NA	NA	0.01	XXX
76376	26	A	3d render w/o postprocess	0.20	0.06	0.08	0.06	0.08	0.01	XXX
76377		A	3d rendering w/postprocess	0.79	1.20	1.81	NA	NA	0.04	XXX
76377	TC	A	3d rendering w/postprocess	0.00	0.96	1.53	NA	NA	0.01	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.24	0.28	0.24	0.28	0.03	XXX
76380		A	CAT scan follow-up study	0.98	4.20	4.48	NA	NA	0.04	XXX
76380	TC	A	CAT scan follow-up study	0.00	3.89	4.13	NA	NA	0.01	XXX
76380	26	A	CAT scan follow-up study	0.98	0.31	0.35	0.31	0.35	0.03	XXX
76390		N	Mr spectroscopy	1.40	10.17	10.78	NA	NA	0.04	XXX
76390	TC	N	Mr spectroscopy	0.00	9.66	10.29	NA	NA	0.01	XXX
76390	26	N	Mr spectroscopy	1.40	0.51	0.49	0.51	0.49	0.03	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498		C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
76499		C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76506		A	Echo exam of head	0.63	2.49	2.49	NA	NA	0.04	XXX
76506	TC	A	Echo exam of head	0.00	2.28	2.26	NA	NA	0.01	XXX
76506	26	A	Echo exam of head	0.63	0.21	0.23	0.21	0.23	0.03	XXX
76510		A	Ophth us, b & quant a	1.55	2.77	2.56	NA	NA	0.19	XXX
76510	TC	A	Ophth us, b & quant a	0.00	1.86	1.85	NA	NA	0.01	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.91	0.71	0.91	0.71	0.18	XXX
76511		A	Ophth us, quant a only	0.94	1.63	1.65	NA	NA	0.02	XXX
76511	TC	A	Ophth us, quant a only	0.00	1.11	1.24	NA	NA	0.01	XXX
76511	26	A	Ophth us, quant a only	0.94	0.52	0.41	0.52	0.41	0.01	XXX
76512		A	Ophth us, b w/non-quant a	0.94	1.44	1.48	NA	NA	0.04	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	0.91	1.05	NA	NA	0.01	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.53	0.43	0.53	0.43	0.03	XXX
76513		A	Echo exam of eye, water bath	0.66	1.67	1.60	NA	NA	0.02	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.35	1.34	NA	NA	0.01	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.32	0.26	0.32	0.26	0.01	XXX
76514		A	Echo exam of eye, thickness	0.17	0.21	0.18	NA	NA	0.02	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.12	0.10	NA	NA	0.01	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.09	0.08	0.09	0.08	0.01	XXX
76516		A	Echo exam of eye	0.54	1.37	1.29	NA	NA	0.02	XXX
76516	TC	A	Echo exam of eye	0.00	1.07	1.05	NA	NA	0.01	XXX
76516	26	A	Echo exam of eye	0.54	0.30	0.24	0.30	0.24	0.01	XXX
76519		A	Echo exam of eye	0.54	1.51	1.42	NA	NA	0.02	XXX
76519	TC	A	Echo exam of eye	0.00	1.20	1.17	NA	NA	0.01	XXX
76519	26	A	Echo exam of eye	0.54	0.31	0.25	0.31	0.25	0.01	XXX
76529		A	Echo exam of eye	0.57	1.40	1.27	NA	NA	0.03	XXX
76529	TC	A	Echo exam of eye	0.00	1.06	1.02	NA	NA	0.01	XXX
76529	26	A	Echo exam of eye	0.57	0.34	0.25	0.34	0.25	0.02	XXX
76536		A	Us exam of head and neck	0.56	2.43	2.43	NA	NA	0.03	XXX
76536	TC	A	Us exam of head and neck	0.00	2.25	2.24	NA	NA	0.01	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.19	0.18	0.19	0.02	XXX
76604		A	Us exam, chest	0.55	1.60	1.73	NA	NA	0.03	XXX
76604	TC	A	Us exam, chest	0.00	1.44	1.54	NA	NA	0.01	XXX
76604	26	A	Us exam, chest	0.55	0.16	0.19	0.16	0.19	0.02	XXX
76645		A	Us exam, breast(s)	0.54	1.85	1.91	NA	NA	0.04	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.69	1.72	NA	NA	0.01	XXX
76645	26	A	Us exam, breast(s)	0.54	0.16	0.19	0.16	0.19	0.03	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
76700		A	Us exam, abdom, complete	0.81	2.67	2.83	NA	NA	0.04	XXX
76700	TC	A	Us exam, abdom, complete	0.00	2.42	2.54	NA	NA	0.01	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.25	0.29	0.25	0.29	0.03	XXX
76705		A	Echo exam of abdomen	0.59	2.05	2.17	NA	NA	0.03	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.87	1.96	NA	NA	0.01	XXX
76705	26	A	Echo exam of abdomen	0.59	0.18	0.21	0.18	0.21	0.02	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.54	2.72	NA	NA	0.04	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	2.31	2.46	NA	NA	0.01	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.23	0.26	0.23	0.26	0.03	XXX
76775		A	Us exam abdo back wall, lim	0.58	2.07	2.35	NA	NA	0.03	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.89	2.13	NA	NA	0.01	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.18	0.22	0.18	0.22	0.02	XXX
76776		A	Us exam k transpl w/doppler	0.76	2.98	3.13	NA	NA	0.04	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	2.75	2.86	NA	NA	0.01	XXX
76776	26	A	Us exam k transpl w/doppler	0.76	0.23	0.27	0.23	0.27	0.03	XXX
76800		A	Us exam, spinal canal	1.13	2.37	2.23	NA	NA	0.04	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.97	1.88	NA	NA	0.01	XXX
76800	26	A	Us exam, spinal canal	1.13	0.40	0.35	0.40	0.35	0.03	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.21	2.44	NA	NA	0.03	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	1.88	2.09	NA	NA	0.01	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.33	0.35	0.33	0.35	0.02	XXX
76802		A	Ob us < 14 wks, addl fetus	0.83	0.92	1.05	NA	NA	0.03	ZZZ
76802	TC	A	Ob us < 14 wks, addl fetus	0.00	0.63	0.76	NA	NA	0.01	ZZZ
76802	26	A	Ob us < 14 wks, addl fetus	0.83	0.29	0.29	0.29	0.29	0.02	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	2.73	2.89	NA	NA	0.03	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.39	2.54	NA	NA	0.01	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.34	0.35	0.34	0.35	0.02	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.53	1.59	NA	NA	0.03	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.19	1.25	NA	NA	0.01	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.34	0.34	0.34	0.34	0.02	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	2.90	3.28	NA	NA	0.05	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	2.19	2.63	NA	NA	0.01	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.71	0.65	0.71	0.65	0.04	XXX
76812		A	Ob us, detailed, addl fetus	1.78	3.68	3.50	NA	NA	0.04	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	3.01	2.89	NA	NA	0.01	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.67	0.61	0.67	0.61	0.03	ZZZ
76813		A	Ob us nuchal meas, 1 gest	1.18	2.05	2.18	NA	NA	0.03	XXX
76813	TC	A	Ob us nuchal meas, 1 gest	0.00	1.61	1.79	NA	NA	0.01	XXX
76813	26	A	Ob us nuchal meas, 1 gest	1.18	0.44	0.39	0.44	0.39	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
76814		A	Ob us nuchal meas, add-on	0.99	1.14	1.16	NA	NA	0.03	XXX
76814	TC	A	Ob us nuchal meas, add-on	0.00	0.76	0.83	NA	NA	0.01	XXX
76814	26	A	Ob us nuchal meas, add-on	0.99	0.38	0.33	0.38	0.33	0.02	XXX
76815		A	Ob us, limited, fetus(s)	0.65	1.62	1.74	NA	NA	0.02	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.40	1.52	NA	NA	0.01	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.22	0.22	0.22	0.22	0.01	XXX
76816		A	Ob us, follow-up, per fetus	0.85	2.17	2.16	NA	NA	0.03	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.86	1.87	NA	NA	0.01	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.31	0.29	0.31	0.29	0.02	XXX
76817		A	Transvaginal us, obstetric	0.75	1.82	1.95	NA	NA	0.02	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.56	1.69	NA	NA	0.01	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.26	0.26	0.26	0.26	0.01	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.06	2.16	NA	NA	0.03	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.67	1.80	NA	NA	0.01	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.39	0.36	0.39	0.36	0.02	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.48	1.67	NA	NA	0.02	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.21	1.40	NA	NA	0.01	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.27	0.27	0.27	0.27	0.01	XXX
76820		A	Umbilical artery echo	0.50	0.56	0.81	NA	NA	0.02	XXX
76820	TC	A	Umbilical artery echo	0.00	0.37	0.64	NA	NA	0.01	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.17	0.19	0.17	0.01	XXX
76821		A	Middle cerebral artery echo	0.70	1.71	1.84	NA	NA	0.02	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.45	1.60	NA	NA	0.01	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.26	0.24	0.26	0.24	0.01	XXX
76825		A	Echo exam of fetal heart	1.67	3.95	3.97	NA	NA	0.04	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.34	3.40	NA	NA	0.01	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.61	0.57	0.61	0.57	0.03	XXX
76826		A	Echo exam of fetal heart	0.83	2.48	2.35	NA	NA	0.03	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.18	2.07	NA	NA	0.01	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.30	0.28	0.30	0.28	0.02	XXX
76827		A	Echo exam of fetal heart	0.58	1.00	1.23	NA	NA	0.02	XXX
76827	TC	A	Echo exam of fetal heart	0.00	0.79	1.03	NA	NA	0.01	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.20	0.21	0.20	0.01	XXX
76828		A	Echo exam of fetal heart	0.56	0.63	0.78	NA	NA	0.02	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.42	0.59	NA	NA	0.01	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.21	0.19	0.21	0.19	0.01	XXX
76830		A	Transvaginal us, non-ob	0.69	2.44	2.52	NA	NA	0.03	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	2.21	2.28	NA	NA	0.01	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.24	0.23	0.24	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
76831		A	Echo exam, uterus	0.72	2.47	2.50	NA	NA	0.03	XXX
76831	TC	A	Echo exam, uterus	0.00	2.20	2.26	NA	NA	0.01	XXX
76831	26	A	Echo exam, uterus	0.72	0.27	0.24	0.27	0.24	0.02	XXX
76856		A	Us exam, pelvic, complete	0.69	2.41	2.53	NA	NA	0.03	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	2.19	2.28	NA	NA	0.01	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.22	0.25	0.22	0.25	0.02	XXX
76857		A	Us exam, pelvic, limited	0.38	1.99	2.27	NA	NA	0.03	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.87	2.12	NA	NA	0.01	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.12	0.15	0.12	0.15	0.02	XXX
76870		A	Us exam, scrotum	0.64	2.42	2.54	NA	NA	0.04	XXX
76870	TC	A	Us exam, scrotum	0.00	2.22	2.31	NA	NA	0.01	XXX
76870	26	A	Us exam, scrotum	0.64	0.20	0.23	0.20	0.23	0.03	XXX
76872		A	Us, transrectal	0.69	2.61	3.03	NA	NA	0.04	XXX
76872	TC	A	Us, transrectal	0.00	2.38	2.76	NA	NA	0.01	XXX
76872	26	A	Us, transrectal	0.69	0.23	0.27	0.23	0.27	0.03	XXX
76873		A	Echograp trans r, pros study	1.55	3.02	3.18	NA	NA	0.07	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.43	2.60	NA	NA	0.01	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.59	0.58	0.59	0.58	0.06	XXX
76880		A	Us exam, extremity	0.59	2.98	2.85	NA	NA	0.03	XXX
76880	TC	A	Us exam, extremity	0.00	2.80	2.66	NA	NA	0.01	XXX
76880	26	A	Us exam, extremity	0.59	0.18	0.19	0.18	0.19	0.02	XXX
76885		A	Us exam infant hips, dynamic	0.74	2.90	2.93	NA	NA	0.04	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	2.67	2.67	NA	NA	0.01	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.23	0.26	0.23	0.26	0.03	XXX
76886		A	Us exam infant hips, static	0.62	2.54	2.20	NA	NA	0.02	XXX
76886	TC	A	Us exam infant hips, static	0.00	2.30	1.98	NA	NA	0.01	XXX
76886	26	A	Us exam infant hips, static	0.62	0.24	0.22	0.24	0.22	0.01	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.40	1.83	NA	NA	0.03	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.18	1.53	NA	NA	0.02	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.22	0.30	0.22	0.30	0.01	XXX
76932		C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.22	0.30	0.22	0.30	0.04	XXX
76936		A	Echo guide for artery repair	1.99	5.35	6.13	NA	NA	0.17	XXX
76936	TC	A	Echo guide for artery repair	0.00	4.74	5.42	NA	NA	0.02	XXX
76936	26	A	Echo guide for artery repair	1.99	0.61	0.71	0.61	0.71	0.15	XXX
76937		A	Us guide, vascular access	0.30	0.57	0.60	NA	NA	0.03	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.48	0.49	NA	NA	0.01	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.09	0.11	0.09	0.11	0.02	ZZZ

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
76940		C	Us guide, tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	TC	C	Us guide, tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	26	A	Us guide, tissue ablation	2.00	0.66	0.69	0.66	0.69	0.20	XXX
76941		C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	TC	C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	26	A	Echo guide for transfusion	1.34	0.52	0.47	0.52	0.47	0.09	XXX
76942		A	Echo guide for biopsy	0.67	4.17	4.33	NA	NA	0.04	XXX
76942	TC	A	Echo guide for biopsy	0.00	3.96	4.09	NA	NA	0.01	XXX
76942	26	A	Echo guide for biopsy	0.67	0.21	0.24	0.21	0.24	0.03	XXX
76945		C	Echo guide, villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	TC	C	Echo guide, villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.26	0.23	0.26	0.23	0.03	XXX
76946		A	Echo guide for amniocentesis	0.38	0.44	0.69	NA	NA	0.02	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.30	0.56	NA	NA	0.01	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.13	0.14	0.13	0.01	XXX
76948		A	Echo guide, ova aspiration	0.38	0.52	0.71	NA	NA	0.03	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	0.38	0.58	NA	NA	0.01	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.14	0.13	0.14	0.13	0.02	XXX
76950		A	Echo guidance radiotherapy	0.58	1.17	1.27	NA	NA	0.03	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	0.93	1.06	NA	NA	0.01	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.24	0.21	0.24	0.21	0.02	XXX
76965		A	Echo guidance radiotherapy	1.34	1.05	2.11	NA	NA	0.07	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.56	1.60	NA	NA	0.01	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.49	0.51	0.49	0.51	0.06	XXX
76970		A	Ultrasound exam follow-up	0.40	2.22	1.95	NA	NA	0.04	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	2.07	1.82	NA	NA	0.01	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.15	0.13	0.15	0.13	0.03	XXX
76975		C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	TC	C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.31	0.32	0.31	0.32	0.06	XXX
76977		A	Us bone density measure	0.05	0.12	0.25	NA	NA	0.02	XXX
76977	TC	A	Us bone density measure	0.00	0.10	0.23	NA	NA	0.01	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.02	0.02	0.01	XXX
76998		C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	TC	C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide, intraop	1.20	0.40	0.40	0.40	0.40	0.18	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
77001		A	Fluoroguide for vein device	0.38	2.56	2.48	NA	NA	0.02	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.44	2.34	NA	NA	0.01	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.12	0.14	0.12	0.14	0.01	ZZZ
77002		A	Needle localization by xray	0.54	1.36	1.36	NA	NA	0.03	XXX
77002	TC	A	Needle localization by xray	0.00	1.16	1.17	NA	NA	0.01	XXX
77002	26	A	Needle localization by xray	0.54	0.20	0.19	0.20	0.19	0.02	XXX
77003		A	Fluoroguide for spine inject	0.60	1.03	0.97	NA	NA	0.03	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.80	0.80	NA	NA	0.01	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.23	0.17	0.23	0.17	0.02	XXX
77011		A	Ct scan for localization	1.21	18.45	17.67	NA	NA	0.04	XXX
77011	TC	A	Ct scan for localization	0.00	18.00	17.23	NA	NA	0.01	XXX
77011	26	A	Ct scan for localization	1.21	0.45	0.44	0.45	0.44	0.03	XXX
77012		A	Ct scan for needle biopsy	1.16	2.06	3.52	NA	NA	0.04	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	1.71	3.10	NA	NA	0.01	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.35	0.42	0.35	0.42	0.03	XXX
77013		C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	TC	C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	26	A	Ct guide for tissue ablation	3.99	1.18	1.46	1.18	1.46	0.27	XXX
77014		A	Ct scan for therapy guide	0.85	4.10	4.15	NA	NA	0.04	XXX
77014	TC	A	Ct scan for therapy guide	0.00	3.75	3.84	NA	NA	0.01	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.35	0.31	0.35	0.31	0.03	XXX
77021		A	Mr guidance for needle place	1.50	8.38	9.97	NA	NA	0.10	XXX
77021	TC	A	Mr guidance for needle place	0.00	7.92	9.43	NA	NA	0.01	XXX
77021	26	A	Mr guidance for needle place	1.50	0.46	0.54	0.46	0.54	0.09	XXX
77022		C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.27	1.46	1.27	1.46	0.28	XXX
77031		A	Stereotact guide for brst bx	1.59	1.70	2.98	NA	NA	0.10	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.20	2.42	NA	NA	0.01	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.50	0.56	0.50	0.56	0.09	XXX
77032		A	Guidance for needle, breast	0.56	0.73	0.95	NA	NA	0.03	XXX
77032	TC	A	Guidance for needle, breast	0.00	0.56	0.75	NA	NA	0.01	XXX
77032	26	A	Guidance for needle, breast	0.56	0.17	0.20	0.17	0.20	0.02	XXX
77051		A	Computer dx mammogram add-on	0.06	0.17	0.24	NA	NA	0.02	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.15	0.22	NA	NA	0.01	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
77052		A	Comp screen mammogram add-on	0.06	0.17	0.24	NA	NA	0.02	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.15	0.22	NA	NA	0.01	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77053		A	X-ray of mammary duct	0.36	1.07	1.50	NA	NA	0.02	XXX
77053	TC	A	X-ray of mammary duct	0.00	0.96	1.37	NA	NA	0.01	XXX
77053	26	A	X-ray of mammary duct	0.36	0.11	0.13	0.11	0.13	0.01	XXX
77054		A	X-ray of mammary ducts	0.45	1.46	2.05	NA	NA	0.03	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.32	1.89	NA	NA	0.01	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.14	0.16	0.14	0.16	0.02	XXX
77055		A	Mammogram, one breast	0.70	1.42	1.55	NA	NA	0.04	XXX
77055	TC	A	Mammogram, one breast	0.00	1.21	1.30	NA	NA	0.01	XXX
77055	26	A	Mammogram, one breast	0.70	0.21	0.25	0.21	0.25	0.03	XXX
77056		A	Mammogram, both breasts	0.87	1.86	2.00	NA	NA	0.05	XXX
77056	TC	A	Mammogram, both breasts	0.00	1.60	1.69	NA	NA	0.01	XXX
77056	26	A	Mammogram, both breasts	0.87	0.26	0.31	0.26	0.31	0.04	XXX
77057		A	Mammogram, screening	0.70	1.26	1.43	NA	NA	0.04	XXX
77057	TC	A	Mammogram, screening	0.00	1.05	1.18	NA	NA	0.01	XXX
77057	26	A	Mammogram, screening	0.70	0.21	0.25	0.21	0.25	0.03	XXX
77058		A	Mri, one breast	1.63	11.36	18.65	NA	NA	0.09	XXX
77058	TC	A	Mri, one breast	0.00	10.87	18.07	NA	NA	0.02	XXX
77058	26	A	Mri, one breast	1.63	0.49	0.58	0.49	0.58	0.07	XXX
77059		A	Mri, both breasts	1.63	11.25	19.75	NA	NA	0.09	XXX
77059	TC	A	Mri, both breasts	0.00	10.76	19.17	NA	NA	0.02	XXX
77059	26	A	Mri, both breasts	1.63	0.49	0.58	0.49	0.58	0.07	XXX
77071		A	X-ray stress view	0.41	0.85	0.69	0.85	0.69	0.05	XXX
77072		A	X-rays for bone age	0.19	0.38	0.42	NA	NA	0.02	XXX
77072	TC	A	X-rays for bone age	0.00	0.32	0.35	NA	NA	0.01	XXX
77072	26	A	X-rays for bone age	0.19	0.06	0.07	0.06	0.07	0.01	XXX
77073		A	X-rays, bone length studies	0.27	0.68	0.71	NA	NA	0.04	XXX
77073	TC	A	X-rays, bone length studies	0.00	0.57	0.61	NA	NA	0.01	XXX
77073	26	A	X-rays, bone length studies	0.27	0.11	0.10	0.11	0.10	0.03	XXX
77074		A	X-rays, bone survey, limited	0.45	1.25	1.36	NA	NA	0.03	XXX
77074	TC	A	X-rays, bone survey, limited	0.00	1.11	1.20	NA	NA	0.01	XXX
77074	26	A	X-rays, bone survey, limited	0.45	0.14	0.16	0.14	0.16	0.02	XXX
77075		A	X-rays, bone survey complete	0.54	1.99	2.11	NA	NA	0.03	XXX
77075	TC	A	X-rays, bone survey complete	0.00	1.82	1.92	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
77075	26	A	X-rays, bone survey complete	0.54	0.17	0.19	0.17	0.19	0.02	XXX
77076		A	X-rays, bone survey, infant	0.70	1.86	1.83	NA	NA	0.04	XXX
77076	TC	A	X-rays, bone survey, infant	0.00	1.65	1.61	NA	NA	0.01	XXX
77076	26	A	X-rays, bone survey, infant	0.70	0.21	0.22	0.21	0.22	0.03	XXX
77077		A	Joint survey, single view	0.31	0.69	0.78	NA	NA	0.04	XXX
77077	TC	A	Joint survey, single view	0.00	0.57	0.66	NA	NA	0.01	XXX
77077	26	A	Joint survey, single view	0.31	0.12	0.12	0.12	0.12	0.03	XXX
77078		A	Ct bone density, axial	0.25	4.22	4.35	NA	NA	0.02	XXX
77078	TC	A	Ct bone density, axial	0.00	4.14	4.26	NA	NA	0.01	XXX
77078	26	A	Ct bone density, axial	0.25	0.08	0.09	0.08	0.09	0.01	XXX
77079		A	Ct bone density, peripheral	0.22	0.78	1.20	NA	NA	0.02	XXX
77079	TC	A	Ct bone density, peripheral	0.00	0.70	1.13	NA	NA	0.01	XXX
77079	26	A	Ct bone density, peripheral	0.22	0.08	0.07	0.08	0.07	0.01	XXX
77080		A	Dxa bone density, axial	0.20	1.02	1.49	NA	NA	0.02	XXX
77080	TC	A	Dxa bone density, axial	0.00	0.95	1.42	NA	NA	0.01	XXX
77080	26	A	Dxa bone density, axial	0.20	0.07	0.07	0.07	0.07	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.47	0.54	NA	NA	0.02	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.39	0.47	NA	NA	0.01	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.08	0.07	0.08	0.07	0.01	XXX
77082		A	Dxa bone density, vert fx	0.17	0.51	0.57	NA	NA	0.02	XXX
77082	TC	A	Dxa bone density, vert fx	0.00	0.45	0.52	NA	NA	0.01	XXX
77082	26	A	Dxa bone density, vert fx	0.17	0.06	0.05	0.06	0.05	0.01	XXX
77083		A	Radiographic absorptiometry	0.20	0.40	0.46	NA	NA	0.02	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.33	0.40	NA	NA	0.01	XXX
77083	26	A	Radiographic absorptiometry	0.20	0.07	0.06	0.07	0.06	0.01	XXX
77084		A	Magnetic image, bone marrow	1.60	13.02	13.82	NA	NA	0.08	XXX
77084	TC	A	Magnetic image, bone marrow	0.00	12.52	13.24	NA	NA	0.01	XXX
77084	26	A	Magnetic image, bone marrow	1.60	0.50	0.58	0.50	0.58	0.07	XXX
77261		A	Radiation therapy planning	1.39	0.61	0.54	0.61	0.54	0.08	XXX
77262		A	Radiation therapy planning	2.11	0.89	0.79	0.89	0.79	0.13	XXX
77263		A	Radiation therapy planning	3.14	1.33	1.17	1.33	1.17	0.19	XXX
77280		A	Set radiation therapy field	0.70	4.12	4.24	NA	NA	0.03	XXX
77280	TC	A	Set radiation therapy field	0.00	3.82	3.98	NA	NA	0.01	XXX
77280	26	A	Set radiation therapy field	0.70	0.30	0.26	0.30	0.26	0.02	XXX
77285		A	Set radiation therapy field	1.05	7.44	7.54	NA	NA	0.04	XXX
77285	TC	A	Set radiation therapy field	0.00	7.00	7.15	NA	NA	0.01	XXX
77285	26	A	Set radiation therapy field	1.05	0.44	0.39	0.44	0.39	0.03	XXX
77290		A	Set radiation therapy field	1.56	12.41	12.03	NA	NA	0.06	XXX
77290	TC	A	Set radiation therapy field	0.00	11.75	11.46	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
77290	26	A	Set radiation therapy field	1.56	0.66	0.57	0.66	0.57	0.05	XXX
77295		A	Set radiation therapy field	4.56	7.34	11.70	NA	NA	0.19	XXX
77295	TC	A	Set radiation therapy field	0.00	5.41	10.03	NA	NA	0.04	XXX
77295	26	A	Set radiation therapy field	4.56	1.93	1.67	1.93	1.67	0.15	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.15	1.26	NA	NA	0.03	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.89	1.03	NA	NA	0.01	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.26	0.23	0.26	0.23	0.02	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	53.19	51.60	NA	NA	0.45	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	49.83	48.67	NA	NA	0.18	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	3.36	2.93	3.36	2.93	0.27	XXX
77305		A	Teletx isodose plan simple	0.70	0.90	1.15	NA	NA	0.03	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.61	0.89	NA	NA	0.01	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.29	0.26	0.29	0.26	0.02	XXX
77310		A	Teletx isodose plan intermed	1.05	1.26	1.55	NA	NA	0.05	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.82	1.16	NA	NA	0.01	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.44	0.39	0.44	0.39	0.04	XXX
77315		A	Teletx isodose plan complex	1.56	2.09	2.32	NA	NA	0.06	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.43	1.75	NA	NA	0.01	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.66	0.57	0.66	0.57	0.05	XXX
77321		A	Special teletx port plan	0.95	1.49	2.07	NA	NA	0.04	XXX
77321	TC	A	Special teletx port plan	0.00	1.09	1.72	NA	NA	0.01	XXX
77321	26	A	Special teletx port plan	0.95	0.40	0.35	0.40	0.35	0.03	XXX
77326		A	Brachytx isodose calc simp	0.93	2.83	2.90	NA	NA	0.05	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.44	2.56	NA	NA	0.02	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.39	0.34	0.39	0.34	0.03	XXX
77327		A	Brachytx isodose calc interm	1.39	3.90	4.04	NA	NA	0.08	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.31	3.53	NA	NA	0.03	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.59	0.51	0.59	0.51	0.05	XXX
77328		A	Brachytx isodose plan compl	2.09	5.01	5.31	NA	NA	0.10	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.13	4.54	NA	NA	0.03	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.88	0.77	0.88	0.77	0.07	XXX
77331		A	Special radiation dosimetry	0.87	0.84	0.82	NA	NA	0.04	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.47	0.50	NA	NA	0.01	XXX
77331	26	A	Special radiation dosimetry	0.87	0.37	0.32	0.37	0.32	0.03	XXX
77332		A	Radiation treatment aid(s)	0.54	1.48	1.54	NA	NA	0.03	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.25	1.34	NA	NA	0.01	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.23	0.20	0.23	0.20	0.02	XXX
77333		A	Radiation treatment aid(s)	0.84	0.58	0.86	NA	NA	0.04	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.22	0.55	NA	NA	0.01	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.36	0.31	0.36	0.31	0.03	XXX
77334		A	Radiation treatment aid(s)	1.24	2.62	2.90	NA	NA	0.05	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.10	2.45	NA	NA	0.01	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.52	0.45	0.52	0.45	0.04	XXX
77336		A	Radiation physics consult	0.00	1.04	1.47	NA	NA	0.01	XXX
77338		A	Design mlc device for imrt	4.29	8.79	8.79	NA	NA	0.15	XXX
77338	TC	A	Design mlc device for imrt	0.00	6.98	6.98	NA	NA	0.01	XXX
77338	26	A	Design mlc device for imrt	4.29	1.81	1.81	1.81	1.81	0.14	XXX
77370		A	Radiation physics consult	0.00	2.77	3.06	NA	NA	0.04	XXX
77371		C	Srs, multisource	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77372		A	Srs, linear based	0.00	20.84	22.30	NA	NA	0.05	XXX
77373		A	Sbrt delivery	0.00	38.80	41.42	NA	NA	0.06	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	0.42	0.71	NA	NA	0.01	XXX
77402		A	Radiation treatment delivery	0.00	3.83	3.76	NA	NA	0.01	XXX
77403		A	Radiation treatment delivery	0.00	3.41	3.31	NA	NA	0.01	XXX
77404		A	Radiation treatment delivery	0.00	3.83	3.67	NA	NA	0.01	XXX
77406		A	Radiation treatment delivery	0.00	3.89	3.70	NA	NA	0.01	XXX
77407		A	Radiation treatment delivery	0.00	6.79	6.12	NA	NA	0.01	XXX
77408		A	Radiation treatment delivery	0.00	4.70	4.48	NA	NA	0.01	XXX
77409		A	Radiation treatment delivery	0.00	5.25	4.96	NA	NA	0.01	XXX
77411		A	Radiation treatment delivery	0.00	5.25	4.94	NA	NA	0.01	XXX
77412		A	Radiation treatment delivery	0.00	6.20	5.82	NA	NA	0.01	XXX
77413		A	Radiation treatment delivery	0.00	6.24	5.86	NA	NA	0.01	XXX
77414		A	Radiation treatment delivery	0.00	7.02	6.54	NA	NA	0.01	XXX
77416		A	Radiation treatment delivery	0.00	7.05	6.57	NA	NA	0.01	XXX
77417		A	Radiology port film(s)	0.00	0.33	0.40	NA	NA	0.01	XXX
77418		A	Radiation tx delivery, imrt	0.00	12.00	13.88	NA	NA	0.01	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.22	2.57	NA	NA	0.02	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	2.06	2.43	NA	NA	0.01	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.16	0.14	0.16	0.14	0.01	XXX
77422		A	Neutron beam tx, simple	0.00	6.17	5.57	NA	NA	0.01	XXX
77423		A	Neutron beam tx, complex	0.00	6.81	6.33	NA	NA	0.02	XXX
77427		A	Radiation tx management, x5	3.70	1.72	1.47	1.72	1.47	0.22	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
77431		A	Radiation therapy management	1.81	0.93	0.82	0.93	0.82	0.11	XXX
77432		A	Stereotactic radiation trmt	7.92	3.37	2.98	3.37	2.98	0.47	XXX
77435		A	Sbrt management	13.00	5.80	5.10	NA	NA	0.77	XXX
77470		A	Special radiation treatment	2.09	2.01	3.88	NA	NA	0.08	XXX
77470	TC	A	Special radiation treatment	0.00	1.13	3.11	NA	NA	0.01	XXX
77470	26	A	Special radiation treatment	2.09	0.88	0.77	0.88	0.77	0.07	XXX
77499		C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520		C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment, complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	9.50	8.83	NA	NA	0.08	XXX
77600	TC	R	Hyperthermia treatment	0.00	8.83	8.26	NA	NA	0.03	XXX
77600	26	R	Hyperthermia treatment	1.56	0.67	0.57	0.67	0.57	0.05	XXX
77605		R	Hyperthermia treatment	2.09	25.93	18.63	NA	NA	0.28	XXX
77605	TC	R	Hyperthermia treatment	0.00	25.16	17.98	NA	NA	0.01	XXX
77605	26	R	Hyperthermia treatment	2.09	0.77	0.65	0.77	0.65	0.27	XXX
77610		R	Hyperthermia treatment	1.56	15.49	15.56	NA	NA	0.08	XXX
77610	TC	R	Hyperthermia treatment	0.00	14.83	15.03	NA	NA	0.03	XXX
77610	26	R	Hyperthermia treatment	1.56	0.66	0.53	0.66	0.53	0.05	XXX
77615		R	Hyperthermia treatment	2.09	23.94	22.62	NA	NA	0.14	XXX
77615	TC	R	Hyperthermia treatment	0.00	23.05	21.86	NA	NA	0.07	XXX
77615	26	R	Hyperthermia treatment	2.09	0.89	0.76	0.89	0.76	0.07	XXX
77620		R	Hyperthermia treatment	1.56	12.28	9.85	NA	NA	0.06	XXX
77620	TC	R	Hyperthermia treatment	0.00	11.71	9.35	NA	NA	0.03	XXX
77620	26	R	Hyperthermia treatment	1.56	0.57	0.50	0.57	0.50	0.03	XXX
77750		A	Infuse radioactive materials	5.00	4.78	4.37	NA	NA	0.20	090
77750	TC	A	Infuse radioactive materials	0.00	2.66	2.55	NA	NA	0.03	090
77750	26	A	Infuse radioactive materials	5.00	2.12	1.82	2.12	1.82	0.17	090
77761		A	Apply intrcav radiat simple	3.85	6.15	5.83	NA	NA	0.17	090
77761	TC	A	Apply intrcav radiat simple	0.00	4.60	4.47	NA	NA	0.04	090
77761	26	A	Apply intrcav radiat simple	3.85	1.55	1.36	1.55	1.36	0.13	090
77762		A	Apply intrcav radiat interm	5.76	7.68	7.35	NA	NA	0.24	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.27	5.25	NA	NA	0.05	090
77762	26	A	Apply intrcav radiat interm	5.76	2.41	2.10	2.41	2.10	0.19	090
77763		A	Apply intrcav radiat compl	8.66	10.40	9.92	NA	NA	0.35	090
77763	TC	A	Apply intrcav radiat compl	0.00	6.83	6.78	NA	NA	0.06	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
77763	26	A	Apply intrcav radiat compl	8.66	3.57	3.14	3.57	3.14	0.29	090
77776		A	Apply interstit radiat simpl	4.70	6.61	6.45	NA	NA	0.26	090
77776	TC	A	Apply interstit radiat simpl	0.00	4.84	4.81	NA	NA	0.05	090
77776	26	A	Apply interstit radiat simpl	4.70	1.77	1.64	1.77	1.64	0.21	090
77777		A	Apply interstit radiat inter	7.52	7.91	7.97	NA	NA	0.38	090
77777	TC	A	Apply interstit radiat inter	0.00	4.99	5.19	NA	NA	0.05	090
77777	26	A	Apply interstit radiat inter	7.52	2.92	2.78	2.92	2.78	0.33	090
77778		A	Apply interstit radiat compl	11.32	11.62	11.12	NA	NA	0.46	090
77778	TC	A	Apply interstit radiat compl	0.00	6.91	6.99	NA	NA	0.07	090
77778	26	A	Apply interstit radiat compl	11.32	4.71	4.13	4.71	4.13	0.39	090
77785		A	Hdr brachytx, 1 channel	1.42	3.43	3.58	NA	NA	0.04	XXX
77785	TC	A	Hdr brachytx, 1 channel	0.00	2.83	3.05	NA	NA	0.01	XXX
77785	26	A	Hdr brachytx, 1 channel	1.42	0.60	0.53	0.60	0.53	0.03	XXX
77786		A	Hdr brachytx, 2-12 channel	3.25	7.99	10.99	NA	NA	0.11	XXX
77786	TC	A	Hdr brachytx, 2-12 channel	0.00	6.61	9.85	NA	NA	0.03	XXX
77786	26	A	Hdr brachytx, 2-12 channel	3.25	1.38	1.14	1.38	1.14	0.08	XXX
77787		A	Hdr brachytx over 12 chan	4.89	13.99	16.83	NA	NA	0.19	XXX
77787	TC	A	Hdr brachytx over 12 chan	0.00	11.91	15.00	NA	NA	0.07	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	2.08	1.83	2.08	1.83	0.12	XXX
77789		A	Apply surface radiation	1.14	1.97	1.78	NA	NA	0.05	000
77789	TC	A	Apply surface radiation	0.00	1.46	1.35	NA	NA	0.01	000
77789	26	A	Apply surface radiation	1.14	0.51	0.43	0.51	0.43	0.04	000
77790		A	Radiation handling	1.05	1.46	1.37	NA	NA	0.04	XXX
77790	TC	A	Radiation handling	0.00	1.02	0.98	NA	NA	0.01	XXX
77790	26	A	Radiation handling	1.05	0.44	0.39	0.44	0.39	0.03	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78000		A	Thyroid, single uptake	0.19	1.50	1.63	NA	NA	0.03	XXX
78000	TC	A	Thyroid, single uptake	0.00	1.45	1.56	NA	NA	0.02	XXX
78000	26	A	Thyroid, single uptake	0.19	0.05	0.07	0.05	0.07	0.01	XXX
78001		A	Thyroid, multiple uptakes	0.26	1.92	2.07	NA	NA	0.03	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.85	1.97	NA	NA	0.02	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.07	0.10	0.07	0.10	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.62	1.71	NA	NA	0.03	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.52	1.59	NA	NA	0.02	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.10	0.12	0.10	0.12	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	5.32	5.38	NA	NA	0.05	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	5.18	5.21	NA	NA	0.03	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
78006	26	A	Thyroid imaging with uptake	0.49	0.14	0.17	0.14	0.17	0.02	XXX
78007		A	Thyroid image, mult uptakes	0.50	2.53	2.91	NA	NA	0.05	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.39	2.73	NA	NA	0.03	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.14	0.18	0.14	0.18	0.02	XXX
78010		A	Thyroid imaging	0.39	3.59	3.66	NA	NA	0.03	XXX
78010	TC	A	Thyroid imaging	0.00	3.48	3.53	NA	NA	0.02	XXX
78010	26	A	Thyroid imaging	0.39	0.11	0.13	0.11	0.13	0.01	XXX
78011		A	Thyroid imaging with flow	0.45	3.82	4.10	NA	NA	0.03	XXX
78011	TC	A	Thyroid imaging with flow	0.00	3.69	3.94	NA	NA	0.02	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.13	0.16	0.13	0.16	0.01	XXX
78015		A	Thyroid met imaging	0.67	4.49	4.75	NA	NA	0.05	XXX
78015	TC	A	Thyroid met imaging	0.00	4.32	4.52	NA	NA	0.02	XXX
78015	26	A	Thyroid met imaging	0.67	0.17	0.23	0.17	0.23	0.03	XXX
78016		A	Thyroid met imaging/studies	0.82	6.04	7.21	NA	NA	0.04	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	5.93	6.94	NA	NA	0.03	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.11	0.27	0.11	0.27	0.01	XXX
78018		A	Thyroid met imaging, body	0.86	6.65	7.32	NA	NA	0.06	XXX
78018	TC	A	Thyroid met imaging, body	0.00	6.43	7.02	NA	NA	0.03	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.22	0.30	0.22	0.30	0.03	XXX
78020		A	Thyroid met uptake	0.60	1.40	1.70	NA	NA	0.03	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.26	1.49	NA	NA	0.01	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.14	0.21	0.14	0.21	0.02	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	2.86	3.59	NA	NA	0.06	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	2.63	3.30	NA	NA	0.03	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.23	0.29	0.23	0.29	0.03	XXX
78075		A	Adrenal nuclear imaging	0.74	9.46	10.07	NA	NA	0.07	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	9.28	9.81	NA	NA	0.04	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.18	0.26	0.18	0.26	0.03	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	3.44	3.70	NA	NA	0.04	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	3.30	3.50	NA	NA	0.02	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.14	0.20	0.14	0.20	0.02	XXX
78103		A	Bone marrow imaging, mult	0.75	4.50	4.92	NA	NA	0.05	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	4.31	4.66	NA	NA	0.02	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.19	0.26	0.19	0.26	0.03	XXX
78104		A	Bone marrow imaging, body	0.80	5.11	5.66	NA	NA	0.05	XXX
78104	TC	A	Bone marrow imaging, body	0.00	4.90	5.37	NA	NA	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
78104	26	A	Bone marrow imaging, body	0.80	0.21	0.29	0.21	0.29	0.03	XXX
78110		A	Plasma volume, single	0.19	1.84	1.87	NA	NA	0.03	XXX
78110	TC	A	Plasma volume, single	0.00	1.78	1.80	NA	NA	0.02	XXX
78110	26	A	Plasma volume, single	0.19	0.06	0.07	0.06	0.07	0.01	XXX
78111		A	Plasma volume, multiple	0.22	1.52	2.17	NA	NA	0.03	XXX
78111	TC	A	Plasma volume, multiple	0.00	1.48	2.09	NA	NA	0.02	XXX
78111	26	A	Plasma volume, multiple	0.22	0.04	0.08	0.04	0.08	0.01	XXX
78120		A	Red cell mass, single	0.23	1.67	1.98	NA	NA	0.03	XXX
78120	TC	A	Red cell mass, single	0.00	1.61	1.90	NA	NA	0.02	XXX
78120	26	A	Red cell mass, single	0.23	0.06	0.08	0.06	0.08	0.01	XXX
78121		A	Red cell mass, multiple	0.32	1.42	2.22	NA	NA	0.03	XXX
78121	TC	A	Red cell mass, multiple	0.00	1.38	2.12	NA	NA	0.02	XXX
78121	26	A	Red cell mass, multiple	0.32	0.04	0.10	0.04	0.10	0.01	XXX
78122		A	Blood volume	0.45	1.72	2.67	NA	NA	0.03	XXX
78122	TC	A	Blood volume	0.00	1.62	2.51	NA	NA	0.02	XXX
78122	26	A	Blood volume	0.45	0.10	0.16	0.10	0.16	0.01	XXX
78130		A	Red cell survival study	0.61	3.00	3.37	NA	NA	0.06	XXX
78130	TC	A	Red cell survival study	0.00	2.81	3.15	NA	NA	0.03	XXX
78130	26	A	Red cell survival study	0.61	0.19	0.22	0.19	0.22	0.03	XXX
78135		A	Red cell survival kinetics	0.64	7.72	7.92	NA	NA	0.06	XXX
78135	TC	A	Red cell survival kinetics	0.00	7.52	7.69	NA	NA	0.03	XXX
78135	26	A	Red cell survival kinetics	0.64	0.20	0.23	0.20	0.23	0.03	XXX
78140		A	Red cell sequestration	0.61	2.42	3.08	NA	NA	0.05	XXX
78140	TC	A	Red cell sequestration	0.00	2.24	2.86	NA	NA	0.02	XXX
78140	26	A	Red cell sequestration	0.61	0.18	0.22	0.18	0.22	0.03	XXX
78185		A	Spleen imaging	0.40	4.48	4.60	NA	NA	0.03	XXX
78185	TC	A	Spleen imaging	0.00	4.37	4.46	NA	NA	0.02	XXX
78185	26	A	Spleen imaging	0.40	0.11	0.14	0.11	0.14	0.01	XXX
78190		A	Platelet survival, kinetics	1.09	9.03	8.81	NA	NA	0.06	XXX
78190	TC	A	Platelet survival, kinetics	0.00	8.63	8.43	NA	NA	0.03	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.40	0.38	0.40	0.38	0.03	XXX
78191		A	Platelet survival	0.61	2.98	4.18	NA	NA	0.06	XXX
78191	TC	A	Platelet survival	0.00	2.79	3.97	NA	NA	0.03	XXX
78191	26	A	Platelet survival	0.61	0.19	0.21	0.19	0.21	0.03	XXX
78195		A	Lymph system imaging	1.20	7.45	7.71	NA	NA	0.08	XXX
78195	TC	A	Lymph system imaging	0.00	7.12	7.28	NA	NA	0.03	XXX
78195	26	A	Lymph system imaging	1.20	0.33	0.43	0.33	0.43	0.05	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	4.21	4.21	NA	NA	0.05	XXX
78201	TC	A	Liver imaging	0.00	4.09	4.06	NA	NA	0.02	XXX
78201	26	A	Liver imaging	0.44	0.12	0.15	0.12	0.15	0.03	XXX
78202		A	Liver imaging with flow	0.51	4.29	4.72	NA	NA	0.03	XXX
78202	TC	A	Liver imaging with flow	0.00	4.17	4.55	NA	NA	0.02	XXX
78202	26	A	Liver imaging with flow	0.51	0.12	0.17	0.12	0.17	0.01	XXX
78205		A	Liver imaging (3D)	0.71	4.42	5.30	NA	NA	0.05	XXX
78205	TC	A	Liver imaging (3D)	0.00	4.23	5.05	NA	NA	0.02	XXX
78205	26	A	Liver imaging (3D)	0.71	0.19	0.25	0.19	0.25	0.03	XXX
78206		A	Liver image (3d) with flow	0.96	7.47	7.97	NA	NA	0.06	XXX
78206	TC	A	Liver image (3d) with flow	0.00	7.20	7.63	NA	NA	0.03	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.27	0.34	0.27	0.34	0.03	XXX
78215		A	Liver and spleen imaging	0.49	4.10	4.37	NA	NA	0.04	XXX
78215	TC	A	Liver and spleen imaging	0.00	3.96	4.20	NA	NA	0.02	XXX
78215	26	A	Liver and spleen imaging	0.49	0.14	0.17	0.14	0.17	0.02	XXX
78216		A	Liver & spleen image/flow	0.57	2.34	2.92	NA	NA	0.04	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.18	2.72	NA	NA	0.02	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.16	0.20	0.16	0.20	0.02	XXX
78220		A	Liver function study	0.49	2.54	3.14	NA	NA	0.04	XXX
78220	TC	A	Liver function study	0.00	2.40	2.97	NA	NA	0.03	XXX
78220	26	A	Liver function study	0.49	0.14	0.17	0.14	0.17	0.01	XXX
78223		A	Hepatobiliary imaging	0.84	7.33	7.45	NA	NA	0.06	XXX
78223	TC	A	Hepatobiliary imaging	0.00	7.09	7.15	NA	NA	0.03	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.24	0.30	0.24	0.30	0.03	XXX
78230		A	Salivary gland imaging	0.45	3.60	3.72	NA	NA	0.04	XXX
78230	TC	A	Salivary gland imaging	0.00	3.46	3.56	NA	NA	0.02	XXX
78230	26	A	Salivary gland imaging	0.45	0.14	0.16	0.14	0.16	0.02	XXX
78231		A	Serial salivary imaging	0.52	2.39	2.86	NA	NA	0.03	XXX
78231	TC	A	Serial salivary imaging	0.00	2.23	2.68	NA	NA	0.02	XXX
78231	26	A	Serial salivary imaging	0.52	0.16	0.18	0.16	0.18	0.01	XXX
78232		A	Salivary gland function exam	0.47	1.83	2.80	NA	NA	0.04	XXX
78232	TC	A	Salivary gland function exam	0.00	1.76	2.65	NA	NA	0.02	XXX
78232	26	A	Salivary gland function exam	0.47	0.07	0.15	0.07	0.15	0.02	XXX
78258		A	Esophageal motility study	0.74	5.12	5.14	NA	NA	0.04	XXX
78258	TC	A	Esophageal motility study	0.00	4.88	4.86	NA	NA	0.02	XXX
78258	26	A	Esophageal motility study	0.74	0.24	0.28	0.24	0.28	0.02	XXX
78261		A	Gastric mucosa imaging	0.69	5.29	5.65	NA	NA	0.05	XXX
78261	TC	A	Gastric mucosa imaging	0.00	5.08	5.40	NA	NA	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
78261	26	A	Gastric mucosa imaging	0.69	0.21	0.25	0.21	0.25	0.03	XXX
78262		A	Gastroesophageal reflux exam	0.68	5.23	5.58	NA	NA	0.03	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.04	5.35	NA	NA	0.02	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.19	0.23	0.19	0.23	0.01	XXX
78264		A	Gastric emptying study	0.78	6.11	6.47	NA	NA	0.06	XXX
78264	TC	A	Gastric emptying study	0.00	5.89	6.19	NA	NA	0.03	XXX
78264	26	A	Gastric emptying study	0.78	0.22	0.28	0.22	0.28	0.03	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78268		X	Breath test analysis, c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit B-12 absorption exam	0.20	1.70	1.86	NA	NA	0.03	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.64	1.79	NA	NA	0.02	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.06	0.07	0.06	0.07	0.01	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	2.00	1.94	NA	NA	0.03	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.93	1.88	NA	NA	0.02	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.06	0.07	0.06	0.01	XXX
78272		A	Vit B-12 absorp, combined	0.27	1.83	2.06	NA	NA	0.03	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	1.75	1.98	NA	NA	0.02	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.08	0.08	0.08	0.08	0.01	XXX
78278		A	Acute GI blood loss imaging	0.99	7.37	7.76	NA	NA	0.07	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	7.09	7.41	NA	NA	0.03	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.28	0.35	0.28	0.35	0.04	XXX
78282		C	GI protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.11	0.14	0.11	0.14	0.03	XXX
78290		A	Meckels divert exam	0.68	7.29	7.32	NA	NA	0.06	XXX
78290	TC	A	Meckels divert exam	0.00	7.10	7.07	NA	NA	0.03	XXX
78290	26	A	Meckels divert exam	0.68	0.19	0.25	0.19	0.25	0.03	XXX
78291		A	Leveen/shunt patency exam	0.88	5.28	5.51	NA	NA	0.06	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.04	5.20	NA	NA	0.02	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.24	0.31	0.24	0.31	0.04	XXX
78299		C	GI nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging, limited area	0.62	3.66	3.84	NA	NA	0.04	XXX
78300	TC	A	Bone imaging, limited area	0.00	3.47	3.62	NA	NA	0.02	XXX
78300	26	A	Bone imaging, limited area	0.62	0.19	0.22	0.19	0.22	0.02	XXX
78305		A	Bone imaging, multiple areas	0.83	4.77	5.08	NA	NA	0.05	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	4.53	4.79	NA	NA	0.02	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.24	0.29	0.24	0.29	0.03	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
78306		A	Bone imaging, whole body	0.86	5.16	5.64	NA	NA	0.05	XXX
78306	TC	A	Bone imaging, whole body	0.00	4.92	5.33	NA	NA	0.02	XXX
78306	26	A	Bone imaging, whole body	0.86	0.24	0.31	0.24	0.31	0.03	XXX
78315		A	Bone imaging, 3 phase	1.02	7.34	7.73	NA	NA	0.07	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	7.05	7.37	NA	NA	0.03	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.29	0.36	0.29	0.36	0.04	XXX
78320		A	Bone imaging (3D)	1.04	4.48	5.41	NA	NA	0.06	XXX
78320	TC	A	Bone imaging (3D)	0.00	4.20	5.04	NA	NA	0.02	XXX
78320	26	A	Bone imaging (3D)	1.04	0.28	0.37	0.28	0.37	0.04	XXX
78350		N	Bone mineral, single photon	0.22	0.58	0.64	NA	NA	0.02	XXX
78350	TC	N	Bone mineral, single photon	0.00	0.50	0.57	NA	NA	0.01	XXX
78350	26	N	Bone mineral, single photon	0.22	0.08	0.07	0.08	0.07	0.01	XXX
78351		N	Bone mineral, dual photon	0.30	0.11	0.11	0.11	0.11	0.02	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.17	0.14	0.17	0.14	0.02	XXX
78428		A	Cardiac shunt imaging	0.78	3.94	4.35	NA	NA	0.04	XXX
78428	TC	A	Cardiac shunt imaging	0.00	3.73	4.04	NA	NA	0.02	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.21	0.31	0.21	0.31	0.02	XXX
78445		A	Vascular flow imaging	0.49	3.64	3.87	NA	NA	0.03	XXX
78445	TC	A	Vascular flow imaging	0.00	3.52	3.70	NA	NA	0.02	XXX
78445	26	A	Vascular flow imaging	0.49	0.12	0.17	0.12	0.17	0.01	XXX
78451		A	Ht muscle image spect, sing	1.38	4.73	4.73	NA	NA	0.05	XXX
78451	TC	A	Ht muscle image spect, sing	0.00	4.30	4.30	NA	NA	0.01	XXX
78451	26	A	Ht muscle image spect, sing	1.38	0.43	0.43	0.43	0.43	0.04	XXX
78452		A	Ht muscle image spect, mult	1.62	8.84	8.84	NA	NA	0.06	XXX
78452	TC	A	Ht muscle image spect, mult	0.00	8.32	8.32	NA	NA	0.01	XXX
78452	26	A	Ht muscle image spect, mult	1.62	0.52	0.52	0.52	0.52	0.05	XXX
78453		A	Ht muscle image,planar,sing	1.00	4.32	4.32	NA	NA	0.04	XXX
78453	TC	A	Ht muscle image,planar,sing	0.00	4.01	4.01	NA	NA	0.01	XXX
78453	26	A	Ht muscle image,planar,sing	1.00	0.31	0.31	0.31	0.31	0.03	XXX
78454		A	Ht musc image, planar, mult	1.34	3.77	3.77	NA	NA	0.05	XXX
78454	TC	A	Ht musc image, planar, mult	0.00	3.37	3.37	NA	NA	0.01	XXX
78454	26	A	Ht musc image, planar, mult	1.34	0.40	0.40	0.40	0.40	0.04	XXX
78456		A	Acute venous thrombus image	1.00	7.12	8.04	NA	NA	0.05	XXX
78456	TC	A	Acute venous thrombus image	0.00	6.79	7.60	NA	NA	0.03	XXX
78456	26	A	Acute venous thrombus image	1.00	0.33	0.44	0.33	0.44	0.02	XXX
78457		A	Venous thrombosis imaging	0.77	4.00	4.23	NA	NA	0.04	XXX
78457	TC	A	Venous thrombosis imaging	0.00	3.77	3.96	NA	NA	0.01	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.23	0.27	0.23	0.27	0.03	XXX
78458		A	Ven thrombosis images, bilat	0.90	3.58	4.38	NA	NA	0.06	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	3.38	4.07	NA	NA	0.02	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.20	0.31	0.20	0.31	0.04	XXX
78459		C	Heart muscle imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	26	A	Heart muscle imaging (PET)	1.50	0.37	0.59	0.37	0.59	0.08	XXX
78466		A	Heart infarct image	0.69	3.54	4.00	NA	NA	0.04	XXX
78466	TC	A	Heart infarct image	0.00	3.33	3.72	NA	NA	0.02	XXX
78466	26	A	Heart infarct image	0.69	0.21	0.28	0.21	0.28	0.02	XXX
78468		A	Heart infarct image (ef)	0.80	4.20	5.03	NA	NA	0.04	XXX
78468	TC	A	Heart infarct image (ef)	0.00	3.94	4.68	NA	NA	0.02	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.26	0.35	0.26	0.35	0.02	XXX
78469		A	Heart infarct image (3D)	0.92	4.98	5.72	NA	NA	0.04	XXX
78469	TC	A	Heart infarct image (3D)	0.00	4.67	5.34	NA	NA	0.02	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.38	0.31	0.38	0.02	XXX
78472		A	Gated heart, planar, single	0.98	4.71	5.69	NA	NA	0.05	XXX
78472	TC	A	Gated heart, planar, single	0.00	4.42	5.30	NA	NA	0.02	XXX
78472	26	A	Gated heart, planar, single	0.98	0.29	0.39	0.29	0.39	0.03	XXX
78473		A	Gated heart, multiple	1.47	5.91	7.53	NA	NA	0.06	XXX
78473	TC	A	Gated heart, multiple	0.00	5.45	6.92	NA	NA	0.03	XXX
78473	26	A	Gated heart, multiple	1.47	0.46	0.61	0.46	0.61	0.03	XXX
78481		A	Heart first pass, single	0.98	3.61	4.76	NA	NA	0.04	XXX
78481	TC	A	Heart first pass, single	0.00	3.28	4.32	NA	NA	0.02	XXX
78481	26	A	Heart first pass, single	0.98	0.33	0.44	0.33	0.44	0.02	XXX
78483		A	Heart first pass, multiple	1.47	4.76	6.57	NA	NA	0.05	XXX
78483	TC	A	Heart first pass, multiple	0.00	4.28	5.89	NA	NA	0.02	XXX
78483	26	A	Heart first pass, multiple	1.47	0.48	0.68	0.48	0.68	0.03	XXX
78491		C	Heart image (pet), single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	TC	C	Heart image (pet), single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	26	A	Heart image (pet), single	1.50	0.42	0.62	0.42	0.62	0.08	XXX
78492		C	Heart image (pet), multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	TC	C	Heart image (pet), multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	26	A	Heart image (pet), multiple	1.87	0.54	0.80	0.54	0.80	0.09	XXX
78494		A	Heart image, spect	1.19	4.75	6.03	NA	NA	0.05	XXX
78494	TC	A	Heart image, spect	0.00	4.35	5.54	NA	NA	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
78494	26	A	Heart image, spect	1.19	0.40	0.49	0.40	0.49	0.03	XXX
78496		A	Heart first pass add-on	0.50	0.63	2.05	NA	NA	0.02	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.47	1.83	NA	NA	0.01	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.16	0.22	0.16	0.22	0.01	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	4.29	4.71	NA	NA	0.04	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.08	4.44	NA	NA	0.02	XXX
78580	26	A	Lung perfusion imaging	0.74	0.21	0.27	0.21	0.27	0.02	XXX
78584		A	Lung V/Q image single breath	0.99	2.52	3.04	NA	NA	0.06	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.23	2.68	NA	NA	0.02	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.29	0.36	0.29	0.36	0.04	XXX
78585		A	Lung V/Q imaging	1.09	7.36	7.93	NA	NA	0.06	XXX
78585	TC	A	Lung V/Q imaging	0.00	7.06	7.54	NA	NA	0.03	XXX
78585	26	A	Lung V/Q imaging	1.09	0.30	0.39	0.30	0.39	0.03	XXX
78586		A	Aerosol lung image, single	0.40	3.60	3.79	NA	NA	0.03	XXX
78586	TC	A	Aerosol lung image, single	0.00	3.48	3.65	NA	NA	0.02	XXX
78586	26	A	Aerosol lung image, single	0.40	0.12	0.14	0.12	0.14	0.01	XXX
78587		A	Aerosol lung image, multiple	0.49	4.52	4.81	NA	NA	0.03	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	4.39	4.63	NA	NA	0.02	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.13	0.18	0.13	0.18	0.01	XXX
78588		A	Perfusion lung image	1.09	7.43	7.50	NA	NA	0.07	XXX
78588	TC	A	Perfusion lung image	0.00	7.12	7.11	NA	NA	0.03	XXX
78588	26	A	Perfusion lung image	1.09	0.31	0.39	0.31	0.39	0.04	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	3.59	3.84	NA	NA	0.03	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	3.47	3.70	NA	NA	0.02	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.12	0.14	0.12	0.14	0.01	XXX
78593		A	Vent image, 1 proj, gas	0.49	4.12	4.48	NA	NA	0.04	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	3.98	4.31	NA	NA	0.02	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.14	0.17	0.14	0.17	0.02	XXX
78594		A	Vent image, mult proj, gas	0.53	4.37	5.14	NA	NA	0.04	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.24	4.95	NA	NA	0.02	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.13	0.19	0.13	0.19	0.02	XXX
78596		A	Lung differential function	1.27	7.57	8.33	NA	NA	0.06	XXX
78596	TC	A	Lung differential function	0.00	7.22	7.91	NA	NA	0.03	XXX
78596	26	A	Lung differential function	1.27	0.35	0.42	0.35	0.42	0.03	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain image < 4 views	0.44	3.86	4.12	NA	NA	0.03	XXX
78600	TC	A	Brain image < 4 views	0.00	3.73	3.96	NA	NA	0.02	XXX
78600	26	A	Brain image < 4 views	0.44	0.13	0.16	0.13	0.16	0.01	XXX
78601		A	Brain image w/flow < 4 views	0.51	4.53	4.90	NA	NA	0.04	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	4.39	4.72	NA	NA	0.02	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.14	0.18	0.14	0.18	0.02	XXX
78605		A	Brain image 4+ views	0.53	4.11	4.50	NA	NA	0.04	XXX
78605	TC	A	Brain image 4+ views	0.00	3.96	4.30	NA	NA	0.02	XXX
78605	26	A	Brain image 4+ views	0.53	0.15	0.20	0.15	0.20	0.02	XXX
78606		A	Brain image w/flow 4 + views	0.64	7.54	7.51	NA	NA	0.04	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	7.35	7.28	NA	NA	0.03	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.19	0.23	0.19	0.23	0.01	XXX
78607		A	Brain imaging (3D)	1.23	7.25	8.14	NA	NA	0.06	XXX
78607	TC	A	Brain imaging (3D)	0.00	6.94	7.71	NA	NA	0.03	XXX
78607	26	A	Brain imaging (3D)	1.23	0.31	0.43	0.31	0.43	0.03	XXX
78608		C	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	TC	C	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	26	A	Brain imaging (PET)	1.50	0.39	0.53	0.39	0.53	0.09	XXX
78609		N	Brain imaging (PET)	1.50	0.55	0.51	NA	NA	0.08	XXX
78609	TC	N	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78609	26	N	Brain imaging (PET)	1.50	0.55	0.51	0.55	0.51	0.08	XXX
78610		A	Brain flow imaging only	0.30	3.77	4.27	NA	NA	0.03	XXX
78610	TC	A	Brain flow imaging only	0.00	3.69	4.15	NA	NA	0.02	XXX
78610	26	A	Brain flow imaging only	0.30	0.08	0.12	0.08	0.12	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	7.44	7.81	NA	NA	0.05	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	7.25	7.56	NA	NA	0.03	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.19	0.25	0.19	0.25	0.02	XXX
78635		A	CSF ventriculography	0.61	7.44	7.35	NA	NA	0.04	XXX
78635	TC	A	CSF ventriculography	0.00	7.26	7.12	NA	NA	0.03	XXX
78635	26	A	CSF ventriculography	0.61	0.18	0.23	0.18	0.23	0.01	XXX
78645		A	CSF shunt evaluation	0.57	7.15	7.36	NA	NA	0.05	XXX
78645	TC	A	CSF shunt evaluation	0.00	7.00	7.15	NA	NA	0.03	XXX
78645	26	A	CSF shunt evaluation	0.57	0.15	0.21	0.15	0.21	0.02	XXX
78647		A	Cerebrospinal fluid scan	0.90	5.87	7.58	NA	NA	0.07	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	5.75	7.30	NA	NA	0.03	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.12	0.28	0.12	0.28	0.04	XXX
78650		A	CSF leakage imaging	0.61	7.22	7.66	NA	NA	0.06	XXX
78650	TC	A	CSF leakage imaging	0.00	7.06	7.44	NA	NA	0.03	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
78650	26	A	CSF leakage imaging	0.61	0.16	0.22	0.16	0.22	0.03	XXX
78660		A	Nuclear exam of tear flow	0.53	3.77	3.84	NA	NA	0.04	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	3.60	3.64	NA	NA	0.02	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.17	0.20	0.17	0.20	0.02	XXX
78699		C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging, morphol	0.45	3.63	4.02	NA	NA	0.04	XXX
78700	TC	A	Kidney imaging, morphol	0.00	3.50	3.86	NA	NA	0.02	XXX
78700	26	A	Kidney imaging, morphol	0.45	0.13	0.16	0.13	0.16	0.02	XXX
78701		A	Kidney imaging with flow	0.49	4.61	4.92	NA	NA	0.04	XXX
78701	TC	A	Kidney imaging with flow	0.00	4.47	4.75	NA	NA	0.02	XXX
78701	26	A	Kidney imaging with flow	0.49	0.14	0.17	0.14	0.17	0.02	XXX
78707		A	K flow/funct image w/o drug	0.96	4.61	5.22	NA	NA	0.05	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	4.35	4.88	NA	NA	0.02	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.26	0.34	0.26	0.34	0.03	XXX
78708		A	K flow/funct image w/drug	1.21	2.81	3.65	NA	NA	0.07	XXX
78708	TC	A	K flow/funct image w/drug	0.00	2.48	3.22	NA	NA	0.03	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.33	0.43	0.33	0.43	0.04	XXX
78709		A	K flow/funct image, multiple	1.41	7.53	7.93	NA	NA	0.08	XXX
78709	TC	A	K flow/funct image, multiple	0.00	7.14	7.43	NA	NA	0.03	XXX
78709	26	A	K flow/funct image, multiple	1.41	0.39	0.50	0.39	0.50	0.05	XXX
78710		A	Kidney imaging (3D)	0.66	4.14	5.23	NA	NA	0.03	XXX
78710	TC	A	Kidney imaging (3D)	0.00	3.99	5.00	NA	NA	0.02	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.15	0.23	0.15	0.23	0.01	XXX
78725		A	Kidney function study	0.38	2.13	2.23	NA	NA	0.03	XXX
78725	TC	A	Kidney function study	0.00	2.01	2.10	NA	NA	0.02	XXX
78725	26	A	Kidney function study	0.38	0.12	0.13	0.12	0.13	0.01	XXX
78730		A	Urinary bladder retention	0.15	1.49	1.79	NA	NA	0.02	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.44	1.72	NA	NA	0.01	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.05	0.07	0.05	0.07	0.01	ZZZ
78740		A	Ureteral reflux study	0.57	4.90	4.93	NA	NA	0.04	XXX
78740	TC	A	Ureteral reflux study	0.00	4.72	4.72	NA	NA	0.02	XXX
78740	26	A	Ureteral reflux study	0.57	0.18	0.21	0.18	0.21	0.02	XXX
78761		A	Testicular imaging w/flow	0.71	4.36	4.68	NA	NA	0.05	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.14	4.42	NA	NA	0.02	XXX
78761	26	A	Testicular imaging w/flow	0.71	0.22	0.26	0.22	0.26	0.03	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging, limited area	0.66	3.91	4.15	NA	NA	0.04	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.71	3.92	NA	NA	0.02	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.20	0.23	0.20	0.23	0.02	XXX
78801		A	Tumor imaging, mult areas	0.79	5.20	5.62	NA	NA	0.05	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	4.97	5.34	NA	NA	0.02	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.23	0.28	0.23	0.28	0.03	XXX
78802		A	Tumor imaging, whole body	0.86	6.83	7.51	NA	NA	0.06	XXX
78802	TC	A	Tumor imaging, whole body	0.00	6.60	7.21	NA	NA	0.03	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.23	0.30	0.23	0.30	0.03	XXX
78803		A	Tumor imaging (3D)	1.09	7.08	8.04	NA	NA	0.06	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.81	7.66	NA	NA	0.03	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.27	0.38	0.27	0.38	0.03	XXX
78804		A	Tumor imaging, whole body	1.07	12.59	13.86	NA	NA	0.08	XXX
78804	TC	A	Tumor imaging, whole body	0.00	12.30	13.47	NA	NA	0.05	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.29	0.39	0.29	0.39	0.03	XXX
78805		A	Abscess imaging, ltd area	0.73	3.59	4.03	NA	NA	0.04	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.39	3.77	NA	NA	0.02	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.20	0.26	0.20	0.26	0.02	XXX
78806		A	Abscess imaging, whole body	0.86	7.06	7.85	NA	NA	0.06	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.83	7.55	NA	NA	0.03	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.23	0.30	0.23	0.30	0.03	XXX
78807		A	Nuclear localization/abscess	1.09	7.00	8.04	NA	NA	0.06	XXX
78807	TC	A	Nuclear localization/abscess	0.00	6.74	7.65	NA	NA	0.03	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.26	0.39	0.26	0.39	0.03	XXX
78808		A	Iv inj ra drug dx study	0.18	0.88	0.99	NA	NA	0.02	XXX
78811		C	Pet image, ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	TC	C	Pet image, ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	26	A	Pet image, ltd area	1.54	0.44	0.55	0.44	0.55	0.13	XXX
78812		C	Pet image, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	TC	C	Pet image, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	26	A	Pet image, skull-thigh	1.93	0.54	0.69	0.54	0.69	0.12	XXX
78813		C	Pet image, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	TC	C	Pet image, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	26	A	Pet image, full body	2.00	0.55	0.72	0.55	0.72	0.13	XXX
78814		C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	TC	C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	26	A	Pet image w/ct, lmtd	2.20	0.60	0.79	0.60	0.79	0.14	XXX
78815		C	Pet image w/ct, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
78815	TC	C	Pet image w/ct, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	26	A	Pet image w/ct, skull-thigh	2.44	0.67	0.87	0.67	0.87	0.15	XXX
78816		C	Pet image w/ct, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	TC	C	Pet image w/ct, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	26	A	Pet image w/ct, full body	2.50	0.66	0.89	0.66	0.89	0.15	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx, oral admin	1.80	1.61	2.12	NA	NA	0.06	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	1.07	1.49	NA	NA	0.01	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.54	0.63	0.54	0.63	0.05	XXX
79101		A	Nuclear rx, iv admin	1.96	1.88	2.46	NA	NA	0.05	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	1.14	1.62	NA	NA	0.01	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.74	0.84	0.74	0.84	0.04	XXX
79200		A	Nuclear rx, intracav admin	1.99	2.04	2.53	NA	NA	0.09	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	1.42	1.80	NA	NA	0.01	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.62	0.73	0.62	0.73	0.08	XXX
79300		C	Nuclr rx, interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.48	0.56	0.48	0.56	0.11	XXX
79403		A	Hematopoietic nuclear tx	2.25	2.48	3.36	NA	NA	0.10	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	1.81	2.53	NA	NA	0.02	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.67	0.83	0.67	0.83	0.08	XXX
79440		A	Nuclear rx, intra-articular	1.99	1.64	2.15	NA	NA	0.05	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	1.02	1.42	NA	NA	0.01	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.62	0.73	0.62	0.73	0.04	XXX
79445		C	Nuclear rx, intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	TC	C	Nuclear rx, intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.64	0.86	0.64	0.86	0.14	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.17	0.19	0.11	0.12	0.02	XXX
80502		A	Lab pathology consultation	1.33	0.40	0.42	0.35	0.37	0.06	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.15	0.14	0.15	0.14	0.02	XXX
83912	26	A	Genetic examination	0.37	0.13	0.12	0.13	0.12	0.02	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.13	0.14	0.13	0.02	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.13	0.14	0.13	0.02	XXX
84181	26	A	Western blot test	0.37	0.15	0.13	0.15	0.13	0.02	XXX
84182	26	A	Protein, western blot test	0.37	0.15	0.14	0.15	0.14	0.02	XXX
85060		A	Blood smear interpretation	0.45	0.17	0.16	0.17	0.16	0.02	XXX
85097		A	Bone marrow interpretation	0.94	1.14	1.36	0.32	0.32	0.04	XXX
85390	26	A	Fibrinolysins screen	0.37	0.15	0.14	0.15	0.14	0.02	XXX
85396		A	Clotting assay, whole blood	0.37	NA	NA	0.13	0.12	0.02	XXX
85576	26	A	Blood platelet aggregation	0.37	0.15	0.14	0.15	0.14	0.02	XXX
86077		A	Physician blood bank service	0.94	0.44	0.40	0.36	0.34	0.04	XXX
86078		A	Physician blood bank service	0.94	0.45	0.42	0.37	0.34	0.04	XXX
86079		A	Physician blood bank service	0.94	0.45	0.43	0.37	0.35	0.04	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.15	0.14	0.15	0.14	0.02	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.14	0.14	0.14	0.14	0.02	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.14	0.14	0.14	0.14	0.01	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.14	0.13	0.14	0.13	0.02	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.16	0.16	0.16	0.16	0.02	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.14	0.14	0.14	0.14	0.02	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.14	0.13	0.14	0.13	0.02	XXX
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86486		A	Skin test, nos antigen	0.00	0.11	0.12	NA	NA	0.01	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.11	0.16	NA	NA	0.01	XXX
86510		A	Histoplasmosis skin test	0.00	0.13	0.16	NA	NA	0.01	XXX
86580		A	TB intradermal test	0.00	0.17	0.18	NA	NA	0.01	XXX
87164	26	A	Dark field examination	0.37	0.15	0.13	0.15	0.13	0.02	XXX
87207	26	A	Smear, special stain	0.37	0.15	0.14	0.15	0.14	0.02	XXX
88104		A	Cytopath fl nongyn, smears	0.56	1.12	1.11	NA	NA	0.02	XXX
88104	TC	A	Cytopath fl nongyn, smears	0.00	0.92	0.92	NA	NA	0.01	XXX
88104	26	A	Cytopath fl nongyn, smears	0.56	0.20	0.19	0.20	0.19	0.01	XXX
88106		A	Cytopath fl nongyn, filter	0.56	1.48	1.52	NA	NA	0.02	XXX
88106	TC	A	Cytopath fl nongyn, filter	0.00	1.28	1.33	NA	NA	0.01	XXX
88106	26	A	Cytopath fl nongyn, filter	0.56	0.20	0.19	0.20	0.19	0.01	XXX
88107		A	Cytopath fl nongyn, sm/fltr	0.76	1.86	1.86	NA	NA	0.02	XXX
88107	TC	A	Cytopath fl nongyn, sm/fltr	0.00	1.58	1.59	NA	NA	0.01	XXX
88107	26	A	Cytopath fl nongyn, sm/fltr	0.76	0.28	0.27	0.28	0.27	0.01	XXX
88108		A	Cytopath, concentrate tech	0.56	1.31	1.38	NA	NA	0.02	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	1.12	1.20	NA	NA	0.01	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.19	0.18	0.19	0.18	0.01	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.36	1.54	NA	NA	0.04	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.00	1.18	NA	NA	0.01	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.36	0.36	0.36	0.36	0.03	XXX
88125		A	Forensic cytopathology	0.26	0.30	0.31	NA	NA	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
88125	TC	A	Forensic cytopathology	0.00	0.20	0.22	NA	NA	0.01	XXX
88125	26	A	Forensic cytopathology	0.26	0.10	0.09	0.10	0.09	0.01	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.34	0.32	0.34	0.32	0.02	XXX
88160		A	Cytopath smear, other source	0.50	0.83	0.88	NA	NA	0.02	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.67	0.72	NA	NA	0.01	XXX
88160	26	A	Cytopath smear, other source	0.50	0.16	0.16	0.16	0.16	0.01	XXX
88161		A	Cytopath smear, other source	0.50	0.83	0.93	NA	NA	0.02	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.68	0.78	NA	NA	0.01	XXX
88161	26	A	Cytopath smear, other source	0.50	0.15	0.15	0.15	0.15	0.01	XXX
88162		A	Cytopath smear, other source	0.76	0.98	1.26	NA	NA	0.02	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.79	1.02	NA	NA	0.01	XXX
88162	26	A	Cytopath smear, other source	0.76	0.19	0.24	0.19	0.24	0.01	XXX
88172		A	Cytopathology eval of fna	0.60	0.84	0.82	NA	NA	0.02	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.61	0.61	NA	NA	0.01	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.23	0.21	0.23	0.21	0.01	XXX
88173		A	Cytopath eval, fna, report	1.39	2.11	2.21	NA	NA	0.04	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.63	1.74	NA	NA	0.01	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.48	0.47	0.48	0.47	0.03	XXX
88182		A	Cell marker study	0.77	1.75	1.94	NA	NA	0.03	XXX
88182	TC	A	Cell marker study	0.00	1.58	1.76	NA	NA	0.02	XXX
88182	26	A	Cell marker study	0.77	0.17	0.18	0.17	0.18	0.01	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	1.96	2.14	NA	NA	0.01	XXX
88185		A	Flowcytometry/tc, add-on	0.00	1.19	1.27	NA	NA	0.01	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.47	0.43	0.47	0.43	0.06	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.59	0.52	0.59	0.52	0.08	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.56	0.56	0.56	0.56	0.10	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.25	0.25	0.25	0.25	0.02	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.53	0.55	NA	NA	0.02	XXX
88300	TC	A	Surgical path, gross	0.00	0.50	0.52	NA	NA	0.01	XXX
88300	26	A	Surgical path, gross	0.08	0.03	0.03	0.03	0.03	0.01	XXX
88302		A	Tissue exam by pathologist	0.13	1.15	1.19	NA	NA	0.02	XXX
88302	TC	A	Tissue exam by pathologist	0.00	1.10	1.15	NA	NA	0.01	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.05	0.04	0.05	0.04	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.36	1.45	NA	NA	0.02	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.28	1.38	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
88304	26	A	Tissue exam by pathologist	0.22	0.08	0.07	0.08	0.07	0.01	XXX
88305		A	Tissue exam by pathologist	0.75	1.87	2.05	NA	NA	0.02	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.62	1.79	NA	NA	0.01	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.25	0.26	0.25	0.26	0.01	XXX
88307		A	Tissue exam by pathologist	1.59	4.17	4.15	NA	NA	0.05	XXX
88307	TC	A	Tissue exam by pathologist	0.00	3.58	3.59	NA	NA	0.02	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.59	0.56	0.59	0.56	0.03	XXX
88309		A	Tissue exam by pathologist	2.80	6.04	5.90	NA	NA	0.07	XXX
88309	TC	A	Tissue exam by pathologist	0.00	4.99	4.95	NA	NA	0.02	XXX
88309	26	A	Tissue exam by pathologist	2.80	1.05	0.95	1.05	0.95	0.05	XXX
88311		A	Decalcify tissue	0.24	0.25	0.24	NA	NA	0.02	XXX
88311	TC	A	Decalcify tissue	0.00	0.16	0.16	NA	NA	0.01	XXX
88311	26	A	Decalcify tissue	0.24	0.09	0.08	0.09	0.08	0.01	XXX
88312		A	Special stains group 1	0.54	2.10	2.16	NA	NA	0.02	XXX
88312	TC	A	Special stains group 1	0.00	1.92	1.99	NA	NA	0.01	XXX
88312	26	A	Special stains group 1	0.54	0.18	0.17	0.18	0.17	0.01	XXX
88313		A	Special stains group 2	0.24	1.63	1.73	NA	NA	0.02	XXX
88313	TC	A	Special stains group 2	0.00	1.56	1.66	NA	NA	0.01	XXX
88313	26	A	Special stains group 2	0.24	0.07	0.07	0.07	0.07	0.01	XXX
88314		A	Histochemical stain add-on	0.45	1.69	1.90	NA	NA	0.02	XXX
88314	TC	A	Histochemical stain add-on	0.00	1.52	1.74	NA	NA	0.01	XXX
88314	26	A	Histochemical stain add-on	0.45	0.17	0.16	0.17	0.16	0.01	XXX
88318		A	Chemical histochemistry	0.42	2.09	2.26	NA	NA	0.02	XXX
88318	TC	A	Chemical histochemistry	0.00	1.97	2.13	NA	NA	0.01	XXX
88318	26	A	Chemical histochemistry	0.42	0.12	0.13	0.12	0.13	0.01	XXX
88319		A	Enzyme histochemistry	0.53	2.94	3.20	NA	NA	0.03	XXX
88319	TC	A	Enzyme histochemistry	0.00	2.75	3.02	NA	NA	0.02	XXX
88319	26	A	Enzyme histochemistry	0.53	0.19	0.18	0.19	0.18	0.01	XXX
88321		A	Microslide consultation	1.63	0.79	0.76	0.57	0.53	0.07	XXX
88323		A	Microslide consultation	1.83	1.85	2.01	NA	NA	0.04	XXX
88323	TC	A	Microslide consultation	0.00	1.35	1.52	NA	NA	0.01	XXX
88323	26	A	Microslide consultation	1.83	0.50	0.49	0.50	0.49	0.03	XXX
88325		A	Comprehensive review of data	2.50	2.73	2.71	1.01	0.88	0.10	XXX
88329		A	Path consult introp	0.67	0.68	0.68	0.25	0.24	0.03	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.23	1.22	NA	NA	0.02	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.77	0.78	NA	NA	0.01	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.46	0.44	0.46	0.44	0.01	XXX
88332		A	Path consult intraop, addl	0.59	0.48	0.48	NA	NA	0.02	XXX
88332	TC	A	Path consult intraop, addl	0.00	0.26	0.27	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
88332	26	A	Path consult intraop, addl	0.59	0.22	0.21	0.22	0.21	0.01	XXX
88333		A	Intraop cyto path consult, 1	1.20	1.32	1.28	NA	NA	0.03	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.87	0.85	NA	NA	0.01	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.45	0.43	0.45	0.43	0.02	XXX
88334		A	Intraop cyto path consult, 2	0.73	0.82	0.78	NA	NA	0.02	XXX
88334	TC	A	Intraop cyto path consult, 2	0.00	0.54	0.53	NA	NA	0.01	XXX
88334	26	A	Intraop cyto path consult, 2	0.73	0.28	0.25	0.28	0.25	0.01	XXX
88342		A	Immunohistochemistry	0.85	1.78	1.84	NA	NA	0.03	XXX
88342	TC	A	Immunohistochemistry	0.00	1.51	1.57	NA	NA	0.01	XXX
88342	26	A	Immunohistochemistry	0.85	0.27	0.27	0.27	0.27	0.02	XXX
88346		A	Immunofluorescent study	0.86	1.70	1.82	NA	NA	0.02	XXX
88346	TC	A	Immunofluorescent study	0.00	1.42	1.54	NA	NA	0.01	XXX
88346	26	A	Immunofluorescent study	0.86	0.28	0.28	0.28	0.28	0.01	XXX
88347		A	Immunofluorescent study	0.86	1.11	1.23	NA	NA	0.02	XXX
88347	TC	A	Immunofluorescent study	0.00	0.90	1.01	NA	NA	0.01	XXX
88347	26	A	Immunofluorescent study	0.86	0.21	0.22	0.21	0.22	0.01	XXX
88348		A	Electron microscopy	1.51	14.87	15.59	NA	NA	0.10	XXX
88348	TC	A	Electron microscopy	0.00	14.39	15.10	NA	NA	0.07	XXX
88348	26	A	Electron microscopy	1.51	0.48	0.49	0.48	0.49	0.03	XXX
88349		A	Scanning electron microscopy	0.76	8.75	7.79	NA	NA	0.03	XXX
88349	TC	A	Scanning electron microscopy	0.00	8.45	7.52	NA	NA	0.01	XXX
88349	26	A	Scanning electron microscopy	0.76	0.30	0.27	0.30	0.27	0.02	XXX
88355		A	Analysis, skeletal muscle	1.85	2.60	4.15	NA	NA	0.06	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	2.20	3.68	NA	NA	0.02	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.40	0.47	0.40	0.47	0.04	XXX
88356		A	Analysis, nerve	3.02	3.93	4.61	NA	NA	0.13	XXX
88356	TC	A	Analysis, nerve	0.00	3.44	3.96	NA	NA	0.04	XXX
88356	26	A	Analysis, nerve	3.02	0.49	0.65	0.49	0.65	0.09	XXX
88358		A	Analysis, tumor	0.95	0.95	1.03	NA	NA	0.03	XXX
88358	TC	A	Analysis, tumor	0.00	0.76	0.81	NA	NA	0.01	XXX
88358	26	A	Analysis, tumor	0.95	0.19	0.22	0.19	0.22	0.02	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.05	2.13	NA	NA	0.03	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.71	1.79	NA	NA	0.01	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.34	0.34	0.34	0.34	0.02	XXX
88361		A	Tumor immunohistochem/comput	1.18	2.45	2.78	NA	NA	0.03	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.12	2.44	NA	NA	0.01	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.33	0.34	0.33	0.34	0.02	XXX
88362		A	Nerve teasing preparations	2.17	5.10	5.01	NA	NA	0.11	XXX
88362	TC	A	Nerve teasing preparations	0.00	4.34	4.30	NA	NA	0.04	XXX
88362	26	A	Nerve teasing preparations	2.17	0.76	0.71	0.76	0.71	0.07	XXX
88365		A	Insitu hybridization (fish)	1.20	3.00	3.08	NA	NA	0.03	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	2.63	2.71	NA	NA	0.01	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.37	0.37	0.37	0.37	0.02	XXX
88367		A	Insitu hybridization, auto	1.30	4.83	5.16	NA	NA	0.05	XXX
88367	TC	A	Insitu hybridization, auto	0.00	4.50	4.81	NA	NA	0.01	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.33	0.35	0.33	0.35	0.04	XXX
88368		A	Insitu hybridization, manual	1.40	3.99	4.27	NA	NA	0.04	XXX
88368	TC	A	Insitu hybridization, manual	0.00	3.72	3.94	NA	NA	0.01	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.27	0.33	0.27	0.33	0.03	XXX
88371	26	A	Protein, western blot tissue	0.37	0.15	0.13	0.15	0.13	0.02	XXX
88372	26	A	Protein analysis w/probe	0.37	0.14	0.13	0.14	0.13	0.02	XXX
88380		A	Microdissection, laser	1.56	3.50	3.70	NA	NA	0.04	XXX
88380	TC	A	Microdissection, laser	0.00	2.91	3.17	NA	NA	0.01	XXX
88380	26	A	Microdissection, laser	1.56	0.59	0.53	0.59	0.53	0.03	XXX
88381		A	Microdissection, manual	1.18	2.37	4.12	NA	NA	0.04	XXX
88381	TC	A	Microdissection, manual	0.00	2.17	3.78	NA	NA	0.02	XXX
88381	26	A	Microdissection, manual	1.18	0.20	0.34	0.20	0.34	0.02	XXX
88384		C	Eval molecular probes, 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	TC	C	Eval molecular probes, 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	26	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385		A	Eval molecul probes, 51-250	1.50	22.61	15.46	NA	NA	0.06	XXX
88385	TC	A	Eval molecul probes, 51-250	0.00	22.02	15.05	NA	NA	0.03	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.59	0.41	0.59	0.41	0.03	XXX
88386		A	Eval molecul probes, 251-500	1.88	13.72	15.96	NA	NA	0.07	XXX
88386	TC	A	Eval molecul probes, 251-500	0.00	13.21	15.28	NA	NA	0.03	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.51	0.68	0.51	0.68	0.04	XXX
88387		A	Tiss exam molecular study	0.62	0.45	0.45	NA	NA	0.02	XXX
88387	TC	A	Tiss exam molecular study	0.00	0.21	0.21	NA	NA	0.01	XXX
88387	26	A	Tiss exam molecular study	0.62	0.24	0.24	0.24	0.24	0.01	XXX
88388		A	Tiss ex molecul study add-on	0.45	0.18	0.18	NA	NA	0.02	XXX
88388	TC	A	Tiss ex molecul study add-on	0.00	0.10	0.10	NA	NA	0.01	XXX
88388	26	A	Tiss ex molecul study add-on	0.45	0.08	0.08	0.08	0.08	0.01	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	4.94	5.12	0.37	0.41	0.08	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.14	0.14	0.14	0.14	0.02	XXX
89100		A	Sample intestinal contents	0.60	7.55	6.49	0.53	0.47	0.03	XXX
89105		A	Sample intestinal contents	0.50	6.76	6.51	0.43	0.41	0.02	XXX
89130		A	Sample stomach contents	0.45	6.26	5.62	0.39	0.34	0.02	XXX
89132		A	Sample stomach contents	0.19	6.33	6.46	0.30	0.30	0.01	XXX
89135		A	Sample stomach contents	0.79	7.53	7.26	0.60	0.60	0.04	XXX
89136		A	Sample stomach contents	0.21	6.31	5.67	0.30	0.27	0.01	XXX
89140		A	Sample stomach contents	0.94	6.70	5.92	0.57	0.49	0.05	XXX
89141		A	Sample stomach contents	0.85	6.66	6.15	0.54	0.50	0.04	XXX
89220		A	Sputum specimen collection	0.00	0.37	0.39	NA	NA	0.01	XXX
89230		A	Collect sweat for test	0.00	0.15	0.11	NA	NA	0.01	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90284		X	Human ig, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig, im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig, heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv, mab, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393		E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396		E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.42	0.41	NA	NA	0.01	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.16	0.14	0.06	0.06	0.01	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.17	0.26	0.22	0.10	0.09	0.01	XXX
90468		R	Immune admin o/n, addl < 8 y	0.15	0.15	0.13	0.06	0.05	0.01	ZZZ
90470		N	Immune admin H1N1 im/nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90471		A	Immunization admin	0.17	0.42	0.41	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
90472		A	Immunization admin, each add	0.15	0.16	0.14	0.06	0.06	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.26	0.22	0.07	0.05	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.11	0.10	0.06	0.05	0.01	ZZZ
90476		E	Adenovirus vaccine, type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine, type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine, percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine, intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc, ped/adol, 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc, ped/adol, 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90644		X	HIB/men/tt vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine, hboc, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646		E	Hib vaccine, prp-d, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647		E	Hib vaccine, prp-omp, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648		E	Hib vaccine, prp-t, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90649		E	Hpv vaccine 4 valent, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90650		E	Hpv vaccine 2 valent, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655		X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656		X	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657		X	Flu vaccine, 3 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658		X	Flu vaccine, 3 yrs & >, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660		X	Flu vaccine, nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90661		X	Flu vacc cell cult prsv free	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90662		X	Flu vacc prsv free inc antig	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90663		X	Flu vacc pandemic H1N1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665		E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669		X	Pneumococcal vacc, 7 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90670		X	Pneumococcal vacc, 13 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675		E	Rabies vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676		E	Rabies vaccine, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90680		E	Rotovirus vacc 3 dose, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90681		E	Rotavirus vacc 2 dose oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690		E	Typhoid vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691		E	Typhoid vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692		E	Typhoid vaccine, h-p, sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693		E	Typhoid vaccine, akd, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90696		E	Dtap-ipv vacc 4-6 yr im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
90698		E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700		E	Dtap vaccine, < 7 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701		E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702		E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703		E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704		E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705		E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706		E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707		E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708		E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710		E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712		E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713		E	Poliovirus, ipv, sc/im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90714		E	Td vaccine no prsrv >/= 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715		E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716		E	Chicken pox vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717		E	Yellow fever vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718		E	Td vaccine > 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719		E	Diphtheria vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720		E	Dtp/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721		E	Dtap/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723		I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725		E	Cholera vaccine, injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727		E	Plague vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732		X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733		E	Meningococcal vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734		E	Meningococcal vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735		E	Encephalitis vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90736		E	Zoster vacc, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90738		I	Inactivated je vacc im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740		X	Hepb vacc, ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743		X	Hep b vacc, adol, 2 dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744		X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746		X	Hep b vaccine, adult, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747		X	Hepb vacc, ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90748		I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749		E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.30	1.38	0.50	0.65	0.08	XXX
90802		A	Intac psy dx interview	3.01	1.47	1.47	0.59	0.71	0.10	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
90804		A	Psytx, office, 20-30 min	1.21	0.47	0.52	0.15	0.24	0.04	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.58	0.58	0.23	0.28	0.04	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.38	0.53	0.20	0.36	0.05	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.68	0.71	0.34	0.41	0.07	XXX
90808		A	Psytx, office, 75-80 min	2.79	0.49	0.72	0.31	0.54	0.08	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	0.84	0.90	0.52	0.62	0.10	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.43	0.51	0.17	0.26	0.04	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.70	0.69	0.26	0.31	0.05	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.48	0.64	0.21	0.38	0.05	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.80	0.82	0.35	0.44	0.07	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	0.64	0.88	0.32	0.62	0.09	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.00	1.02	0.54	0.64	0.10	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	NA	0.22	0.33	0.03	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	NA	0.34	0.38	0.05	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	NA	0.28	0.46	0.05	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	NA	0.45	0.51	0.07	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	NA	0.40	0.64	0.08	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	NA	0.60	0.70	0.10	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	NA	0.22	0.34	0.04	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	NA	0.35	0.40	0.05	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	NA	0.30	0.48	0.05	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	NA	0.46	0.53	0.07	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	NA	0.38	0.66	0.08	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	NA	0.61	0.72	0.10	XXX
90845		A	Psychoanalysis	1.79	0.39	0.43	0.33	0.38	0.06	XXX
90846		R	Family psytx w/o patient	1.83	0.41	0.52	0.33	0.46	0.05	XXX
90847		R	Family psytx w/patient	2.21	0.58	0.72	0.36	0.53	0.06	XXX
90849		R	Multiple family group psytx	0.59	0.30	0.30	0.18	0.21	0.02	XXX
90853		A	Group psychotherapy	0.59	0.27	0.27	0.20	0.21	0.02	XXX
90857		A	Intac group psytx	0.63	0.32	0.33	0.19	0.22	0.02	XXX
90862		A	Medication management	0.95	0.61	0.58	0.27	0.28	0.03	XXX
90865		A	Narcosynthesis	2.84	1.46	1.38	0.57	0.70	0.09	XXX
90870		A	Electroconvulsive therapy	1.88	1.85	1.90	0.37	0.43	0.06	000
90875		N	Psychophysiological therapy	1.20	0.70	0.74	0.44	0.43	0.06	XXX
90876		N	Psychophysiological therapy	1.90	0.94	0.97	0.69	0.68	0.10	XXX
90880		A	Hypnotherapy	2.19	0.41	0.64	0.28	0.44	0.06	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	0.97	0.35	0.35	0.35	0.35	0.05	XXX
90887		B	Consultation with family	1.48	0.83	0.82	0.54	0.53	0.07	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.54	0.52	0.13	0.12	0.02	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.22	1.40	0.30	0.32	0.05	000
90935		A	Hemodialysis, one evaluation	1.22	NA	NA	0.63	0.60	0.05	000
90937		A	Hemodialysis, repeated eval	2.11	NA	NA	0.93	0.88	0.09	000
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	NA	0.65	0.62	0.05	000
90947		A	Dialysis, repeated eval	2.16	NA	NA	0.94	0.89	0.09	000
90951		A	Esrd serv, 4 visits p mo, <2	18.46	8.37	7.92	8.37	7.92	0.93	XXX
90952		C	Esrd serv, 2-3 vsts p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv, 1 visit p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv, 4 vsts p mo, 2-11	15.98	6.54	5.71	6.54	5.71	0.80	XXX
90955		A	Esrd srv 2-3 vsts p mo, 2-11	8.79	3.67	3.44	3.67	3.44	0.44	XXX
90956		A	Esrd srv, 1 visit p mo, 2-11	5.95	2.28	2.29	2.28	2.29	0.30	XXX
90957		A	Esrd srv, 4 vsts p mo, 12-19	12.52	5.51	4.92	5.51	4.92	0.63	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.62	3.38	3.62	3.38	0.42	XXX
90959		A	Esrd serv, 1 vst p mo, 12-19	5.50	2.14	2.14	2.14	2.14	0.28	XXX
90960		A	Esrd srv, 4 visits p mo, 20+	5.18	2.68	2.56	2.68	2.56	0.26	XXX
90961		A	Esrd srv, 2-3 vsts p mo, 20+	4.26	2.02	1.96	2.02	1.96	0.21	XXX
90962		A	Esrd serv, 1 visit p mo, 20+	3.15	1.30	1.32	1.30	1.32	0.16	XXX
90963		A	Esrd home pt, serv p mo, <2	10.56	4.06	4.19	4.06	4.19	0.53	XXX
90964		A	Esrd home pt serv p mo, 2-11	9.14	3.60	3.26	3.60	3.26	0.46	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	3.46	3.13	3.46	3.13	0.44	XXX
90966		A	Esrd home pt, serv p mo, 20+	4.26	2.11	1.93	2.11	1.93	0.21	XXX
90967		A	Esrd home pt serv p day, <2	0.35	0.19	0.19	0.19	0.19	0.02	XXX
90968		A	Esrd home pt srv p day, 2-11	0.30	0.13	0.12	0.13	0.12	0.02	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.13	0.12	0.13	0.12	0.01	XXX
90970		A	Esrd home pt serv p day, 20+	0.14	0.07	0.07	0.07	0.07	0.01	XXX
90989		X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	NA	0.60	0.58	0.08	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91000		A	Esophageal intubation	0.73	2.12	1.79	NA	NA	0.03	000
91000	TC	A	Esophageal intubation	0.00	1.85	1.54	NA	NA	0.01	000
91000	26	A	Esophageal intubation	0.73	0.27	0.25	0.27	0.25	0.02	000
91010		A	Esophagus motility study	1.25	3.21	3.68	NA	NA	0.06	000
91010	TC	A	Esophagus motility study	0.00	2.67	3.13	NA	NA	0.01	000
91010	26	A	Esophagus motility study	1.25	0.54	0.55	0.54	0.55	0.05	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
91011		A	Esophagus motility study	1.50	4.51	5.13	NA	NA	0.05	000
91011	TC	A	Esophagus motility study	0.00	3.85	4.43	NA	NA	0.01	000
91011	26	A	Esophagus motility study	1.50	0.66	0.70	0.66	0.70	0.04	000
91012		A	Esophagus motility study	1.46	4.61	5.28	NA	NA	0.05	000
91012	TC	A	Esophagus motility study	0.00	3.97	4.61	NA	NA	0.01	000
91012	26	A	Esophagus motility study	1.46	0.64	0.67	0.64	0.67	0.04	000
91020		A	Gastric motility studies	1.44	4.29	4.64	NA	NA	0.05	000
91020	TC	A	Gastric motility studies	0.00	3.67	4.02	NA	NA	0.01	000
91020	26	A	Gastric motility studies	1.44	0.62	0.62	0.62	0.62	0.04	000
91022		A	Duodenal motility study	1.44	2.83	3.43	NA	NA	0.05	000
91022	TC	A	Duodenal motility study	0.00	2.19	2.76	NA	NA	0.01	000
91022	26	A	Duodenal motility study	1.44	0.64	0.67	0.64	0.67	0.04	000
91030		A	Acid perfusion of esophagus	0.91	2.47	2.73	NA	NA	0.03	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.07	2.31	NA	NA	0.01	000
91030	26	A	Acid perfusion of esophagus	0.91	0.40	0.42	0.40	0.42	0.02	000
91034		A	Gastroesophageal reflux test	0.97	3.64	4.20	NA	NA	0.03	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.22	3.78	NA	NA	0.01	000
91034	26	A	Gastroesophageal reflux test	0.97	0.42	0.42	0.42	0.42	0.02	000
91035		A	G-esoph reflx tst w/electrod	1.59	9.90	10.85	NA	NA	0.06	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	9.22	10.15	NA	NA	0.01	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.68	0.70	0.68	0.70	0.05	000
91037		A	Esoph imped function test	0.97	2.98	3.22	NA	NA	0.06	000
91037	TC	A	Esoph imped function test	0.00	2.56	2.79	NA	NA	0.01	000
91037	26	A	Esoph imped function test	0.97	0.42	0.43	0.42	0.43	0.05	000
91038		A	Esoph imped funct test > 1h	1.10	2.39	2.58	NA	NA	0.05	000
91038	TC	A	Esoph imped funct test > 1h	0.00	1.91	2.09	NA	NA	0.01	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.48	0.49	0.48	0.49	0.04	000
91040		A	Esoph balloon distension tst	0.97	6.11	8.52	NA	NA	0.02	000
91040	TC	A	Esoph balloon distension tst	0.00	5.79	8.08	NA	NA	0.01	000
91040	26	A	Esoph balloon distension tst	0.97	0.32	0.44	0.32	0.44	0.01	000
91052		A	Gastric analysis test	0.79	2.50	2.53	NA	NA	0.02	000
91052	TC	A	Gastric analysis test	0.00	2.15	2.21	NA	NA	0.01	000
91052	26	A	Gastric analysis test	0.79	0.35	0.32	0.35	0.32	0.01	000
91055		A	Gastric intubation for smear	0.94	2.87	2.70	NA	NA	0.03	000
91055	TC	A	Gastric intubation for smear	0.00	2.41	2.36	NA	NA	0.01	000
91055	26	A	Gastric intubation for smear	0.94	0.46	0.34	0.46	0.34	0.02	000
91065		A	Breath hydrogen test	0.20	1.52	1.56	NA	NA	0.02	000
91065	TC	A	Breath hydrogen test	0.00	1.43	1.48	NA	NA	0.01	000
91065	26	A	Breath hydrogen test	0.20	0.09	0.08	0.09	0.08	0.01	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
91105		A	Gastric intubation treatment	0.37	1.95	1.82	0.09	0.08	0.02	000
91110		A	Gi tract capsule endoscopy	3.64	17.78	20.16	NA	NA	0.11	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	16.19	18.51	NA	NA	0.01	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.59	1.65	1.59	1.65	0.10	XXX
91111		A	Esophageal capsule endoscopy	1.00	16.03	17.74	NA	NA	0.04	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	15.59	17.27	NA	NA	0.01	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.44	0.47	0.44	0.47	0.03	XXX
91120		A	Rectal sensation test	0.97	8.65	9.36	NA	NA	0.07	XXX
91120	TC	A	Rectal sensation test	0.00	8.27	9.02	NA	NA	0.01	XXX
91120	26	A	Rectal sensation test	0.97	0.38	0.34	0.38	0.34	0.06	XXX
91122		A	Anal pressure record	1.77	3.72	4.24	NA	NA	0.08	000
91122	TC	A	Anal pressure record	0.00	3.08	3.60	NA	NA	0.01	000
91122	26	A	Anal pressure record	1.77	0.64	0.64	0.64	0.64	0.07	000
91123		B	Irrigate fecal impaction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.20	0.23	0.20	0.23	0.02	XXX
91133		C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.29	0.31	0.29	0.31	0.03	XXX
91299		C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam, new patient	0.88	1.16	1.03	0.41	0.33	0.05	XXX
92004		A	Eye exam, new patient	1.82	2.01	1.76	0.89	0.71	0.09	XXX
92012		A	Eye exam established pat	0.92	1.25	1.10	0.50	0.38	0.05	XXX
92014		A	Eye exam & treatment	1.42	1.75	1.52	0.75	0.57	0.08	XXX
92015		N	Refraction	0.38	0.15	0.40	0.14	0.13	0.02	XXX
92018		A	New eye exam & treatment	2.50	NA	NA	1.41	1.10	0.11	XXX
92019		A	Eye exam & treatment	1.31	NA	NA	0.57	0.47	0.06	XXX
92020		A	Special eye evaluation	0.37	0.34	0.30	0.20	0.16	0.02	XXX
92025		A	Corneal topography	0.35	0.60	0.53	NA	NA	0.02	XXX
92025	TC	A	Corneal topography	0.00	0.41	0.38	NA	NA	0.01	XXX
92025	26	A	Corneal topography	0.35	0.19	0.15	0.19	0.15	0.01	XXX
92060		A	Special eye evaluation	0.69	0.97	0.83	NA	NA	0.03	XXX
92060	TC	A	Special eye evaluation	0.00	0.61	0.54	NA	NA	0.01	XXX
92060	26	A	Special eye evaluation	0.69	0.36	0.29	0.36	0.29	0.02	XXX
92065		A	Orthoptic/pleoptic training	0.37	0.98	0.85	NA	NA	0.02	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.85	0.73	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
92065	26	A	Orthoptic/pleoptic training	0.37	0.13	0.12	0.13	0.12	0.01	XXX
92070		A	Fitting of contact lens	0.70	1.11	1.01	0.36	0.29	0.04	XXX
92081		A	Visual field examination(s)	0.36	1.11	1.00	NA	NA	0.03	XXX
92081	TC	A	Visual field examination(s)	0.00	0.94	0.86	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	0.36	0.17	0.14	0.17	0.14	0.02	XXX
92082		A	Visual field examination(s)	0.44	1.51	1.38	NA	NA	0.04	XXX
92082	TC	A	Visual field examination(s)	0.00	1.30	1.20	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	0.44	0.21	0.18	0.21	0.18	0.03	XXX
92083		A	Visual field examination(s)	0.50	1.76	1.58	NA	NA	0.03	XXX
92083	TC	A	Visual field examination(s)	0.00	1.49	1.37	NA	NA	0.01	XXX
92083	26	A	Visual field examination(s)	0.50	0.27	0.21	0.27	0.21	0.02	XXX
92100		A	Serial tonometry exam(s)	0.92	1.54	1.37	0.46	0.36	0.04	XXX
92120		A	Tonography & eye evaluation	0.81	1.19	1.07	0.39	0.32	0.04	XXX
92130		A	Water provocation tonography	0.81	1.44	1.28	0.44	0.35	0.04	XXX
92135		A	Ophth dx imaging post seg	0.35	0.93	0.85	NA	NA	0.02	XXX
92135	TC	A	Ophth dx imaging post seg	0.00	0.74	0.69	NA	NA	0.01	XXX
92135	26	A	Ophth dx imaging post seg	0.35	0.19	0.16	0.19	0.16	0.01	XXX
92136		A	Ophthalmic biometry	0.54	1.66	1.55	NA	NA	0.02	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.35	1.30	NA	NA	0.01	XXX
92136	26	A	Ophthalmic biometry	0.54	0.31	0.25	0.31	0.25	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	1.07	0.98	0.23	0.19	0.02	XXX
92225		A	Special eye exam, initial	0.38	0.33	0.27	0.20	0.16	0.02	XXX
92226		A	Special eye exam, subsequent	0.33	0.32	0.26	0.19	0.15	0.01	XXX
92230		A	Eye exam with photos	0.60	0.87	0.91	0.32	0.24	0.03	XXX
92235		A	Eye exam with photos	0.81	2.64	2.46	NA	NA	0.03	XXX
92235	TC	A	Eye exam with photos	0.00	2.16	2.09	NA	NA	0.01	XXX
92235	26	A	Eye exam with photos	0.81	0.48	0.37	0.48	0.37	0.02	XXX
92240		A	Icg angiography	1.10	5.02	4.94	NA	NA	0.03	XXX
92240	TC	A	Icg angiography	0.00	4.37	4.43	NA	NA	0.01	XXX
92240	26	A	Icg angiography	1.10	0.65	0.51	0.65	0.51	0.02	XXX
92250		A	Eye exam with photos	0.44	1.49	1.41	NA	NA	0.02	XXX
92250	TC	A	Eye exam with photos	0.00	1.27	1.23	NA	NA	0.01	XXX
92250	26	A	Eye exam with photos	0.44	0.22	0.18	0.22	0.18	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.28	0.26	0.11	0.09	0.01	XXX
92265		A	Eye muscle evaluation	0.81	1.33	1.18	NA	NA	0.02	XXX
92265	TC	A	Eye muscle evaluation	0.00	0.87	0.87	NA	NA	0.01	XXX
92265	26	A	Eye muscle evaluation	0.81	0.46	0.31	0.46	0.31	0.01	XXX
92270		A	Electro-oculography	0.81	1.48	1.44	NA	NA	0.02	XXX
92270	TC	A	Electro-oculography	0.00	1.15	1.15	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
92270	26	A	Electro-oculography	0.81	0.33	0.29	0.33	0.29	0.01	XXX
92275		A	Electroretinography	1.01	2.89	2.49	NA	NA	0.05	XXX
92275	TC	A	Electroretinography	0.00	2.31	2.04	NA	NA	0.02	XXX
92275	26	A	Electroretinography	1.01	0.58	0.45	0.58	0.45	0.03	XXX
92283		A	Color vision examination	0.17	1.14	1.03	NA	NA	0.02	XXX
92283	TC	A	Color vision examination	0.00	1.06	0.96	NA	NA	0.01	XXX
92283	26	A	Color vision examination	0.17	0.08	0.07	0.08	0.07	0.01	XXX
92284		A	Dark adaptation eye exam	0.24	1.22	1.29	NA	NA	0.02	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.12	1.21	NA	NA	0.01	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.10	0.08	0.10	0.08	0.01	XXX
92285		A	Eye photography	0.20	0.90	0.87	NA	NA	0.03	XXX
92285	TC	A	Eye photography	0.00	0.80	0.78	NA	NA	0.01	XXX
92285	26	A	Eye photography	0.20	0.10	0.09	0.10	0.09	0.02	XXX
92286		A	Internal eye photography	0.66	2.40	2.38	NA	NA	0.02	XXX
92286	TC	A	Internal eye photography	0.00	2.05	2.10	NA	NA	0.01	XXX
92286	26	A	Internal eye photography	0.66	0.35	0.28	0.35	0.28	0.01	XXX
92287		A	Internal eye photography	0.81	2.26	2.12	0.46	0.35	0.03	XXX
92310		N	Contact lens fitting	1.17	1.27	1.26	0.43	0.42	0.06	XXX
92311		A	Contact lens fitting	1.08	1.57	1.35	0.49	0.38	0.06	XXX
92312		A	Contact lens fitting	1.26	1.82	1.52	0.55	0.45	0.04	XXX
92313		A	Contact lens fitting	0.92	1.72	1.45	0.49	0.37	0.05	XXX
92314		N	Prescription of contact lens	0.69	1.29	1.25	0.25	0.25	0.03	XXX
92315		A	Prescription of contact lens	0.45	1.46	1.27	0.19	0.15	0.03	XXX
92316		A	Prescription of contact lens	0.68	1.96	1.60	0.40	0.29	0.03	XXX
92317		A	Prescription of contact lens	0.45	2.18	1.49	0.07	0.12	0.01	XXX
92325		A	Modification of contact lens	0.00	0.93	0.79	NA	NA	0.01	XXX
92326		A	Replacement of contact lens	0.00	0.80	0.93	NA	NA	0.01	XXX
92340		N	Fitting of spectacles	0.37	0.51	0.56	0.14	0.13	0.02	XXX
92341		N	Fitting of spectacles	0.47	0.55	0.60	0.17	0.17	0.02	XXX
92342		N	Fitting of spectacles	0.53	0.57	0.62	0.19	0.19	0.03	XXX
92352		B	Special spectacles fitting	0.37	0.64	0.67	0.14	0.13	0.02	XXX
92353		B	Special spectacles fitting	0.50	0.69	0.71	0.18	0.18	0.03	XXX
92354		B	Special spectacles fitting	0.00	0.30	1.95	NA	NA	0.01	XXX
92355		B	Special spectacles fitting	0.00	0.47	1.23	NA	NA	0.01	XXX
92358		B	Eye prosthesis service	0.00	0.25	0.40	NA	NA	0.01	XXX
92370		N	Repair & adjust spectacles	0.32	0.45	0.48	0.12	0.11	0.02	XXX
92371		B	Repair & adjust spectacles	0.00	0.26	0.34	NA	NA	0.01	XXX
92499		C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	NA	1.13	1.03	0.06	000
92504		A	Ear microscopy examination	0.18	0.63	0.59	0.09	0.08	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	3.69	3.37	0.39	0.34	0.05	XXX
92507		A	Speech/hearing therapy	0.52	1.37	1.23	0.21	0.19	0.02	XXX
92508		A	Speech/hearing therapy	0.26	0.75	0.60	0.12	0.11	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.23	3.22	0.79	0.73	0.03	000
92512		A	Nasal function studies	0.55	1.04	1.04	0.26	0.21	0.02	XXX
92516		A	Facial nerve function test	0.43	1.28	1.24	0.20	0.18	0.02	XXX
92520		A	Laryngeal function studies	0.75	1.09	0.92	0.36	0.31	0.03	XXX
92526		A	Oral function therapy	1.34	0.65	1.39	0.51	0.27	0.02	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92540		A	Basic vestibular evaluation	1.50	1.09	1.09	NA	NA	0.04	XXX
92540	TC	A	Basic vestibular evaluation	0.00	0.45	0.45	NA	NA	0.01	XXX
92540	26	A	Basic vestibular evaluation	1.50	0.64	0.64	0.64	0.64	0.03	XXX
92541		A	Spontaneous nystagmus test	0.40	0.38	0.97	NA	NA	0.02	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.21	0.82	NA	NA	0.01	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.17	0.15	0.17	0.15	0.01	XXX
92542		A	Positional nystagmus test	0.33	0.34	1.07	NA	NA	0.02	XXX
92542	TC	A	Positional nystagmus test	0.00	0.20	0.94	NA	NA	0.01	XXX
92542	26	A	Positional nystagmus test	0.33	0.14	0.13	0.14	0.13	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.25	0.55	NA	NA	0.02	XXX
92543	TC	A	Caloric vestibular test	0.00	0.21	0.51	NA	NA	0.01	XXX
92543	26	A	Caloric vestibular test	0.10	0.04	0.04	0.04	0.04	0.01	XXX
92544		A	Optokinetic nystagmus test	0.26	0.31	0.87	NA	NA	0.02	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.20	0.77	NA	NA	0.01	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.11	0.10	0.11	0.10	0.01	XXX
92545		A	Oscillating tracking test	0.23	0.30	0.83	NA	NA	0.02	XXX
92545	TC	A	Oscillating tracking test	0.00	0.20	0.74	NA	NA	0.01	XXX
92545	26	A	Oscillating tracking test	0.23	0.10	0.09	0.10	0.09	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	2.18	2.01	NA	NA	0.02	XXX
92546	TC	A	Sinusoidal rotational test	0.00	2.06	1.90	NA	NA	0.01	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.12	0.11	0.12	0.11	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.12	0.11	0.12	0.11	0.01	ZZZ
92548		A	Posturography	0.50	2.20	2.01	NA	NA	0.02	XXX
92548	TC	A	Posturography	0.00	1.99	1.82	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
92548	26	A	Posturography	0.50	0.21	0.19	0.21	0.19	0.01	XXX
92550		A	Tympanometry & reflex thresh	0.35	0.21	0.21	NA	NA	0.01	XXX
92551		N	Pure tone hearing test, air	0.00	0.27	0.28	NA	NA	0.01	XXX
92552		A	Pure tone audiometry, air	0.00	0.66	0.59	NA	NA	0.01	XXX
92553		A	Audiometry, air & bone	0.00	0.80	0.76	NA	NA	0.01	XXX
92555		A	Speech threshold audiometry	0.00	0.47	0.42	NA	NA	0.01	XXX
92556		A	Speech audiometry, complete	0.00	0.71	0.65	NA	NA	0.01	XXX
92557		A	Comprehensive hearing test	0.60	0.38	0.50	0.28	0.42	0.02	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.86	0.76	NA	NA	0.01	XXX
92562		A	Loudness balance test	0.00	0.96	0.69	NA	NA	0.01	XXX
92563		A	Tone decay hearing test	0.00	0.67	0.57	NA	NA	0.01	XXX
92564		A	Sisi hearing test	0.00	0.62	0.53	NA	NA	0.01	XXX
92565		A	Stenger test, pure tone	0.00	0.31	0.32	NA	NA	0.01	XXX
92567		A	Tympanometry	0.20	0.17	0.22	0.09	0.16	0.01	XXX
92568		A	Acoustic refl threshold tst	0.29	0.14	0.16	0.13	0.16	0.01	XXX
92570		A	Acoustic immittance testing	0.55	0.30	0.30	0.25	0.25	0.02	XXX
92571		A	Filtered speech hearing test	0.00	0.51	0.44	NA	NA	0.01	XXX
92572		A	Staggered spondaic word test	0.00	1.07	0.62	NA	NA	0.01	XXX
92575		A	Sensorineural acuity test	0.00	1.36	1.06	NA	NA	0.01	XXX
92576		A	Synthetic sentence test	0.00	0.74	0.59	NA	NA	0.01	XXX
92577		A	Stenger test, speech	0.00	0.35	0.40	NA	NA	0.01	XXX
92579		A	Visual audiometry (vra)	0.70	0.50	0.47	0.34	0.37	0.03	XXX
92582		A	Conditioning play audiometry	0.00	1.36	1.15	NA	NA	0.01	XXX
92583		A	Select picture audiometry	0.00	0.98	0.88	NA	NA	0.01	XXX
92584		A	Electrocochleography	0.00	1.51	1.64	NA	NA	0.01	XXX
92585		A	Auditor evoke potent, compre	0.50	2.47	2.22	NA	NA	0.02	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	2.25	2.03	NA	NA	0.01	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.22	0.19	0.22	0.19	0.01	XXX
92586		A	Auditor evoke potent, limit	0.00	1.78	1.65	NA	NA	0.01	XXX
92587		A	Evoked auditory test	0.13	0.73	0.81	NA	NA	0.02	XXX
92587	TC	A	Evoked auditory test	0.00	0.67	0.76	NA	NA	0.01	XXX
92587	26	A	Evoked auditory test	0.13	0.06	0.05	0.06	0.05	0.01	XXX
92588		A	Evoked auditory test	0.36	1.30	1.28	NA	NA	0.02	XXX
92588	TC	A	Evoked auditory test	0.00	1.14	1.14	NA	NA	0.01	XXX
92588	26	A	Evoked auditory test	0.36	0.16	0.14	0.16	0.14	0.01	XXX
92590		N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
92592		N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test, one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst, both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	1.39	1.03	NA	NA	0.01	XXX
92597		A	Oral speech device eval	1.26	0.67	1.61	0.60	0.41	0.03	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.51	1.79	1.02	1.39	0.09	XXX
92602		A	Reprogram cochlear implt < 7	1.30	1.20	1.27	0.55	0.86	0.05	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.54	1.51	1.03	1.13	0.09	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	0.99	0.97	0.57	0.66	0.05	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	4.69	4.33	NA	NA	0.06	XXX
92608		A	Ex for speech device rx addl	0.00	1.18	0.88	NA	NA	0.01	XXX
92609		A	Use of speech device service	0.00	2.70	2.35	NA	NA	0.03	XXX
92610		A	Evaluate swallowing function	1.30	0.79	1.79	0.57	1.73	0.01	XXX
92611		A	Motion fluoroscopy/swallow	1.34	0.97	1.98	NA	NA	0.01	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	3.13	3.00	0.60	0.53	0.05	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.33	0.31	0.33	0.31	0.03	XXX
92614		A	Laryngoscopic sensory test	1.27	2.68	2.53	0.62	0.54	0.05	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.30	0.28	0.30	0.27	0.02	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.36	3.29	0.86	0.77	0.08	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.36	0.33	0.36	0.33	0.03	XXX
92620		A	Auditory function, 60 min	1.50	0.97	0.58	0.74	0.52	0.06	XXX
92621		A	Auditory function, + 15 min	0.35	0.23	0.13	0.15	0.11	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.69	0.47	0.52	0.43	0.04	XXX
92626		A	Eval aud rehab status	1.40	0.91	0.79	0.62	0.71	0.05	XXX
92627		A	Eval aud status rehab add-on	0.33	0.23	0.20	0.15	0.18	0.01	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92640		A	Aud brainstem implt programg	1.76	0.97	0.44	0.65	0.36	0.27	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	3.49	3.49	0.88	0.86	0.21	000
92953		A	Temporary external pacing	0.23	NA	NA	0.06	0.08	0.01	000
92960		A	Cardioversion electric, ext	2.25	3.13	4.42	0.97	1.30	0.11	000
92961		A	Cardioversion, electric, int	4.59	NA	NA	1.75	2.27	0.33	000
92970		A	Cardioassist, internal	3.51	NA	NA	1.11	1.33	0.17	000
92971		A	Cardioassist, external	1.77	NA	NA	0.70	0.97	0.09	000
92973		A	Percut coronary thrombectomy	3.28	NA	NA	1.09	1.54	0.16	ZZZ

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
92974		A	Cath place, cardio brachytx	3.00	NA	NA	1.00	1.41	0.17	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	NA	2.45	3.36	0.36	000
92977		A	Dissolve clot, heart vessel	0.00	1.24	2.80	NA	NA	0.02	XXX
92978		C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	TC	C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.60	0.84	0.60	0.84	0.09	ZZZ
92979		C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	TC	C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.48	0.68	0.48	0.68	0.07	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	NA	5.10	7.14	0.73	000
92981		A	Insert intracoronary stent	4.16	NA	NA	1.39	1.95	0.20	ZZZ
92982		A	Coronary artery dilation	10.96	NA	NA	3.81	5.32	0.54	000
92984		A	Coronary artery dilation	2.97	NA	NA	0.99	1.39	0.15	ZZZ
92986		A	Revision of aortic valve	22.85	NA	NA	10.02	13.50	1.17	090
92987		A	Revision of mitral valve	23.63	NA	NA	10.29	13.95	1.13	090
92990		A	Revision of pulmonary valve	18.27	NA	NA	8.35	10.82	0.88	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	NA	4.18	5.87	0.59	000
92996		A	Coronary atherectomy add-on	3.26	NA	NA	1.08	1.53	0.16	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	NA	4.13	5.05	0.58	000
92998		A	Pul art balloon repr, percut	5.99	NA	NA	1.99	2.63	0.29	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.28	0.36	NA	NA	0.02	XXX
93005		A	Electrocardiogram, tracing	0.00	0.22	0.29	NA	NA	0.01	XXX
93010		A	Electrocardiogram report	0.17	0.06	0.07	0.06	0.07	0.01	XXX
93012		A	Transmission of ecg	0.00	3.53	4.61	NA	NA	0.02	XXX
93014		A	Report on transmitted ecg	0.52	0.18	0.22	0.18	0.22	0.02	XXX
93015		A	Cardiovascular stress test	0.75	1.36	1.79	NA	NA	0.03	XXX
93016		A	Cardiovascular stress test	0.45	0.15	0.20	0.15	0.20	0.01	XXX
93017		A	Cardiovascular stress test	0.00	1.11	1.46	NA	NA	0.01	XXX
93018		A	Cardiovascular stress test	0.30	0.10	0.13	0.10	0.13	0.01	XXX
93024		A	Cardiac drug stress test	1.17	1.68	2.02	NA	NA	0.04	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.28	1.51	NA	NA	0.01	XXX
93024	26	A	Cardiac drug stress test	1.17	0.40	0.51	0.40	0.51	0.03	XXX
93025		A	Microvolt t-wave assess	0.75	3.16	4.63	NA	NA	0.03	XXX
93025	TC	A	Microvolt t-wave assess	0.00	2.91	4.29	NA	NA	0.01	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.25	0.34	0.25	0.34	0.02	XXX
93040		A	Rhythm ECG with report	0.16	0.16	0.19	NA	NA	0.02	XXX
93041		A	Rhythm ECG, tracing	0.00	0.12	0.14	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93042		A	Rhythm ECG, report	0.16	0.04	0.05	0.04	0.05	0.01	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	1.70	2.37	NA	NA	0.03	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	0.62	0.85	NA	NA	0.01	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	0.88	1.28	NA	NA	0.01	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.20	0.24	0.20	0.24	0.01	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.19	0.18	0.19	0.18	0.03	XXX
93229		C	Remote 30 day ecg tech supp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	1.74	2.42	NA	NA	0.03	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	0.54	0.81	NA	NA	0.01	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	1.02	1.40	NA	NA	0.01	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.18	0.21	0.18	0.21	0.01	XXX
93235		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93236		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.15	0.20	0.15	0.20	0.02	XXX
93268		A	ECG record/review	0.52	4.88	6.24	NA	NA	0.04	XXX
93270		A	ECG recording	0.00	0.21	0.45	NA	NA	0.01	XXX
93271		A	Ecg/monitoring and analysis	0.00	4.50	5.58	NA	NA	0.02	XXX
93272		A	Ecg/review, interpret only	0.52	0.17	0.21	0.17	0.21	0.01	XXX
93278		A	ECG/signal-averaged	0.25	0.51	0.71	NA	NA	0.02	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.42	0.61	NA	NA	0.01	XXX
93278	26	A	ECG/signal-averaged	0.25	0.09	0.10	0.09	0.10	0.01	XXX
93279		A	Pm device progr eval, sngl	0.65	0.61	0.80	NA	NA	0.03	XXX
93279	TC	A	Pm device progr eval, sngl	0.00	0.39	0.49	NA	NA	0.01	XXX
93279	26	A	Pm device progr eval, sngl	0.65	0.22	0.31	0.22	0.31	0.02	XXX
93280		A	Pm device progr eval, dual	0.77	0.70	0.95	NA	NA	0.03	XXX
93280	TC	A	Pm device progr eval, dual	0.00	0.44	0.57	NA	NA	0.01	XXX
93280	26	A	Pm device progr eval, dual	0.77	0.26	0.38	0.26	0.38	0.02	XXX
93281		A	Pm device progr eval, multi	0.90	0.81	1.10	NA	NA	0.03	XXX
93281	TC	A	Pm device progr eval, multi	0.00	0.51	0.66	NA	NA	0.01	XXX
93281	26	A	Pm device progr eval, multi	0.90	0.30	0.44	0.30	0.44	0.02	XXX
93282		A	Icd device prog eval, 1 sngl	0.85	0.74	0.99	NA	NA	0.03	XXX
93282	TC	A	Icd device prog eval, 1 sngl	0.00	0.45	0.59	NA	NA	0.01	XXX
93282	26	A	Icd device prog eval, 1 sngl	0.85	0.29	0.40	0.29	0.40	0.02	XXX
93283		A	Icd device progr eval, dual	1.15	0.91	1.21	NA	NA	0.04	XXX
93283	TC	A	Icd device progr eval, dual	0.00	0.52	0.68	NA	NA	0.01	XXX
93283	26	A	Icd device progr eval, dual	1.15	0.39	0.53	0.39	0.53	0.03	XXX
93284		A	Icd device progr eval, mult	1.25	1.01	1.40	NA	NA	0.04	XXX
93284	TC	A	Icd device progr eval, mult	0.00	0.59	0.78	NA	NA	0.01	XXX
93284	26	A	Icd device progr eval, mult	1.25	0.42	0.62	0.42	0.62	0.03	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93285		A	Ilr device eval progr	0.52	0.53	0.71	NA	NA	0.02	XXX
93285	TC	A	Ilr device eval progr	0.00	0.35	0.45	NA	NA	0.01	XXX
93285	26	A	Ilr device eval progr	0.52	0.18	0.26	0.18	0.26	0.01	XXX
93286		A	Pre-op pm device eval	0.30	0.42	0.42	NA	NA	0.02	XXX
93286	TC	A	Pre-op pm device eval	0.00	0.31	0.32	NA	NA	0.01	XXX
93286	26	A	Pre-op pm device eval	0.30	0.11	0.10	0.11	0.10	0.01	XXX
93287		A	Pre-op icd device eval	0.45	0.50	0.51	NA	NA	0.02	XXX
93287	TC	A	Pre-op icd device eval	0.00	0.34	0.35	NA	NA	0.01	XXX
93287	26	A	Pre-op icd device eval	0.45	0.16	0.16	0.16	0.16	0.01	XXX
93288		A	Pm device eval in person	0.43	0.49	0.67	NA	NA	0.02	XXX
93288	TC	A	Pm device eval in person	0.00	0.35	0.46	NA	NA	0.01	XXX
93288	26	A	Pm device eval in person	0.43	0.14	0.21	0.14	0.21	0.01	XXX
93289		A	Icd device interrogate	0.92	0.74	0.96	NA	NA	0.03	XXX
93289	TC	A	Icd device interrogate	0.00	0.43	0.57	NA	NA	0.01	XXX
93289	26	A	Icd device interrogate	0.92	0.31	0.39	0.31	0.39	0.02	XXX
93290		A	Icm device eval	0.43	0.41	0.41	NA	NA	0.02	XXX
93290	TC	A	Icm device eval	0.00	0.25	0.26	NA	NA	0.01	XXX
93290	26	A	Icm device eval	0.43	0.16	0.15	0.16	0.15	0.01	XXX
93291		A	Ilr device interrogate	0.43	0.47	0.63	NA	NA	0.02	XXX
93291	TC	A	Ilr device interrogate	0.00	0.32	0.42	NA	NA	0.01	XXX
93291	26	A	Ilr device interrogate	0.43	0.15	0.21	0.15	0.21	0.01	XXX
93292		A	Wcd device interrogate	0.43	0.38	0.52	NA	NA	0.02	XXX
93292	TC	A	Wcd device interrogate	0.00	0.24	0.31	NA	NA	0.01	XXX
93292	26	A	Wcd device interrogate	0.43	0.14	0.21	0.14	0.21	0.01	XXX
93293		A	Pm phone r-strip device eval	0.32	0.99	1.18	NA	NA	0.02	XXX
93293	TC	A	Pm phone r-strip device eval	0.00	0.89	1.05	NA	NA	0.01	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.10	0.13	0.10	0.13	0.01	XXX
93294		A	Pm device interrogate remote	0.65	0.22	0.31	0.22	0.31	0.03	XXX
93295		A	Icd device interrogat remote	1.29	0.43	0.59	0.43	0.59	0.06	XXX
93296		A	Pm/icd remote tech serv	0.00	0.71	0.94	NA	NA	0.01	XXX
93297		A	Icm device interrogat remote	0.52	0.19	0.18	0.19	0.18	0.03	XXX
93298		A	Ilr device interrogat remote	0.52	0.18	0.26	0.18	0.26	0.03	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93303		A	Echo transthoracic	1.30	3.56	4.32	NA	NA	0.04	XXX
93303	TC	A	Echo transthoracic	0.00	3.12	3.77	NA	NA	0.01	XXX
93303	26	A	Echo transthoracic	1.30	0.44	0.55	0.44	0.55	0.03	XXX
93304		A	Echo transthoracic	0.75	2.48	2.79	NA	NA	0.03	XXX
93304	TC	A	Echo transthoracic	0.00	2.23	2.49	NA	NA	0.01	XXX
93304	26	A	Echo transthoracic	0.75	0.25	0.30	0.25	0.30	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93306		A	Tte w/doppler, complete	1.30	3.47	5.27	NA	NA	0.04	XXX
93306	TC	A	Tte w/doppler, complete	0.00	3.03	4.66	NA	NA	0.01	XXX
93306	26	A	Tte w/doppler, complete	1.30	0.44	0.61	0.44	0.61	0.03	XXX
93307		A	Tte w/o doppler, complete	0.92	1.87	3.32	NA	NA	0.03	XXX
93307	TC	A	Tte w/o doppler, complete	0.00	1.56	2.91	NA	NA	0.01	XXX
93307	26	A	Tte w/o doppler, complete	0.92	0.31	0.41	0.31	0.41	0.02	XXX
93308		A	Tte, f-up or lmtd	0.53	1.87	2.32	NA	NA	0.02	XXX
93308	TC	A	Tte, f-up or lmtd	0.00	1.69	2.08	NA	NA	0.01	XXX
93308	26	A	Tte, f-up or lmtd	0.53	0.18	0.24	0.18	0.24	0.01	XXX
93312		A	Echo transesophageal	2.20	5.61	6.35	NA	NA	0.07	XXX
93312	TC	A	Echo transesophageal	0.00	4.95	5.47	NA	NA	0.02	XXX
93312	26	A	Echo transesophageal	2.20	0.66	0.88	0.66	0.88	0.05	XXX
93313		A	Echo transesophageal	0.95	NA	NA	0.17	0.15	0.05	XXX
93314		A	Echo transesophageal	1.25	5.70	6.17	NA	NA	0.05	XXX
93314	TC	A	Echo transesophageal	0.00	5.30	5.66	NA	NA	0.02	XXX
93314	26	A	Echo transesophageal	1.25	0.40	0.51	0.40	0.51	0.03	XXX
93315		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	0.89	1.18	0.89	1.18	0.16	XXX
93316		A	Echo transesophageal	0.95	NA	NA	0.22	0.25	0.05	XXX
93317		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.54	0.63	0.54	0.63	0.16	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.67	0.77	0.67	0.77	0.22	XXX
93320		A	Doppler echo exam, heart	0.38	0.76	1.46	NA	NA	0.02	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	0.63	1.29	NA	NA	0.01	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.13	0.17	0.13	0.17	0.01	ZZZ
93321		A	Doppler echo exam, heart	0.15	0.44	0.67	NA	NA	0.02	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.39	0.60	NA	NA	0.01	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.05	0.07	0.05	0.07	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.41	1.03	NA	NA	0.02	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.39	1.00	NA	NA	0.01	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.02	0.03	0.02	0.03	0.01	ZZZ
93350		A	Stress tte only	1.46	3.61	4.14	NA	NA	0.04	XXX
93350	TC	A	Stress tte only	0.00	3.12	3.47	NA	NA	0.01	XXX
93350	26	A	Stress tte only	1.46	0.49	0.67	0.49	0.67	0.03	XXX
93351		A	Stress tte complete	1.75	4.11	4.91	NA	NA	0.06	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93351	TC	A	Stress tte complete	0.00	3.52	4.06	NA	NA	0.02	XXX
93351	26	A	Stress tte complete	1.75	0.59	0.85	0.59	0.85	0.04	XXX
93352		A	Admin ecg contrast agent	0.19	0.62	0.80	NA	NA	0.01	ZZZ
93501		A	Right heart catheterization	3.02	13.55	17.17	NA	NA	0.09	000
93501	TC	A	Right heart catheterization	0.00	12.54	15.79	NA	NA	0.02	000
93501	26	A	Right heart catheterization	3.02	1.01	1.38	1.01	1.38	0.07	000
93503		A	Insert/place heart catheter	2.91	NA	NA	0.77	0.77	0.18	000
93505		A	Biopsy of heart lining	4.37	15.07	15.93	NA	NA	0.21	000
93505	TC	A	Biopsy of heart lining	0.00	13.61	13.93	NA	NA	0.02	000
93505	26	A	Biopsy of heart lining	4.37	1.46	2.00	1.46	2.00	0.19	000
93508		A	Cath placement, angiography	4.09	20.72	23.86	NA	NA	0.12	000
93508	TC	A	Cath placement, angiography	0.00	19.36	21.86	NA	NA	0.03	000
93508	26	A	Cath placement, angiography	4.09	1.36	2.00	1.36	2.00	0.09	000
93510		A	Left heart catheterization	4.32	20.22	28.05	NA	NA	0.13	000
93510	TC	A	Left heart catheterization	0.00	18.78	25.95	NA	NA	0.03	000
93510	26	A	Left heart catheterization	4.32	1.44	2.10	1.44	2.10	0.10	000
93511		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93511	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93511	26	A	Left heart catheterization	5.02	1.67	2.43	1.67	2.43	0.25	000
93514		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93514	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93514	26	A	Left heart catheterization	7.04	2.35	3.25	2.35	3.25	0.34	000
93524		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93524	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93524	26	A	Left heart catheterization	6.94	2.32	3.34	2.32	3.34	0.33	000
93526		A	Rt & Lt heart catheters	5.98	25.17	35.39	NA	NA	0.17	000
93526	TC	A	Rt & Lt heart catheters	0.00	23.18	32.51	NA	NA	0.03	000
93526	26	A	Rt & Lt heart catheters	5.98	1.99	2.88	1.99	2.88	0.14	000
93527		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93527	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93527	26	A	Rt & Lt heart catheters	7.27	2.42	3.47	2.42	3.47	0.36	000
93528		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	26	A	Rt & Lt heart catheters	8.99	3.08	3.89	3.08	3.89	0.44	000
93529		C	Rt, lt heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93529	TC	C	Rt, lt heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93529	26	A	Rt, lt heart catheterization	4.79	1.63	2.33	1.63	2.33	0.23	000
93530		C	Rt heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93530	TC	C	Rt heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93530	26	A	Rt heart cath, congenital	4.22	1.41	1.88	1.41	1.88	0.24	000
93531		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93531	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93531	26	A	R & l heart cath, congenital	8.34	2.78	3.61	2.78	3.61	0.40	000
93532		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93532	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93532	26	A	R & l heart cath, congenital	9.99	3.33	4.21	3.33	4.21	0.48	000
93533		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93533	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93533	26	A	R & l heart cath, congenital	6.69	2.22	2.85	2.22	2.85	0.32	000
93539		A	Injection, cardiac cath	0.40	1.77	1.83	0.13	0.19	0.02	000
93540		A	Injection, cardiac cath	0.43	6.24	6.30	0.14	0.20	0.02	000
93541		A	Injection for lung angiogram	0.29	0.10	0.13	0.10	0.13	0.01	000
93542		A	Injection for heart x-rays	0.29	3.80	3.80	0.10	0.13	0.01	000
93543		A	Injection for heart x-rays	0.29	1.89	1.93	0.10	0.13	0.01	000
93544		A	Injection for aortography	0.25	1.33	1.36	0.08	0.12	0.01	000
93545		A	Inject for coronary x-rays	0.40	4.25	4.30	0.13	0.19	0.02	000
93555		A	Imaging, cardiac cath	0.81	0.38	1.69	NA	NA	0.03	XXX
93555	TC	A	Imaging, cardiac cath	0.00	0.11	1.32	NA	NA	0.01	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.27	0.37	0.27	0.37	0.02	XXX
93556		A	Imaging, cardiac cath	0.83	0.57	2.58	NA	NA	0.03	XXX
93556	TC	A	Imaging, cardiac cath	0.00	0.29	2.20	NA	NA	0.01	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.28	0.38	0.28	0.38	0.02	XXX
93561		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	26	A	Cardiac output measurement	0.50	0.16	0.15	0.16	0.15	0.03	000
93562		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	26	A	Cardiac output measurement	0.16	0.04	0.04	0.04	0.04	0.01	000
93571		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.60	0.83	0.60	0.83	0.09	ZZZ
93572		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.48	0.64	0.48	0.64	0.09	ZZZ
93580		A	Transcath closure of asd	17.97	NA	NA	6.30	8.49	0.89	000
93581		A	Transcath closure of vsd	24.39	NA	NA	8.40	10.44	1.18	000
93600		C	Bundle of His recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	TC	C	Bundle of His recording	0.00	0.00	0.00	NA	NA	0.00	000

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
93600	26	A	Bundle of His recording	2.12	0.71	0.97	0.71	0.97	0.11	000
93602		C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	TC	C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	26	A	Intra-atrial recording	2.12	0.70	0.95	0.70	0.95	0.13	000
93603		C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	TC	C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	26	A	Right ventricular recording	2.12	0.70	0.95	0.70	0.95	0.14	000
93609		C	Map tachycardia, add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	TC	C	Map tachycardia, add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	1.67	2.30	1.67	2.30	0.25	ZZZ
93610		C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	TC	C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	26	A	Intra-atrial pacing	3.02	0.99	1.34	0.99	1.34	0.19	000
93612		C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	TC	C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	26	A	Intraventricular pacing	3.02	0.99	1.32	0.99	1.32	0.20	000
93613		A	Electrophys map 3d, add-on	6.99	NA	NA	2.33	3.25	0.35	ZZZ
93615		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	26	A	Esophageal recording	0.99	0.33	0.44	0.33	0.44	0.05	000
93616		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	26	A	Esophageal recording	1.49	0.24	0.33	0.24	0.33	0.09	000
93618		C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	1.41	2.00	1.41	2.00	0.21	000
93619		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	2.43	3.48	2.43	3.48	0.36	000
93620		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	3.87	5.41	3.87	5.41	0.58	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.10	0.70	0.97	0.70	0.97	0.11	ZZZ
93622		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.03	1.40	1.03	1.40	0.16	ZZZ
93623		C	Stimulation, pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	0.95	1.32	0.95	1.32	0.15	ZZZ
93624		C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	TC	C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	26	A	Electrophysiologic study	4.80	1.59	2.29	1.59	2.29	0.24	000
93631		C	Heart pacing, mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	TC	C	Heart pacing, mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	26	A	Heart pacing, mapping	7.59	2.38	2.71	2.38	2.71	1.13	000
93640		C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.18	1.61	1.18	1.61	0.21	000
93641		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	26	A	Electrophysiology evaluation	5.92	1.97	2.74	1.97	2.74	0.31	000
93642		A	Electrophysiology evaluation	4.88	4.91	7.09	NA	NA	0.14	000
93642	TC	A	Electrophysiology evaluation	0.00	3.27	4.76	NA	NA	0.03	000
93642	26	A	Electrophysiology evaluation	4.88	1.64	2.33	1.64	2.33	0.11	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	NA	3.73	5.12	0.53	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	NA	5.42	7.50	0.81	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	NA	5.91	8.18	0.89	000
93660		A	Tilt table evaluation	1.89	2.03	2.63	NA	NA	0.07	000
93660	TC	A	Tilt table evaluation	0.00	1.39	1.76	NA	NA	0.02	000
93660	26	A	Tilt table evaluation	1.89	0.64	0.87	0.64	0.87	0.05	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	0.93	1.29	0.93	1.29	0.14	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.44	0.46	NA	NA	0.01	XXX
93701		A	Bioimpedance, cv analysis	0.00	0.55	0.71	NA	NA	0.02	XXX
93720		A	Total body plethysmography	0.17	1.00	1.05	NA	NA	0.02	XXX
93721		A	Plethysmography tracing	0.00	0.95	1.00	NA	NA	0.01	XXX
93722		A	Plethysmography report	0.17	0.05	0.05	0.05	0.05	0.01	XXX
93724		A	Analyze pacemaker system	4.88	2.28	3.64	NA	NA	0.12	000
93724	TC	A	Analyze pacemaker system	0.00	0.62	1.40	NA	NA	0.01	000
93724	26	A	Analyze pacemaker system	4.88	1.66	2.24	1.66	2.24	0.11	000
93740		B	Temperature gradient studies	0.16	NA	NA	NA	NA	0.02	XXX
93740	TC	B	Temperature gradient studies	0.00	NA	NA	NA	NA	0.01	XXX
93740	26	B	Temperature gradient studies	0.16	0.06	0.05	0.06	0.05	0.01	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93750		A	Interrogation vad, in person	0.92	0.48	0.48	0.30	0.30	0.05	XXX
93770		B	Measure venous pressure	0.16	NA	NA	NA	NA	0.02	XXX
93770	TC	B	Measure venous pressure	0.00	NA	NA	NA	NA	0.01	XXX
93770	26	B	Measure venous pressure	0.16	0.06	0.05	0.06	0.05	0.01	XXX
93784		A	Ambulatory BP monitoring	0.38	1.25	1.38	NA	NA	0.03	XXX
93786		A	Ambulatory BP recording	0.00	0.71	0.80	NA	NA	0.01	XXX
93788		A	Ambulatory BP analysis	0.00	0.40	0.44	NA	NA	0.01	XXX
93790		A	Review/report BP recording	0.38	0.14	0.14	0.14	0.14	0.01	XXX
93797		A	Cardiac rehab	0.18	0.26	0.30	0.07	0.08	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.34	0.42	0.10	0.12	0.01	000
93799		C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.37	2.48	NA	NA	0.02	XXX
93875	TC	A	Extracranial study	0.00	2.29	2.40	NA	NA	0.01	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.08	0.08	0.01	XXX
93880		A	Extracranial study	0.60	5.38	5.87	NA	NA	0.05	XXX
93880	TC	A	Extracranial study	0.00	5.19	5.65	NA	NA	0.02	XXX
93880	26	A	Extracranial study	0.60	0.19	0.22	0.19	0.22	0.03	XXX
93882		A	Extracranial study	0.40	3.97	3.96	NA	NA	0.05	XXX
93882	TC	A	Extracranial study	0.00	3.84	3.83	NA	NA	0.01	XXX
93882	26	A	Extracranial study	0.40	0.13	0.13	0.13	0.13	0.04	XXX
93886		A	Intracranial study	0.94	7.85	7.23	NA	NA	0.05	XXX
93886	TC	A	Intracranial study	0.00	7.51	6.91	NA	NA	0.02	XXX
93886	26	A	Intracranial study	0.94	0.34	0.32	0.34	0.32	0.03	XXX
93888		A	Intracranial study	0.62	4.87	4.81	NA	NA	0.04	XXX
93888	TC	A	Intracranial study	0.00	4.65	4.59	NA	NA	0.01	XXX
93888	26	A	Intracranial study	0.62	0.22	0.22	0.22	0.22	0.03	XXX
93890		A	Tcd, vasoreactivity study	1.00	6.74	6.15	NA	NA	0.05	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	6.37	5.80	NA	NA	0.02	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.37	0.35	0.37	0.35	0.03	XXX
93892		A	Tcd, emboli detect w/o inj	1.15	8.74	7.06	NA	NA	0.05	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	8.31	6.67	NA	NA	0.02	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.43	0.39	0.43	0.39	0.03	XXX
93893		A	Tcd, emboli detect w/inj	1.15	8.06	6.88	NA	NA	0.06	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	7.63	6.48	NA	NA	0.02	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.43	0.40	0.43	0.40	0.04	XXX
93922		A	Extremity study	0.25	2.85	2.96	NA	NA	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93922	TC	A	Extremity study	0.00	2.77	2.88	NA	NA	0.01	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.08	0.08	0.01	XXX
93923		A	Extremity study	0.45	4.27	4.48	NA	NA	0.04	XXX
93923	TC	A	Extremity study	0.00	4.13	4.33	NA	NA	0.01	XXX
93923	26	A	Extremity study	0.45	0.14	0.15	0.14	0.15	0.03	XXX
93924		A	Extremity study	0.50	5.24	5.57	NA	NA	0.05	XXX
93924	TC	A	Extremity study	0.00	5.08	5.39	NA	NA	0.02	XXX
93924	26	A	Extremity study	0.50	0.16	0.18	0.16	0.18	0.03	XXX
93925		A	Lower extremity study	0.58	7.03	7.57	NA	NA	0.05	XXX
93925	TC	A	Lower extremity study	0.00	6.84	7.37	NA	NA	0.02	XXX
93925	26	A	Lower extremity study	0.58	0.19	0.20	0.19	0.20	0.03	XXX
93926		A	Lower extremity study	0.39	4.66	4.84	NA	NA	0.05	XXX
93926	TC	A	Lower extremity study	0.00	4.54	4.71	NA	NA	0.01	XXX
93926	26	A	Lower extremity study	0.39	0.12	0.13	0.12	0.13	0.04	XXX
93930		A	Upper extremity study	0.46	5.63	5.93	NA	NA	0.05	XXX
93930	TC	A	Upper extremity study	0.00	5.48	5.77	NA	NA	0.02	XXX
93930	26	A	Upper extremity study	0.46	0.15	0.16	0.15	0.16	0.03	XXX
93931		A	Upper extremity study	0.31	3.72	3.96	NA	NA	0.03	XXX
93931	TC	A	Upper extremity study	0.00	3.62	3.86	NA	NA	0.01	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.10	0.10	0.02	XXX
93965		A	Extremity study	0.35	2.67	2.91	NA	NA	0.03	XXX
93965	TC	A	Extremity study	0.00	2.56	2.79	NA	NA	0.01	XXX
93965	26	A	Extremity study	0.35	0.11	0.12	0.11	0.12	0.02	XXX
93970		A	Extremity study	0.68	5.57	5.92	NA	NA	0.07	XXX
93970	TC	A	Extremity study	0.00	5.36	5.69	NA	NA	0.02	XXX
93970	26	A	Extremity study	0.68	0.21	0.23	0.21	0.23	0.05	XXX
93971		A	Extremity study	0.45	3.61	3.90	NA	NA	0.05	XXX
93971	TC	A	Extremity study	0.00	3.47	3.74	NA	NA	0.01	XXX
93971	26	A	Extremity study	0.45	0.14	0.16	0.14	0.16	0.04	XXX
93975		A	Vascular study	1.80	7.34	8.07	NA	NA	0.12	XXX
93975	TC	A	Vascular study	0.00	6.77	7.43	NA	NA	0.02	XXX
93975	26	A	Vascular study	1.80	0.57	0.64	0.57	0.64	0.10	XXX
93976		A	Vascular study	1.21	4.00	4.44	NA	NA	0.07	XXX
93976	TC	A	Vascular study	0.00	3.63	4.01	NA	NA	0.01	XXX
93976	26	A	Vascular study	1.21	0.37	0.43	0.37	0.43	0.06	XXX
93978		A	Vascular study	0.65	5.27	5.56	NA	NA	0.07	XXX
93978	TC	A	Vascular study	0.00	5.06	5.34	NA	NA	0.02	XXX
93978	26	A	Vascular study	0.65	0.21	0.22	0.21	0.22	0.05	XXX
93979		A	Vascular study	0.44	3.62	3.86	NA	NA	0.04	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93979	TC	A	Vascular study	0.00	3.48	3.71	NA	NA	0.01	XXX
93979	26	A	Vascular study	0.44	0.14	0.15	0.14	0.15	0.03	XXX
93980		A	Penile vascular study	1.25	3.01	3.40	NA	NA	0.06	XXX
93980	TC	A	Penile vascular study	0.00	2.59	2.92	NA	NA	0.01	XXX
93980	26	A	Penile vascular study	1.25	0.42	0.48	0.42	0.48	0.05	XXX
93981		A	Penile vascular study	0.44	2.32	2.76	NA	NA	0.03	XXX
93981	TC	A	Penile vascular study	0.00	2.18	2.60	NA	NA	0.01	XXX
93981	26	A	Penile vascular study	0.44	0.14	0.16	0.14	0.16	0.02	XXX
93982		R	Aneurysm pressure sens study	0.30	0.76	0.80	NA	NA	0.04	XXX
93990		A	Doppler flow testing	0.25	5.14	4.99	NA	NA	0.04	XXX
93990	TC	A	Doppler flow testing	0.00	5.06	4.92	NA	NA	0.01	XXX
93990	26	A	Doppler flow testing	0.25	0.08	0.07	0.08	0.07	0.03	XXX
94002		A	Vent mgmt inpat, init day	1.99	NA	NA	0.46	0.38	0.12	XXX
94003		A	Vent mgmt inpat, subq day	1.37	NA	NA	0.40	0.35	0.08	XXX
94004		A	Vent mgmt nf per day	1.00	NA	NA	0.28	0.26	0.05	XXX
94005		B	Home vent mgmt supervision	1.50	0.92	0.91	NA	NA	0.08	XXX
94010		A	Breathing capacity test	0.17	0.70	0.72	NA	NA	0.03	XXX
94010	TC	A	Breathing capacity test	0.00	0.64	0.67	NA	NA	0.02	XXX
94010	26	A	Breathing capacity test	0.17	0.06	0.05	0.06	0.05	0.01	XXX
94011		A	Up to 2 yrs old, spirometry	2.00	0.62	0.62	0.62	0.62	0.05	XXX
94012		A	= 2 yrs, spiromtry w/dilator	3.10	0.94	0.94	0.94	0.94	0.08	XXX
94013		A	= 2 yrs, lung volumes	0.66	0.18	0.18	0.18	0.18	0.03	XXX
94014		A	Patient recorded spirometry	0.52	0.73	0.79	NA	NA	0.02	XXX
94015		A	Patient recorded spirometry	0.00	0.57	0.63	NA	NA	0.01	XXX
94016		A	Review patient spirometry	0.52	0.16	0.16	0.16	0.16	0.01	XXX
94060		A	Evaluation of wheezing	0.31	1.20	1.24	NA	NA	0.02	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.10	1.15	NA	NA	0.01	XXX
94060	26	A	Evaluation of wheezing	0.31	0.10	0.09	0.10	0.09	0.01	XXX
94070		A	Evaluation of wheezing	0.60	0.93	0.95	NA	NA	0.03	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.74	0.78	NA	NA	0.01	XXX
94070	26	A	Evaluation of wheezing	0.60	0.19	0.17	0.19	0.17	0.02	XXX
94150		B	Vital capacity test	0.07	0.52	0.54	NA	NA	0.02	XXX
94150	TC	B	Vital capacity test	0.00	0.49	0.51	NA	NA	0.01	XXX
94150	26	B	Vital capacity test	0.07	0.03	0.03	0.03	0.03	0.01	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.47	0.49	NA	NA	0.02	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.44	0.46	NA	NA	0.01	XXX
94200	26	A	Lung function test	0.11	0.03	0.03	0.03	0.03	0.01	XXX
94240		A	Residual lung capacity	0.26	0.72	0.76	NA	NA	0.02	XXX
94240	TC	A	Residual lung capacity	0.00	0.64	0.69	NA	NA	0.01	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94250		A	Expired gas collection	0.11	0.47	0.53	NA	NA	0.02	XXX
94250	TC	A	Expired gas collection	0.00	0.44	0.50	NA	NA	0.01	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.03	0.03	0.01	XXX
94260		A	Thoracic gas volume	0.13	0.65	0.69	NA	NA	0.02	XXX
94260	TC	A	Thoracic gas volume	0.00	0.61	0.66	NA	NA	0.01	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.03	0.04	0.03	0.01	XXX
94350		A	Lung nitrogen washout curve	0.26	0.58	0.64	NA	NA	0.02	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.50	0.57	NA	NA	0.01	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94360		A	Measure airflow resistance	0.26	0.84	0.87	NA	NA	0.02	XXX
94360	TC	A	Measure airflow resistance	0.00	0.76	0.80	NA	NA	0.01	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.57	0.62	NA	NA	0.02	XXX
94370	TC	A	Breath airway closing volume	0.00	0.49	0.55	NA	NA	0.01	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94375		A	Respiratory flow volume loop	0.31	0.65	0.69	NA	NA	0.02	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.56	0.60	NA	NA	0.01	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.09	0.09	0.09	0.09	0.01	XXX
94400		A	CO2 breathing response curve	0.40	0.94	0.98	NA	NA	0.02	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.83	0.87	NA	NA	0.01	XXX
94400	26	A	CO2 breathing response curve	0.40	0.11	0.11	0.11	0.11	0.01	XXX
94450		A	Hypoxia response curve	0.40	1.34	1.06	NA	NA	0.02	XXX
94450	TC	A	Hypoxia response curve	0.00	1.19	0.95	NA	NA	0.01	XXX
94450	26	A	Hypoxia response curve	0.40	0.15	0.11	0.15	0.11	0.01	XXX
94452		A	Hast w/report	0.31	1.07	1.17	NA	NA	0.02	XXX
94452	TC	A	Hast w/report	0.00	0.98	1.09	NA	NA	0.01	XXX
94452	26	A	Hast w/report	0.31	0.09	0.08	0.09	0.08	0.01	XXX
94453		A	Hast w/oxygen titrate	0.40	1.48	1.60	NA	NA	0.02	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.37	1.49	NA	NA	0.01	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.11	0.11	0.11	0.11	0.01	XXX
94610		A	Surfactant admin thru tube	1.16	0.46	0.40	0.46	0.40	0.05	XXX
94620		A	Pulmonary stress test/simple	0.64	0.75	1.12	NA	NA	0.03	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.56	0.93	NA	NA	0.01	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.19	0.19	0.19	0.19	0.02	XXX
94621		A	Pulm stress test/complex	1.42	2.64	2.87	NA	NA	0.05	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
94621	TC	A	Pulm stress test/complex	0.00	2.20	2.40	NA	NA	0.02	XXX
94621	26	A	Pulm stress test/complex	1.42	0.44	0.47	0.44	0.47	0.03	XXX
94640		A	Airway inhalation treatment	0.00	0.41	0.37	NA	NA	0.01	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94644		A	Cbt, 1st hour	0.00	1.01	0.96	NA	NA	0.01	XXX
94645		A	Cbt, each addl hour	0.00	0.32	0.35	NA	NA	0.01	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.80	0.77	0.24	0.21	0.04	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	NA	0.20	0.20	0.04	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.40	0.38	NA	NA	0.01	XXX
94667		A	Chest wall manipulation	0.00	0.54	0.53	NA	NA	0.01	XXX
94668		A	Chest wall manipulation	0.00	0.53	0.52	NA	NA	0.01	XXX
94680		A	Exhaled air analysis, o2	0.26	1.10	1.25	NA	NA	0.02	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.01	1.17	NA	NA	0.01	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.09	0.08	0.09	0.08	0.01	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	1.05	1.35	NA	NA	0.02	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	0.98	1.29	NA	NA	0.01	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.07	0.06	0.07	0.06	0.01	XXX
94690		A	Exhaled air analysis	0.07	1.10	1.25	NA	NA	0.02	XXX
94690	TC	A	Exhaled air analysis	0.00	1.07	1.23	NA	NA	0.01	XXX
94690	26	A	Exhaled air analysis	0.07	0.03	0.02	0.03	0.02	0.01	XXX
94720		A	Monoxide diffusing capacity	0.26	1.00	1.08	NA	NA	0.02	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.92	1.01	NA	NA	0.01	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94725		A	Membrane diffusion capacity	0.26	0.94	1.35	NA	NA	0.02	XXX
94725	TC	A	Membrane diffusion capacity	0.00	0.86	1.28	NA	NA	0.01	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94750		A	Pulmonary compliance study	0.23	1.72	1.71	NA	NA	0.02	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.65	1.65	NA	NA	0.01	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.06	0.07	0.06	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.06	0.06	NA	NA	0.01	XXX
94761		T	Measure blood oxygen level	0.00	0.10	0.10	NA	NA	0.01	XXX
94762		A	Measure blood oxygen level	0.00	0.26	0.61	NA	NA	0.01	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.82	0.78	NA	NA	0.02	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.77	0.74	NA	NA	0.01	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.05	0.04	0.05	0.04	0.01	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec, compl	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94775		C	Ped home apnea rec, hk-up	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec, downld	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec, report	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.14	0.14	NA	NA	0.01	XXX
95010		A	Percut allergy titrate test	0.15	0.31	0.32	NA	NA	0 01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.47	0.52	NA	NA	0 01	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.20	0.20	NA	NA	0.01	XXX
95024		A	Id allergy test, drug/bug	0.01	0.16	0.17	NA	NA	0.01	XXX
95027		A	Id allergy titrate-airborne	0.01	0.10	0.11	NA	NA	0.01	XXX
95028		A	Id allergy test-delayed type	0.00	0.32	0.30	NA	NA	0.01	XXX
95044		A	Allergy patch tests	0.00	0.13	0.15	NA	NA	0.01	XXX
95052		A	Photo patch test	0.00	0.14	0.17	NA	NA	0.01	XXX
95056		A	Photosensitivity tests	0.00	1.03	0.98	NA	NA	0.01	XXX
95060		A	Eye allergy tests	0.00	0.78	0.67	0.78	0.67	0.01	XXX
95065		A	Nose allergy test	0.00	0.60	0.59	0.60	0.59	0.01	XXX
95070		A	Bronchial allergy tests	0.00	0.68	1.06	NA	NA	0.01	XXX
95071		A	Bronchial allergy tests	0.00	0.83	1.31	NA	NA	0.01	XXX
95075		A	Ingestion challenge test	0.95	0.75	0.75	0.35	0.33	0.03	XXX
95115		A	Immunotherapy, one injection	0.00	0.22	0.26	NA	NA	0.01	XXX
95117		A	Immunotherapy injections	0.00	0.26	0.32	NA	NA	0.01	XXX
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.25	0.25	0.02	0.02	0.01	XXX
95145		A	Antigen therapy services	0.06	0.32	0.35	0.02	0.02	0.01	XXX
95146		A	Antigen therapy services	0.06	0.59	0.62	0.02	0.02	0.01	XXX
95147		A	Antigen therapy services	0.06	0.58	0.60	0.02	0.02	0.01	XXX
95148		A	Antigen therapy services	0.06	0.86	0.88	0.02	0.02	0.01	XXX
95149		A	Antigen therapy services	0.06	1.14	1.17	0.02	0.02	0.01	XXX
95165		A	Antigen therapy services	0.06	0.25	0.26	0.02	0.02	0.01	XXX
95170		A	Antigen therapy services	0.06	0.18	0.18	0.02	0.02	0.01	XXX
95180		A	Rapid desensitization	2.01	1.61	1.78	0.82	0.87	0.06	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95250		A	Glucose monitoring, cont	0.00	3.56	3.61	NA	NA	0.01	XXX
95251		A	Gluc monitor, cont, phys i&r	0.85	0.34	0.26	0.34	0.26	0.04	XXX
95803		C	Actigraphy testing	0.00	0.00	0.00	NA	NA	0.00	XXX
95803	TC	C	Actigraphy testing	0.00	0.00	0.00	NA	NA	0.00	XXX
95803	26	C	Actigraphy testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95805		A	Multiple sleep latency test	1.88	6.33	8.76	NA	NA	0.09	XXX
95805	TC	A	Multiple sleep latency test	0.00	5.73	8.18	NA	NA	0.04	XXX
95805	26	A	Multiple sleep latency test	1.88	0.60	0.58	0.60	0.58	0.05	XXX
95806		A	Sleep study unatt&resp efft	1.66	3.73	3.81	NA	NA	0.07	XXX
95806	TC	A	Sleep study unatt&resp efft	0.00	3.18	3.29	NA	NA	0.03	XXX
95806	26	A	Sleep study unatt&resp efft	1.66	0.55	0.52	0.55	0.52	0.04	XXX
95807		A	Sleep study, attended	1.66	9.54	11.21	NA	NA	0.13	XXX
95807	TC	A	Sleep study, attended	0.00	9.03	10.71	NA	NA	0.09	XXX
95807	26	A	Sleep study, attended	1.66	0.51	0.50	0.51	0.50	0.04	XXX
95808		A	Polysomnography, 1-3	2.65	16.26	15.33	NA	NA	0.17	XXX
95808	TC	A	Polysomnography, 1-3	0.00	15.36	14.51	NA	NA	0.09	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.90	0.82	0.90	0.82	0.08	XXX
95810		A	Polysomnography, 4 or more	3.52	15.93	17.14	NA	NA	0.19	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	14.81	16.09	NA	NA	0.10	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.12	1.05	1.12	1.05	0.09	XXX
95811		A	Polysomnography w/cpap	3.79	17.63	19.00	NA	NA	0.21	XXX
95811	TC	A	Polysomnography w/cpap	0.00	16.44	17.88	NA	NA	0.11	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.19	1.12	1.19	1.12	0.10	XXX
95812		A	Eeg, 41-60 minutes	1.08	8.29	6.12	NA	NA	0.06	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	7.87	5.75	NA	NA	0.03	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.42	0.37	0.42	0.37	0.03	XXX
95813		A	Eeg, over 1 hour	1.73	8.90	6.88	NA	NA	0.08	XXX
95813	TC	A	Eeg, over 1 hour	0.00	8.22	6.29	NA	NA	0.03	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.68	0.59	0.68	0.59	0.05	XXX
95816		A	Eeg, awake and drowsy	1.08	7.51	5.52	NA	NA	0.06	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	7.09	5.15	NA	NA	0.02	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.42	0.37	0.42	0.37	0.04	XXX
95819		A	Eeg, awake and asleep	1.08	8.70	6.16	NA	NA	0.06	XXX
95819	TC	A	Eeg, awake and asleep	0.00	8.28	5.79	NA	NA	0.03	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.42	0.37	0.42	0.37	0.03	XXX
95822		A	Eeg, coma or sleep only	1.08	7.80	5.89	NA	NA	0.05	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	7.38	5.52	NA	NA	0.02	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.42	0.37	0.42	0.37	0.03	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved. Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
95824		C	Eeg, cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	TC	C	Eeg, cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.29	0.26	0.29	0.26	0.04	XXX
95827		A	Eeg, all night recording	1.08	16.97	11.23	NA	NA	0.11	XXX
95827	TC	A	Eeg, all night recording	0.00	16.55	10.86	NA	NA	0.08	XXX
95827	26	A	Eeg, all night recording	1.08	0.42	0.37	0.42	0.37	0.03	XXX
95829		A	Surgery electrocorticogram	6.20	35.68	29.28	NA	NA	0.14	XXX
95829	TC	A	Surgery electrocorticogram	0.00	33.19	27.11	NA	NA	0.04	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.49	2.17	2.49	2.17	0.10	XXX
95830		A	Insert electrodes for EEG	1.70	3.76	3.26	0.63	0.57	0.10	XXX
95831		A	Limb muscle testing, manual	0.28	0.49	0.44	0.11	0.10	0.02	XXX
95832		A	Hand muscle testing, manual	0.29	0.47	0.39	0.13	0.11	0.03	XXX
95833		A	Body muscle testing, manual	0.47	0.50	0.49	0.13	0.16	0.01	XXX
95834		A	Body muscle testing, manual	0.60	0.66	0.57	0.20	0.19	0.02	XXX
95851		A	Range of motion measurements	0.16	0.30	0.29	0.05	0.05	0.01	XXX
95852		A	Range of motion measurements	0.11	0.29	0.25	0.04	0.04	0.01	XXX
95857		A	Tensilon test	0.53	0.78	0.64	0.24	0.21	0.03	XXX
95860		A	Muscle test, one limb	0.96	1.54	1.30	NA	NA	0.03	XXX
95860	TC	A	Muscle test, one limb	0.00	1.13	0.93	NA	NA	0.01	XXX
95860	26	A	Muscle test, one limb	0.96	0.41	0.37	0.41	0.37	0.02	XXX
95861		A	Muscle test, 2 limbs	1.54	2.17	1.75	NA	NA	0.05	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	1.52	1.16	NA	NA	0.01	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.65	0.59	0.65	0.59	0.04	XXX
95863		A	Muscle test, 3 limbs	1.87	2.62	2.07	NA	NA	0.06	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	1.86	1.39	NA	NA	0.01	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.76	0.68	0.76	0.68	0.05	XXX
95864		A	Muscle test, 4 limbs	1.99	2.82	2.42	NA	NA	0.06	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	2.00	1.68	NA	NA	0.01	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.82	0.74	0.82	0.74	0.05	XXX
95865		A	Muscle test, larynx	1.57	1.70	1.52	NA	NA	0.04	XXX
95865	TC	A	Muscle test, larynx	0.00	0.99	0.89	NA	NA	0.01	XXX
95865	26	A	Muscle test, larynx	1.57	0.71	0.63	0.71	0.63	0.03	XXX
95866		A	Muscle test, hemidiaphragm	1.25	1.70	1.34	NA	NA	0.05	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	1.21	0.86	NA	NA	0.01	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.49	0.48	0.49	0.48	0.04	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.47	1.20	NA	NA	0.03	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	1.13	0.90	NA	NA	0.01	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.34	0.30	0.34	0.30	0.02	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.87	1.53	NA	NA	0.04	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved. Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
95868	TC	A	Muscle test cran nerve bilat	0.00	1.38	1.09	NA	NA	0.01	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.49	0.44	0.49	0.44	0.03	XXX
95869		A	Muscle test, thor paraspinal	0.37	1.40	0.99	NA	NA	0.02	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	1.25	0.85	NA	NA	0.01	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.15	0.14	0.15	0.14	0.01	XXX
95870		A	Muscle test, nonparaspinal	0.37	1.34	0.95	NA	NA	0.02	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	1.19	0.81	NA	NA	0.01	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.15	0.14	0.15	0.14	0.01	XXX
95872		A	Muscle test, one fiber	2.88	2.16	1.72	NA	NA	0.09	XXX
95872	TC	A	Muscle test, one fiber	0.00	1.02	0.78	NA	NA	0.01	XXX
95872	26	A	Muscle test, one fiber	2.88	1.14	0.94	1.14	0.94	0.08	XXX
95873		A	Guide nerv destr, elec stim	0.37	1.35	0.99	NA	NA	0.02	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	1.17	0.82	NA	NA	0.01	ZZZ
95873	26	A	Guide nerv destr, elec stim	0.37	0.18	0.17	0.18	0.17	0.01	ZZZ
95874		A	Guide nerv destr, needle emg	0.37	1.28	0.92	NA	NA	0.02	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	1.12	0.77	NA	NA	0.01	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.16	0.15	0.16	0.15	0.01	ZZZ
95875		A	Limb exercise test	1.10	1.85	1.49	NA	NA	0.04	XXX
95875	TC	A	Limb exercise test	0.00	1.42	1.10	NA	NA	0.01	XXX
95875	26	A	Limb exercise test	1.10	0.43	0.39	0.43	0.39	0.03	XXX
95900		A	Motor nerve conduction test	0.42	1.21	1.06	NA	NA	0.02	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.03	0.90	NA	NA	0.01	XXX
95900	26	A	Motor nerve conduction test	0.42	0.18	0.16	0.18	0.16	0.01	XXX
95903		A	Motor nerve conduction test	0.60	1.29	1.13	NA	NA	0.03	XXX
95903	TC	A	Motor nerve conduction test	0.00	1.05	0.92	NA	NA	0.01	XXX
95903	26	A	Motor nerve conduction test	0.60	0.24	0.21	0.24	0.21	0.02	XXX
95904		A	Sense nerve conduction test	0.34	1.09	0.97	NA	NA	0.02	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.95	0.84	NA	NA	0.01	XXX
95904	26	A	Sense nerve conduction test	0.34	0.14	0.13	0.14	0.13	0.01	XXX
95905		A	Motor/sens nrve conduct test	0.05	2.04	2.04	NA	NA	0.02	XXX
95905	TC	A	Motor/sens nrve conduct test	0.00	2.02	2.02	NA	NA	0.01	XXX
95905	26	A	Motor/sens nrve conduct test	0.05	0.02	0.02	0.02	0.02	0.01	XXX
95920		A	Intraop nerve test add-on	2.11	2.23	1.95	NA	NA	0.07	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.39	1.20	NA	NA	0.01	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.84	0.75	0.84	0.75	0.06	ZZZ
95921		A	Autonomic nerv function test	0.90	1.27	1.13	NA	NA	0.03	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.94	0.82	NA	NA	0.01	XXX
95921	26	A	Autonomic nerv function test	0.90	0.33	0.31	0.33	0.31	0.02	XXX
95922		A	Autonomic nerv function test	0.96	1.76	1.50	NA	NA	0.03	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.40	1.17	NA	NA	0.01	XXX
95922	26	A	Autonomic nerv function test	0.96	0.36	0.33	0.36	0.33	0.02	XXX
95923		A	Autonomic nerv function test	0.90	3.20	2.49	NA	NA	0.04	XXX
95923	TC	A	Autonomic nerv function test	0.00	2.85	2.17	NA	NA	0.01	XXX
95923	26	A	Autonomic nerv function test	0.90	0.35	0.32	0.35	0.32	0.03	XXX
95925		A	Somatosensory testing	0.54	4.06	3.00	NA	NA	0.03	XXX
95925	TC	A	Somatosensory testing	0.00	3.85	2.81	NA	NA	0.02	XXX
95925	26	A	Somatosensory testing	0.54	0.21	0.19	0.21	0.19	0.01	XXX
95926		A	Somatosensory testing	0.54	3.92	2.92	NA	NA	0.03	XXX
95926	TC	A	Somatosensory testing	0.00	3.71	2.73	NA	NA	0.02	XXX
95926	26	A	Somatosensory testing	0.54	0.21	0.19	0.21	0.19	0.01	XXX
95927		A	Somatosensory testing	0.54	3.37	2.84	NA	NA	0.03	XXX
95927	TC	A	Somatosensory testing	0.00	3.16	2.64	NA	NA	0.02	XXX
95927	26	A	Somatosensory testing	0.54	0.21	0.20	0.21	0.20	0.01	XXX
95928		A	C motor evoked, uppr limbs	1.50	5.28	4.04	NA	NA	0.07	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	4.69	3.52	NA	NA	0.02	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.59	0.52	0.59	0.52	0.05	XXX
95929		A	C motor evoked, lwr limbs	1.50	5.70	4.36	NA	NA	0.07	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	5.11	3.83	NA	NA	0.02	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.59	0.53	0.59	0.53	0.05	XXX
95930		A	Visual evoked potential test	0.35	3.41	2.74	NA	NA	0.02	XXX
95930	TC	A	Visual evoked potential test	0.00	3.26	2.61	NA	NA	0.01	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.13	0.15	0.13	0.01	XXX
95933		A	Blink reflex test	0.59	1.55	1.21	NA	NA	0.03	XXX
95933	TC	A	Blink reflex test	0.00	1.31	1.00	NA	NA	0.01	XXX
95933	26	A	Blink reflex test	0.59	0.24	0.21	0.24	0.21	0.02	XXX
95934		A	H-reflex test	0.51	1.12	0.86	NA	NA	0.02	XXX
95934	TC	A	H-reflex test	0.00	0.91	0.67	NA	NA	0.01	XXX
95934	26	A	H-reflex test	0.51	0.21	0.19	0.21	0.19	0.01	XXX
95936		A	H-reflex test	0.55	0.75	0.62	NA	NA	0.02	XXX
95936	TC	A	H-reflex test	0.00	0.53	0.42	NA	NA	0.01	XXX
95936	26	A	H-reflex test	0.55	0.22	0.20	0.22	0.20	0.01	XXX
95937		A	Neuromuscular junction test	0.65	1.15	0.91	NA	NA	0.04	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.89	0.68	NA	NA	0.01	XXX
95937	26	A	Neuromuscular junction test	0.65	0.26	0.23	0.26	0.23	0.03	XXX
95950		A	Ambulatory eeg monitoring	1.51	6.87	5.22	NA	NA	0.06	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	6.28	4.70	NA	NA	0.02	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.59	0.52	0.59	0.52	0.04	XXX
95951		C	EEG monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
95951	TC	C	EEG monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.36	2.09	2.36	2.09	0.35	XXX
95953		A	EEG monitoring/computer	3.30	10.33	8.08	NA	NA	0.14	XXX
95953	TC	A	EEG monitoring/computer	0.00	9.03	6.95	NA	NA	0.03	XXX
95953	26	A	EEG monitoring/computer	3.30	1.30	1.13	1.30	1.13	0.11	XXX
95954		A	EEG monitoring/giving drugs	2.45	6.13	4.69	NA	NA	0.12	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	5.48	4.10	NA	NA	0.04	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	0.65	0.59	0.65	0.59	0.08	XXX
95955		A	EEG during surgery	1.01	3.75	2.90	NA	NA	0.04	XXX
95955	TC	A	EEG during surgery	0.00	3.36	2.57	NA	NA	0.01	XXX
95955	26	A	EEG during surgery	1.01	0.39	0.33	0.39	0.33	0.03	XXX
95956		A	Eeg monitoring, cable/radio	3.08	18.26	16.65	NA	NA	0.23	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	17.11	15.59	NA	NA	0.14	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.15	1.06	1.15	1.06	0.09	XXX
95957		A	EEG digital analysis	1.98	8.11	5.80	NA	NA	0.08	XXX
95957	TC	A	EEG digital analysis	0.00	7.34	5.11	NA	NA	0.02	XXX
95957	26	A	EEG digital analysis	1.98	0.77	0.69	0.77	0.69	0.06	XXX
95958		A	EEG monitoring/function test	4.24	8.81	6.73	NA	NA	0.17	XXX
95958	TC	A	EEG monitoring/function test	0.00	7.24	5.26	NA	NA	0.04	XXX
95958	26	A	EEG monitoring/function test	4.24	1.57	1.47	1.57	1.47	0.13	XXX
95961		A	Electrode stimulation, brain	2.97	4.15	3.26	NA	NA	0.10	XXX
95961	TC	A	Electrode stimulation, brain	0.00	2.95	2.18	NA	NA	0.01	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.20	1.08	1.20	1.08	0.09	XXX
95962		A	Electrode stim, brain add-on	3.21	3.09	2.53	NA	NA	0.11	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.81	1.41	NA	NA	0.01	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	1.28	1.12	1.28	1.12	0.10	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	3.15	2.98	3.15	2.98	0.46	XXX
95966		C	Meg, evoked, single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	26	A	Meg, evoked, single	3.99	1.57	1.50	1.57	1.50	0.23	XXX
95967		C	Meg, evoked, each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	TC	C	Meg, evoked, each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	26	A	Meg, evoked, each addl	3.49	1.38	1.23	1.38	1.23	0.20	ZZZ
95970		A	Analyze neurostim, no prog	0.45	1.19	0.97	0.18	0.14	0.03	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.72	0.27	0.27	0.05	XXX
95972		A	Analyze neurostim, complex	1.50	1.30	1.22	0.57	0.50	0.11	XXX
95973		A	Analyze neurostim, complex	0.92	0.71	0.59	0.37	0.29	0.06	ZZZ

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
95974		A	Cranial neurostim, complex	3.00	2.03	1.68	1.13	1.00	0.18	XXX
95975		A	Cranial neurostim, complex	1.70	1.00	0.85	0.67	0.59	0.09	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	2.58	2.09	1.42	1.22	0.28	XXX
95979		A	Analyz neurostim brain addon	1.64	1.04	0.85	0.67	0.58	0.11	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.34	0.28	0.12	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.50	0.46	0.17	0.13	0.02	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.69	0.55	0.31	0.23	0.05	XXX
95990		A	Spin/brain pump refil & main	0.00	2.12	1.73	NA	NA	0.02	XXX
95991		A	Spin/brain pump refil & main	0.77	2.20	1.76	0.29	0.21	0.05	XXX
95992		I	Canalith repositioning proc	0.75	0.38	0.37	0.27	0.26	0.04	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	NA	0.71	0.55	0.08	XXX
96001		A	Motion test w/ft press meas	2.15	NA	NA	0.76	0.63	0.10	XXX
96002		A	Dynamic surface emg	0.41	NA	NA	0.15	0.14	0.02	XXX
96003		A	Dynamic fine wire emg	0.37	NA	NA	0.15	0.11	0.02	XXX
96004		A	Phys review of motion tests	2.14	0.87	0.82	0.87	0.82	0.11	XXX
96020		C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.03	1.27	1.03	1.27	0.23	XXX
96040		B	Genetic counseling, 30 min	0.00	1.05	1.11	NA	NA	0.01	XXX
96101		A	Psycho testing by psych/phys	1.86	0.24	0.39	0.23	0.38	0.05	XXX
96102		A	Psycho testing by technician	0.50	0.98	0.94	0.10	0.12	0.03	XXX
96103		A	Psycho testing admin by comp	0.51	1.10	0.85	0.15	0.14	0.02	XXX
96105		A	Assessment of aphasia	0.00	2.46	2.04	NA	NA	0.03	XXX
96110		A	Developmental test, lim	0.00	0.20	0.19	NA	NA	0.01	XXX
96111		A	Developmental test, extend	2.60	1.00	0.89	0.87	0.79	0.12	XXX
96116		A	Neurobehavioral status exam	1.86	0.58	0.61	0.45	0.47	0.07	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.57	0.88	0.21	0.37	0.05	XXX
96119		A	Neuropsych testing by tec	0.55	1.17	1.31	0.07	0.12	0.02	XXX
96120		A	Neuropsych tst admin w/comp	0.51	1.77	1.49	0.14	0.13	0.02	XXX
96125		A	Cognitive test by hc pro	1.70	1.03	0.85	0.61	0.45	0.05	XXX
96150		A	Assess hlth/behave, init	0.50	0.06	0.11	0.05	0.10	0.01	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.06	0.11	0.05	0.10	0.01	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.06	0.10	0.05	0.09	0.01	XXX
96153		A	Intervene hlth/behave, group	0.10	0.02	0.03	0.01	0.02	0.01	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.05	0.10	0.05	0.09	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.16	0.16	0.16	0.16	0.02	XXX
96360		A	Hydration iv infusion, init	0.17	1.13	1.30	NA	NA	0.02	XXX
96361		A	Hydrate iv infusion, add-on	0.09	0.26	0.32	NA	NA	0.01	ZZZ

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Malpractice RVUs[2,4]	CPT[1]/ HCPCS
96365		A	Ther/proph/diag iv inf, init	0.21	1.43	1.61	NA	NA	0.03	XXX
96366		A	Ther/proph/diag iv inf addon	0.18	0.34	0.38	NA	NA	0.01	ZZZ
96367		A	Tx/proph/dg addl seq iv inf	0.19	0.55	0.70	NA	NA	0.01	ZZZ
96368		A	Ther/diag concurrent inf	0.17	0.29	0.35	NA	NA	0.01	ZZZ
96369		A	Sc ther infusion, up to 1 hr	0.21	3.35	3.81	NA	NA	0.02	XXX
96370		A	Sc ther infusion, addl hr	0.18	0.22	0.22	NA	NA	0.01	ZZZ
96371		A	Sc ther infusion, reset pump	0.00	2.18	2.08	NA	NA	0.01	ZZZ
96372		A	Ther/proph/diag inj, sc/im	0.17	0.42	0.41	NA	NA	0.01	XXX
96373		A	Ther/proph/diag inj, ia	0.17	0.32	0.32	NA	NA	0.01	XXX
96374		A	Ther/proph/diag inj, iv push	0.18	1.09	1.26	NA	NA	0.02	XXX
96375		A	Tx/pro/dx inj new drug addon	0.10	0.41	0.50	NA	NA	0.01	ZZZ
96376		X	Tx/pro/dx inj new drug adon	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
96379		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96401		A	Chemo, anti-neopl, sq/im	0.21	1.48	1.63	NA	NA	0.01	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.57	0.77	NA	NA	0.01	XXX
96405		A	Chemo intralesional, up to 7	0.52	1.46	1.74	0.28	0.26	0.02	000
96406		A	Chemo intralesional over 7	0.80	1.99	2.34	0.39	0.35	0.03	000
96409		A	Chemo, iv push, sngl drug	0.24	2.21	2.70	NA	NA	0.04	XXX
96411		A	Chemo, iv push, addl drug	0.20	1.19	1.45	NA	NA	0.02	ZZZ
96413		A	Chemo, iv infusion, 1 hr	0.28	2.87	3.57	NA	NA	0.05	XXX
96415		A	Chemo, iv infusion, addl hr	0.19	0.52	0.64	NA	NA	0.01	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	3.23	4.00	NA	NA	0.05	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.37	1.69	NA	NA	0.02	ZZZ
96420		A	Chemo, ia, push tecnique	0.17	2.19	2.65	NA	NA	0.06	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	3.57	4.39	NA	NA	0.06	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.58	1.90	NA	NA	0.03	ZZZ
96425		A	Chemotherapy,infusion method	0.17	3.83	4.41	NA	NA	0.07	XXX
96440		A	Chemotherapy, intracavitary	2.37	18.32	15.36	1.05	1.13	0.40	000
96445		A	Chemotherapy, intracavitary	2.20	4.34	5.35	0.94	0.93	0.14	000
96450		A	Chemotherapy, into CNS	1.53	2.87	3.89	0.62	0.78	0.09	000
96521		A	Refill/maint, portable pump	0.21	2.77	3.18	NA	NA	0.04	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.30	2.66	NA	NA	0.04	XXX
96523		T	Irrig drug delivery device	0.04	0.51	0.63	NA	NA	0.01	XXX
96542		A	Chemotherapy injection	0.75	1.99	2.72	0.36	0.43	0.04	XXX
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	3.17	3.25	NA	NA	0.01	XXX
96570		A	Photodynmc tx, 30 min add-on	1.10	0.37	0.40	0.37	0.40	0.13	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.15	0.18	0.15	0.18	0.03	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.48	0.52	NA	NA	0.01	XXX
96902		B	Trichogram	0.41	0.17	0.16	0.15	0.14	0.02	XXX
96904		R	Whole body photography	0.00	1.50	1.73	NA	NA	0.01	XXX
96910		A	Photochemotherapy with UV-B	0.00	1.66	1.72	NA	NA	0.01	XXX
96912		A	Photochemotherapy with UV-A	0.00	2.13	2.20	NA	NA	0.01	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	3.00	3.05	NA	NA	0.01	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	3.18	3.30	0.69	0.62	0.03	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	3.28	3.24	0.68	0.59	0.04	000
96922		A	Laser tx, skin > 500 sq cm	2.10	4.22	4.35	1.26	1.07	0.06	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.20	0.77	0.72	NA	NA	0.04	XXX
97002		A	Pt re-evaluation	0.60	0.48	0.44	NA	NA	0.02	XXX
97003		A	Ot evaluation	1.20	1.00	0.86	NA	NA	0.05	XXX
97004		A	Ot re-evaluation	0.60	0.73	0.62	NA	NA	0.02	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.08	0.07	NA	NA	0.01	XXX
97012		A	Mechanical traction therapy	0.25	0.17	0.15	NA	NA	0.01	XXX
97014		I	Electric stimulation therapy	0.18	0.21	0.19	NA	NA	0.01	XXX
97016		A	Vasopneumatic device therapy	0.18	0.29	0.25	NA	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.19	0.16	NA	NA	0.01	XXX
97022		A	Whirlpool therapy	0.17	0.40	0.33	NA	NA	0.01	XXX
97024		A	Diathermy eg, microwave	0.06	0.10	0.09	NA	NA	0.01	XXX
97026		A	Infrared therapy	0.06	0.08	0.07	NA	NA	0.01	XXX
97028		A	Ultraviolet therapy	0.08	0.10	0.09	NA	NA	0.01	XXX
97032		A	Electrical stimulation	0.25	0.24	0.20	NA	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.53	0.44	NA	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.24	0.21	NA	NA	0.01	XXX
97035		A	Ultrasound therapy	0.21	0.12	0.11	NA	NA	0.01	XXX
97036		A	Hydrotherapy	0.28	0.53	0.45	NA	NA	0.02	XXX
97039		C	Physical therapy treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.38	0.33	NA	NA	0.01	XXX
97112		A	Neuromuscular reeducation	0.45	0.41	0.36	NA	NA	0.02	XXX
97113		A	Aquatic therapy/exercises	0.44	0.64	0.54	NA	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.33	0.29	NA	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.32	0.28	NA	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97140		A	Manual therapy	0.43	0.34	0.30	NA	NA	0.01	XXX
97150		A	Group therapeutic procedures	0.27	0.26	0.23	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
97530		A	Therapeutic activities	0.44	0.45	0.40	NA	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.26	0.23	NA	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.32	0.29	NA	NA	0.01	XXX
97535		A	Self care mngment training	0.45	0.44	0.39	NA	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.33	0.30	NA	NA	0.01	XXX
97542		A	Wheelchair mngment training	0.45	0.34	0.31	NA	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597		A	Active wound care/20 cm or <	0.58	1.33	1.09	0.14	0.23	0.04	XXX
97598		A	Active wound care > 20 cm	0.80	1.54	1.27	0.19	0.30	0.05	XXX
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605		A	Neg press wound tx, < 50 cm	0.55	0.48	0.42	0.13	0.15	0.06	XXX
97606		A	Neg press wound tx, > 50 cm	0.60	0.50	0.43	0.14	0.16	0.08	XXX
97750		A	Physical performance test	0.45	0.39	0.35	NA	NA	0.02	XXX
97755		A	Assistive technology assess	0.62	0.32	0.30	NA	NA	0.02	XXX
97760		A	Orthotic mgmt and training	0.45	0.51	0.44	NA	NA	0.02	XXX
97761		A	Prosthetic training	0.45	0.39	0.34	NA	NA	0.02	XXX
97762		A	C/o for orthotic/prosth use	0.25	0.89	0.72	NA	NA	0.01	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition, indiv, in	0.53	0.23	0.26	0.19	0.22	0.02	XXX
97803		A	Med nutrition, indiv, subseq	0.45	0.20	0.24	0.16	0.19	0.02	XXX
97804		A	Medical nutrition, group	0.25	0.10	0.10	0.09	0.10	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.35	0.35	0.22	0.22	0.03	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.22	0.22	0.18	0.18	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.37	0.37	0.24	0.24	0.03	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.27	0.27	0.20	0.20	0.03	ZZZ
98925		A	Osteopathic manipulation	0.45	0.37	0.32	0.17	0.14	0.02	000
98926		A	Osteopathic manipulation	0.65	0.47	0.41	0.23	0.21	0.03	000
98927		A	Osteopathic manipulation	0.87	0.58	0.51	0.29	0.26	0.04	000
98928		A	Osteopathic manipulation	1.03	0.65	0.58	0.34	0.31	0.04	000
98929		A	Osteopathic manipulation	1.19	0.76	0.66	0.40	0.36	0.05	000
98940		A	Chiropractic manipulation	0.45	0.25	0.23	0.13	0.12	0.01	000
98941		A	Chiropractic manipulation	0.65	0.31	0.29	0.19	0.18	0.02	000
98942		A	Chiropractic manipulation	0.87	0.38	0.36	0.25	0.25	0.02	000
98943		N	Chiropractic manipulation	0.40	0.23	0.23	0.15	0.14	0.02	XXX
98960		B	Self-mgmt educ & train, 1 pt	0.00	0.62	0.65	NA	NA	0.01	XXX
98961		B	Self-mgmt educ/train, 2-4 pt	0.00	0.30	0.31	NA	NA	0.01	XXX
98962		B	Self-mgmt educ/train, 5-8 pt	0.00	0.22	0.23	NA	NA	0.01	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.12	0.12	0.09	0.08	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
98967		N	Hc pro phone call 11-20 min	0.50	0.21	0.21	0.18	0.18	0.03	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.30	0.29	0.27	0.26	0.04	XXX
98969		N	Online service by hc pro	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv, eve/wkend/holiday	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.40	0.38	NA	NA	0.06	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		A	Anogenital exam, child	1.75	1.81	2.07	0.70	0.77	0.09	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.06	0.06	NA	NA	0.01	XXX
99174		N	Ocular photoscreening	0.00	0.67	0.70	NA	NA	0.01	XXX
99175		A	Induction of vomiting	0.00	0.55	0.61	NA	NA	0.01	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.08	2.88	0.80	0.69	0.18	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	2.08	2.00	NA	NA	0.04	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.48	0.61	0.57	0.21	0.18	0.03	XXX
99202		A	Office/outpatient visit, new	0.93	0.97	0.88	0.40	0.35	0.06	XXX
99203		A	Office/outpatient visit, new	1.42	1.31	1.19	0.59	0.50	0.10	XXX
99204		A	Office/outpatient visit, new	2.43	1.80	1.61	1.00	0.82	0.16	XXX
99205		A	Office/outpatient visit, new	3.17	2.10	1.91	1.24	1.05	0.20	XXX
99211		A	Office/outpatient visit, est	0.18	0.31	0.34	0.07	0.06	0.01	XXX
99212		A	Office/outpatient visit, est	0.48	0.61	0.57	0.20	0.17	0.03	XXX
99213		A	Office/outpatient visit, est	0.97	0.88	0.80	0.39	0.32	0.05	XXX
99214		A	Office/outpatient visit, est	1.50	1.24	1.15	0.58	0.49	0.08	XXX
99215		A	Office/outpatient visit, est	2.11	1.59	1.46	0.82	0.70	0.11	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.60	0.54	0.06	XXX
99218		A	Observation care	1.28	NA	NA	0.47	0.42	0.07	XXX
99219		A	Observation care	2.14	NA	NA	0.80	0.69	0.10	XXX
99220		A	Observation care	2.99	NA	NA	1.08	0.97	0.14	XXX
99221		A	Initial hospital care	1.89	NA	NA	0.70	0.59	0.13	XXX
99222		A	Initial hospital care	2.57	NA	NA	0.98	0.81	0.15	XXX
99223		A	Initial hospital care	3.79	NA	NA	1.43	1.19	0.20	XXX
99231		A	Subsequent hospital care	0.76	NA	NA	0.28	0.26	0.04	XXX
99232		A	Subsequent hospital care	1.39	NA	NA	0.52	0.45	0.07	XXX
99233		A	Subsequent hospital care	2.00	NA	NA	0.73	0.64	0.10	XXX
99234		A	Observ/hosp same date	2.56	NA	NA	0.95	0.88	0.15	XXX
99235		A	Observ/hosp same date	3.41	NA	NA	1.27	1.13	0.17	XXX
99236		A	Observ/hosp same date	4.26	NA	NA	1.55	1.38	0.21	XXX
99238		A	Hospital discharge day	1.28	NA	NA	0.61	0.54	0.06	XXX
99239		A	Hospital discharge day	1.90	NA	NA	0.89	0.76	0.08	XXX
99241		I	Office consultation	0.64	0.66	0.66	0.24	0.24	0.05	XXX
99242		I	Office consultation	1.34	1.10	1.10	0.51	0.51	0.10	XXX
99243		I	Office consultation	1.88	1.46	1.46	0.71	0.71	0.13	XXX
99244		I	Office consultation	3.02	1.96	1.96	1.14	1.14	0.16	XXX
99245		I	Office consultation	3.77	2.30	2.30	1.38	1.38	0.21	XXX
99251		I	Inpatient consultation	1.00	NA	NA	0.32	0.32	0.05	XXX
99252		I	Inpatient consultation	1.50	NA	NA	0.52	0.52	0.09	XXX
99253		I	Inpatient consultation	2.27	NA	NA	0.84	0.84	0.11	XXX
99254		I	Inpatient consultation	3.29	NA	NA	1.23	1.23	0.13	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved. Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
99255		I	Inpatient consultation	4.00	NA	NA	1.44	1.44	0.18	XXX
99281		A	Emergency dept visit	0.45	NA	NA	0.12	0.10	0.03	XXX
99282		A	Emergency dept visit	0.88	NA	NA	0.23	0.19	0.05	XXX
99283		A	Emergency dept visit	1.34	NA	NA	0.33	0.29	0.08	XXX
99284		A	Emergency dept visit	2.56	NA	NA	0.56	0.50	0.15	XXX
99285		A	Emergency dept visit	3.80	NA	NA	0.76	0.72	0.22	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99291		A	Critical care, first hour	4.50	2.51	2.41	1.37	1.24	0.25	XXX
99292		A	Critical care, addl 30 min	2.25	0.93	0.86	0.69	0.62	0.12	ZZZ
99304		A	Nursing facility care, init	1.61	0.76	0.62	0.76	0.62	0.10	XXX
99305		A	Nursing facility care, init	2.31	1.04	0.82	1.04	0.82	0.14	XXX
99306		A	Nursing facility care, init	3.01	1.28	1.00	1.28	1.00	0.16	XXX
99307		A	Nursing fac care, subseq	0.76	0.41	0.34	0.41	0.34	0.03	XXX
99308		A	Nursing fac care, subseq	1.16	0.64	0.53	0.64	0.53	0.05	XXX
99309		A	Nursing fac care, subseq	1.55	0.83	0.68	0.83	0.68	0.07	XXX
99310		A	Nursing fac care, subseq	2.35	1.17	0.95	1.17	0.95	0.10	XXX
99315		A	Nursing fac discharge day	1.13	0.57	0.47	0.57	0.47	0.05	XXX
99316		A	Nursing fac discharge day	1.50	0.72	0.59	0.72	0.59	0.07	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.82	0.63	0.82	0.63	0.08	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.44	0.45	NA	NA	0.05	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.60	0.60	NA	NA	0.08	XXX
99326		A	Domicil/r-home visit new pat	2.63	1.10	0.94	NA	NA	0.12	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.46	1.20	NA	NA	0.15	XXX
99328		A	Domicil/r-home visit new pat	4.09	1.63	1.38	NA	NA	0.17	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.52	0.46	NA	NA	0.05	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.78	0.66	NA	NA	0.08	XXX
99336		A	Domicil/r-home visit est pat	2.46	1.10	0.89	NA	NA	0.11	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.54	1.23	NA	NA	0.16	XXX
99339		B	Domicil/r-home care supervis	1.25	0.77	0.76	NA	NA	0.06	XXX
99340		B	Domicil/r-home care supervis	1.80	1.03	1.02	NA	NA	0.09	XXX
99341		A	Home visit, new patient	1.01	0.43	0.45	NA	NA	0.06	XXX
99342		A	Home visit, new patient	1.52	0.57	0.59	NA	NA	0.08	XXX
99343		A	Home visit, new patient	2.53	0.96	0.91	NA	NA	0.13	XXX
99344		A	Home visit, new patient	3.38	1.43	1.19	NA	NA	0.15	XXX
99345		A	Home visit, new patient	4.09	1.72	1.41	NA	NA	0.18	XXX
99347		A	Home visit, est patient	1.00	0.46	0.44	NA	NA	0.05	XXX
99348		A	Home visit, est patient	1.56	0.67	0.61	NA	NA	0.08	XXX
99349		A	Home visit, est patient	2.33	1.05	0.86	NA	NA	0.11	XXX
99350		A	Home visit, est patient	3.28	1.43	1.16	NA	NA	0.15	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
99354		A	Prolonged service, office	1.77	0.83	0.74	0.67	0.60	0.09	ZZZ
99355		A	Prolonged service, office	1.77	0.79	0.72	0.63	0.57	0.09	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	NA	0.69	0.59	0.08	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	NA	0.69	0.59	0.08	ZZZ
99358		B	Prolong service w/o contact	2.10	0.80	0.77	0.80	0.77	0.11	XXX
99359		B	Prolong serv w/o contact add	1.00	0.40	0.38	0.40	0.38	0.05	ZZZ
99360		X	Physician standby services	1.20	NA	NA	0.44	0.42	0.06	XXX
99363		B	Anticoag mgmt, init	1.65	1.58	1.59	0.60	0.57	0.08	XXX
99364		B	Anticoag mgmt, subseq	0.63	0.48	0.48	0.23	0.22	0.03	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.32	0.30	0.30	0.28	0.04	XXX
99367		B	Team conf w/o pat by phys	1.10	NA	NA	0.40	0.38	0.06	XXX
99368		B	Team conf w/o pat by hc pro	0.72	NA	NA	0.26	0.25	0.04	XXX
99374		B	Home health care supervision	1.10	0.71	0.71	0.40	0.39	0.06	XXX
99375		I	Home health care supervision	1.73	1.00	1.10	0.63	0.79	0.09	XXX
99377		B	Hospice care supervision	1.10	0.71	0.71	0.40	0.39	0.06	XXX
99378		I	Hospice care supervision	1.73	1.00	1.18	0.63	0.86	0.09	XXX
99379		B	Nursing fac care supervision	1.10	0.71	0.71	0.40	0.39	0.06	XXX
99380		B	Nursing fac care supervision	1.73	1.00	1.00	0.63	0.62	0.09	XXX
99381		N	Init pm e/m, new pat, inf	1.19	1.20	1.27	0.43	0.42	0.06	XXX
99382		N	Init pm e/m, new pat 1-4 yrs	1.36	1.26	1.33	0.50	0.48	0.07	XXX
99383		N	Prev visit, new, age 5-11	1.36	1.26	1.31	0.50	0.48	0.07	XXX
99384		N	Prev visit, new, age 12-17	1.53	1.32	1.37	0.56	0.55	0.08	XXX
99385		N	Prev visit, new, age 18-39	1.53	1.32	1.37	0.56	0.55	0.08	XXX
99386		N	Prev visit, new, age 40-64	1.88	1.45	1.51	0.69	0.67	0.09	XXX
99387		N	Init pm e/m, new pat 65+ yrs	2.06	1.61	1.67	0.75	0.74	0.10	XXX
99391		N	Per pm reeval, est pat, inf	1.02	1.04	1.05	0.37	0.36	0.05	XXX
99392		N	Prev visit, est, age 1-4	1.19	1.10	1.11	0.43	0.42	0.06	XXX
99393		N	Prev visit, est, age 5-11	1.19	1.09	1.10	0.43	0.42	0.06	XXX
99394		N	Prev visit, est, age 12-17	1.36	1.15	1.16	0.50	0.48	0.07	XXX
99395		N	Prev visit, est, age 18-39	1.36	1.16	1.17	0.50	0.48	0.07	XXX
99396		N	Prev visit, est, age 40-64	1.53	1.22	1.23	0.56	0.55	0.08	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.39	1.40	0.62	0.62	0.09	XXX
99401		N	Preventive counseling, indiv	0.48	0.44	0.48	0.18	0.17	0.02	XXX
99402		N	Preventive counseling, indiv	0.98	0.62	0.67	0.36	0.35	0.05	XXX
99403		N	Preventive counseling, indiv	1.46	0.80	0.85	0.53	0.52	0.07	XXX
99404		N	Preventive counseling, indiv	1.95	0.98	1.03	0.71	0.70	0.10	XXX
99406		A	Behav chng smoking 3-10 min	0.24	0.13	0.12	0.09	0.08	0.01	XXX
99407		A	Behav chng smoking > 10 min	0.50	0.23	0.19	0.18	0.16	0.02	XXX
99408		N	Audit/dast, 15-30 min	0.65	0.28	0.27	0.24	0.23	0.03	XXX
99409		N	Audit/dast, over 30 min	1.30	0.52	0.50	0.47	0.46	0.07	XXX
99411		N	Preventive counseling, group	0.15	0.25	0.25	0.05	0.05	0.01	XXX
99412		N	Preventive counseling, group	0.25	0.29	0.29	0.09	0.09	0.01	XXX
99420		N	Health risk assessment test	0.00	0.24	0.25	NA	NA	0.01	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.12	0.12	0.09	0.08	0.01	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.21	0.21	0.18	0.18	0.03	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.30	0.29	0.27	0.26	0.04	XXX
99444		N	Online e/m by phys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99450		N	Basic life disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Work related disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99460		A	Init nb em per day, hosp	1.17	NA	NA	0.44	0.37	0.06	XXX
99461		A	Init nb em per day, non-fac	1.26	1.22	1.08	0.46	0.44	0.06	XXX
99462		A	Sbsq nb em per day, hosp	0.62	NA	NA	0.23	0.20	0.03	XXX
99463		A	Same day nb discharge	1.50	NA	NA	0.70	0.58	0.08	XXX
99464		A	Attendance at delivery	1.50	NA	NA	0.50	0.43	0.08	XXX
99465		A	Nb resuscitation	2.93	NA	NA	1.07	1.01	0.15	XXX
99466		A	Ped crit care transport	4.79	NA	NA	1.77	1.52	0.24	XXX
99467		A	Ped crit care transport addl	2.40	NA	NA	0.95	0.77	0.12	ZZZ
99468		A	Neonate crit care, initial	18.46	NA	NA	6.98	5.22	0.93	XXX
99469		A	Neonate crit care, subsq	7.99	NA	NA	2.65	2.36	0.40	XXX
99471		A	Ped critical care, initial	15.98	NA	NA	5.30	4.76	0.80	XXX
99472		A	Ped critical care, subsq	7.99	NA	NA	2.75	2.39	0.40	XXX
99475		A	Ped crit care age 2-5, init	11.25	3.43	3.03	3.43	3.03	0.56	XXX
99476		A	Ped crit care age 2-5, subsq	6.75	2.06	1.82	2.06	1.82	0.34	XXX
99477		A	Init day hosp neonate care	7.00	NA	NA	2.32	2.15	0.28	XXX
99478		A	Ic, lbw inf < 1500 gm subsq	2.75	NA	NA	1.09	0.97	0.14	XXX
99479		A	Ic lbw inf 1500-2500 g subsq	2.50	NA	NA	0.99	0.79	0.13	XXX
99480		A	Ic inf pbw 2501-5000 g subsq	2.40	NA	NA	0.91	0.76	0.12	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit, prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved. Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99605		X	Mtms by pharm, np, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99606		X	Mtms by pharm, est, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99607		X	Mtms by pharm, addl 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9500		C	Tc99m sestamibi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9501		C	Technetium TC-99m teboroxime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9502		C	Tc99m tetrofosmin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9503		C	Tc99m medronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9504		C	Tc99m apcitide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9505		C	TL201 thallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9507		C	In111 capromab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9508		C	I131 iodobenguate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9509		C	Iodine I-123 sod iodide mil	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9510		C	Tc99m disofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9512		C	Tc99m pertechnetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9516		C	Iodine I-123 sod iodide mic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9517		C	I131 iodide cap, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9521		C	Tc99m exametazime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9524		C	I131 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9526		C	Nitrogen N-13 ammonia	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9527		C	Iodine I-125 sodium iodide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9528		C	Iodine I-131 iodide cap, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9529		C	I131 iodide sol, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9530		C	I131 iodide sol, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9531		C	I131 max 100uCi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9532		C	I125 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9536		C	Tc99m depreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9537		C	Tc99m mebrofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9538		C	Tc99m pyrophosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9539		C	Tc99m pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9540		C	Tc99m MAA	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
A9541		C	Tc99m sulfur colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9542		C	In111 ibritumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9543		C	Y90 ibritumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9544		C	I131 tositumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9545		C	I131 tositumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9546		C	Co57/58	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9547		C	In111 oxyquinoline	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9548		C	In111 pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9550		C	Tc99m gluceptate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9551		C	Tc99m succimer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9552		C	F18 fdg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9553		C	Cr51 chromate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9554		C	I125 iothalamate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9555		C	Rb82 rubidium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9556		C	Ga67 gallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9557		C	Tc99m bicisate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9558		C	Xe133 xenon 10mci	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9559		C	Co57 cyano	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9560		C	Tc99m labeled rbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9561		C	Tc99m oxidronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9562		C	Tc99m mertiatide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9563		C	P32 Na phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9564		C	P32 chromic phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9566		C	Tc99m fanolesomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9567		C	Technetium TC-99m aerosol	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9568		C	Technetium tc99m arcitumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9569		C	Technetium TC-99m auto WBC	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9570		C	Indium In-111 auto WBC	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9571		C	Indium IN-111 auto platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9572		C	Indium In-111 pentetreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9580		C	Sodium fluoride F-18	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9600		C	Sr89 strontium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9698		C	Non-rad contrast materialNOC	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9699		C	Radiopharm rx agent noc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved. Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
G0101		A	CA screen;pelvic/breast exam	0.45	0.51	0.50	NA	NA	0.02	XXX
G0102		A	Prostate ca screening; dre	0.17	0.31	0.34	0.07	0.06	0.01	XXX
G0103		X	PSA screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.44	2.47	0.65	0.62	0.06	000
G0105		A	Colorectal scrn; hi risk ind	3.69	5.90	6.26	1.83	1.82	0.24	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.44	2.47	0.65	0.62	0.05	000
G0106		A	Colon CA screen;barium enema	0.99	4.34	4.41	NA	NA	0.03	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	4.04	4.05	NA	NA	0.01	XXX
G0106	26	A	Colon CA screen;barium enema	0.99	0.30	0.36	0.30	0.36	0.02	XXX
G0108		A	Diab manage trn per indiv	0.00	0.62	0.64	NA	NA	0.01	XXX
G0109		A	Diab manage trn ind/group	0.00	0.32	0.35	NA	NA	0.01	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.88	0.80	NA	NA	0.02	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.89	0.71	NA	NA	0.01	XXX
G0120		A	Colon ca scrn; barium enema	0.99	4.34	4.41	NA	NA	0.03	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.04	4.05	NA	NA	0.01	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.30	0.36	0.30	0.36	0.02	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	5.90	6.26	1.83	1.82	0.25	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.44	2.47	0.65	0.62	0.08	000
G0122		N	Colon ca scrn; barium enema	0.99	6.10	5.65	NA	NA	0.03	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	5.74	5.30	NA	NA	0.01	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.36	0.35	0.36	0.35	0.02	XXX
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.34	0.32	0.34	0.32	0.02	XXX
G0127		R	Trim nail(s)	0.17	0.40	0.36	0.04	0.05	0.01	000
G0128		R	CORF skilled nursing service	0.08	0.17	0.15	NA	NA	0.01	XXX
G0130		A	Single energy x-ray study	0.22	0.61	0.63	NA	NA	0.02	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.53	0.56	NA	NA	0.01	XXX
G0130	26	A	Single energy x-ray study	0.22	0.08	0.07	0.08	0.07	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.34	0.32	0.34	0.32	0.02	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.31	3.95	NA	NA	0.01	XXX
G0168		A	Wound closure by adhesive	0.45	1.88	1.71	0.26	0.23	0.03	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	OPPS Service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	OPPS/PHP;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
G0177		X	OPPS/PHP; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	MD recertification HHA PT	0.45	0.57	0.61	NA	NA	0.02	XXX
G0180		A	MD certification HHA patient	0.67	0.67	0.73	NA	NA	0.04	XXX
G0181		A	Home health care supervision	1.73	1.05	1.01	NA	NA	0.08	XXX
G0182		A	Hospice care supervision	1.73	1.06	1.06	NA	NA	0.08	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	2.80	2.84	NA	NA	0.04	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.56	2.60	NA	NA	0.01	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.24	0.24	0.24	0.24	0.03	XXX
G0204		A	Diagnosticmammographydigital	0.87	3.40	3.35	NA	NA	0.05	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	3.10	3.05	NA	NA	0.01	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.30	0.30	0.30	0.30	0.04	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.67	2.63	NA	NA	0.04	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.43	2.39	NA	NA	0.01	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.24	0.24	0.24	0.24	0.03	XXX
G0219		N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235		N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	TC	N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	26	N	PET not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic prod strg endur	0.00	0.20	0.26	NA	NA	0.01	XXX
G0238		A	Oth resp proc, indiv	0.00	0.21	0.28	NA	NA	0.01	XXX
G0239		A	Oth resp proc, group	0.00	0.26	0.30	NA	NA	0.01	XXX
G0245		R	Initial foot exam pt lops	0.88	0.97	0.88	0.40	0.35	0.05	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.61	0.57	0.20	0.17	0.02	XXX
G0247		R	Routine footcare pt w lops	0.50	0.72	0.66	0.16	0.17	0.03	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	2.77	3.84	NA	NA	0.01	XXX
G0249		R	Provide INR test mater/equip	0.00	2.68	3.34	NA	NA	0.01	XXX
G0250		R	MD INR test revie inter mgmt	0.18	0.06	0.08	NA	NA	0.01	XXX
G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	TC	N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	26	N	PET imaging initial dx	1.50	0.00	0.60	0.00	0.60	0.04	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved. Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis ESRD pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.76	0.70	0.29	0.24	0.02	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	MNT subs tx for change dx	0.45	0.20	0.24	0.16	0.19	0.02	XXX
G0271		A	Group MNT 2 or more 30 mins	0.25	0.10	0.10	0.09	0.10	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	NA	0.08	0.12	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	NA	0.08	0.12	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.17	0.14	NA	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.17	0.14	NA	NA	0.01	XXX
G0288		A	Recon, CTA for surg plan	0.00	0.82	2.80	NA	NA	0.01	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	NA	0.72	0.69	0.21	ZZZ
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service LVRS complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service LVRS 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0304		X	Pre-op service LVRS 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service LVRS min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	CBC/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	CBC without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.18	0.16	NA	NA	0.01	XXX
G0333		X	Dispense fee initial 30 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	1.42	0.52	0.52	0.52	0.52	0.10	XXX
G0339		C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340		C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	45.38	14.46	2.41	3.53	0.35	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	NA	6.71	5.72	0.60	090
G0343		A	Laparotomy islet cell transp	19.85	NA	NA	11.34	9.65	0.99	090
G0364		A	Bone marrow aspirate &biopsy	0.16	0.16	0.16	0.08	0.07	0.01	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.14	4.99	NA	NA	0.03	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.06	4.92	NA	NA	0.01	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.08	0.07	0.08	0.07	0.02	XXX
G0372		A	MD service required for PMD	0.17	0.07	0.12	0.07	0.05	0.01	XXX
G0378		X	Hospital observation per hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0379		X	Direct refer hospital observ	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0389		A	Ultrasound exam AAA screen	0.58	2.07	2.35	NA	NA	0.03	XXX
G0389	TC	A	Ultrasound exam AAA screen	0.00	1.89	2.13	NA	NA	0.01	XXX
G0389	26	A	Ultrasound exam AAA screen	0.58	0.18	0.22	0.18	0.22	0.02	XXX
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.27	0.22	0.22	0.18	0.03	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.64	0.43	0.59	0.39	0.07	XXX
G0398		C	Home sleep test/type 2 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	TC	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	26	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0399		C	Home sleep test/type 3 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	TC	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	26	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	TC	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	26	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0402		A	Initial preventive exam	2.30	1.82	1.32	NA	NA	0.07	XXX
G0403		A	EKG for initial prevent exam	0.17	0.28	0.36	NA	NA	0.02	XXX
G0404		A	EKG tracing for initial prev	0.00	0.22	0.29	NA	NA	0.01	XXX
G0405		A	EKG interpret & report preve	0.17	0.06	0.07	0.06	0.05	0.01	XXX
G0406		A	Telhealth inpt consult 15min	0.76	NA	NA	0.28	0.26	0.04	XXX
G0407		A	Telhealth inpt consult 25min	1.39	NA	NA	0.52	0.45	0.07	XXX
G0408		A	Telhealth inpt consult 35mn	2.00	NA	NA	0.73	0.64	0.10	XXX
G0409		A	CORF related serv 15 mins ea	0.00	0.22	0.23	NA	NA	0.01	XXX
G0410		X	Grp psych partial hosp 45-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0411		X	Inter active grp psych parti	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	NA	7.66	7.06	0.52	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	NA	10.75	10.00	0.79	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	NA	10.40	9.74	0.73	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	NA	13.57	12.36	1.05	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	13.96	13.96	NA	NA	0.08	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	12.14	12.14	NA	NA	0.01	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.82	1.82	1.82	1.82	0.07	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	27.26	27.26	NA	NA	0.15	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	23.71	23.71	NA	NA	0.01	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	3.55	3.55	3.55	3.55	0.14	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	46.56	46.56	NA	NA	0.26	XXX
G0418	TC	A	Sat biopsy prostate 41-60	0.00	40.50	40.50	NA	NA	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
G0418	26	A	Sat biopsy prostate 41-60	10.30	6.06	6.06	6.06	6.06	0.25	XXX
G0419		A	Sat biopsy prostate: >60	11.61	55.86	55.86	NA	NA	0.29	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	48.60	48.60	NA	NA	0.01	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	7.26	7.26	7.26	7.26	0.28	XXX
G0420		A	Ed svc CKD ind per session	2.12	0.86	0.86	NA	NA	0.02	XXX
G0421		A	Ed svc CKD grp per session	0.50	0.20	0.20	NA	NA	0.01	XXX
G0422		A	Intens cardiac rehab w/exerc	0.60	0.74	0.75	0.74	0.75	0.01	XXX
G0423		A	Intens cardiac rehab no exer	0.60	0.74	0.75	0.74	0.75	0.01	XXX
G0424		A	Pulmonary rehab w exer	0.18	0.46	0.46	0.07	0.07	0.01	XXX
G0425		A	Inpt telehealth consult 30m	1.89	NA	NA	0.70	0.70	0.13	XXX
G0426		A	Inpt telehealth consult 50m	2.57	NA	NA	0.98	0.98	0.15	XXX
G0427		A	Inpt telehealth con 70/>m	3.79	NA	NA	1.43	1.43	0.20	XXX
G0430		X	Drug screen multi class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0431		X	Drug screen single class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	MCCD, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	MCCD,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9003		X	MCCD, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	MCCD, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	MCCD, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	MCCD, Home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	MCCD, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	MCCD, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	MCCD, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	MCCD, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other Specified Case Mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	ESRD demo bundle level I	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	ESRD demo bundle-level II	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir,inhalation pwd 10m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosphate 75mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9033		X	Amantadine HCL oral brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9034		X	Zanamivir, inh pwdr, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9035		X	Oseltamivir phosp, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9036		X	Rimantadine HCL, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041		A	Low vision rehab occupationa	0.69	0.28	0.28	0.28	0.28	0.02	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
G9042		A	Low vision rehab orient/mobi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9043		A	Low vision lowvision therapi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9044		A	Low vision rehabilate teache	0.24	0.19	0.19	0.19	0.19	0.01	XXX
G9140		X	Frontier extended stay demo	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9141		X	Influenza A H1N1,admin w cou	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9142		X	Influenza A H1N1, vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9143		X	Warfarin respon genetic test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	0.89	0.79	0.06	0.08	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.34	0.32	0.34	0.32	0.02	XXX
Q0035		A	Cardiokymography	0.17	0.26	0.32	NA	NA	0.02	XXX
Q0035	TC	A	Cardiokymography	0.00	0.21	0.27	NA	NA	0.01	XXX
Q0035	26	A	Cardiokymography	0.17	0.05	0.05	0.05	0.05	0.01	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.74	0.74	0.14	0.12	0.02	XXX
Q0092		A	Set up port xray equipment	0.00	0.60	0.49	0.60	0.49	0.01	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

ADDENDUM C: Codes with Interim RVUs

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Fully Implemented Non-Facility PE RVUs[2]	Year 2010 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2010 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
14301		A	Skin tissue rearrangement	12.65	14.34	14.34	9.96	9.96	1.53	090
14302		A	Skin tissue rearrange add-on	3.73	2.08	2.08	2.08	2.08	0.45	ZZZ
19340		A	Immediate breast prosthesis	13.78	NA	NA	11.45	5.19	0.89	090
21011		A	Exc face les sc < 2 cm	2.99	5.18	5.18	3.33	3.33	0.32	090
21012		A	Exc face les sc = 2 cm	4.45	NA	NA	4.12	4.12	0.52	090
21013		A	Exc face tum deep < 2 cm	5.42	7.18	7.18	4.69	4.69	0.59	090
21014		A	Exc face tum deep = 2 cm	7.13	NA	NA	6.09	6.09	0.82	090
21015		A	Resect face tum < 2 cm	9.89	NA	NA	7.95	5.50	0.76	090
21016		A	Resect face tum = 2 cm	15.26	NA	NA	10.90	10.90	2.07	090
21025		A	Excision of bone, lower jaw	10.03	12.65	11.69	9.37	8.39	1.02	090
21552		A	Exc neck les sc = 3 cm	6.49	NA	NA	4.74	4.74	0.91	090
21554		A	Exc neck tum deep = 5 cm	11.13	NA	NA	7.31	7.31	1.50	090
21555		A	Exc neck les sc < 3 cm	3.96	6.30	5.97	3.77	3.57	0.63	090
21556		A	Exc neck tum deep < 5 cm	7.66	NA	NA	5.78	4.66	0.76	090
21557		A	Resect neck tum < 5 cm	14.75	NA	NA	9.67	6.16	1.21	090
21558		A	Resect neck tum = 5 cm	21.58	NA	NA	12.92	12.92	2.93	090
21930		A	Exc back les sc < 3 cm	4.94	6.61	6.23	4.13	3.89	0.75	090
21931		A	Exc back les sc = 3 cm	6.88	NA	NA	4.82	4.82	1.01	090
21932		A	Exc back tum deep < 5 cm	9.82	NA	NA	6.95	6.95	1.50	090
21933		A	Exc back tum deep = 5 cm	11.13	NA	NA	7.31	7.31	1.71	090
21935		A	Resect back tum < 5 cm	15.72	NA	NA	9.95	9.41	2.72	090
21936		A	Resect back tum = 5 cm	22.55	NA	NA	13.14	13.14	3.30	090
22900		A	Exc back tum deep < 5 cm	8.32	NA	NA	5.68	4.13	0.92	090
22901		A	Exc back tum deep = 5 cm	10.11	NA	NA	6.36	6.36	1.51	090
22902		A	Exc abd les sc < 3 cm	4.42	6.41	6.41	4.14	4.14	0.51	090
22903		A	Exc abd les sc > 3 cm	6.39	NA	NA	4.63	4.63	0.86	090
22904		A	Resect abd tum < 5 cm	16.69	NA	NA	8.91	8.91	2.56	090
22905		A	Resect abd tum > 5 cm	21.58	NA	NA	11.62	11.62	3.30	090
23071		A	Exc shoulder les sc > 3 cm	5.91	NA	NA	4.52	4.52	0.86	090
23073		A	Exc shoulder tum deep > 5 cm	10.13	NA	NA	7.11	7.11	1.48	090
23075		A	Exc shoulder les sc < 3 cm	4.21	7.06	4.59	3.92	2.34	0.36	090
23076		A	Exc shoulder tum deep < 5 cm	7.41	NA	NA	5.88	5.63	1.14	090
23077		A	Resect shoulder tum < 5 cm	17.66	NA	NA	11.18	10.44	2.67	090
23078		A	Resect shoulder tum > 5 cm	22.55	NA	NA	11.98	11.98	3.45	090
23200		A	Resect clavicle tumor	22.71	NA	NA	15.21	10.03	1.82	090
23210		A	Resect scapula tumor	27.21	NA	NA	17.41	10.97	1.89	090
23220		A	Resect prox humerus tumor	30.21	NA	NA	18.64	12.16	2.20	090
23415		A	Release of shoulder ligament	9.23	NA	NA	7.98	7.47	1.28	090
24071		A	Exc arm/elbow les sc = 3 cm	5.70	NA	NA	4.44	4.44	0.82	090
24073		A	Ex arm/elbow tum deep > 5 cm	10.13	NA	NA	7.23	7.23	1.45	090
24075		A	Exc arm/elbow les sc < 3 cm	4.24	7.55	7.40	3.99	3.56	0.57	090
24076		A	Ex arm/elbow tum deep < 5 cm	7.41	NA	NA	6.03	5.13	0.92	090
24077		A	Resect arm/elbow tum < 5 cm	15.72	NA	NA	10.27	8.08	1.76	090
24079		A	Resect arm/elbow tum > 5 cm	20.61	NA	NA	11.26	11.26	3.15	090
24150		A	Resect distal humerus tumor	23.46	NA	NA	15.48	10.87	1.97	090
24152		A	Resect radius tumor	19.99	NA	NA	13.78	8.90	1.46	090
25071		A	Exc forearm les sc > 3 cm	5.91	NA	NA	4.74	4.74	0.83	090
25073		A	Exc forearm tum deep = 3 cm	7.13	NA	NA	6.20	6.20	0.96	090
25075		A	Exc forearm les sc < 3 cm	3.96	7.56	4.96	3.96	4.04	0.54	090
25076		A	Exc forearm tum deep < 3 cm	6.74	NA	NA	6.02	5.74	0.68	090
25077		A	Resect forearm/wrist tum<3cm	12.93	NA	NA	9.12	8.23	1.45	090
25078		A	Resect forearm/wrist tum=3cm	17.69	NA	NA	10.18	10.18	2.71	090
25116		A	Remove wrist/forearm lesion	7.56	NA	NA	7.41	7.98	0.94	090
25170		A	Resect radius/ulnar tumor	22.21	NA	NA	14.77	11.07	1.62	090
26111		A	Exc hand les sc > 1.5 cm	5.42	NA	NA	5.01	5.01	0.69	090
26113		A	Exc hand tum deep > 1.5 cm	7.13	NA	NA	6.61	6.61	0.89	090
26115		A	Exc hand les sc < 1.5 cm	3.96	8.07	10.11	4.36	4.46	0.51	090
26116		A	Exc hand tum deep < 1.5 cm	6.74	NA	NA	6.41	5.85	0.71	090
26117		A	Exc hand tum ra < 3 cm	10.13	NA	NA	8.60	7.16	1.13	090
26118		A	Exc hand tum ra > 3 cm	14.81	NA	NA	11.83	11.83	2.09	090
26250		A	Extensive hand surgery	15.21	NA	NA	11.43	7.50	1.08	090
26260		A	Resect prox finger tumor	11.16	NA	NA	8.80	6.56	1.01	090
26262		A	Resect distal finger tumor	8.29	NA	NA	7.39	5.62	0.81	090
26480		A	Transplant hand tendon	6.90	NA	NA	11.35	11.29	0.86	090
27043		A	Exc hip pelvis les sc > 3 cm	6.88	NA	NA	4.80	4.80	1.01	090
27045		A	Exc hip/pelv tum deep > 5 cm	11.13	NA	NA	7.42	7.42	1.63	090
27047		A	Exc hip/pelvis les sc < 3 cm	4.94	6.57	7.05	4.12	4.57	1.12	090
27048		A	Exc hip/pelv tum deep < 5 cm	8.85	NA	NA	6.34	5.22	0.95	090
27049		A	Resect hip/pelv tum < 5 cm	21.55	NA	NA	12.40	9.56	2.22	090
27059		A	Resect hip/pelv tum > 5 cm	29.35	NA	NA	15.95	15.95	4.17	090
27075		A	Resect hip tumor	32.71	NA	NA	19.16	18.45	5.26	090
27076		A	Resect hip tum incl acetabul	40.21	NA	NA	22.86	16.14	3.46	090
27077		A	Resect hip tum w/innom bone	45.21	NA	NA	26.15	22.51	6.08	090
27078		A	Rsect hip tum incl femur	32.21	NA	NA	19.77	12.21	2.09	090
27327		A	Exc thigh/knee les sc < 3 cm	3.96	7.19	6.42	3.83	3.76	0.67	090
27328		A	Exc thigh/knee tum deep <5cm	8.85	NA	NA	6.52	4.87	0.83	090

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Fully Implemented Non-Facility PE RVUs[2]	Year 2010 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2010 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
27329		A	Resect thigh/knee tum < 5 cm	15.72	NA	NA	10.37	9.38	2.30	090
27337		A	Exc thigh/knee les sc > 3 cm	5.91	NA	NA	4.55	4.55	0.86	090
27339		A	Exc thigh/knee tum deep >5cm	11.13	NA	NA	7.63	7.63	1.63	090
27364		A	Resect thigh/knee tum >5 cm	24.49	NA	NA	14.54	14.54	3.56	090
27365		A	Resect femur/knee tumor	32 21	NA	NA	19.78	13.45	2.57	090
27615		A	Resect leg/ankle tum < 5 cm	15 72	NA	NA	10.32	8.67	1.87	090
27616		A	Resect leg/ankle tum > 5 cm	19.63	NA	NA	12.32	12.32	2.81	090
27618		A	Exc leg/ankle tum < 3 cm	3.96	7.04	6.62	3.76	3.93	0.70	090
27619		A	Exc leg/ankle tum deep <5 cm	6.91	NA	NA	5.29	5.51	1.08	090
27632		A	Exc leg/ankle les sc > 3 cm	5.91	NA	NA	4.47	4.47	0.80	090
27634		A	Exc leg/ankle tum deep >5 cm	10.13	NA	NA	6.81	6.81	1.28	090
27645		A	Resect tibia tumor	27 21	NA	NA	17.41	12.04	2.12	090
27646		A	Resect fibula tumor	23 21	NA	NA	15.45	10.59	1.90	090
27647		A	Resect talus/calcaneus tum	20.26	NA	NA	8.40	7.18	0.93	090
28039		A	Exc foot/toe tum sc > 1.5 cm	5.42	7.03	7.03	3.38	3.38	0.40	090
28041		A	Exc foot/toe tum deep >1.5cm	7.13	NA	NA	4.43	4.43	0.53	090
28043		A	Exc foot/toe tum sc < 1.5 cm	3.96	6.33	5.00	2.95	2.89	0.27	090
28045		A	Exc foot/toe tum deep <1.5cm	5.45	7.50	6.86	3.81	3.50	0.36	090
28046		A	Resect foot/toe tumor < 3 cm	12.38	NA	NA	6.94	6.29	1.03	090
28047		A	Resect foot/toe tumor > 3 cm	17.45	NA	NA	7.06	7.06	0.95	090
28120		A	Part removal of ankle/heel	8.27	10.23	8.51	5.86	4.59	0.56	090
28122		A	Partial removal of foot bone	7.72	9.01	8.35	5.15	5.04	0.58	090
28171		A	Resect tarsal tumor	16.41	NA	NA	6.35	5.59	0.54	090
28173		A	Resect metatarsal tumor	14.16	NA	NA	6.49	5.28	0.72	090
28175		A	Resect phalanx of toe tumor	8.29	NA	NA	4.83	3.98	0.43	090
28725		A	Fusion of foot bones	12.18	NA	NA	7.88	7.50	1.33	090
28730		A	Fusion of foot bones	12.42	NA	NA	9.00	8.40	1.36	090
29581		A	Apply multlay comprs lwr leg	0.60	1.74	1.74	0.23	0.23	0.06	000
31626		A	Bronchoscopy w/markers	4.16	7.33	7.33	1.46	1.46	0.23	000
31627		A	Navigational bronchoscopy	2.00	30.18	30.18	0.73	0.73	0.11	ZZZ
32552		A	Remove lung catheter	2.53	2.06	2.06	1.49	1.49	0.42	010
32553		A	Ins mark thor for rt perq	3.80	11.67	11.67	1.29	1.29	0.64	000
32560		A	Treat pleurodesis w/agent	1.54	4.48	5.23	0.48	0.62	0.28	000
32561		A	Lyse chest fibrin init day	1.39	1.04	1.04	0.43	0.43	0.18	000
32562		A	Lyse chest fibrin subq day	1.24	0.92	0.92	0.39	0.39	0.16	000
33782		A	Nikaidoh proc	60.08	NA	NA	20.65	20.65	10.19	090
33783		A	Nikaidoh proc w/ostia implt	65.08	NA	NA	22.16	22.16	11.04	090
33981		C	Replace vad pump ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33982		C	Replace vad intra w/o bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33983		C	Replace vad intra w/bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36147		A	Access av dial grft for eval	3.72	17.20	17.20	1.20	1.20	0.36	XXX
36148		A	Access av dial grft for proc	1.00	5.60	5.60	0.31	0.31	0.10	ZZZ
36825		A	Artery-vein autograft	15.13	NA	NA	6.80	5.20	1.61	090
37761		A	Ligate leg veins open	9.13	NA	NA	5.37	5.37	1.41	090
42415		A	Excise parotid gland/lesion	18.12	NA	NA	11.42	10.15	1.76	090
42420		A	Excise parotid gland/lesion	21.00	NA	NA	12.80	11.36	2.04	090
42440		A	Excise submaxillary gland	7.13	NA	NA	5.26	4.71	0.69	090
43281		A	Lap paraesophag hern repair	26.60	NA	NA	12.03	12.03	4.08	090
43282		A	Lap paraesoph her rpr w/mesh	30.10	NA	NA	13.32	13.32	4.62	090
43775		A	Lap sleeve gastrectomy	21.56	NA	NA	10.99	10.99	3.31	090
45171		A	Exc rect tum transanal part	8.13	NA	NA	6.90	6.90	1.06	090
45172		A	Exc rect tum transanal full	12.13	NA	NA	8.37	8.37	1.61	090
46707		A	Repair anorectal fist w/plug	6.39	NA	NA	5.27	5.27	0.65	090
49411		A	Ins mark abd/pel for rt perq	3.82	9.91	9.91	1.42	1.42	0.26	000
49507		A	Prp i/hern init block >5 yr	10.05	NA	NA	5.79	4.95	1.52	090
49521		A	Rerepair ing hernia, blocked	12.44	NA	NA	6.57	5.63	1.89	090
49587		A	Rpr umbil hern, block > 5 yr	8.04	NA	NA	4.98	4.25	1.21	090
51727	26	A	Cystometrogram w/up	2.11	0.75	0.75	0.75	0.75	0.14	000
51728	26	A	Cystometrogram w/vp	2.11	0.73	0.73	0.73	0.73	0.12	000
51729	26	A	Cystometrogram w/vp&up	2.11	0.74	0.74	0.74	0.74	0.13	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.22	2.66	0.38	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	2.38	2.86	0.41	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	2.61	3.14	0.46	000
52344		A	Cysto/uretero, stricture tx	7.05	NA	NA	2.90	3.47	0.50	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	3.07	3.67	0.53	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	3.40	4.08	0.60	000
52400		A	Cystouretero w/congen repr	8.69	NA	NA	2.81	4.29	0.61	090
52500		A	Revision of bladder neck	8.14	NA	NA	4.49	5.24	0.56	090
52640		A	Relieve bladder contracture	4.79	NA	NA	2.81	3.39	0.33	090
53445		A	Insert uro/ves nck sphincter	15.39	NA	NA	7.43	8.76	1.07	090
53855		A	Insert prost urethral stent	1.64	16.31	16.31	0.54	0.54	0.11	000
54410		A	Remove/replace penis prosth	15.18	NA	NA	7.22	8.49	1.06	090
54530		A	Removal of testis	8.46	NA	NA	4.63	5.39	0.62	090
55873		A	Cryoablate prostate	13.60	147.06	45.92	6.30	10.14	1.46	090
57287		A	Revise/remove sling repair	11.15	NA	NA	6.33	6.69	1.04	090
57426		A	Revise prosth vag graft lap	14.30	NA	NA	7.61	7.61	1.74	090
62263		A	Epidural lysis mult sessions	6.54	12.48	10.60	4.37	3.37	0.37	010
62350		A	Implant spinal canal cath	6.05	NA	NA	4.07	3.39	0.75	010

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply.

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Fully Implemented Non-Facility PE RVUs[2]	Year 2010 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2010 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63650		A	Implant neuroelectrodes	7.20	NA	NA	4.29	3.25	0.46	010
63661		A	Remove spine eltrd perq aray	5.08	9.73	9.73	3.19	3.19	0.01	010
63662		A	Remove spine eltrd plate	11.00	NA	NA	6.94	6.94	1.10	090
63663		A	Revise spine eltrd perq aray	7.75	13.43	13.43	4.27	4.27	0.78	010
63664		A	Revise spine eltrd plate	11.52	NA	NA	7.15	7.15	1.15	090
63685		A	Insrt/redo spine n generator	6.05	NA	NA	4.13	3.51	0.79	010
64490		A	Inj paravert f jnt c/t 1 lev	1.82	2.57	2.57	1.02	1.02	0.14	000
64491		A	Inj paravert f jnt c/t 2 lev	1.16	0.98	0.98	0.46	0.46	0.09	ZZZ
64492		A	Inj paravert f jnt c/t 3 lev	1.16	1.01	1.01	0.49	0.49	0.09	ZZZ
64493		A	Inj paravert f jnt l/s 1 lev	1.52	2.47	2.47	0.90	0.90	0.11	000
64494		A	Inj paravert f jnt l/s 2 lev	1.00	0.93	0.93	0.39	0.39	0.07	ZZZ
64495		A	Inj paravert f jnt l/s 3 lev	1.00	0.96	0.96	0.42	0.42	0.07	ZZZ
64708		A	Revise arm/leg nerve	6.36	NA	NA	5.98	5.33	0.81	090
64831		A	Repair of digit nerve	9.16	NA	NA	8.04	7.28	1.17	090
65285		A	Repair of eye wound	14.71	NA	NA	12.18	9.93	1.85	090
69100		A	Biopsy of external ear	0.81	1.68	1.80	0.48	0.43	0.08	000
74261	26	A	Ct colonography, w/o dye	2.28	0.69	0.69	0.69	0.69	0.09	XXX
74262	26	A	Ct colonography, w/dye	2.50	0.76	0.76	0.76	0.76	0.10	XXX
74263	26	N	Ct colonography, screen	2.28	0.83	0.83	0.83	0.83	0.09	XXX
75565	26	A	Card mri vel flw map add-on	0.25	0.09	0.09	0.09	0.09	0.01	XXX
75571	26	A	Ct hrt w/o dye w/ca test	0.58	0.18	0.18	0.18	0.18	0.01	XXX
75572	26	A	Ct hrt w/3d image	1.75	0.57	0.57	0.57	0.57	0.04	XXX
75573	26	A	Ct hrt w/3d image, congen	2.55	0.77	0.77	0.77	0.77	0.06	XXX
75574	26	A	Ct angio hrt w/3d image	2.40	0.77	0.77	0.77	0.77	0.05	XXX
75791	26	A	Av dialysis shunt imaging	1.71	0.53	0.53	0.53	0.53	0.07	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.19	0.18	0.19	0.02	XXX
77338	26	A	Design mlc device for imrt	4.29	1.81	1.81	1.81	1.81	0.14	XXX
78451	26	A	Ht muscle image spect, sing	1.38	0.43	0.43	0.43	0.43	0.04	XXX
78452	26	A	Ht muscle image spect, mult	1.62	0.52	0.52	0.52	0.52	0.05	XXX
78453	26	A	Ht muscle image,planar,sing	1.00	0.31	0.31	0.31	0.31	0.03	XXX
78454	26	A	Ht musc image, planar, mult	1.34	0.40	0.40	0.40	0.40	0.04	XXX
88387	26	A	Tiss exam molecular study	0.62	0.24	0.24	0.24	0.24	0.01	XXX
88388	26	A	Tiss ex molecul study add-on	0.45	0.08	0.08	0.08	0.08	0.01	XXX
92526		A	Oral function therapy	1.34	0.65	1.39	0.51	0.27	0.02	XXX
92540	26	A	Basic vestibular evaluation	1.50	0.64	0.64	0.64	0.64	0.03	XXX
92550		A	Tympanometry & reflex thresh	0.35	0.21	0.21	NA	NA	0.01	XXX
92570		A	Acoustic immittance testing	0.55	0.30	0.30	0.25	0.25	0.02	XXX
92597		A	Oral speech device eval	1.26	0.67	1.61	0.60	0.41	0.03	XXX
92610		A	Evaluate swallowing function	1.30	0.79	1.79	0.57	1.73	0.01	XXX
92611		A	Motion fluoroscopy/swallow	1.34	0.97	1.98	NA	NA	0.01	XXX
93701		A	Bioimpedance, cv analysis	0.00	0.55	0.71	NA	NA	0.02	XXX
93750		A	Interrogation vad, in person	0.92	0.48	0.48	0.30	0.30	0.05	XXX
94011		A	Up to 2 yrs old, spirometry	2.00	0.62	0.62	0.62	0.62	0.05	XXX
94012		A	= 2 yrs, spiromtry w/dilator	3.10	0.94	0.94	0.94	0.94	0.08	XXX
94013		A	= 2 yrs, lung volumes	0.66	0.18	0.18	0.18	0.18	0.03	XXX
95905	26	A	Motor/sens nrve conduct test	0.05	0.02	0.02	0.02	0.02	0.01	XXX
96570		A	Photodynmc tx, 30 min add-on	1.10	0.37	0.40	0.37	0.40	0.13	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.15	0.18	0.15	0.18	0.03	ZZZ
99358		B	Prolong service w/o contact	2.10	0.80	0.77	0.80	0.77	0.11	XXX
99359		B	Prolong serv w/o contact add	1.00	0.40	0.38	0.40	0.38	0.05	ZZZ

[1] CPT codes and descriptors only are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment

ADDENDUM D: 2010 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality name	2010 GAF **
00831	01	Alaska	1.288***
01102	06	San Mateo, CA	1.204
01102	05	San Francisco, CA	1.201
13202	01	Manhattan, NY	1.164
13202	02	NYC Suburbs/Long I., NY	1.162
01102	09	Santa Clara, CA	1.148
12402	01	Northern NJ	1.134
14202	01	Metropolitan Boston	1.134
01102	07	Oakland/Berkley, CA	1.131
13292	04	Queens, NY	1.130
01192	26	Anaheim/Santa Ana, CA	1.128
12202	01	DC + MD/VA Suburbs	1.121
01192	17	Ventura, CA	1.121
09102	04	Miami, FL	1.114
01192	18	Los Angeles, CA	1.112
01102	03	Marin/Napa/Solano, CA	1.112
13102	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
12402	99	Rest of New Jersey	1.082
12502	01	Metropolitan Philadelphia, PA	1.075
00953	01	Detroit, MI	1.072
00952	15	Suburban Chicago, IL	1.063
01202	01	Hawaii/Guam	1.056
09102	03	Fort Lauderdale, FL	1.050
14402	01	Rhode Island	1.045
14202	99	Rest of Massachusetts	1.041
12302	01	Baltimore/Surr. Cntys, MD	1.035
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034
00836	02	Seattle (King Cnty), WA	1.033
01302	00	Nevada	1.016
04402	18	Houston, TX	1.016
12102	01	Delaware	1.014
01102	99	Rest of California*	1.012
01192	99	Rest of California*	1.012
00528	01	New Orleans, LA	1.010
04402	11	Dallas, TX	1.010
10202	01	Atlanta, GA	1.005
00952	12	East St. Louis, IL	0.989
09202	50	Virgin Islands	0.989
00835	01	Portland, OR	0.987
04402	31	Austin, TX	0.987
09102	99	Rest of Florida	0.987
14302	40	New Hampshire	0.986
04402	15	Galveston, TX	0.986
04402	09	Brazoria, TX	0.985
12302	99	Rest of Maryland	0.984
04402	28	Fort Worth, TX	0.982
14102	03	Southern Maine	0.980
05302	02	Metropolitan Kansas City, MO	0.978
04102	01	Colorado	0.975
00883	00	Ohio	0.973
00836	99	Rest of Washington	0.970
05302	01	Metropolitan St Louis, MO	0.969
00953	99	Rest of Michigan	0.968
03102	00	Arizona	0.968
12502	99	Rest of Pennsylvania	0.966
00954	00	Minnesota	0.959
14502	50	Vermont	0.956
00904	00	Virginia	0.952
04402	20	Beaumont, TX	0.950
03502	09	Utah	0.948
00952	99	Rest of Illinois	0.943
13282	99	Rest of New York	0.941
04202	05	New Mexico	0.941
00630	00	Indiana	0.941
05535	00	North Carolina	0.938
00951	00	Wisconsin	0.936
04402	99	Rest of Texas	0.933
10202	99	Rest of Georgia	0.931
00835	99	Rest of Oregon	0.930
00528	99	Rest of Louisiana	0.927
10302	35	Tennessee	0.924
00880	01	South Carolina	0.924
00884	16	West Virginia	0.924
05202	00	Kansas	0.915
05130	00	Idaho	0.914
14102	99	Rest of Maine	0.913
00660	00	Kentucky	0.909
00512	00	Mississippi	0.907
10102	00	Alabama	0.907
03602	21	Wyoming	0.904
05102	00	Iowa	0.903
04302	00	Oklahoma	0.901
05402	00	Nebraska	0.901
05302	99	Rest of Missouri	0.895
03202	01	Montana	0.894
00520	13	Arkansas	0.891
03402	02	South Dakota	0.888
03302	01	North Dakota	0.880
09202	20	Puerto Rico	0.787

GAF equation: (0.52466 * work GPCI) + (0.43669 * pe GPCI)+(0.03865 * mp GPCI).

* Indicates multiple contractors.

**GAF values do not reflect the 1.000 floor on physician work GPCI established by the MIPPA.

***GAF value for Alaska reflects 1.500 floor on physician work GPCI established by the MIPPA.

ADDENDUM E: 2010 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
10102	00	Alabama	0.982	0.853	0.496
00831	01	Alaska	1.500***	1.090	0.646
03102	00	Arizona	0.988	0.957	0.822
00520	13	Arkansas	0.961	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California*	1.007	1.058	0.549
01192	99	Rest of California*	1.007	1.058	0.549
04102	01	Colorado	0.986	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
09102	03	Fort Lauderdale, FL	0.989	1.018	2.250
09102	04	Miami, FL	1.000	1.069	3.167
09102	99	Rest of Florida	0.973	0.939	1.724
10202	01	Atlanta, GA	1.009	1.014	0.836
10202	99	Rest of Georgia	0.979	0.883	0.829
01202	01	Hawaii/Guam	0.998	1.161	0.665
05130	00	Idaho	0.967	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St Louis, IL	0.989	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	0.975	0.880	1.219
00630	00	Indiana	0.986	0.918	0.599
05102	00	Iowa	0.965	0.870	0.434
05202	00	Kansas	0.969	0.882	0.557
00660	00	Kentucky	0.969	0.860	0.652
00528	01	New Orleans, LA	0.986	1.044	0.956
00528	99	Rest of Louisiana	0.970	0.878	0.892
14102	03	Southern Maine	0.980	1.025	0.492
14102	99	Rest of Maine	0.962	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	0.994	0.982	0.874
14202	01	Metropolitan Boston	1.029	1.291	0.764
14202	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	0.998	0.923	1.083
00954	00	Minnesota	0.992	0.983	0.245
00512	00	Mississippi	0.959	0.854	0.808
05302	02	Metropolitan Kansas City, MO	0.990	0.945	1.188
05302	01	Metropolitan St Louis, MO	0.993	0.931	1.075
05302	99	Rest of Missouri	0.949	0.821	0.997
03202	01	Montana	0.950	0.847	0.673
05402	00	Nebraska	0.959	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
14302	40	New Hampshire	0.982	1.039	0.462
12402	01	Northern NJ	1.057	1.228	1.116
12402	99	Rest of New Jersey	1.042	1.126	1.116
04202	05	New Mexico	0.973	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	0.997	0.921	0.425
05535	00	North Carolina	0.972	0.925	0.634
03302	01	North Dakota	0.947	0.844	0.387
00883	00	Ohio	0.993	0.927	1.232
04302	00	Oklahoma	0.964	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	0.968	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	0.993	0.925	1.081
09202	20	Puerto Rico	0.904	0.694	0.250
14402	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	0.975	0.906	0.446
03402	02	South Dakota	0.942	0.864	0.420
10302	35	Tennessee	0.978	0.889	0.608
04402	31	Austin, TX	0.992	0.984	0.969
04402	20	Beaumont, TX	0.984	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	0.998	0.953	1.110
04402	15	Galveston, TX	0.991	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	0.968	0.879	1.065
03502	09	Utah	0.977	0.907	1.026
14502	50	Vermont	0.968	0.983	0.489
00904	00	Virginia	0.982	0.942	0.657
09202	50	Virgin Islands	0.997	0.978	1.009
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	0.987	0.974	0.693
00884	16	West Virginia	0.973	0.827	1.353
00951	00	Wisconsin	0.988	0.921	0.409
03602	21	Wyoming	0.956	0.842	0.889

* Indicates multiple contractors.

** CY 2010 work GPCI does not reflect the 1.000 floor established by the MIPPA which expires January 1, 2010.

***CY 2010 work GPCI reflects 1.500 floor in Alaska established by the MIPPA.

ADDENDUM F: CY 2010 ESRD Wage Index for Nonurban Areas Based on CBSA Labor Market Areas

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.7750
2	Alaska	1.2343
3	Arizona	0.9297
4	Arkansas	0.7755
5	California	1.2747
6	Colorado	1.0502
7	Connecticut	1.1733
8	Delaware	1.0482
10	Florida	0.9061
11	Georgia	0.8063
12	Hawaii	1.1755
13	Idaho	0.8179
14	Illinois	0.8792
15	Indiana	0.9021
16	Iowa	0.9122
17	Kansas	0.8639
18	Kentucky	0.8264
19	Louisiana	0.8050
20	Maine	0.9074
21	Maryland	0.9658
22	Massachusetts	1.2375
23	Michigan	0.9285
24	Minnesota	0.9689
25	Mississippi	0.8079
26	Missouri	0.8114
27	Montana	0.8884
28	Nebraska	0.9208
29	Nevada	1.0233
30	New Hampshire	1.0532
31	New Jersey[1]	------
32	New Mexico	0.9454
33	New York	0.8746
34	North Carolina	0.9028
35	North Dakota	0.8264
36	Ohio	0.8997
37	Oklahoma	0.8096
38	Oregon	1.0827
39	Pennsylvania	0.8786
40	Puerto Rico	0.6875
41	Rhode Island[1]	------
42	South Carolina	0.8879
43	South Dakota	0.9001
44	Tennessee	0.8259
45	Texas	0.8207
46	Utah	0.8846
47	Vermont	1.0327
48	Virgin Islands	0.7844
49	Virginia	0.8323
50	Washington	1.0814
51	West Virginia	0.7823
52	Wisconsin	0.9738
53	Wyoming	1.0086

[1] All counties within the State are classified as urban

ADDENDUM G: CY 2010 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX	0.8405
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	
10380	Aguadilla-Isabela-San Sebastian, PR	0.6875
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	
10420	Akron, OH	0.9361
	Portage County, OH	
	Summit County, OH	
10500	Albany, GA	0.9413
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	
10580	Albany-Schenectady-Troy, NY	0.9284
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	
10740	Albuquerque, NM	0.9942
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	
10780	Alexandria, LA	0.8475
	Grant Parish, LA	
	Rapides Parish, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ	1.0166
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.9375
	Blair County, PA	
11100	Amarillo, TX	0.9191
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	1.0041
	Story County, IA	
11260	Anchorage, AK	1.2707
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.9575
	Madison County, IN	
11340	Anderson, SC	0.9554
	Anderson County, SC	
11460	Ann Arbor, MI	1.0887
	Washtenaw County, MI	
11500	Anniston-Oxford, AL	0.8084
	Calhoun County, AL	
11540	Appleton, WI	0.9825
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9580
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Madison County, NC	
12020	Athens-Clarke County, GA	1.0040
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	1.0145
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City-Hammonton, NJ	1.2221
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8608
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	0.9952
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	
12420	Austin-Round Rock, TX	1.0068
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	Bakersfield, CA	1.1880
	Kern County, CA	
12580	Baltimore-Towson, MD	1.0604
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	
12620	Bangor, ME	1.0740
	Penobscot County, ME	
12700	Barnstable Town, MA	1.3347
	Barnstable County, MA	
12940	Baton Rouge, LA	0.8652
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	
12980	Battle Creek, MI	1.0577
	Calhoun County, MI	
13020	Bay City, MI	0.9802
	Bay County, MI	
13140	Beaumont-Port Arthur, TX	0.8867
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	
13380	Bellingham, WA	1.2053
	Whatcom County, WA	
13460	Bend, OR	1.2107
	Deschutes County, OR	
13644	Bethesda-Frederick-Gaithersburg, MD	1.0893
	Frederick County, MD	
	Montgomery County, MD	
13740	Billings, MT	0.9288
	Carbon County, MT	
	Yellowstone County, MT	
13780	Binghamton, NY	0.9287
	Broome County, NY	
	Tioga County, NY	
13820	Birmingham-Hoover, AL	0.9048
	Bibb County, AL	
	Blount County, AL	
	Chilton County, AL	
	Jefferson County, AL	
	St. Clair County, AL	
	Shelby County, AL	
	Walker County, AL	
13900	Bismarck, ND	0.8078
	Burleigh County, ND	
	Morton County, ND	
13980	Blacksburg-Christiansburg-Radford, VA	0.8879
	Giles County, VA	
	Montgomery County, VA	
	Pulaski County, VA	
	Radford City, VA	
14020	Bloomington, IN	0.9565
	Greene County, IN	
	Monroe County, IN	
	Owen County, IN	
14060	Bloomington-Normal, IL	0.9919
	McLean County, IL	
14260	Boise City-Nampa, ID	0.9856
	Ada County, ID	
	Boise County, ID	
	Canyon County, ID	
	Gem County, ID	
	Owyhee County, ID	
14484	Boston-Quincy, MA	1.2890
	Norfolk County, MA	
	Plymouth County, MA	
	Suffolk County, MA	
14500	Boulder, CO	1.0859
	Boulder County, CO	
14540	Bowling Green, KY	0.8958
	Edmonson County, KY	
	Warren County, KY	
14600	Bradenton-Sarasota-Venice, FL	1.0297
	Manatee County, FL	
	Sarasota County, FL	
14740	Bremerton-Silverdale, WA	1.1376
	Kitsap County, WA	
14860	Bridgeport-Stamford-Norwalk, CT	1.3531
	Fairfield County, CT	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
15180	Brownsville-Harlingen, TX	0.9541
	Cameron County, TX	
15260	Brunswick, GA	0.9708
	Brantley County, GA	
	Glynn County, GA	
	McIntosh County, GA	
15380	Buffalo-Niagara Falls, NY	1.0302
	Erie County, NY	
	Niagara County, NY	
15500	Burlington, NC	0.9254
	Alamance County, NC	
15540	Burlington-South Burlington, VT	1.0689
	Chittenden County, VT	
	Franklin County, VT	
	Grand Isle County, VT	
15764	Cambridge-Newton-Framingham, MA	1.1929
	Middlesex County, MA	
15804	Camden, NJ	1.0973
	Burlington County, NJ	
	Camden County, NJ	
	Gloucester County, NJ	
15940	Canton-Massillon, OH	0.9322
	Carroll County, OH	
	Stark County, OH	
15980	Cape Coral-Fort Myers, FL	0.9600
	Lee County, FL	
16180	Carson City, NV	1.1150
	Carson City, NV	
16020	Cape Girardeau County, MO-IL	0.9579
	Alexander County, IL	
	Bollinger County, MO	
	Cape Girardeau County, MO	
16220	Casper, WY	1.0070
	Natrona County, WY	
16300	Cedar Rapids, IA	0.9503
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	
16580	Champaign-Urbana, IL	1.0692
	Champaign County, IL	
	Ford County, IL	
	Piatt County, IL	
16620	Charleston, WV	0.8611
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	
16700	Charleston-North Charleston-Summerville, SC	0.9815
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	
16740	Charlotte-Gastonia-Concord, NC-SC	1.0021
	Anson County, NC	
	Cabarrus County, NC	
	Gaston County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	
16820	Charlottesville, VA	0.9913
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	
16860	Chattanooga, TN-GA	0.9341
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Marion County, TN	
	Sequatchie County, TN	
16940	Cheyenne, WY	0.9883
	Laramie County, WY	
16974	Chicago-Naperville-Joliet, IL	1.1076
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	
17020	Chico, CA	1.1845
	Butte County, CA	
17140	Cincinnati-Middletown, OH-KY-IN	1.0031
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	
17300	Clarksville, TN-KY	0.8441
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	
17420	Cleveland, TN	0.8001
	Bradley County, TN	
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH	0.9429
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	
17660	Coeur d'Alene, ID	0.9768
	Kootenai County, ID	
17780	College Station-Bryan, TX	1.0046
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	
17820	Colorado Springs, CO	1.0388
	El Paso County, CO	
	Teller County, CO	
17860	Columbia, MO	0.9116
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.9296
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	0.9228
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
18020	Columbus, IN	1.0087
	Bartholomew County, IN	
18140	Columbus, OH	1.0684
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	
18580	Corpus Christi, TX	0.9195
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	
18700	Corvallis, OR	1.1637
	Benton County, OR	
19060	Cumberland, MD-WV	0.8509
	Allegany County, MD	
	Mineral County, WV	
19124	Dallas-Plano-Irving, TX	1.0422
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	0.9166
	Murray County, GA	
	Whitfield County, GA	
19180	Danville, IL	0.9242
	Vermilion County, IL	
19260	Danville, VA	0.8804
	Pittsylvania County, VA	
	Danville City, VA	
19340	Davenport-Moline-Rock Island, IA-IL	0.8762
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	
19380	Dayton, OH	0.9743
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	
19460	Decatur, AL	0.8249
	Lawrence County, AL	
	Morgan County, AL	
19500	Decatur, IL	0.8457
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9377
	Volusia County, FL	
19740	Denver-Aurora-Broomfield, CO	1.1351
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines-West Des Moines, IA	1.0206
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI	1.0291
	Wayne County, MI	
20020	Dothan, AL	0.7834
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	
20100	Dover, DE	1.0504
	Kent County, DE	
20220	Dubuque, IA	0.9381
	Dubuque County, IA	
20260	Duluth, MN-WI	1.1051
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	
20500	Durham-Chapel Hill, NC	1.0173
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	
20740	Eau Claire, WI	1.0119
	Chippewa County, WI	
	Eau Claire County, WI	
20764	Edison-New Brunswick, NJ	1.1700
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	
20940	El Centro, CA	0.9272
	Imperial County, CA	
21060	Elizabethtown, KY	0.8872
	Hardin County, KY	
	Larue County, KY	
21140	Elkhart-Goshen, IN	1.0037
	Elkhart County, IN	
21300	Elmira, NY	0.8823
	Chemung County, NY	
21340	El Paso, TX	0.9034
	El Paso County, TX	
21500	Erie, PA	0.9266
	Erie County, PA	
21660	Eugene-Springfield, OR	1.1671
	Lane County, OR	
21780	Evansville, IN-KY	0.9014
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	
21820	Fairbanks, AK	1.1756
	Fairbanks North Star Borough, AK	
21940	Fajardo, PR	0.6875
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	
22020	Fargo, ND-MN	0.8644
	Cass County, ND	
	Clay County, MN	
22140	Farmington, NM	0.8344
	San Juan County, NM	
22180	Fayetteville, NC	0.9898
	Cumberland County, NC	
	Hoke County, NC	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.9282
	Benton County, AR	
	Madison County, AR	
	Washington County, AR	
	McDonald County, MO	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
22380	Flagstaff, AZ	1.3195
	Coconino County, AZ	
22420	Flint, MI	1.1883
	Genesee County, MI	
22500	Florence, SC	0.8582
	Darlington County, SC	
	Florence County, SC	
22520	Florence-Muscle Shoals, AL	0.8460
	Colbert County, AL	
	Lauderdale County, AL	
22540	Fond du Lac, WI	1.0218
	Fond du Lac County, WI	
22660	Fort Collins-Loveland, CO	1.0762
	Larimer County, CO	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0982
	Broward County, FL	
22900	Fort Smith, AR-OK	0.8315
	Crawford County, AR	
	Franklin County, AR	
	Sebastian County, AR	
	Le Flore County, OK	
	Sequoyah County, OK	
23020	Fort Walton Beach-Crestview-Destin, FL	0.9264
	Okaloosa County, FL	
23060	Fort Wayne, IN	0.9532
	Allen County, IN	
	Wells County, IN	
	Whitley County, IN	
23104	Fort Worth-Arlington, TX	1.0047
	Johnson County, TX	
	Parker County, TX	
	Tarrant County, TX	
	Wise County, TX	
23420	Fresno, CA	1.1918
	Fresno County, CA	
23460	Gadsden, AL	0.8743
	Etowah County, AL	
23540	Gainesville, FL	0.9496
	Alachua County, FL	
	Gilchrist County, FL	
23580	Gainesville, GA	0.9650
	Hall County, GA	
23844	Gary, IN	0.9824
	Jasper County, IN	
	Lake County, IN	
	Newton County, IN	
	Porter County, IN	
24020	Glens Falls, NY	0.8944
	Warren County, NY	
	Washington County, NY	
24140	Goldsboro, NC	0.9579
	Wayne County, NC	
24220	Grand Forks, ND-MN	0.8224
	Polk County, MN	
	Grand Forks County, ND	
24300	Grand Junction, CO	1.0282
	Mesa County, CO	
24340	Grand Rapids-Wyoming, MI	0.9708
	Barry County, MI	
	Ionia County, MI	
	Kent County, MI	
	Newaygo County, MI	
24500	Great Falls, MT	0.8836
	Cascade County, MT	
24540	Greeley, CO	1.0131
	Weld County, CO	
24580	Green Bay, WI	1.0176
	Brown County, WI	
	Kewaunee County, WI	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Oconto County, WI	
24660	Greensboro-High Point, NC	0.9585
	Guilford County, NC	
	Randolph County, NC	
	Rockingham County, NC	
24780	Greenville, NC	0.9944
	Greene County, NC	
	Pitt County, NC	
24860	Greenville-Mauldin-Easley, SC	1.0556
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	
25020	Guayama, PR	0.6875
	Arroyo Municipio, PR	
	Guayama Municipio, PR	
	Patillas Municipio, PR	
25060	Gulfport-Biloxi, MS	0.9290
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	
25180	Hagerstown-Martinsburg, MD-WV	0.9483
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	
25260	Hanford-Corcoran, CA	1.1646
	Kings County, CA	
25420	Harrisburg-Carlisle, PA	0.9822
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	
25500	Harrisonburg, VA	0.9546
	Rockingham County, VA	
	Harrisonburg City, VA	
25540	Hartford-West Hartford-East Hartford, CT	1.1840
	Hartford County, CT	
	Middlesex County, CT	
	Tolland County, CT	
25620	Hattiesburg, MS	0.8106
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	
25860	Hickory-Lenoir-Morganton, NC	0.9520
	Alexander County, NC	
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	
25980	Hinesville-Fort Stewart, GA	0.9549
	Liberty County, GA	
	Long County, GA	
26100	Holland-Grand Haven, MI	0.9198
	Ottawa County, MI	
26180	Honolulu, HI	1.2335
	Honolulu County, HI	
26300	Hot Springs, AR	0.9524
	Garland County, AR	
26380	Houma-Bayou Cane-Thibodaux, LA	0.8330
	Lafourche Parish, LA	
	Terrebonne Parish, LA	
26420	Houston-Sugar Land-Baytown, TX	1.0409
	Austin County, TX	
	Brazoria County, TX	
	Chambers County, TX	
	Fort Bend County, TX	
	Galveston County, TX	
	Harris County, TX	
	Liberty County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
	Waller County, TX	
26580	Huntington-Ashland, WV-KY-OH	0.9622

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	
26620	Huntsville, AL	0.9587
	Limestone County, AL	
	Madison County, AL	
26820	Idaho Falls, ID	0.9981
	Bonneville County, ID	
	Jefferson County, ID	
26900	Indianapolis-Carmel, IN	1.0304
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	
26980	Iowa City, IA	1.0099
	Johnson County, IA	
	Washington County, IA	
27060	Ithaca, NY	1.0696
	Tompkins County, NY	
27100	Jackson, MI	0.9223
	Jackson County, MI	
27140	Jackson, MS	0.8659
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	
27180	Jackson, TN	0.9076
	Chester County, TN	
	Madison County, TN	
27260	Jacksonville, FL	0.9631
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	
27340	Jacksonville, NC	0.8489
	Onslow County, NC	
27500	Janesville, WI	0.9732
	Rock County, WI	
27620	Jefferson City, MO	0.9212
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	
27740	Johnson City, TN	0.8168
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	
27780	Johnstown, PA	0.8708
	Cambria County, PA	
27860	Jonesboro, AR	0.8166
	Craighead County, AR	
	Poinsett County, AR	
27900	Joplin, MO	0.8763
	Jasper County, MO	
	Newton County, MO	
28020	Kalamazoo-Portage, MI	1.0857
	Kalamazoo County, MI	
	Van Buren County, MI	
28100	Kankakee-Bradley, IL	1.0761
	Kankakee County, IL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
28140	Kansas City, MO-KS	1.0238
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	
28420	Kennewick-Pasco-Richland, WA	1.1051
	Benton County, WA	
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.9204
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8461
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	0.9908
	Ulster County, NY	
28940	Knoxville, TN	0.8336
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	
29020	Kokomo, IN	1.0431
	Howard County, IN	
	Tipton County, IN	
29100	La Crosse, WI-MN	1.0487
	Houston County, MN	
	La Crosse County, WI	
29140	Lafayette, IN	0.9711
	Benton County, IN	
	Carroll County, IN	
	Tippecanoe County, IN	
29180	Lafayette, LA	0.9008
	Lafayette Parish, LA	
	St. Martin Parish, LA	
29340	Lake Charles, LA	0.8446
	Calcasieu Parish, LA	
	Cameron Parish, LA	
29404	Lake County-Kenosha County, IL-WI	1.1080
	Lake County, IL	
	Kenosha County, WI	
29420	Lake Havasu City-Kingman, AZ	1.1177
	Mohave County, AZ	
29460	Lakeland-Winter Haven, FL	0.8874
	Polk County, FL	
29540	Lancaster, PA	0.9735
	Lancaster County, PA	
29620	Lansing-East Lansing, MI	1.0334
	Clinton County, MI	
	Eaton County, MI	
	Ingham County, MI	
29700	Laredo, TX	0.8544
	Webb County, TX	
29740	Las Cruces, NM	0.9455
	Dona Ana County, NM	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
29820	Las Vegas-Paradise, NV	1.2830
	Clark County, NV	
29940	Lawrence, KS	0.9075
	Douglas County, KS	
30020	Lawton, OK	0.8300
	Comanche County, OK	
30140	Lebanon, PA	0.8588
	Lebanon County, PA	
30300	Lewiston, ID-WA	1.0123
	Nez Perce County, ID	
	Asotin County, WA	
30340	Lewiston-Auburn, ME	0.9610
	Androscoggin County, ME	
30460	Lexington-Fayette, KY	0.9402
	Bourbon County, KY	
	Clark County, KY	
	Fayette County, KY	
	Jessamine County, KY	
	Scott County, KY	
	Woodford County, KY	
30620	Lima, OH	0.9920
	Allen County, OH	
30700	Lincoln, NE	1.0115
	Lancaster County, NE	
	Seward County, NE	
30780	Little Rock-North Little Rock-Conway, AR	0.9053
	Faulkner County, AR	
	Grant County, AR	
	Lonoke County, AR	
	Perry County, AR	
	Pulaski County, AR	
	Saline County, AR	
30860	Logan, UT-ID	0.9512
	Franklin County, ID	
	Cache County, UT	
30980	Longview, TX	0.8514
	Gregg County, TX	
	Rusk County, TX	
	Upshur County, TX	
31020	Longview, WA	1.1325
	Cowlitz County, WA	
31084	Los Angeles-Long Beach-Santa Ana, CA	1.2734
	Los Angeles County, CA	
31140	Louisville-Jefferson County, KY-IN	0.9462
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	
31180	Lubbock, TX	0.9256
	Crosby County, TX	
	Lubbock County, TX	
31340	Lynchburg, VA	0.9013
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	
31420	Macon, GA	1.0393
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Monroe County, GA	
	Twiggs County, GA	
31460	Madera-Chowchilla, CA	0.8417
	Madera County, CA	
31540	Madison, WI	1.1883
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	
31700	Manchester-Nashua, NH	1.0758
	Hillsborough County, NH	
31740	Manhattan, KS	0.8333
	Geary County, KS	
	Pottawatomie County, KS	
	Riley County, KS	
31860	Mankato-North Mankato, MN	0.9707
	Blue Earth County, MN	
	Nicollet County, MN	
31900	Mansfield, OH	0.9625
	Richland County, OH	
32420	Mayagüez, PR	0.6875
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	
32580	McAllen-Edinburg-Mission, TX	0.9363
	Hidalgo County, TX	
32780	Medford, OR	1.0651
	Jackson County, OR	
32820	Memphis, TN-MS-AR	0.9803
	Crittenden County, AR	
	DeSoto County, MS	
	Marshall County, MS	
	Tate County, MS	
	Tunica County, MS	
	Fayette County, TN	
	Shelby County, TN	
	Tipton County, TN	
32900	Merced, CA	1.2823
	Merced County, CA	
33124	Miami-Miami Beach-Kendall, FL	1.0529
	Miami-Dade County, FL	
33140	Michigan City-La Porte, IN	0.9849
	LaPorte County, IN	
33260	Midland, TX	1.0097
	Midland County, TX	
33340	Milwaukee-Waukesha-West Allis, WI	1.0737
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1736
	Anoka County, MN	
	Carver County, MN	
	Chisago County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN	
	Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	Pierce County, WI	
	St. Croix County, WI	
33540	Missoula, MT	0.9738
	Missoula County, MT	
33660	Mobile, AL	0.8234
	Mobile County, AL	
33700	Modesto, CA	1.3224
	Stanislaus County, CA	
33740	Monroe, LA	0.8200
	Ouachita Parish, LA	
	Union Parish, LA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
33780	Monroe, MI	0.9398
	Monroe County, MI	
33860	Montgomery, AL	0.8783
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	
34060	Morgantown, WV	0.8947
	Monongalia County, WV	
	Preston County, WV	
34100	Morristown, TN	0.7617
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	
34580	Mount Vernon-Anacortes, WA	1.1055
	Skagit County, WA	
34620	Muncie, IN	0.8870
	Delaware County, IN	
34740	Muskegon-Norton Shores, MI	1.0390
	Muskegon County, MI	
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	0.9234
	Horry County, SC	
34900	Napa, CA	1.5287
	Napa County, CA	
34940	Naples-Marco Island, FL	1.0220
	Collier County, FL	
34980	Nashville-Davidson—Murfreesboro--Franklin, TN	1.0248
	Cannon County, TN	
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, TN	
	Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN	
	Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	
35004	Nassau-Suffolk, NY	1.3197
	Nassau County, NY	
	Suffolk County, NY	
35084	Newark-Union, NJ-PA	1.2078
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	
35300	New Haven-Milford, CT	1.2212
	New Haven County, CT	
35380	New Orleans-Metairie-Kenner, LA	0.9617
	Jefferson Parish, LA	
	Orleans Parish, LA	
	Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
	St. Tammany Parish, LA	
35644	New York-White Plains-Wayne, NY-NJ	1.3756
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ	
	Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY	
	Queens County, NY	
	Richmond County, NY	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Rockland County, NY	
	Westchester County, NY	
35660	Niles-Benton Harbor, MI	0.9417
	Berrien County, MI	
35980	Norwich-New London, CT	1.2057
	New London County, CT	
36084	Oakland-Fremont-Hayward, CA	1.7351
	Alameda County, CA	
	Contra Costa County, CA	
36100	Ocala, FL	0.9050
	Marion County, FL	
36140	Ocean City, NJ	1.0747
	Cape May County, NJ	
36220	Odessa, TX	1.0431
	Ector County, TX	
36260	Ogden-Clearfield, UT	0.9901
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	
36420	Oklahoma City, OK	0.9414
	Canadian County, OK	
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	Logan County, OK	
	McClain County, OK	
	Oklahoma County, OK	
36500	Olympia, WA	1.2197
	Thurston County, WA	
36540	Omaha-Council Bluffs, NE-IA	1.0163
	Harrison County, IA	
	Mills County, IA	
	Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Saunders County, NE	
	Washington County, NE	
36740	Orlando-Kissimmee, FL	0.9468
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	
36780	Oshkosh-Neenah, WI	0.9680
	Winnebago County, WI	
36980	Owensboro, KY	0.8839
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.3011
	Ventura County, CA	
37340	Palm Bay-Melbourne-Titusville, FL	0.9583
	Brevard County, FL	
37380	Palm Coast, FL	1.0157
	Flagler County, FL	
37460	Panama City-Lynn Haven-Panama City, FL	0.8805
	Bay County, FL	
37620	Parkersburg-Marietta-Vienna, WV-OH	0.8161
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	
37700	Pascagoula, MS	0.8920
	George County, MS	
	Jackson County, MS	
37764	Peabody, MA	1.1499
	Essex County, MA	
37860	Pensacola-Ferry Pass-Brent, FL	0.8792
	Escambia County, FL	
	Santa Rosa County, FL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
37900	Peoria, IL	0.9684
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	
37964	Philadelphia, PA	1.1359
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	1.1244
	Maricopa County, AZ	
	Pinal County, AZ	
38220	Pine Bluff, AR	0.7701
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	
38300	Pittsburgh, PA	0.9123
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	
38340	Pittsfield, MA	1.1273
	Berkshire County, MA	
38540	Pocatello, ID	0.9772
	Bannock County, ID	
	Power County, ID	
38660	Ponce, PR	0.6875
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	
38860	Portland-South Portland-Biddeford, ME	1.0775
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	
38900	Portland-Vancouver-Beaverton, OR-WA	1.2162
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	
38940	Port St. Lucie, FL	1.0467
	Martin County, FL	
	St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1864
	Dutchess County, NY	
	Orange County, NY	
39140	Prescott, AZ	1.0705
	Yavapai County, AZ	
39300	Providence-New Bedford-Fall River, RI-MA	1.1404
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	
39340	Provo-Orem, UT	1.0099
	Juab County, UT	
	Utah County, UT	
39380	Pueblo, CO	0.9065
	Pueblo County, CO	
39460	Punta Gorda, FL	0.9281
	Charlotte County, FL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
39540	Racine, WI	0.9914
	Racine County, WI	
39580	Raleigh-Cary, NC	1.0221
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	
39660	Rapid City, SD	1.0626
	Meade County, SD	
	Pennington County, SD	
39740	Reading, PA	0.9798
	Berks County, PA	
39820	Redding, CA	1.4850
	Shasta County, CA	
39900	Reno-Sparks, NV	1.0879
	Storey County, NV	
	Washoe County, NV	
40060	Richmond, VA	1.0071
	Amelia County, VA	
	Caroline County, VA	
	Charles City County, VA	
	Chesterfield County, VA	
	Cumberland County, VA	
	Dinwiddie County, VA	
	Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA	
	King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Powhatan County, VA	
	Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Hopewell City, VA	
	Petersburg City, VA	
	Richmond City, VA	
40140	Riverside-San Bernardino-Ontario, CA	1.1937
	Riverside County, CA	
	San Bernardino County, CA	
40220	Roanoke, VA	0.9172
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	
40340	Rochester, MN	1.1779
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	
40380	Rochester, NY	0.9228
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	
40420	Rockford, IL	1.0738
	Boone County, IL	
	Winnebago County, IL	
40484	Rockingham County, NH	1.0710
	Rockingham County, NH	
	Strafford County, NH	
40580	Rocky Mount, NC	0.9356
	Edgecombe County, NC	
	Nash County, NC	
40660	Rome, GA	0.9430
	Floyd County, GA	
40900	Sacramento--Arden-Arcade--Roseville, CA	1.4886
	El Dorado County, CA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	
40980	Saginaw-Saginaw Township North, MI	0.9649
	Saginaw County, MI	
41060	St. Cloud, MN	1.1748
	Benton County, MN	
	Stearns County, MN	
41100	St. George, UT	0.9769
	Washington County, UT	
41140	St. Joseph, MO-KS	1.0777
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	
41180	St. Louis, MO-IL	0.9628
	Bond County, IL	
	Calhoun County, IL	
	Clinton County, IL	
	Jersey County, IL	
	Macoupin County, IL	
	Madison County, IL	
	Monroe County, IL	
	St. Clair County, IL	
	Crawford County, MO	
	Franklin County, MO	
	Jefferson County, MO	
	Lincoln County, MO	
	St. Charles County, MO	
	St. Louis County, MO	
	Warren County, MO	
	Washington County, MO	
	St. Louis City, MO	
41420	Salem, OR	1.1608
	Marion County, OR	
	Polk County, OR	
41500	Salinas, CA	1.6085
	Monterey County, CA	
41540	Salisbury, MD	0.9636
	Somerset County, MD	
	Wicomico County, MD	
41620	Salt Lake City, UT	0.9919
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	
41660	San Angelo, TX	0.8371
	Irion County, TX	
	Tom Green County, TX	
41700	San Antonio, TX	0.9368
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	
41740	San Diego-Carlsbad-San Marcos, CA	1.2431
	San Diego County, CA	
41780	Sandusky, OH	0.9401
	Erie County, OH	
41884	San Francisco-San Mateo-Redwood City, CA	1.6790
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	
41900	San Germán-Cabo Rojo, PR	0.6875
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41940	San Jose-Sunnyvale-Santa Clara, CA	1.7351
	San Benito County, CA	
	Santa Clara County, CA	
41980	San Juan-Caguas-Guaynabo, PR	0.6875
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA	1.3275
	San Luis Obispo County, CA	
42044	Santa Ana-Anaheim-Irvine, CA	1.2663
	Orange County, CA	
42060	Santa Barbara-Santa Maria-Goleta, CA	1.2918
	Santa Barbara County, CA	
42100	Santa Cruz-Watsonville, CA	1.7701
	Santa Cruz County, CA	
42140	Santa Fe, NM	1.1311
	Santa Fe County, NM	
42220	Santa Rosa-Petaluma, CA	1.6808
	Sonoma County, CA	
42340	Savannah, GA	0.9565
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	
42540	Scranton--Wilkes-Barre, PA	0.8859
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	
42644	Seattle-Bellevue-Everett, WA	1.2245
	King County, WA	
	Snohomish County, WA	
42680	Sebastian-Vero Beach, FL	0.9903
	Indian River County, FL	
43100	Sheboygan, WI	0.9695

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Sheboygan County, WI	
43300	Sherman-Denison, TX	0.8530
	Grayson County, TX	
43340	Shreveport-Bossier City, LA	0.8867
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	
43580	Sioux City, IA-NE-SD	0.9619
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	
43620	Sioux Falls, SD	0.9502
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	
43780	South Bend-Mishawaka, IN-MI	1.0249
	St. Joseph County, IN	
	Cass County, MI	
43900	Spartanburg, SC	0.9880
	Spartanburg County, SC	
44060	Spokane, WA	1.1047
	Spokane County, WA	
44100	Springfield, IL	1.0096
	Menard County, IL	
	Sangamon County, IL	
44140	Springfield, MA	1.0972
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	
44180	Springfield, MO	0.8941
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	
44220	Springfield, OH	0.9726
	Clark County, OH	
44300	State College, PA	0.9621
	Centre County, PA	
44700	Stockton, CA	1.3043
	San Joaquin County, CA	
44940	Sumter, SC	0.8623
	Sumter County, SC	
45060	Syracuse, NY	1.0350
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	
45104	Tacoma, WA	1.1841
	Pierce County, WA	
45220	Tallahassee, FL	0.8891
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9501
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	
45460	Terre Haute, IN	0.9584
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	
45500	Texarkana, TX-Texarkana, AR	0.8581
	Miller County, AR	
	Bowie County, TX	
45780	Toledo, OH	1.0092

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	
45820	Topeka, KS	0.9547
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	
45940	Trenton-Ewing, NJ	1.1161
	Mercer County, NJ	
46060	Tucson, AZ	1.0054
	Pima County, AZ	
46140	Tulsa, OK	0.9162
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	
46220	Tuscaloosa, AL	0.9200
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	
46340	Tyler, TX	0.8792
	Smith County, TX	
46540	Utica-Rome, NY	0.8948
	Herkimer County, NY	
	Oneida County, NY	
46660	Valdosta, GA	0.8403
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	
46700	Vallejo-Fairfield, CA	1.5796
	Solano County, CA	
47020	Victoria, TX	0.8519
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	
47220	Vineland-Millville-Bridgeton, NJ	1.0796
	Cumberland County, NJ	
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9477
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	Visalia-Porterville, CA	1.0611
	Tulare County, CA	
47380	Waco, TX	0.8861
	McLennan County, TX	
47580	Warner Robins, GA	0.9259
	Houston County, GA	
47644	Warren-Troy-Farmington Hills, MI	1.0372
	Lapeer County, MI	
	Livingston County, MI	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1510
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Fauquier County, VA	
	Loudoun County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA	
	Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg City, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA	0.9010
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	
48140	Wausau, WI	0.9985
	Marathon County, WI	
48260	Weirton-Steubenville, WV-OH	0.7793
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	
48300	Wenatchee, WA	1.0280
	Chelan County, WA	
	Douglas County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0449
	Palm Beach County, FL	
48540	Wheeling, WV-OH	0.7266
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9539
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	
48660	Wichita Falls, TX	0.9728
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	
48700	Williamsport, PA	0.8332
	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ	1.1164
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	
48900	Wilmington, NC	0.9505
	Brunswick County, NC	
	New Hanover County, NC	
	Pender County, NC	
49020	Winchester, VA-WV	1.0341
	Frederick County, VA	
	Winchester City, VA	
	Hampshire County, WV	
49180	Winston-Salem, NC	0.9470
	Davie County, NC	
	Forsyth County, NC	
	Stokes County, NC	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Yadkin County, NC	
49340	Worcester, MA	1.1729
	Worcester County, MA	
49420	Yakima, WA	1.0523
	Yakima County, WA	
49500	Yauco, PR	0.6875
	Guánica Municipio, PR	
	Guayanilla Municipio, PR	
	Peñuelas Municipio, PR	
	Yauco Municipio, PR	
49620	York-Hanover, PA	0.9836
	York County, PA	
49660	Youngstown-Warren-Boardman, OH-PA	0.9180
	Mahoning County, OH	
	Trumbull County, OH	
	Mercer County, PA	
49700	Yuba City, CA	1.1915
49740	Yuma, AZ	0.9671
	Yuma County, AZ	

ADDENDUM H: CPT/HCPCS Imaging Codes Defined By Section 5102(b) of the DRA

HCPCS/ CPT*	Short Descriptor
31620	Endobronchial us add-on
37250	Iv us first vessel add-on
37251	Iv us each add vessel add-on
51798	Us urine capacity measure
70010	Contrast x-ray of brain
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye

HCPCS/ CPT*	Short Descriptor
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70557	Mri brain w/o dye
70558	Mri brain w/dye
70559	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray

HCPCS/ CPT*	Short Descriptor
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
71090	X-ray & pacemaker insertion
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye

HCPCS/ CPT*	Short Descriptor
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72265	Contrast x-ray, lower spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72291	Percut vertebroplasty fluor
72293	Percut vertebroplasty, ct
72295	X-ray of lower spine disk
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm

HCPCS/ CPT*	Short Descriptor
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips
73542	X-ray exam, sacroiliac joint
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73615	Contrast x-ray of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)

HCPCS/ CPT*	Short Descriptor
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
74263	Ct colonography, screen

HCPCS/ CPT*	Short Descriptor
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74400	Contrst x-ray, urinary tract
74410	Contrst x-ray, urinary tract
74415	Contrst x-ray, urinary tract
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract
74430	Contrast x-ray, bladder
74440	X-ray, male genital tract
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74455	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74740	X-ray, female genital tract
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75557	Cardiac MRI w/o contrast
75559	Cardiac MRI w/ stress imaging
75561	Cardiac MRI w/ & w/o contrast
75563	Cardiac MRI w/ stress imaging
75565	Card mri vel flw map add-on

HCPCS/ CPT*	Short Descriptor
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75635	Ct angio abdominal arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
75710	Artery x-rays, arm/leg
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75790	Visualize A-V shunt
75791	Av dialysis shunt imaging
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray,arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk

HCPCS/ CPT*	Short Descriptor
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy
75898	Follow-up angiography
75900	Intravascular cath exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75940	X-ray placement, vein filter
75945	Intravascular us
75946	Intravascular us add-on
75953	Abdom aneurysm endovas rpr
75956	Xray, endovasc thor ao repr
75957	Xray, endovasc thor ao repr
75958	Xray, place prox ext thor ao
75959	Xray, place dist ext thor ao
75960	Transcath iv stent rs&i
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast xray exam bile duct
75982	Contrast xray exam bile duct
75984	Xray control catheter change
75989	Abscess drainage under x-ray
75992	Atherectomy, x-ray exam
76000	Fluoroscope examination

HCPCS/ CPT*	Short Descriptor
76001	Fluoroscope exam, extensive
76010	X-ray, nose to rectum
76080	X-ray exam of fistula
76098	X-ray exam, breast specimen
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76140	X-ray consultation
76150	X-ray exam, dry process
76350	Special x-ray contrast study
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76390	Mr spectroscopy
76496	Fluoroscopic procedure
76497	Ct procedure
76498	Mri procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76529	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus

HCPCS/ CPT*	Short Descriptor
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76817	Transvaginal us, obstetric
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76830	Transvaginal us, non-ob
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76872	Us, transrectal
76873	Echograp trans r, pros study
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76930	Echo guide, cardiocentesis
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76937	Us guide, vascular access
76940	Us guide, tissue ablation
76941	Echo guide for transfusion
76942	Echo guide for biopsy
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76950	Echo guidance radiotherapy
76965	Echo guidance radiotherapy
76970	Ultrasound exam follow-up
76975	GI endoscopic ultrasound
76977	Us bone density measure
76998	Ultrasound guide intraoper
77001	Fluoroguide for vein device
77002	Needle localization by x-ray
77003	Fluoroguide for spine inject
77011	Ct scan for localization
77012	Ct scan for needle biopsy

HCPCS/ CPT*	Short Descriptor
77013	Ct guide for tissue ablation
77014	Ct scan for therapy guide
77021	Mr guidance for needle place
77022	Mri for tissue ablation
77031	Stereotactic breast biopsy
77032	X-ray of needle wire, breast
77053	X-ray of mammary duct
77054	X-ray of mammary ducts
77058	Magnetic image, breast
77059	Magnetic image, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone evaluation
77074	X-rays, bone survey
77075	X-rays, bone survey
77076	X-rays, bone evaluation
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77080	Dxa bone density, axial
77081	Dxa bone density/peripheral
77082	Dxa bone density/v-fracture
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
77417	Radiology port film(s)
77421	Stereoscopic x-ray guidance
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging

HCPCS/ CPT*	Short Descriptor
78190	Platelet survival, kinetics
78195	Lymph system imaging
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78350	Bone mineral, single photon
78351	Bone mineral, dual photon
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)

HCPCS/ CPT*	Short Descriptor
78472	Gated heart, planar, single
78473	Gated heart, multiple
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78600	Brain imaging, ltd static
78601	Brain imaging, ltd w/flow
78605	Brain imaging, complete
78606	Brain imaging, compl w/flow
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78700	Kidney imaging, static
78701	Kidney imaging with flow
78704	Imaging renogram
78707	Kidney flow/function image
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney imaging (3D)
78715	Renal vascular flow exam
78730	Urinary bladder retention
78740	Ureteral reflux study

HCPCS/ CPT*	Short Descriptor
78760	Testicular imaging
78761	Testicular imaging/flow
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78808	Iv inj ra drug dx study
78811	Tumor imaging (pet), limited
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumorimage pet/ct skul-thigh
78816	Tumor image pet/ct full body
92135	Scanning computer ophthalmic
92235	Fluorscein angioscopy
92240	IDC green angiography
92250	Fundus photography
92285	External ocular photography
92286	Anterior segment photography
93303	Echo transthoracic
93304	Echo transthoracic
93306	Tte w/doppler, complete
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal
93313	Echo transesophageal
93314	Echo transesophageal
93315	Echo transesophageal
93316	Echo transesophageal
93317	Echo transesophageal
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Echo transthoracic
93351	Stress tte complete
93352	Admin ecg contrast agent

HCPCS/ CPT*	Short Descriptor
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93893	Tcd, emboli detect w/inj
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
0066T	Ct colonography;screen
0067T	Ct colonography;dx
0080T	Endovasc aort repr rad s&i
0081T	Endovasc visc extnsn s&i
0144T	CT heart wo dye; qual calc
0145T	CT heart w/wo dye funct
0146T	CCTA w/wo dye
0147T	CCTA w/wo, quan calcium
0148T	CCTA w/wo, strxr
0149T	CCTA w/wo, strxr quan calc
0150T	CCTA w/wo, disease strxr
0151T	CT heart funct add-on
0152T	Computer chest add-on
G0120	Colon ca scrn; barium enema
G0122	Colon ca scrn; barium enema
G0130	Single energy x-ray study
G0219	PET img wholbod melano

HCPCS/ CPT*	Short Descriptor
	nonco
G0235	PET not otherwise specified
G0275	Renal angio, cardiac cath
G0278	Iliac art angio,cardiac cath
G0288	Recon, CTA for surg plan
G0365	Vessel mapping hemo access

ADDENDUM I: List of CPT[1]/HCPCS Codes Used To Define Certain Designated Health Service Categories[2] Under Section 1877 of the Social Security Act

CLINICAL LABORATORY SERVICES	
INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:	
86890	Autologous blood process
86891	Autologous blood, op salvage
86927	Plasma, fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion
86960	Vol reduction of blood/prod
86965	Pooling blood platelets
86985	Split blood or products
INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:	
0030T	Antiprothrombin antibody
0103T	Holotranscobalamin
0104T	At rest cardio gas rebreathe
0111T	RBC membranes fatty acids
0140T	Exhaled breath condensate ph
36415	Routine venipuncture
78110	Plasma volume, single
78111	Plasma volume, multiple
78120	Red cell mass, single
78121	Red cell mass, multiple
78122	Blood volume
78130	Red cell survival study
78191	Platelet survival
78267	Breath tst attain/anal c-14
78268	Breath test analysis c-14
78270	Vit B-12 absorption exam
78271	Vit B-12 absrp exam, int fac
78272	Vit B-12 absorp, combined
78725	Kidney function study
G0027	Semen analysis
G0103	Psa screening
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
G0328	Fecal blood scrn immunoassay
G0416	Sat biopsy prostate 1-20 spc
G0417	Sat biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60
G0419	Sat biopsy prostate: >60
G0430	Drug screen multi class
G0431	Drug screen single class
G9143	Warfarin respon genetic test
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
INCLUDE the following CPT and HCPCS codes for physical therapy/occupational therapy/outpatient speech-language pathology services:	
0019T	Extracorp shock wv tx,ms nos
0183T	Wound ultrasound

64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
94667	Chest wall manipulation
94668	Chest wall manipulation
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
96000	Motion analysis, video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test, lim
96111	Developmental test, extend
96125	Cognitive test by HC pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	Active wound care/20cm or <
97598	Active wound care > 20cm
97602	Wound(s) care non-selective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press

G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
INCLUDE the following CPT and HCPCS codes:	
0042T	Ct perfusion w/contrast, cbf
0159T	Cad breast mri
0174T	Cad cxr with interp
0175T	Cad cxr remote
51798	Us urine capacity measure
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70380	X-ray exam of salivary gland
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
70555	Fmri brain by phys/psych
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone

71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73500	X-ray exam of hip

73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74710	X-ray measurement of pelvis
75557	Cardiac MRI for morph
75559	Cardiac MRI w/stress img
75561	Cardiac MRI for morph w/dye
75563	Card MRI w/stress img & dye
75565	Card MRI vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76010	X-ray, nose to rectum
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76150	X-ray exam, dry process
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a

76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure
77014	Ct scan for therapy guide
77051	Computer dx mammogram add-on
77052	Comp screen mammogram add-on
77055	Mammogram, one breast
77056	Mammogram, both breasts
77057	Mammogram, screening
77058	Mri, one breast
77059	Mri, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone length studies
77074	X-rays, bone survey, limited
77075	X-rays, bone survey complete
77076	X-rays, bone survey, infant
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77080	Dxa bone density, axial
77081	Dxa bone density/peripheral
77082	Dxa bone density, vert fx
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78099	Endocrine nuclear procedure
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging
78199	Blood/lymph nuclear exam

78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78299	GI nuclear procedure
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78399	Musculoskeletal nuclear exam
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single
78473	Gated heart, multiple
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78499	Cardiovascular nuclear exam
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78599	Respiratory nuclear exam
78600	Brain image < 4 views
78601	Brain image w/flow < 4 views
78605	Brain image 4+ views
78606	Brain image w/flow 4 + views
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78699	Nervous system nuclear exam
78700	Kidney imaging, morphol
78701	Kidney imaging with flow
78707	K flow/funct image w/o drug
78708	K flow/funct image w/drug
78709	K flow/funct image, multiple
78710	Kidney imaging (3D)
78730	Urinary bladder retention

78740	Ureteral reflux study
78761	Testicular imaging w/flow
78799	Genitourinary nuclear exam
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78811	PET image, ltd area
78812	PET image, skull-thigh
78813	PET image, full body
78814	PET image w/ct, lmtd
78815	PET image w/ct, skull-thigh
78816	PET image w/ct, full body
78999	Nuclear diagnostic exam
91110	Gi tract capsule endoscopy
91111	Esophageal capsule endoscopy
93303	Echo transthoracic
93304	Echo transthoracic
93306	TTE w/Doppler, complete
93307	TTE w/o Doppler, complete
93308	TTE, f-up or lmtd
93320	Doppler echo exam, heart [if used in conjunction with 93303-93304]
93321	Doppler echo exam, heart [if used in conjunction with 93303, 93304, 93308]
93325	Doppler color flow add-on [if used in conjunction with 76825, 76826, 76827,76828, 93303, 93304, 93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
A4641	Radiopharm dx agent noc
A4642	In111 satumomab
A9500	Tc99m sestamibi
A9501	Technetium TC-99m teboroxime
A9502	Tc99m tetrofosmin
A9503	Tc99m medronate
A9504	Tc99m apcitide
A9505	TL201 thallium
A9507	In111 capromab
A9508	I131 iodobenguate, dx
A9509	Iodine I-123 sod iodide mil
A9510	Tc99m disofenin
A9512	Tc99m pertechnetate
A9516	Iodine I-123 sod iodide mic
A9521	Tc99m exametazime
A9524	I131 serum albumin, dx
A9526	Nitrogen N-13 ammonia
A9528	Iodine I-131 iodide cap, dx
A9529	I131 iodide sol, dx
A9531	I131 max 100uCi
A9532	I125 serum albumin, dx
A9536	TC99m depreotide
A9537	Tc99m mebrofenin
A9538	Tc99m pyrophosphate
A9539	Tc99m pentetate
A9540	Tc99m MAA
A9541	Tc99m sulfur colloid

A9542	In111 ibritumomab, dx
A9544	I131 tositumomab, dx
A9546	CO57/58
A9547	In111 oxyquinoline
A9548	In111 pentetate
A9550	Tc99m gluceptate
A9551	Tc99m succimer
A9552	F18 fdg
A9553	Cr51 chromate
A9554	I125 iothalamate, dx
A9555	Rb82 rubidium
A9556	Ga67 gallium
A9557	Tc99m bicisate
A9558	Xe133 xenon 10mci
A9559	Co57 cyano
A9560	Tc99m labeled rbc
A9561	Tc99m oxidronate
A9562	Tc99m mertiatide
A9566	Tc99m fanolesomab
A9567	Technetium TC-99m aerosol
A9568	Technetium tc99m arcitumomab
A9569	Technetium TC-99m auto WBC
A9570	Indium In-111 auto WBC
A9571	Indium In-111 auto platelet
A9572	Indium In-111 pentetreotide
A9576	Inj prohance multipack
A9577	Inj multihance
A9578	Inj multihance multipack
A9579	Gad-base MR contrast NOS,1ml
A9580	Sodium fluoride F-18
A9700	Echocardiography contrast
G0130	Single energy x-ray study
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
G0389	Ultrasound exam AAA screen
Q0092	Set up port xray equipment
Q9951	LOCM>=400 mg/ml iodine,1ml
Q9953	Inj Fe-based MR contrast,1ml
Q9954	Oral MR contrast, 100ml
Q9955	Inj perflexane lip micros,ml
Q9956	Inj octafluoropropane mic,ml
Q9957	Inj perflutren lip micros,ml
Q9958	HOCM <=149 mg/ml iodine, 1ml
Q9959	HOCM 150-199mg/ml iodine,1ml
Q9960	HOCM 200-249mg/ml iodine,1ml
Q9961	HOCM 250-299mg/ml iodine,1ml
Q9962	HOCM 300-349mg/ml iodine,1ml
Q9963	HOCM 350-399mg/ml iodine,1ml
Q9964	HOCM>= 400mg/ml iodine, 1ml
Q9965	LOCM 100-199mg/ml iodine,1ml
Q9966	LOCM 200-299mg/ml iodine,1ml
Q9967	LOCM 300-399mg/ml iodine,1ml
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl
RADIATION THERAPY SERVICES AND SUPPLIES	
INCLUDE the following CPT and HCPCS codes:	
0073T	Delivery, comp imrt
0182T	HDR elect brachytherapy
0190T	Place intraoc radiation src
0197T	Intrafraction track motion
19296	Place po breast cath for rad
19297	Place breast cath for rad
19298	Place breast rad tube/caths
20555	Place ndl musc/tis for rt
31643	Diag bronchoscope/catheter
32553	Ins mark thor for rt perq
41019	Place needles h&n for rt
49411	Ins mark abd/pel for rt perq
55875	Transperi needle place, pros
55876	Place rt device/marker, pros
55920	Place needles pelvic for rt
57155	Insert uteri tandems/ovoids
58346	Insert heyman uteri capsule
61770	Incise skull for treatment
61796	SRS, cranial lesion simple
61797	SRS, cran les simple, addl
61798	SRS, cranial lesion complex

61799	SRS, cran les complex, addl
61800	Apply SRS headframe add-on
63620	SRS, spinal lesion
63621	SRS, spinal lesion, addl
77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77305	Teletx isodose plan simple
77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77338	Design mlc device for imrt
77370	Radiation physics consult
77371	Srs, multisource
77372	Srs, linear based
77373	Sbrt delivery
77399	External radiation dosimetry
77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77421	Stereoscopic x-ray guidance
77422	Neutron beam tx, simple
77423	Neutron beam tx, complex
77427	Radiation tx management, x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77435	Sbrt management
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt, simple w/o comp
77522	Proton trmt, simple w/comp
77523	Proton trmt, intermediate
77525	Proton treatment, complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm
77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77785	HDR brachytx, 1 channel
77786	HDR brachytx, 2-12 channel
77787	HDR brachytx over 12 chan
77789	Apply surface radiation
77790	Radiation handling
77799	Radium/radioisotope therapy
79005	Nuclear rx, oral admin
79101	Nuclear rx, iv admin

79200	Nuclear rx, intracav admin
79300	Nuclr rx, interstit colloid
79403	Hematopoietic nuclear tx
79440	Nuclear rx, intra-articular
79445	Nuclear rx, intra-arterial
79999	Nuclear medicine therapy
92974	Cath place, cardio brachytx
A9517	I131 iodide cap, rx
A9527	Iodine I-125 sodium iodide
A9530	I131 iodide sol, rx
A9543	Y90 ibritumomab, rx
A9545	I131 tositumomab, rx
A9563	P32 Na phosphate
A9564	P32 chromic phosphate
A9600	Sr89 strontium
A9604	Sm 153 lexidronam
A9699	Radiopharm rx agent noc
C1716	Brachytx, non-str, Gold-198
C1717	Brachytx, non-str,HDR Ir-192
C1719	Brachytx, NS, Non-HDRIr-192
C2616	Brachytx, non-str,Yttrium-90
C2634	Brachytx, non-str, HA, I-125
C2635	Brachytx, non-str, HA, P-103
C2636	Brachy linear, non-str,P-103
C2638	Brachytx, stranded, I-125
C2639	Brachytx,non-stranded,I-125
C2640	Brachytx, stranded, P-103
C2641	Brachytx, non-stranded,P-103
C2642	Brachytx, stranded, C-131
C2643	Brachytx, non-stranded,C-131
C2698	Brachytx, stranded, NOS
C2699	Brachytx, non-stranded, NOS
G0173	Linear acc stereo radsur com
G0251	Linear acc based stero radio
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5
Q3001	Brachytherapy Radioelements
EPO AND OTHER DIALYSIS-RELATED DRUGS	
The physician self-referral prohibition does not apply to the following codes for EPO and other dialysis-related drugs furnished in or by an ESRD facility if the conditions in §411.355(g) are satisfied:	
J0630	Calcitonin salmon injection
J0636	Inj calcitriol per 0.1 mcg
J0882	Darbepoetin alfa, esrd use
J0895	Deferoxamine mesylate inj
J1270	Injection, doxercalciferol
J1750	Inj iron dextran
J1756	Iron sucrose injection
J1955	Inj levocarnitine per 1 gm
J2501	Paricalcitol
J2916	Na ferric gluconate complex
J2993	Reteplase injection
J2995	Inj streptokinase /250000 IU
J2997	Alteplase recombinant
J3364	Urokinase 5000 IU injection
P9041	Albumin (human),5%, 50ml
P9045	Albumin (human), 5%, 250ml
P9046	Albumin (human), 25%, 20ml
P9047	Albumin (human), 25%, 50ml
Q0139	Ferumoxytol, esrd use
Q4081	Epoetin alfa, 100 units ESRD
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in §411.355(h):	
77052	Comp screen mammogram add-on
77057	Mammogram, screening
80061	Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82270	Occult blood, feces
82465	Assay, bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82947	Assay, glucose, blood quant [only when billed with ICD-9-CM code V77.1]
82950	Glucose test [only when billed with ICD-9-CM code V77.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]
83718	Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
84478	Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
G0103	PSA screening

G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screeningmammographydigital
G0328	Fecal blood scrn immunoassay
G0389	Ultrasound exam AAA screen
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in §411.355(h):	
90655	Flu vaccine no preserv 6-35m
90656	Flu vaccine no preserv 3 & >
90657	Flu vaccine, 3 yrs, im
90658	Flu vaccine, 3 yrs & >, im
90660	Flu vaccine, nasal
90669	Pneumococcal vacc, 7 val im
90732	Pneumococcal vaccine
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose, im
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im

[1] CPT codes and descriptions only are copyright 2009 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

[2] This list does not include codes for the following designated health service (DHS) categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the definitions of these DHS categories, refer to §411.351. For more information, refer to the CMS Web site at http://www.cms.hhs.gov/PhysicianSelfReferral/.

[FR Doc. E9–26502 Filed 10–30–09; 4:15 pm]

BILLING CODE 4120–01–C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6023–N]

Medicare Program; Solicitation of Independent Accrediting Organizations To Participate in the Advanced Diagnostic Imaging Supplier Accreditation Program

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

ACTION: Notice.

SUMMARY: This notice announces to independent accreditation organizations an opportunity to submit applications to participate in the advanced diagnostic imaging supplier accreditation program as a designated accreditation organization. Advanced diagnostic imaging accreditation is required for suppliers furnishing the technical component (TC) of advanced diagnostic imaging services. This notice contains information on accreditation application guidelines for CMS approval of suppliers who furnish the TC of advanced diagnostic imaging services.

DATES: Applications will be considered for the January 1, 2010 designation deadline if received at the address, provided in the **ADDRESSES** section of this notice, no later than 5 p.m. eastern standard time (e.s.t.) on December 1, 2009.

ADDRESSES: Applications should be sent to the following: Attention: Sandra Bastinelli, Office of Financial Management, Mail stop C3–02–16, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244.

FOR FURTHER INFORMATION CONTACT: Sandra Bastinelli, (410) 786–3630.

SUPPLEMENTARY INFORMATION:

I. Background

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added section 1834(e) of the Social Security Act (the Act) that requires the Secretary to designate organizations in order to accredit suppliers furnishing the technical component (TC) of advanced diagnostic imaging service and establish procedures to ensure that the criteria used by an accreditation organization is specific to each imaging modality. Section 1834 (e)(1)(B) of the Act defines advanced diagnostic imaging services as—

(i) Diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine—including positron emission tomography, and

(ii) Such other diagnostic imaging services, including services described in section 1848(b)(4)(B) (excluding x-ray, ultrasound, and fluoroscopy, as specified by the Secretary in consultation with physician specialty organizations and other stakeholders.

Section 1848(b)(4)(B) of the Act defines imaging services as ''imaging and computer-assisted imaging services, including x-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography.'' Suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) of the Act, must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012.

II. Provisions of the Notice

This notice solicits applications from accreditation organizations with the ability to accredit the TC of at least one of the categories of advanced diagnostic imaging services.

A. Eligible Organizations

An accreditation organization that can show evidence of the ability to accredit at least one of the categories of advanced diagnostic imaging services as defined in sections 1834(e)(1)(B) and 1848 (b)(4)(B) of the Act is eligible to apply for approval as a designated accreditation organization.

B. Application Requirements

To be considered for approval as a designated accreditation organization for Medicare requirements under 42 CFR 414.68, an accreditation organization must furnish to us all of the following information:

- A list of the categories of advanced diagnostic imaging services for which the organization is requesting approval.
- A description of the accrediting organization's duration of accreditation (annual, biannual, and triennial), to include a summary of activities that occur at each cycle.
- A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, including the following:

++ Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services.

++ Qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program, expertise obtained through experience or continuing medical education courses.

++ Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished.

++ Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier.

- A detailed description of the organization's survey process, to include the following:

++ Type and frequency of the surveys performed.

++ The ability of the organization to conduct timely reviews of accreditation applications, to include a projection of the organization's national capacity for processing new applications before the January 1, 2012 accreditation deadline.

++ Description of the organization's audit procedures, including—random site visits; site audits or other strategies for ensuring suppliers accredited by the organization maintain compliance throughout the period of accreditation.

++ Procedures for performing unannounced site surveys.

++ Copies of the organization's survey forms.

++ A description of the accreditation survey review process and the accreditation status decision-making process, including the process for addressing identified deficiencies with the accreditation requirements, and the procedures used to monitor the correction of deficiencies found during an accreditation survey.

++ Procedures for coordinating surveys with another accrediting organization (when the organization does not accredit all modalities) provided by an applicant for accreditation which the supplier provided.

++ Comprehensive information about the individuals who perform evaluations for the accreditation organization, including all of the following information:

—Detailed information about the size and composition of accreditation teams for each category of advanced medical imaging service supplier accredited.

—The number of professional and technical staff that are available for survey.

—The education, current employment and experience requirements surveyors must meet.

—The content and length of any orientation program.

—The frequency and types of in-service training provided to survey personnel.
—The evaluation systems used to monitor the performance of individual surveyors and survey teams.
—Policies and procedures regarding an individual's participation in the survey or accreditation decision process of any organization with which the individual is professionally or financially affiliated.

++ Policies and procedures used when an organization has a dispute regarding survey findings or an adverse decision.

• A description of the organization's data management and analysis capabilities in support of its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

• The organization's procedures for investigating and responding to complaints against accredited facilities, including policies and procedures regarding coordination of these activities with relevant licensing bodies and CMS.

• A description of the organization's policies and procedures for withholding or removal of accreditation status for facilities that fail to meet the organization's accreditation standards and other actions taken by the organization in response to noncompliance with its accreditation criteria. These policies and procedures must include notifying CMS of facilities that fail to meet the requirements of the accrediting organization as required by CMS.

• The information submitted for notification of these organizations includes—

++ A list of all accredited suppliers that the accrediting organization has accredited to include the type and category of accreditation currently held by each supplier, and the expiration date of each supplier's current accreditation;

++ A list of all accreditation surveys scheduled to be performed by the organization;

++ A plan for reducing the burden and cost of accreditation to small and rural suppliers;

++ Information to demonstrate the accreditation organization's knowledge and experience in the advanced medical imaging arena;

++ The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation; and

++ Any specific documentation requirements and attestations requested by CMS as a condition of designation.

• The accreditation organization must also submit the following supporting documentation:

++ A written presentation that demonstrates the organization's ability to furnish us with electronic data in ASCII comparable code.

++ A resource analysis that demonstrates that the organization's staffing, funding, and other resources are adequate to perform the required surveys and related activities.

++ A statement acknowledging that, as a condition for approval the organization will agree to the following:

—Provide a statement agreeing to notify us, in writing, of any supplier that had its accreditation revoked, withdrawn, revised, or any other remedial or adverse action taken against it by the accreditation organization within 30 calendar days of any such action taken.
—Notify all accredited suppliers within 10 calendar days of our withdrawal of the organization's approval of deeming authority.
—Notify us, in writing, at least 30 calendar days in advance of the effective date of any proposed changes in accreditation requirements.
—Permit its surveyors to serve as witnesses if we take an adverse action based on accreditation findings.
—Notify us, in writing, within 2 calendar days of a deficiency identified in any accreditation entity where the deficiency poses an immediate jeopardy to the supplier's beneficiaries or a hazard to the general public.
—Provide, on an annual basis, summary data specified by us that relates to the past years' accreditations and trends.
—Attest that the organization will not perform any accreditation surveys of Medicare participating suppliers with which it has a financial relationship with or interest.

If, after review of an accreditation organization's submission of information we determine that additional information is necessary to make a determination for approval or denial of the accreditation organization's application, the organization will be notified and afforded an opportunity to provide additional information. We may visit the organization's office(s) to verify representations made in the organization's accreditation application. The site visit may include, but is not limited to, review of documents and interviews with the organization's staff. The accreditation organization will receive a formal notice from us stating whether the request for designation has been approved or denied, the rationale for any denial and reconsideration, and reapplication procedures.

We will make every effort to issue a final decision within 30 days from the time we receive the completed accreditation reapplication. An accreditation organization may withdraw its application for designation under section 1834(e) of the Act at any time prior to the formal notice of approval or denial is received. An accreditation organization notified of a denial of request for designation may request a reconsideration in accordance with 42 CFR 488.201 through 488.211. Any accreditation organization whose request for approval of designation has been denied may resubmit the application if the organization—

• Revises its accreditation program to address the rationale for denial of its previous request;

• Provides reasonable assurance that its accredited companies meet applicable Medicare requirements; and

• Resubmits the application in its entirety. If an accreditation organization is denied reconsideration determination (as designated under section 1834(e) of the Act), the organization may not submit a new application as a designated accreditation organization for the type of modality that is at issue in the reconsideration until the reconsideration is final.

C. Application Deadline

The deadline for the submission of applications is the date specified in the **DATES** section of this notice.

D. Evaluation of Applications

A panel will evaluate all applications from accreditation organizations seeking designation under section 1834(e) of the Act using the existing survey and certification process as established in 42 CFR part 488.

III. Collection of Information Requirements

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

• The need for the information collection and its usefulness in carrying out the proper functions of our agency.

• The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

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

We detailed the burden associated with the submission of advanced diagnostic imaging provider accreditation applications from independent accrediting bodies in the CY 2010 Physician Fee Schedule final rule that published elsewhere in this **Federal Register**. We are reprinting the discussion of the information collection requirements in this notice.

Section 414.68(b) contains the application and reapplication procedures for accreditation organizations. Specifically, an independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services must furnish CMS with all of the information listed in proposed § 414.68(b)(1) through (14). The requirements include but are not limited to reporting, notification, documentation, and survey requirements.

The burden associated with the collection requirements in § 414.68(b) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(b)(1) through (14). We believe all 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit a complete application for approval or reapproval authority to become an accrediting organization approved by CMS.

Section 414.68(c) contains the information collection requirements pertaining to CMS approved accrediting organizations. An accrediting organization approved by CMS must undertake all of the activities listed in § 414.68(c)(1) through (6). The burden associated with the collection requirements in § 414.68(c) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(c)(1) through (6). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit the required information on an ongoing basis.

Section 414.68(d)(1) states that CMS or its contractor may conduct an audit of an accredited supplier, examine the results of a CMS approved accreditation organization's survey of a supplier, or observe a CMS approved accreditation organization's onsite survey of a supplier, in order to validate the CMS approved accreditation organizations accreditation process. The burden associated with this requirement is the time and effort necessary for an accrediting organization to comply with the components of the validation audit. While this requirement is subject to the PRA, we believe the associated burden is exempt as stated in 5 CFR 1320.3(h)(6). The burden associated with a request for facts addressed to a single person, as defined in 5 CFR 1320.3(j), is not subject to the PRA.

As stated in § 414.68(e)(1), an accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not to renew the approval of deeming authority to an accreditation organization if the accrediting organization files a written request for reconsideration by its authorized officials or through its legal representative. The written request must be filed within 30 calendar days of the receipt of CMS' notice of an adverse determination or nonrenewal. In addition, the request must also specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

The burden associated with this requirement is the time and effort necessary for an accrediting organization to develop and file a written request for reconsideration. While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; accrediting organizations are submitting requests for reconsideration after receiving a notice of an adverse decision.

Authority: Section 1834(e) of the Act.

Dated: October 13, 2009.

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

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E9–26209 Filed 10–29–09; 8:45 am]

BILLING CODE 4120–01–P

Federal Register

Wednesday,
November 25, 2009

Part III

The President

Proclamation 8456—National Family Week, 2009

Proclamation 8457—National Child's Day, 2009

Proclamation 8458—Thanksgiving Day, 2009

Executive Order 13520—Reducing Improper Payments

Federal Register
Vol. 74, No. 226
Wednesday, November 25, 2009

Presidential Documents

Title 3—

The President

Proclamation 8456 of November 20, 2009

National Family Week, 2009

By the President of the United States of America

A Proclamation

American families are the foundation on which our Nation is built. Their expressions of unconditional love and dedication sustain family members and support our Nation's communities. During National Family Week, we celebrate the inclusive spirit of American families and applaud the commitment of those family members who encourage us to reach new heights.

My Administration is committed to helping American families meet the demands of modern life, increase their self-sufficiency, and achieve their full potential. Ten days after taking office, I established the White House Task Force on Middle Class Working Families, led by Vice President Biden. This Task Force is focused on raising the living standards of working families across the country. In addition, the American Recovery and Reinvestment Act provides a broad spectrum of support to families experiencing difficult times. It boosts child care and Head Start programs, essential not only to a child's future but also a parent's peace of mind in the workplace. Health care reform will provide security and stability for American families with insurance and affordable options for uninsured Americans.

As we continue to grow as a Nation, we must also be engaged members of our larger family, composed of our neighbors, our colleagues, and the community where we live. We must appreciate the diversity of other families' traditions; we must reach out to help families in need; and we must take more responsibility for the care and development of all children, not just our own.

In this season of Thanksgiving, we are grateful that, at our best, America is a collection of strong families, standing united to make our Nation a place of hope and opportunity for future generations.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim November 22 through November 28, 2009, as National Family Week. I invite States, local communities, and individuals to join together in observing this week with appropriate ceremonies and activities to honor our Nation's families.

IN WITNESS WHEREOF, I have hereunto set my hand this twentieth day of November, in the year of our Lord two thousand nine, and of the Independence of the United States of America the two hundred and thirty-fourth.



[FR Doc. E9–28481
Filed 11–24–09; 11:15 am]
Billing code 3195–W0–P

Presidential Documents

Proclamation 8457 of November 20, 2009

National Child's Day, 2009

By the President of the United States of America

A Proclamation

America's children deserve every opportunity to reach their fullest potential, and it is our responsibility to ensure they have the tools required to grow and flourish. This includes providing our young people with access to affordable, high-quality health care and an education that both informs and inspires. On National Child's Day, we celebrate the promise living within every child.

Ensuring the health and well-being of our Nation's children is one of our highest responsibilities. I was proud to sign the reauthorization of the Children's Health Insurance Program (CHIP), extending health care to millions of young Americans who were previously uninsured. When given proper nutrition and medical care, healthy children can become productive, healthy adults.

My Administration is also committed to giving our children the educational support necessary for their development and future success. That is why we announced our Race to the Top award program, which challenges States to compete for over $4 billion in grants designed to spur systemic reform and embrace innovative approaches to teaching and learning in America's schools. If we are willing to come together and embrace a spirit of common purpose, our schools will perform better and our students will reach farther.

Across America, countless individuals selflessly provide their time and energy in our homes, schools, and community organizations to ensure our sons and daughters may one day realize their dreams. Today, we recommit ourselves to the vision of our founders to give all our children a fair chance and an equal start in life.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim November 22, 2009, as National Child's Day. I call upon all citizens to observe this day with appropriate programs, ceremonies, and activities.

IN WITNESS WHEREOF, I have hereunto set my hand this twentieth day of November, in the year of our Lord two thousand nine, and of the Independence of the United States of America the two hundred and thirty-fourth.



[FR Doc. E9–28484
Filed 11–24–09; 11:15 am]
Billing code 3195–W0–P

Presidential Documents

Proclamation 8458 of November 20, 2009

Thanksgiving Day, 2009

By the President of the United States of America

A Proclamation

What began as a harvest celebration between European settlers and indigenous communities nearly four centuries ago has become our cherished tradition of Thanksgiving. This day's roots are intertwined with those of our Nation, and its history traces the American narrative.

Today, we recall President George Washington, who proclaimed our first national day of public thanksgiving to be observed ''by acknowledging with grateful hearts the many and signal favors of Almighty God,'' and President Abraham Lincoln, who established our annual Thanksgiving Day to help mend a fractured Nation in the midst of civil war. We also recognize the contributions of Native Americans, who helped the early colonists survive their first harsh winter and continue to strengthen our Nation. From our earliest days of independence, and in times of tragedy and triumph, Americans have come together to celebrate Thanksgiving.

As Americans, we hail from every part of the world. While we observe traditions from every culture, Thanksgiving Day is a unique national tradition we all share. Its spirit binds us together as one people, each of us thankful for our common blessings.

As we gather once again among loved ones, let us also reach out to our neighbors and fellow citizens in need of a helping hand. This is a time for us to renew our bonds with one another, and we can fulfill that commitment by serving our communities and our Nation throughout the year. In doing so, we pay tribute to our country's men and women in uniform who set an example of service that inspires us all. Let us be guided by the legacy of those who have fought for the freedoms for which we give thanks, and be worthy heirs to the noble tradition of goodwill shown on this day.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim Thursday, November 26, 2009, as a National Day of Thanksgiving. I encourage all the people of the United States to come together, whether in our homes, places of worship, community centers, or any place where family, friends and neighbors may gather, with gratitude for all we have received in the past year; to express appreciation to those whose lives enrich our own; and to share our bounty with others.

IN WITNESS WHEREOF, I have hereunto set my hand this twentieth day of November, in the year of our Lord two thousand nine, and of the Independence of the United States of America the two hundred and thirty-fourth.



[FR Doc. E9–28485
Filed 11–24–09; 11:15 am]
Billing code 3195–W0–P

Presidential Documents

Executive Order 13520 of November 20, 2009

Reducing Improper Payments

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in the interest of reducing payment errors and eliminating waste, fraud, and abuse in Federal programs, it is hereby ordered as follows:

Section 1. *Purpose.* When the Federal Government makes payments to individuals and businesses as program beneficiaries, grantees, or contractors, or on behalf of program beneficiaries, it must make every effort to confirm that the right recipient is receiving the right payment for the right reason at the right time. The purpose of this order is to reduce improper payments by intensifying efforts to eliminate payment error, waste, fraud, and abuse in the major programs administered by the Federal Government, while continuing to ensure that Federal programs serve and provide access to their intended beneficiaries. No single step will fully achieve these goals. Therefore, this order adopts a comprehensive set of policies, including transparency and public scrutiny of significant payment errors throughout the Federal Government; a focus on identifying and eliminating the highest improper payments; accountability for reducing improper payments among executive branch agencies and officials; and coordinated Federal, State, and local government action in identifying and eliminating improper payments. Because this order targets error, waste, fraud, and abuse—not legitimate use of Government services—efforts to reduce improper payments under this order must protect access to Federal programs by their intended beneficiaries.

Sec. 2. *Transparency and Public Participation.*

(a) Within 90 days of the date of this order, the Director of the Office of Management and Budget (OMB) shall:

(i) identify Federal programs in which the highest dollar value or majority of Government-wide improper payments occur (high-priority programs);

(ii) establish, in coordination with the executive department or agency (agency) responsible for administering the high-priority program annual or semi-annual targets (or where such targets already exist, supplemental targets), as appropriate, for reducing improper payments associated with each high-priority program;

(iii) issue Government-wide guidance on the implementation of this order, including procedures for identifying and publicizing the list of entities described in subsection (b)(v) of this section and for administrative appeal of the decision to publish the identity of those entities, prior to publication; and

(iv) establish a working group consisting of Federal, State, and local officials to make recommendations to the Director of OMB designed to improve the Federal Government's measurement of access to Federal programs by the programs' intended beneficiaries. The working group's recommendations shall be prepared in consultation with the Council of Inspectors General on Integrity and Efficiency (CIGIE) and submitted within 180 days of the date of this order, and the recommended measurements may be incorporated by the Secretary of the Treasury in the information published pursuant to subsection (b) of this section.

(b) Within 180 days of the date of this order, the Secretary of the Treasury in coordination with the Attorney General and the Director of OMB, shall

publish on the Internet information about improper payments under high-priority programs. The information shall include, subject to Federal privacy policies and to the extent permitted by law:

(i) the names of the accountable officials designated under section 3 of this order;

(ii) current and historical rates and amounts of improper payments, including, where known and appropriate, causes of the improper payments;

(iii) current and historical rates and amounts of recovery of improper payments, where appropriate (or, where improper payments are identified solely on the basis of a sample, recovery rates and amounts estimated on the basis of the applicable sample);

(iv) targets for reducing as well as recovering improper payments, where appropriate; and

(v) the entities that have received the greatest amount of outstanding improper payments (or, where improper payments are identified solely on the basis of a sample, the entities that have received the greatest amount of outstanding improper payments in the applicable sample).

Information on entities that have received the greatest amount of outstanding improper payments shall not include any referrals the agency made or anticipates making to the Department of Justice, or any information provided in connection with such referrals.

(c) Within 180 days of the date of this order, the Secretary of the Treasury in coordination with the Attorney General and the Director of OMB and in consultation with the CIGIE, shall establish a central Internet-based method to collect from the public information concerning suspected incidents of waste, fraud, and abuse by an entity receiving Federal funds that have led or may lead to improper payments by the Federal Government.

(d) Agencies shall place a prominently displayed link to Internet-based resources for addressing improper payments, including the resources established under subsections (b) and (c) of this section, on their Internet home pages.

Sec. 3. *Agency Accountability and Coordination.*

(a) Within 120 days of the date of this order, the head of each agency responsible for operating a high-priority program shall designate an official who holds an existing Senate-confirmed position to be accountable for meeting the targets established under section 2 of this order without unduly burdening program access and participation by eligible beneficiaries. In those agencies where the majority of payments are isolated to a single component, the head of the agency shall name a second accountable official for that component whose sole responsibility would be for program integrity activities and, as appropriate, shall consolidate and coordinate all program integrity activities within the component.

(b) Within 180 days of the date of this order, each agency official designated under subsection (a) of this section, or otherwise designated by the Director of OMB, shall provide the agency's Inspector General a report containing:

(i) the agency's methodology for identifying and measuring improper payments by the agency's high-priority programs;

(ii) the agency's plans, together with supporting analysis, for meeting the reduction targets for improper payments in the agency's high-priority programs; and

(iii) the agency's plan, together with supporting analysis, for ensuring that initiatives undertaken pursuant to this order do not unduly burden program access and participation by eligible beneficiaries.

Following the receipt and review of this information, the agency Inspector General shall assess the level of risk associated with the applicable programs, determine the extent of oversight warranted, and provide the agency head with recommendations, if any, for modifying the agency's methodology,

improper payment reduction plans, or program access and participation plans.

(c) If an agency fails to meet the targets established under section 2 of this order or implement the plan described in subsection (b)(iii) of this section for 2 consecutive years, that agency's accountable official designated under subsection (a) of this section shall submit to the agency head, Inspector General, and Chief Financial Officer a report describing the likely causes of the agency's failure and proposing a remedial plan. The agency head shall review this plan and, in consultation with the Inspector General and Chief Financial Officer, forward the plan with any additional comments and analysis to the Director of OMB.

(d) Within 180 days of the date of this order, the Chief Financial Officers Council (CFOC) in consultation with the CIGIE, the Department of Justice, and program experts, shall make recommendations to the Director of OMB and the Secretary of the Treasury on actions (including actions related to forensic accounting and audits) agencies should take to more effectively tailor their methodologies for identifying and measuring improper payments to those programs, or components of programs, where improper payments are most likely to occur. Recommendations shall address the manner in which the recommended actions would affect program access and participation by eligible beneficiaries.

(e) Within 180 days of the date of this order, the Secretary of the Treasury and the Director of OMB in consultation with the CIGIE, the Department of Justice, and program experts, shall recommend to the President actions designed to reduce improper payments by improving information sharing among agencies and programs, and where applicable, State and local governments and other stakeholders. The recommendations shall address the ways in which information sharing may improve eligibility verification and prepayment scrutiny, shall identify legal or regulatory impediments to effective information sharing, and shall address the manner in which the recommended actions would affect program access and participation by eligible beneficiaries.

(f) Within 180 days of the date of this order, and at least once every quarter thereafter, the head of each agency shall submit to the agency's Inspector General and the CIGIE, and make available to the public, a report on any high-dollar improper payments identified by the agency, subject to Federal privacy policies and to the extent permitted by law. The report shall describe any actions the agency has taken or plans to take to recover improper payments, as well as any actions the agency intends to take to prevent improper payments from occurring in the future. The report shall not include any referrals the agency made or anticipates making to the Department of Justice, or any information provided in connection with such referrals. Following the review of each report, the agency Inspector General and the CIGIE shall assess the level of risk associated with the applicable program, determine the extent of oversight warranted, and provide the agency head with recommendations, if any, for modifying the agency's plans.

Sec. 4. *Enhanced Focus on Contractors and Working with State and Local Stakeholders.*

(a) Within 180 days of the date of this order, the Federal Acquisition Regulatory Council, in coordination with the Director of OMB, and in consultation with the National Procurement Fraud Task Force (or its successor group), the CIGIE, and appropriate agency officials, shall recommend to the President actions designed to enhance contractor accountability for improper payments. The recommendations may include, but are not limited to, subjecting contractors to debarment, suspension, financial penalties, and identification through a public Internet website, subject to Federal privacy policies and to the extent permitted by law and where the identification would not interfere with or compromise an ongoing criminal or civil investigation, for knowingly failing timely to disclose credible evidence of significant overpayments received on Government contracts.

(b) Within 30 days of the date of this order, the Director of OMB shall establish a working group consisting of Federal and elected State and local officials to make recommendations to the Director of OMB designed to improve the effectiveness of single audits of State and local governments and non-profit organizations that are expending Federal funds. The Director of OMB may designate an appropriate official to serve as Chair of the working group to convene its meetings and direct its work. The working group's recommendations shall be prepared in consultation with the CIGIE and submitted within 180 days of the date of this order. The recommendations shall address, among other things, the effectiveness of single audits in identifying improper payments and opportunities to streamline or eliminate single audit requirements where their value is minimal.

(c) Within 30 days of the date of this order, the Director of OMB shall establish a working group (which may be separate from the group established under subsection (b) of this section) consisting of Federal and elected State and local officials to make recommendations to the Director of OMB for administrative actions designed to improve the incentives and accountability of State and local governments, as well as other entities receiving Federal funds, for reducing improper payments. The Director of OMB may designate an appropriate official to serve as Chair of the working group to convene its meetings and direct its work. The working group's recommendations shall be prepared in consultation with the CIGIE and submitted within 180 days of the date of this order.

Sec. 5. *Policy Proposals.* The Director of OMB, in consultation with the appropriate agencies and the CIGIE, shall develop policy recommendations, including potential legislative proposals, designed to reduce improper payments, including those caused by error, waste, fraud, and abuse, across Federal programs without compromising program access, to be included, as appropriate, in the Budget of the United States Government for Fiscal Year 2011 and future years, or other Administration proposals.

Sec. 6. *General Provisions.*

(a) Nothing in this order shall be construed to impair or otherwise affect:

(i) authority granted by law to a department, agency, the head thereof, or any agency Inspector General; or

(ii) functions of the Director of OMB relating to budgetary, administrative, or legislative proposals.

(b) Nothing in this order shall be construed to require the disclosure of classified information, law enforcement sensitive information, or other information that must be protected in the interests of national security.

(c) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(d) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity, by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.



THE WHITE HOUSE,
November 20, 2009.

[FR Doc. E9–28493
Filed 11–24–09; 11:15 am]
Billing code 3195–W0–P

Reader Aids

Federal Register

Vol. 74, No. 226

Wednesday, November 25, 2009

CUSTOMER SERVICE AND INFORMATION

Federal Register/Code of Federal Regulations
General Information, indexes and other finding aids **202–741–6000**
Laws **741–6000**

Presidential Documents
Executive orders and proclamations **741–6000**
The United States Government Manual **741–6000**

Other Services
Electronic and on-line services (voice) **741–6020**
Privacy Act Compilation **741–6064**
Public Laws Update Service (numbers, dates, etc.) **741–6043**
TTY for the deaf-and-hard-of-hearing **741–6086**

ELECTRONIC RESEARCH

World Wide Web

Full text of the daily Federal Register, CFR and other publications is located at: **http://www.gpoaccess.gov/nara/index.html**

Federal Register information and research tools, including Public Inspection List, indexes, and links to GPO Access are located at: **http://www.archives.gov/federal__register**

E-mail

FEDREGTOC-L (Federal Register Table of Contents LISTSERV) is an open e-mail service that provides subscribers with a digital form of the Federal Register Table of Contents. The digital form of the Federal Register Table of Contents includes HTML and PDF links to the full text of each document.

To join or leave, go to **http://listserv.access.gpo.gov** and select *Online mailing list archives, FEDREGTOC-L, Join or leave the list (or change settings);* then follow the instructions.

PENS (Public Law Electronic Notification Service) is an e-mail service that notifies subscribers of recently enacted laws.

To subscribe, go to **http://listserv.gsa.gov/archives/publaws-l.html** and select *Join or leave the list (or change settings);* then follow the instructions.

FEDREGTOC-L and **PENS** are mailing lists only. We cannot respond to specific inquiries.

Reference questions. Send questions and comments about the Federal Register system to: **fedreg.info@nara.gov**

The Federal Register staff cannot interpret specific documents or regulations.

Reminders. Effective January 1, 2009, the Reminders, including Rules Going Into Effect and Comments Due Next Week, no longer appear in the Reader Aids section of the Federal Register. This information can be found online at **http://www.regulations.gov.**

CFR Checklist. Effective January 1, 2009, the CFR Checklist no longer appears in the Federal Register. This information can be found online at **http://bookstore.gpo.gov/.**

FEDERAL REGISTER PAGES AND DATE, NOVEMBER

56521–56692 2
56693–57056 3
57057–57238 4
57239–57400 5
57401–57558 6
57559–57882 9
57883–58188 10
58189–58532 12
58533–58842 13
58843–59032 16
59033–59472 17
59473–59890 18
59891–60126 19
60127–61012 20
61013–61258 23
61259–61500 24
61501–62206 25

CFR PARTS AFFECTED DURING NOVEMBER

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.

2 CFR
382 58189

3 CFR
Proclamations:
8444 57225
8445 57227
8446 57229
8447 57231
8448 57233
8449 57235
8450 57237
8451 58529
8452 58531
8453 59473
8454 61259
8455 61261
8456 62195
8457 62197
8458 62199
Executive Orders:
13183 (amended by 13517) 57239
13271 (revoked by 13519) 60123
13462 (amended by 13516) 57241
13494 (amended by 13517) 57239
13516 ..... 56521, 57241
13517 57239
13518 58533
13519 60123
13520 62201
Administrative Orders:
Memorandums:
Memo. of Nov. 5, 2009 57881
Notices:
Notice of Nov. 6, 2009 58187
Notice of November 12, 2009 58841

4 CFR
200 60127
201 60130

5 CFR
337 61263
Proposed Rules:
731 56747
1604 57125
1651 57125
1653 57125
1690 57125

7 CFR
11 57401
301 57243
319 56523
354 57057
457 61013
959 61263
966 57057
983 ..... 56526, 565231
984 56693
987 ..... 56697, 61265
1710 56542
Proposed Rules:
42 59920
457 ..... 59108, 61286
920 58216
948 61053
989 61585
1710 56569

8 CFR
Proposed Rules:
103 59932
235 59932

9 CFR
78 57245

10 CFR
Proposed Rules:
430 ..... 56928, 58915
431 ..... 57738, 61410

12 CFR
3 60137
205 59033
208 60137
225 60137
226 60143
229 58537
325 60137
327 59056
360 59066
567 60137
Proposed Rules:
205 60986

13 CFR
120 59891
126 56699

14 CFR
23 57060
25 ..... 56702, 56706
39 ..... 56710, 56713, 56717, 57402, 57405, 57408, 57411, 57559, 57561, 57564, 57567, 57571, 57574, 57577, 57578, 58191, 58195, 58539, 61018, 61021, 61023, 61501, 61504
71 ..... 57246, 59475, 59902, 61507
93 59902
95 61508
97 ..... 58200, 58202, 61024, 61027
1245 59476

Proposed Rules:
1.....58918
23.....58918
39 .....56748, 57264, 57266, 57268, 57271, 57273, 57277, 58919, 59480, 59483, 59488, 59941, 60215
71 .....57616, 57617, 57618, 57620, 57621, 58569, 58570, 58571, 58573, 59491, 59492, 61289
73.....61291
91.....60218
119.....60218
121.....61055, 61067
125.....60218
133.....60218
135.....61067
137.....60218
141.....60218
142.....60218
145.....60218
147.....60218

15 CFR

744.....57061
774.....57581
Proposed Rules:
902.....60050
922.....58923

16 CFR

Proposed Rules:
305.....57950

17 CFR

4.....57585
211.....57062
248.....58204
Proposed Rules:
242.....61208

18 CFR

37.....61511
358.....60153
375.....57246
410.....60154

19 CFR

24.....61267
Proposed Rules:
113.....57125, 61585
191.....57125, 61585

20 CFR

655.....59069
1910.....57883
Proposed Rules:
404 .....57970, 57971, 57972, 61292
416.....61292

21 CFR

73.....57248, 58843
201.....61512
510.....61516
520.....60155, 61516
522.....61516
528.....58205
529.....59073
558 .....59911, 61028, 61516
Proposed Rules:
4.....57973
501.....61068
1308.....59108

22 CFR

41.....61517
42.....61517
Proposed Rules:
125.....61292
126.....61586

26 CFR

1 .....57251, 57252, 59074, 59087, 61270
20.....61524
54.....61294
301.....61525
602.....57252
Proposed Rules:
1.....58574, 61294
31.....61294
53.....58574
301 .....59943, 61294, 61589

28 CFR

2.....58540

29 CFR

2550.....59092, 60156
4001.....59093
4022.....58544, 59093
Proposed Rules:
1202.....56750, 57427
1206.....56750, 57427
1910.....57278, 57976
1915.....57278
1926.....57278
4000.....61248
4001.....61248
4041.....61074
4043.....61248
4204.....61248
4206.....61248
4211.....61248
4231.....61248

30 CFR

7.....61531
75.....61531

31 CFR

103.....59096
285.....56719
501.....57593
538.....61030
560.....61030
594.....61036
Proposed Rules:
103.....58926

32 CFR

239.....58846
311.....58205
806b.....57414
Proposed Rules:
806b.....57427

33 CFR

117 .....57884, 58209, 58210, 59476, 59477
165 .....57070, 57415, 57886, 57888, 58211, 58545, 59098, 60157, 61278
334.....58846, 58848
Proposed Rules:
117 .....57975, 58931, 58933
161.....58223
165 .....57427, 58223, 61305

34 CFR

668.....61240
686.....61240
690.....61240
691.....61240
Ch. 11.....58436, 59688

36 CFR

7.....60159, 60183
Proposed Rules:
9.....61596

38 CFR

3.....57072, 58232
9.....59478
200.....57608

39 CFR

20.....57890
111.....57899
3001.....57252
3004.....57252
3020.....56544, 61531
Proposed Rules:
111.....59494
3050.....57280

40 CFR

3.....59104
51.....56721
52 .....56721, 57048, 57051, 57074, 57612, 57904, 57907, 58553, 60194, 60199, 60199, 61037, 61535
63.....61037
81.....58687
86.....61537
97.....61535
112.....58783
141.....57908
180 .....57076, 57078, 57081, 59608
261.....57418
300.....57085, 58554
600.....61537
721.....57424
Proposed Rules:
51.....57126
52 .....56754, 57049, 57055, 57126, 57622, 57978, 59496, 59943, 60227
60.....58574
61.....58574
63.....58574, 61077
70.....57126
71.....57126
81.....59943
82.....61078
86.....61600
271.....59497
300.....58575
600.....61600
721.....57430
1515.....58576

42 CFR

34.....56547
52.....57918
409.....58078
410.....60316, 61737
411.....61737
414.....61737
415.....61737
416.....60316
419.....60316
424.....58078
484.....58078
485.....61737
498.....61737
Proposed Rules:
84.....59501
410.....57127
413.....57127
414.....57127
440.....61096
441.....61096

44 CFR

64.....61555, 61561
65.....57921, 61564
67 .....57923, 57928, 57944, 61566, 61572
206.....58849, 60203
Proposed Rules:
67 .....57979, 61604, 61612, 61622

45 CFR

82.....58189
Proposed Rules:
89.....61096

46 CFR

10.....59354
11.....59354
12.....59354
15.....59354
Proposed Rules:
10.....59502
11.....59502
12.....59502
15.....59502
540.....56756

47 CFR

2.....57092
25.....57092
73 .....56726, 56727, 57103, 57104, 57260, 58851, 59912
Proposed Rules:
36.....57982
54.....57982
73 .....57281, 57282, 57283, 58936, 61308

48 CFR

203.....59913, 59914
205.....59914
208.....59914
209.....59913
212.....59916
225.....59916
227.....61043
236.....59916
252 .....59913, 59914, 59916, 61043, 61045
3009.....58851
3052.....58851
Proposed Rules:
3.....58584
52.....58584

49 CFR

234.....58560
564.....58213
571.....58213, 58562
Proposed Rules:
214.....61633
234.....58589
571.....57623

580.....59503
633.....57986
1520.....59874
1554.....59874

50 CFR

17.....56978, 59444
20.....57615
229.....58859
300 .....57105, 61046, 61581
622.....57261, 58902
648 .....56562, 58567, 59917, 61283
660 .....57117, 57425, 61284
679 .....56728, 56734, 57262, 57949, 59106, 59479, 59918, 61583

Proposed Rules:

17 .....56757, 56770, 57804, 57987, 59956, 61100
92.....60228
222.....59508
223.....57436, 60050
224.....57436
404.....60050
635.....57128
648.....57134, 58234
665.....60050

LIST OF PUBLIC LAWS

This is a continuing list of public bills from the current session of Congress which have become Federal laws. It may be used in conjunction with ''P L U S'' (Public Laws Update Service) on 202–741–6043. This list is also available online at *http://www.archives.gov/federal-register/laws.html*.

The text of laws is not published in the **Federal Register** but may be ordered in ''slip law'' (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202–512–1808). The text will also be made available on the Internet from GPO Access at *http://www.gpoaccess.gov/plaws/index.html*. Some laws may not yet be available.

S. 475/P.L. 111–97
Military Spouses Residency Relief Act (Nov. 11, 2009; 123 Stat. 3007)

S. 509/P.L. 111–98
To authorize a major medical facility project at the Department of Veterans Affairs Medical Center, Walla Walla, Washington, and for other purposes. (Nov. 11, 2009; 123 Stat. 3010)

Last List November 10, 2009

Public Laws Electronic Notification Service (PENS)

PENS is a free electronic mail notification service of newly enacted public laws. To subscribe, go to *http://listserv.gsa.gov/archives/publaws-l.html*

Note: This service is strictly for E-mail notification of new laws. The text of laws is not available through this service. **PENS** cannot respond to specific inquiries sent to this address.