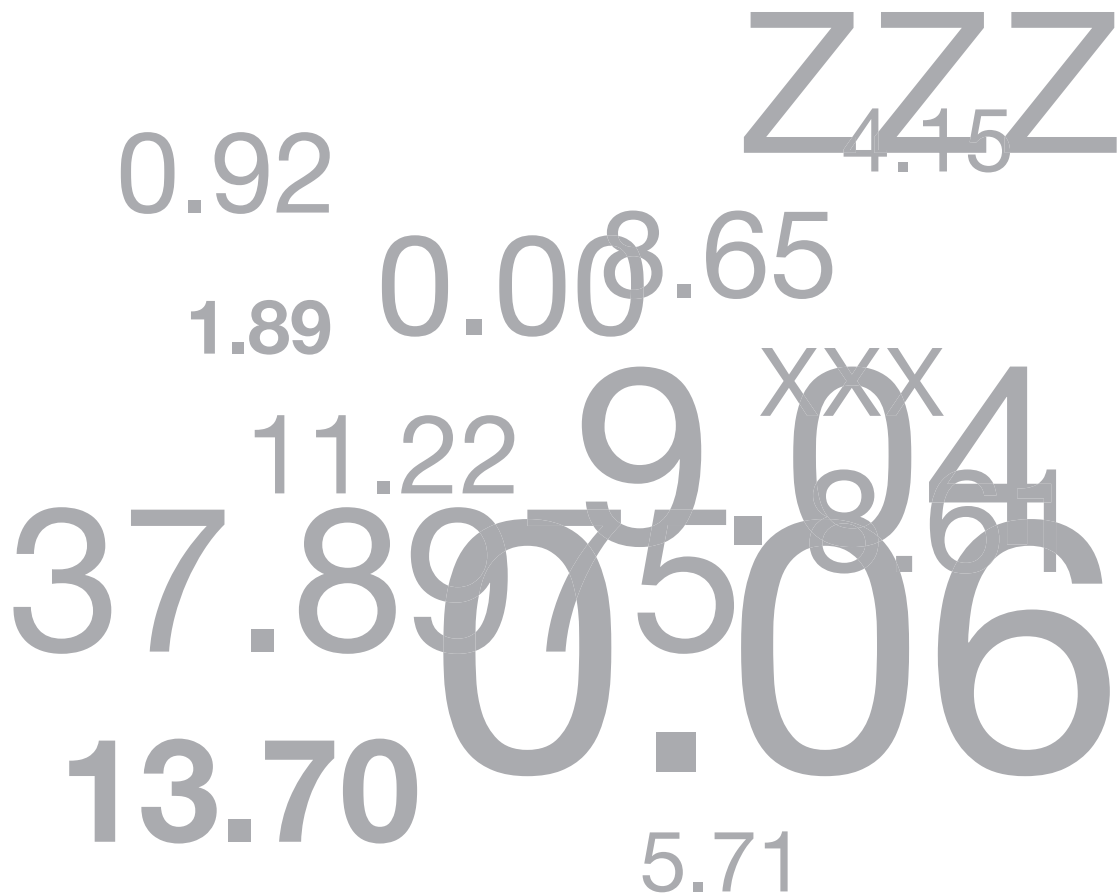


Medicare RBRVS Sourcebook

The Comprehensive Guide to Resource Based Relative Value Scale



2011

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In the Physician Fee Schedule Final Rule, the update to the MPFS conversion factor for 2011 was calculated at -24.9 percent resulting in a conversion factor of \$25.5217 for calendar year 2011. The estimated sustainable growth rate for 2011 was calculated at -13.4 percent.

Formula for Calculating CF Update in the Absence of Emergency Legislation

In the absence of emergency legislation, the conversion factor update is determined each year by applying a number of inputs. These include the Sustainable Growth Rate (SGR), Medicare Economic Index (MEI), and Update Adjustment Factor (UAF). While the formulas and calculations for these inputs are not required to calculate reimbursement on a code-by-code basis, they provide insight into the Medicare Physician Fee Schedule (MPFS) update process and an explanation for the yearly fluctuations in the conversion factor.

Sustainable Growth Rate (SGR)

The SGR is the target growth rate and is calculated based on medical inflation, projected growth in the number of beneficiaries in fee-for-service Medicare, the projected growth in the domestic economy, and changes in law or regulation.

Section 1848 (d)(1)(e) of the Social Security Act (Act) requires the Secretary to make available to the Medicare Payment Advisory Commission (MEDPAC) and the public by March 1, an estimate of the Sustainable Growth Rate (SGR), the resulting conversion factor applicable to Medicare payments for physicians' services for the following year, and the data underlying these estimates.

The use of SGR targets is intended to control the growth in aggregate Medicare expenditures for physicians' services.

Growth in aggregate Medicare expenditures include changes (increases or decreases) in expenditures due to:

- Changes in fees
- Changes in enrollment
- Changes in the 10-year moving average of Real Per Capita Gross Domestic Product (GDP)
- Changes resulting from changes in laws or regulations governing Medicare

The SGR targets are not direct limits on expenditures. Payments for services are not withheld if the SGR target is exceeded by actual expenditures. Rather, the fee schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures.

If expenditures exceed the target, the update is reduced. If expectations are less than the target, the update is increased. The update is determined by comparing cumulative actual expenditures to cumulative target expenditures from April 1, 1996 through the end of the year preceding the year at issue. In this case, December, 2010 for the SGR for 2011.

For 2011, the comparison of actual expenditures were less than target expenditures.

The SGR for 2011 based on the current estimate is -13.4%. This number was derived by adding estimated changes in expenditures for the four components as follows:

Statutory Factors	March Estimate	Current Estimate
Fees	0.2 percent (1.002)	0.2 percent (1.002)

Statutory Factors	March Estimate	Current Estimate
Enrollment	3.1 percent (1.031)	2.4 percent (1.024)
Real Per Capita GDP	0.8 percent (1.008)	0.7 percent (1.007)
Law and Regulation	-4.4 percent (0.956)	-16.2 percent (0.838)
Total SGR	-0.4 percent (0.996)	-13.4 percent (0.866)

Medicare Economic Index (MEI)

The Medicare Physician Fee Schedule (MPFS) is updated on an annual basis according to a formula specified by statute. The formula specifies that the update for a year is equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to the SGR.

The MEI is a measure of inflation experienced by physicians with respect to their practice costs and general wage levels.

The MEI includes a bundle of inputs used in furnishing physicians' services such as physician's own time, non-physician employees' compensation, rents, medical equipment, etc. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies.

The MEI for 2011 is 0.4%.

Updated Adjustment Factor (UAF)

The updated adjustment factor (UAF) uses the targeted expenditures for the year and compares them with the actual expenditures to determine the accuracy of the previous year's projections. If the previous year's projections are significantly higher or lower than the actual expenditures, any over or under expenditures must be recouped during the next fiscal year. This is accomplished by increasing or decreasing the MPFS conversion factor.

In 2010, actual expenditures exceeded target expenditures. Whenever actual expenditures exceed target expenditures a negative UAF is the result. The UAF for 2011 is -2.9.

Note: The Act does not allow the UAF for a given year to be more than 3% nor less than -7%.

CF Update Formula

The MPFS update is determined by multiplying the CF for the previous year by the percentage increase in the MEI times the update adjustment factor (UAF) times the BN adjustment factor.

$$\text{Unadjusted CF Previous Year} \times \text{MEI} \times \text{UAF} \times \text{BN adjustment} = \text{Updated (Current Year) CF}$$

Anesthesia Conversion Factor Update

Anesthesia services use adjustments to the respective shares of the anesthesia CF that represent the three components of physician fees, which are physician work, practice expense, and malpractice expense. When an adjustment is required of a single component, such as the BN adjustment required for 2007 and 2008 to the work RVUs, the share of the anesthesia CF representing physician work is adjusted. However, beginning in 2009, MIPPA required that the BN adjustment be applied to the entire anesthesia CF. So in 2010, CMS removed the BN adjustor for work in years 2007 and 2008 and recalculated the CF for both years by applying the BN adjustment to the total CF for years 2007 and 2008.

The anesthesia CF update for 2010 was complicated by two additional adjustments. The calculation required a 32 percent increase in the anesthesia physician work component adopted following the 2007 Five Year Review of Work RVUs for anesthesia as well as adjustments to both practice expense and malpractice

made in 2007 and 2008 respectively. The inputs in the table below were used to calculate the 2011 anesthesia CF.

Input	Amount
December 2010 Anesthesia Conversion Factor	\$16.6058
CY 2011 Medicare Economic Index	0.4 percent (1.0040)
CY 2011 Update Adjustment Factor	-2.9 percent (0.9710)
CY 2011 Anesthesia Adjustment	-2.3 percent (0.97651)
CY 2011 Anesthesia Conversion Factor	\$15.8085

The anesthesia update is determined by multiplying the unadjusted anesthesia CF for the previous year by the percentage increase or decrease in MEI times the UAF times the BN adjustment.

$$\text{Unadjusted Anesthesia CF Previous Year} \times \text{MEI} \times \text{UAF} \times \text{BN adjustment} = \text{Updated (Current Year) Anesthesia CF}$$

Medicare Conversion Factors for 2011

The conversion factor for all physician fee schedule services (excluding anesthesia) for 2011 is \$25.5217.

The national average conversion factor for anesthesia for 2011 is \$15.8085

2011 Payment Formula

The formula for calculating the Medicare fee schedule amount for a given service and fee schedule area can be expressed as:

$$[(\text{Relative Value Unit (RVU) (work)} \times \text{Geographic Practice Cost Index (GPCI) (work)}) + (\text{RVU (practice expense)} \times \text{GPCI (practice expense)}) + (\text{RVU (malpractice)} \times \text{GPCI (malpractice)})] \times \text{CF (Conversion Factor)}$$

In 2007 and 2008 it was necessary to apply a BN adjustment to the work RVUs to calculate the locality specific reimbursement amount. However, MIPPA required that the BN adjustment that was previously applied only to the work RVUs be applied to the CF instead. This calculation is performed by CMS and the 2011 MPFS conversion factor of \$25.5217 reflects the BN adjustment. RBRVS users no longer need to calculate the BN adjustment separately.

Geographic Practice Cost Indices (GPCIs)

According to statute, GPCIs must be reviewed and, if necessary, revised at least every 3 years. The first GPCI revision occurred in 1993. The second revision was implemented in 1998, the third in 2001, and the fourth in 2005. In 2008, as required by statute the fifth revision to the GPCIs was implemented. The revised GPCIs for 2008 were budget neutralized to the pre-MIEA-TRHCA values and the 1.000 floor for work values initially removed as mandated. The updated GPCIs were then to be phased in over a two year period with the 2008 GPCI values calculated as one-half the difference between the fully implemented 2007 GPCIs and the fully implemented 2009 (updated) GPCIs. This was done with one exception. The MMSEA which was enacted in December 2007 restored the 1.000 floor to the work values for the period January 1, 2008 through June 30, 2008. The 1.000 floor was first implemented in January 1, 2004 but was set to expire on January 1, 2008.

MIPPA, a second piece of legislation enacted in July 2008 maintained the 1.000 work value floor for the remaining six months of 2008. MIPPA also extended the 1.000 work GPCI floor

through December 31, 2009 and established of a permanent 1.5 work GPCI floor in Alaska for services beginning January 1, 2009.

The 1.000 GPCI work floor was scheduled to expire on January 1, 2010. However, emergency legislation passed subsequent to publication of the 2010 PFS Final Rule maintained the 1.000 GPCI floor for work through November of 2010. In 2011, the sixth revision to the GPCIs will be implemented. As is customary the revised GPCIs will be phased in over two years. The 2011 GPCIs are not subject to the 1.000 floor.

Other Factors Affecting Reimbursement

There are a number of other factors that affect reimbursement. Some of these factors, such as the non-participating physician limiting charge are older pieces of legislation, while others, such as those affecting imaging procedures are the result of more recent legislation.

Non-Participating Physician Limiting Charge

The Medicare limiting charge is set by law at 115 percent of the payment amount for the service furnished by the nonparticipating physician. However, the law sets the payment amount for nonparticipating physicians at 95 percent of the payment amount for participating physicians (i.e., the fee schedule amount). Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925 (or 109.25 percent). Therefore, to calculate the Medicare limiting charge for a physician service for a locality, multiply the fee schedule amount by a factor of 1.0925. The result is the Medicare limiting charge for that service for that locality to which the fee schedule amount applies.

Outpatient Prospective Payment System (OPPS) Cap

In 2005, Congress passed the Deficit Reduction Act (DRA). One of many provisions included in the DRA was a payment cap on the technical component of diagnostic imaging services. Essentially, this provision requires that CMS reimburse the lesser of the MPFS or OPPS rate when paying for the technical component of certain diagnostic imaging services. This cap remains in effect for 2011. See Appendix D for detailed information including the diagnostic imaging codes affected by the OPPS cap, formulas for calculating reimbursement under the OPPS cap, and instructions on comparing OPPS and MPFS reimbursement rates to determine which value should be used.

Payment for Multiple Imaging Procedures

In general, Medicare prices diagnostic imaging procedures in the following three ways:

- The PC represents the physician's component (PC-only services are billed with the 26 modifier).
- The Technical Component (TC) represents the Practice Expense (PE) and includes clinical staff, supplies, and equipment (TC-only services are billed with the TC modifier).
- The global service represents both the Physician Component (PC) and the Technical Component (TC).

Beginning in 2011, two significant changes have been made to payment for multiple imaging procedures under the multiple procedure payment reduction (MPPR). The first change is an increase in the multiple imaging procedure payment reduction from 25% to 50%. The second is the elimination of the diagnostic imaging families for these procedures.

level at which fees can be set, to determine what the current profit margin is, and to develop business strategies aimed at increasing net profit. To determine break-even and to set profit margins, cost accounting and financial management skills must be applied.

Computing the Practice's Break-Even Point

Historically, cost accounting, finance, economics, and other managerial sciences have not been applied to the healthcare system. Healthcare was considered too unique, too complex, and too unapproachable to apply business systems. This lack of a business approach to providing health services produced a reimbursement system that worked backwards with profit being targeted and then revenue and cost inputted to achieve the desired profit.

Today's healthcare reimbursement system has changed significantly. Practices can no longer simply increase fees to meet a desired target income or profit. There are too many constraints on the charge structures of physician services including third party payers (e.g., Medicare, managed care organizations, and indemnity plans), employers, and consumers of health care (i.e. patients). In today's healthcare market, practices must understand what it costs to provide each service, and which services can be performed at a profit. Without good cost data, the practice cannot be effectively managed nor can appropriate reimbursement rates be negotiated with payers.

There are two types of break-even points that should be determined, the break-even point for specific services or types of services and the overall break-even point for the practice. Knowing what payers allow for the services and then comparing that amount with the cost of providing the service can help the practice determine whether it is cost effective to provide the service. It can also help the practice determine which payers to contract with.

Calculating Break-Even Point for a Specific Service

In order to calculate the break-even point for a specific service, the practice must have readily accessible data on revenue and cost. Revenue data includes the fee or payer allowed amount for the service and the number of units provided. The number of units is the number of times the service or procedure was performed during a given time period. Cost data must include all costs allocated to the service which may include a portion of rent and utilities, all related equipment and supplies, and labor inputs. An example of calculating break-even and net profit is provided below for echocardiography services, CPT code 93307

Break-Even Point for 93307

Revenue

Current Fee or Allowed Amount	\$300
Number Performed Last Year	800
Total Revenue	\$240,000

Note: If the current fee is more than the total allowed for contracted payers use the total allowed amount to calculate revenue

Costs

Echocardiography Equipment	\$25,000
Office Space (allocated amount for echocardiography)	\$4,000
Supplies	\$7,000
Administrative Costs (allocated for echocardiography)	\$40,500
Technician costs	\$35,000
Physician costs	\$34,300*
Total Costs (Break-Even Point)	\$145,800
Net Revenue (Profit) (Total Revenue – Total Costs)	\$94,200

*Note: physician costs were calculated based on the amount of physician time required for echocardiography services as follows:

Physician's salary and benefits	\$250,000/year
Hours worked	60/week, 52 weeks/year
Physician time required for each echocardiography	32 minutes
Total minutes available per year (60 hours X 52 weeks X 60 minutes) =	187,200 minutes
Cost per minute (physician salary/total minutes) =	$\$250,000/187,200 = \$1.34/\text{minute}$
Physician cost per procedure (cost per minute X minutes per procedure) =	$\$1.34 \times 32 = \$34,300(\text{rounded to nearest } 100)$

In this example, the physician's office is making a profit on the provision of echocardiography services and would likely want to continue to provide these services. However, if the result was a net loss, then additional analysis would need to be done to determine whether costs could be cut or allowed amounts negotiated with payers so that the full cost of providing the service is covered.

Healthcare should be priced in relationship to its true cost, and this requires a detailed understanding of the cost related to providing care. An accurate cost/pricing mechanism is essential before any other elements of practice management can be applied. A practice cannot sell competitively if costs are not known, or if a practice subsidizes one service by over-pricing another service.

Traditionally, costs are differentiated as being fixed or variable. Fixed costs are those that would exist whether a specific service was provided or not. Fixed costs include things like rent, utilities, office and equipment, salaries of nontechnical staff. Variable costs are those that are unique to the service provided and vary based on how often or how many units of the service are performed. Variable costs include medication, vaccines, supplies specific to the service, and salaries of technical staff required to perform a special service.

Both fixed and variable costs should be addressed when analyzing the cost of providing a service. Examples of ways to reduce fixed costs include renegotiating rents and developing more efficient administrative practices. Variable costs could be reduced by renegotiating the cost of echocardiography supplies with vendors, changing vendors, becoming more efficient at providing the echocardiography service.

In addition to understanding the costs of services, the practice must also know the amount each payer will allow for specific

E = Excluded from Physician Fee Schedule by regulation

These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures.

I = Not valid for Medicare purposes

Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90-day grace period.)

J = Anesthesia Services

There are no RVUs and no payment amounts listed for anesthesia services. The J status is informational only and is used to identify anesthesia services.

M = Measurement codes

These codes are 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.

N = Noncovered Services

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

P = Bundled/Excluded Codes

There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.

- If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)
- If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

R = Restricted Coverage

Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alphanumeric dental codes, which begin with "D". CMS assigns the indicator to a limited number of CPT® codes which represent services that are covered only in unusual circumstances.)

T = Injections

There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that special services services are bundled into any other services billed on the same date.)

X = Statutory Exclusion

These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. Examples are ambulance services and clinical diagnostic laboratory services.

Work RVU = Physician Work RVUs.

These are the RVUs for the physician work for this service.

N-Fac PE RVU = Non-facility practice expense RVUs.

These are the transitional resource-based practice expense RVUs for non-facility settings.

N-Fac NA IND = Non-facility NA Indicator

A NA in this field indicates that this procedure is rarely or never performed in the non-facility setting.

Fac PE RVU = Facility practice expense RVUs.

These are the transitional resource-based practice expense RVUs for facility settings.

Fac NA IND = Facility NA Indicator

A NA in this field indicates that this procedure is rarely or never performed in the facility setting.

MP RVU = Malpractice expense RVUs

These are the RVUs for the malpractice expense for the service.

N-Fac Total = Non-facility total

This is the sum of the 2010 work, transitional non-facility practice expense, and malpractice expense RVUs.

Fac Tot = Facility total

This is the sum of the 2010 work, transitional facility practice expense, and malpractice expense RVUs.

PCTC IND = Professional Component/Technical Component Indicator**0 Physician Service Codes**

Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 Diagnostic Tests for Radiology Services

Identifies codes that describe diagnostic tests. Examples include pulmonary function tests and therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.

Code	Mod	Description	Stat Code	Work RVU	N-Fac		Fac PE RVU	Fac NA Ind	MP RVU	N-Fac Total	Fac Total	PC/TC Ind	Glob Days	Global Percentage			Modifier Rules					Phy Sup Diag Proc	Diag Image Fam Ind	
					PE RVU	NA Ind								Pre Op	Intra Op	Post Op	51 Mult Proc	50 Bilat Surg	80 Asst Surg	62 Co Surg	66 Team Surg			Endo Base
36248	0	Place catheter in artery	A	1.01	3.66		0.42		0.16	4.83	1.59	0	ZZZ	0.00	0.00	0.00	0	0	1	0	0		09	99
36260	0	Insertion of infusion pump	A	9.91	6.55	NA	6.55		2.12	18.58	18.58	0	090	0.09	0.84	0.07	2	0	1	0	0		09	99
36261	0	Revision of infusion pump	A	5.63	4.61	NA	4.61		1.33	11.57	11.57	0	090	0.09	0.84	0.07	2	0	2	0	0		09	99
36262	0	Removal of infusion pump	A	4.11	3.74	NA	3.74		0.87	8.72	8.72	0	090	0.09	0.84	0.07	2	0	1	0	0		09	99
36299	0	Vessel injection procedure	C	0.00	0.00		0.00		0.00	0.00	0.00	0	YYY	0.00	0.00	0.00	2	0	0	1	1		09	99
36400	0	Bl draw < 3 yrs fem/jugular	A	0.38	0.43		0.09		0.05	0.86	0.52	0	XXX	0.00	0.00	0.00	2	0	1	0	0		09	99
36405	0	Bl draw < 3 yrs scalp vein	A	0.31	0.36		0.12		0.05	0.72	0.48	0	XXX	0.00	0.00	0.00	2	0	1	0	0		09	99
36406	0	Bl draw < 3 yrs other vein	A	0.18	0.30		0.07		0.03	0.51	0.28	0	XXX	0.00	0.00	0.00	2	0	1	0	0		09	99
36410	0	Non-routine bl draw > 3 yrs	A	0.18	0.33		0.07		0.03	0.54	0.28	0	XXX	0.00	0.00	0.00	2	0	1	0	0		09	99
36415	0	Routine venipuncture	X	<i>0.14</i>	<i>0.11</i>	~	<i>0.11</i>	~	<i>0.01</i>	<i>0.26</i>	<i>0.26</i>	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
36416	0	Capillary blood draw	B	<i>0.09</i>	<i>0.06</i>	~	<i>0.06</i>	~	<i>0.00</i>	<i>0.15</i>	<i>0.15</i>	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
36420	0	Vein access cutdown < 1 yr	A	1.01	0.27	NA	0.27		0.12	1.40	1.40	0	XXX	0.00	0.00	0.00	2	0	0	0	0		09	99
36425	0	Vein access cutdown > 1 yr	A	0.76	0.31	NA	0.31		0.11	1.18	1.18	0	XXX	0.00	0.00	0.00	2	0	1	0	0		09	99
36430	0	Blood transfusion service	A	0.00	1.03		1.03	NA	0.01	1.04	1.04	5	XXX	0.00	0.00	0.00	0	0	1	0	0		09	99
36440	0	Bl push transfuse 2 yr or <	A	1.03	0.43	NA	0.43		0.24	1.70	1.70	0	XXX	0.00	0.00	0.00	2	0	0	0	0		09	99
36450	0	Bl exchange/transfuse nb	A	2.23	1.04	NA	1.04		0.11	3.38	3.38	0	XXX	0.00	0.00	0.00	2	0	0	0	0		09	99
36455	0	Bl exchange/transfuse non-nb	A	2.43	0.99	NA	0.99		0.14	3.56	3.56	0	XXX	0.00	0.00	0.00	2	0	1	0	0		09	99
36460	0	Transfusion service fetal	A	6.58	2.72	NA	2.72		1.40	10.70	10.70	0	XXX	0.00	0.00	0.00	2	0	2	0	0		09	99
36468	0	Injection(s) spider veins	R	<i>0.63</i>	<i>0.46</i>	~	<i>0.46</i>	~	<i>0.09</i>	<i>1.18</i>	<i>1.18</i>	0	000	0.00	0.00	0.00	2	0	0	0	0		09	99
36469	0	Injection(s) spider veins	R	<i>0.77</i>	<i>0.56</i>	~	<i>0.56</i>	~	<i>0.11</i>	<i>1.44</i>	<i>1.44</i>	0	000	0.00	0.00	0.00	2	0	0	0	0		09	99
36470	0	Injection therapy of vein	A	1.10	2.95		0.83		0.22	4.27	2.15	0	010	0.10	0.80	0.10	2	1	1	0	0		09	99
36471	0	Injection therapy of veins	A	1.65	3.28		1.08		0.33	5.26	3.06	0	010	0.10	0.80	0.10	2	1	1	0	0		09	99
36475	0	Endovenous rf 1st vein	A	6.72	46.52		2.74		1.41	54.65	10.87	0	000	0.00	0.00	0.00	2	1	1	0	0		09	99
36476	0	Endovenous rf vein add-on	A	3.38	7.83		1.22		0.72	11.93	5.32	0	ZZZ	0.00	0.00	0.00	0	1	1	0	0		09	99
36478	0	Endovenous laser 1st vein	A	6.72	35.16		2.77		1.32	43.20	10.81	0	000	0.00	0.00	0.00	2	1	1	0	0		09	99
36479	0	Endovenous laser vein add-on	A	3.38	8.25		1.26		0.65	12.28	5.29	0	ZZZ	0.00	0.00	0.00	0	1	1	0	0		09	99
36481	0	Insertion of catheter vein	A	6.98	29.60		3.01		0.88	37.46	10.87	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36500	0	Insertion of catheter vein	A	3.51	1.49	NA	1.49		0.53	5.53	5.53	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36510	0	Insertion of catheter vein	A	1.09	1.82		0.50		0.24	3.15	1.83	0	000	0.00	0.00	0.00	2	0	0	0	0		09	99
36511	0	Apheresis wbc	A	1.74	0.83	NA	0.83		0.27	2.84	2.84	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36512	0	Apheresis rbc	A	1.74	0.84	NA	0.84		0.16	2.74	2.74	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36513	0	Apheresis platelets	A	1.74	0.91	NA	0.91		0.34	2.99	2.99	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36514	0	Apheresis plasma	A	1.74	13.39		0.77		0.27	15.40	2.78	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36515	0	Apheresis adsorp/reinfuse	A	1.74	55.40		0.78		0.24	57.38	2.76	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36516	0	Apheresis selective	A	1.22	61.86		0.53		0.35	63.43	2.10	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36522	0	Photopheresis	A	1.67	38.52		1.20		0.16	40.35	3.03	0	000	0.00	0.00	0.00	2	0	1	0	0		09	99
36555	0	Insert non-tunnel cv cath	A	2.68	5.09		0.74		0.22	7.99	3.64	0	000	0.00	0.00	0.00	0	0	1	0	0		09	99
36556	0	Insert non-tunnel cv cath	A	2.50	4.14		0.81		0.31	6.95	3.62	0	000	0.00	0.00	0.00	0	0	1	0	0		09	99
36557	0	Insert tunneled cv cath	A	5.14	21.68		3.38		1.09	27.91	9.61	0	010	0.10	0.80	0.10	2	1	0	0	0		09	99
36558	0	Insert tunneled cv cath	A	4.84	18.46		2.95		0.72	24.02	8.51	0	010	0.10	0.80	0.10	2	1	0	0	0		09	99
36560	0	Insert tunneled cv cath	A	6.29	30.73		3.83		0.58	37.60	10.70	0	010	0.10	0.80	0.10	2	1	0	0	0		09	99

Gap Fill RVU Data noted in *italics*

Code	Mod	Description	Stat Code	Work RVU	N-Fac		Fac PE RVU	Fac NA Ind	Fac PE RVU	Fac NA Ind	MP RVU	N-Fac Total	Fac Total	PC/TC Ind	Glob Days	Global Percentage			Modifier Rules					Phy Sup Diag Proc	Diag Image Fam Ind
					PE RVU	NA Ind										Pre Op	Intra Op	Post Op	51 Mult Proc	50 Bilat Surg	80 Asst Surg	62 Co Surg	66 Team Surg		
76821	TC	Middle cerebral artery echo	A	0.00	1.85		1.85	NA	0.01	1.86	1.86	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
76821	26	Middle cerebral artery echo	A	0.70	0.30		0.30		0.03	1.03	1.03	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76825	0	Echo exam of fetal heart	A	1.67	4.71		4.71	NA	0.05	6.43	6.43	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76825	TC	Echo exam of fetal heart	A	0.00	4.01		4.01	NA	0.01	4.02	4.02	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
76825	26	Echo exam of fetal heart	A	1.67	0.70		0.70		0.04	2.41	2.41	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76826	0	Echo exam of fetal heart	A	0.83	2.84		2.84	NA	0.04	3.71	3.71	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76826	TC	Echo exam of fetal heart	A	0.00	2.50		2.50	NA	0.01	2.51	2.51	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
76826	26	Echo exam of fetal heart	A	0.83	0.34		0.34		0.03	1.20	1.20	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76827	0	Echo exam of fetal heart	A	0.58	1.37		1.37	NA	0.02	1.97	1.97	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76827	TC	Echo exam of fetal heart	A	0.00	1.13		1.13	NA	0.01	1.14	1.14	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
76827	26	Echo exam of fetal heart	A	0.58	0.24		0.24		0.01	0.83	0.83	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76828	0	Echo exam of fetal heart	A	0.56	0.87		0.87	NA	0.02	1.45	1.45	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76828	TC	Echo exam of fetal heart	A	0.00	0.63		0.63	NA	0.01	0.64	0.64	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
76828	26	Echo exam of fetal heart	A	0.56	0.24		0.24		0.01	0.81	0.81	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76830	0	Transvaginal us non-ob	A	0.69	2.98		2.98	NA	0.04	3.71	3.71	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76830	TC	Transvaginal us non-ob	A	0.00	2.69		2.69	NA	0.01	2.70	2.70	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
76830	26	Transvaginal us non-ob	A	0.69	0.29		0.29		0.03	1.01	1.01	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76831	0	Echo exam uterus	A	0.72	2.96		2.96	NA	0.04	3.72	3.72	1	XXX	0.00	0.00	0.00	4	0	0	0	0		09	88	
76831	TC	Echo exam uterus	A	0.00	2.66		2.66	NA	0.01	2.67	2.67	1	XXX	0.00	0.00	0.00	4	0	0	0	0		03	88	
76831	26	Echo exam uterus	A	0.72	0.30		0.30		0.03	1.05	1.05	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76856	0	Us exam pelvic complete	A	0.69	2.97		2.97	NA	0.04	3.70	3.70	1	XXX	0.00	0.00	0.00	4	0	0	0	0		09	88	
76856	TC	Us exam pelvic complete	A	0.00	2.68		2.68	NA	0.01	2.69	2.69	1	XXX	0.00	0.00	0.00	4	0	0	0	0		01	88	
76856	26	Us exam pelvic complete	A	0.69	0.29		0.29		0.03	1.01	1.01	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76857	0	Us exam pelvic limited	A	0.38	2.59		2.59	NA	0.04	3.01	3.01	1	XXX	0.00	0.00	0.00	4	0	0	0	0		09	88	
76857	TC	Us exam pelvic limited	A	0.00	2.42		2.42	NA	0.01	2.43	2.43	1	XXX	0.00	0.00	0.00	4	0	0	0	0		01	88	
76857	26	Us exam pelvic limited	A	0.38	0.17		0.17		0.03	0.58	0.58	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76870	0	Us exam scrotum	A	0.64	2.99		2.99	NA	0.05	3.68	3.68	1	XXX	0.00	0.00	0.00	4	0	0	0	0		09	88	
76870	TC	Us exam scrotum	A	0.00	2.72		2.72	NA	0.01	2.73	2.73	1	XXX	0.00	0.00	0.00	4	0	0	0	0		01	88	
76870	26	Us exam scrotum	A	0.64	0.27		0.27		0.04	0.95	0.95	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76872	0	Us transrectal	A	0.69	3.43		3.43	NA	0.05	4.17	4.17	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76872	TC	Us transrectal	A	0.00	3.12		3.12	NA	0.01	3.13	3.13	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
76872	26	Us transrectal	A	0.69	0.31		0.31		0.04	1.04	1.04	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
76873	0	Echograp trans r pros study	A	1.55	3.65		3.65	NA	0.09	5.29	5.29	1	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99	
76873	TC	Echograp trans r pros study	A	0.00	2.98		2.98	NA	0.01	2.99	2.99	1	XXX	0.00	0.00	0.00	9	9	9	9	9		02	99	
76873	26	Echograp trans r pros study	A	1.55	0.67		0.67		0.08	2.30	2.30	1	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99	
76881	0	Us xtr non-vasc complete	A	0.59	2.76		2.76	NA	0.05	3.40	3.40	1	XXX	0.00	0.00	0.00	0	0	9	0	0		09	99	
76881	TC	Us xtr non-vasc complete	A	0.00	2.54		2.54	NA	0.01	2.55	2.55	1	XXX	0.00	0.00	0.00	0	0	9	0	0		01	99	
76881	26	Us xtr non-vasc complete	A	0.59	0.22		0.22		0.04	0.85	0.85	1	XXX	0.00	0.00	0.00	0	0	9	0	0		09	99	
76882	0	Us xtr non-vasc lmted	A	0.41	0.44		0.44	NA	0.04	0.89	0.89	1	XXX	0.00	0.00	0.00	0	0	9	0	0		09	99	
76882	TC	Us xtr non-vasc lmted	A	0.00	0.29		0.29	NA	0.01	0.30	0.30	1	XXX	0.00	0.00	0.00	0	0	9	0	0		01	99	
76882	26	Us xtr non-vasc lmted	A	0.41	0.15		0.15		0.03	0.59	0.59	1	XXX	0.00	0.00	0.00	0	0	9	0	0		09	99	

Gap Fill RVU Data noted in *italics*

Code	Mod	Description	Stat Code	Work RVU	N-Fac		N-Fac		Fac		MP RVU	N-Fac Total	Fac Total	PC/TC Ind	Glob Days	Global Percentage			Modifier Rules					Phy Sup Diag Proc	Diag Image Fam Ind
					PE RVU	NA Ind	Fac PE RVU	NA Ind	Pre Op	Intra Op						Post Op	51 Mult Proc	50 Bilat Surg	80 Asst Surg	62 Co Surg	66 Team Surg	Endo Base			
95147	0	Antigen therapy services	A	0.06	0.85		0.03		0.01	0.92	0.10	0	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95148	0	Antigen therapy services	A	0.06	1.27		0.03		0.01	1.34	0.10	0	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95149	0	Antigen therapy services	A	0.06	1.71		0.03		0.01	1.78	0.10	0	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95165	0	Antigen therapy services	A	0.06	0.30		0.03		0.01	0.37	0.10	0	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95170	0	Antigen therapy services	A	0.06	0.22		0.03		0.01	0.29	0.10	0	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95180	0	Rapid desensitization	A	2.01	2.08		1.03		0.07	4.16	3.11	0	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95199	0	Allergy immunology services	C	0.00	0.00		0.00		0.00	0.00	0.00	0	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95250	0	Glucose monitoring cont	A	0.00	4.36		4.36	NA	0.01	4.37	4.37	3	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95251	0	Gluc monitor cont phys i&r	A	0.85	0.34		0.34		0.04	1.23	1.23	2	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95800	0	Slp stdy unattended	A	1.05	37.51		37.51	NA	0.05	38.61	38.61	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95800	TC	Slp stdy unattended	A	0.00	36.89		36.89	NA	0.01	36.90	36.90	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95800	26	Slp stdy unattended	A	1.05	0.62		0.62		0.04	1.71	1.71	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95801	0	Slp stdy unatnd w/anal	A	1.00	64.32		64.32	NA	0.05	65.37	65.37	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95801	TC	Slp stdy unatnd w/anal	A	0.00	63.85		63.85	NA	0.01	63.86	63.86	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95801	26	Slp stdy unatnd w/anal	A	1.00	0.47		0.47		0.04	1.51	1.51	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95803	0	Actigraphy testing	A	0.90	3.84		3.84	NA	0.04	4.78	4.78	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95803	TC	Actigraphy testing	A	0.00	3.40		3.40	NA	0.01	3.41	3.41	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95803	26	Actigraphy testing	A	0.90	0.44		0.44		0.03	1.37	1.37	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95805	0	Multiple sleep latency test	A	1.20	10.84		10.84	NA	0.08	12.12	12.12	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95805	TC	Multiple sleep latency test	A	0.00	10.26		10.26	NA	0.04	10.30	10.30	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95805	26	Multiple sleep latency test	A	1.20	0.58		0.58		0.04	1.82	1.82	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95806	0	Sleep study unatt&resp efft	A	1.25	4.05		4.05	NA	0.08	5.38	5.38	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95806	TC	Sleep study unatt&resp efft	A	0.00	3.50		3.50	NA	0.03	3.53	3.53	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95806	26	Sleep study unatt&resp efft	A	1.25	0.55		0.55		0.05	1.85	1.85	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95807	0	Sleep study attended	A	1.28	12.45		12.45	NA	0.15	13.88	13.88	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95807	TC	Sleep study attended	A	0.00	11.92		11.92	NA	0.10	12.02	12.02	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95807	26	Sleep study attended	A	1.28	0.53		0.53		0.05	1.86	1.86	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95808	0	Polysomnography 1-3	A	1.74	17.28		17.28	NA	0.17	19.19	19.19	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95808	TC	Polysomnography 1-3	A	0.00	16.44		16.44	NA	0.10	16.54	16.54	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95808	26	Polysomnography 1-3	A	1.74	0.84		0.84		0.07	2.65	2.65	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95810	0	Polysomnography 4 or more	A	2.50	17.80		17.80	NA	0.21	20.51	20.51	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95810	TC	Polysomnography 4 or more	A	0.00	16.70		16.70	NA	0.11	16.81	16.81	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95810	26	Polysomnography 4 or more	A	2.50	1.10		1.10		0.10	3.70	3.70	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95811	0	Polysomnography w/cpap	A	2.60	19.30		19.30	NA	0.23	22.13	22.13	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95811	TC	Polysomnography w/cpap	A	0.00	18.15		18.15	NA	0.12	18.27	18.27	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95811	26	Polysomnography w/cpap	A	2.60	1.15		1.15		0.11	3.86	3.86	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95812	0	Eeg 41-60 minutes	A	1.08	8.16		8.16	NA	0.07	9.31	9.31	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95812	TC	Eeg 41-60 minutes	A	0.00	7.68		7.68	NA	0.03	7.71	7.71	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	
95812	26	Eeg 41-60 minutes	A	1.08	0.48		0.48		0.04	1.60	1.60	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95813	0	Eeg over 1 hour	A	1.73	8.64		8.64	NA	0.11	10.48	10.48	1	XXX	0.00	0.00	0.00	0	0	0	0	0		09	99	
95813	TC	Eeg over 1 hour	A	0.00	7.90		7.90	NA	0.04	7.94	7.94	1	XXX	0.00	0.00	0.00	0	0	0	0	0		01	99	

Gap Fill RVU Data noted in *italics*

Code	Mod	Description	Stat Code	Work RVU	N-Fac		Fac PE RVU	Fac NA Ind	MP RVU	N-Fac Total	Fac Total	PC/TC Ind	Glob Days	Global Percentage			Modifier Rules					Phy Sup Diag Proc	Diag Image Fam Ind	
					PE RVU	NA Ind								Pre Op	Intra Op	Post Op	51 Proc	50 Bilat Surg	80 Asst Surg	62 Co Surg	66 Team Surg			Endo Base
S0800	0	Laser in situ keratomileusis	I	1.06	1.54	~	1.54	~	0.06	2.66	2.66	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S0810	0	Photorefractive keratectomy	I	1.06	1.54	~	1.54	~	0.06	2.66	2.66	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S0812	0	Phototherap keratect	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S1001	0	Deluxe item	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S1002	0	Custom item	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S1015	0	IV tubing extension set	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S1016	0	Non-pvc intravenous administ	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S1030	0	Gluc monitor purchase	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S1031	0	Gluc monitor rental	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S1040	0	Cranial remolding orthosis	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2053	0	Transplantation of small int	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2054	0	Transplantation of multivisc	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2055	0	Harvesting of donor multivis	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2060	0	Lobar lung transplantation	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2061	0	Donor lobectomy (lung)	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2065	0	Simult panc kidn trans	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2066	0	Breast GAP flap reconst	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2067	0	Breast "stacked" DIEP/GAP	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2068	0	Breast DIEP or SIEA flap	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2070	0	Cysto laser tx ureteral calc	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2079	0	Lap esophagomyotomy	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2080	0	Laup	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2083	0	Adjustment gastric band	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2095	0	Transcath emboliz microspher	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2102	0	Islet cell tissue transplant	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2103	0	Adrenal tissue transplant	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2107	0	Adoptive immunotherapy	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2112	0	Knee arthroscop harv	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2115	0	Periacetabular osteotomy	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2117	0	Arthroereisis, subtalar	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2118	0	Total hip resurfacing	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2120	0	Low density lipoprotein(LDL)	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2140	0	Cord blood harvesting	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2142	0	Cord blood-derived stem-cell	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2150	0	BMT harv/transpl 28d pkg	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2152	0	Solid organ transpl pkg	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2202	0	Echosclectotherapy	I	0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2205	0	Minimally invasive direct co	I	25.83	25.72	~	25.72	~	3.33	54.88	54.88	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2206	0	Minimally invasive direct co	I	28.82	27.82	~	27.82	~	3.68	60.32	60.32	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2207	0	Minimally invasive direct co	I	25.12	25.10	~	25.10	~	3.27	53.49	53.49	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99
S2208	0	Minimally invasive direct co	I	28.40	27.80	~	27.80	~	3.66	59.86	59.86	9	XXX	0.00	0.00	0.00	9	9	9	9	9		09	99

Gap Fill RVU Data noted in *italics*

Carrier	Locality	Locality name	2011 Work GPCI ³	2011 PE GPCI ³	2011 MP GPCI
05302	02	Metropolitan Kansas City, MO	0.986	0.973	1.204
05302	01	Metropolitan St Louis, MO	0.992	0.968	1.064
05302	99	Rest of Missouri	0.953	0.913	1.004
03202	01	Montana ***	0.948	1.000	0.887
05402	00	Nebraska	0.964	0.943	0.280
01302	00	Nevada ***	0.999	1.042	1.149
14302	40	New Hampshire	0.987	1.046	0.658
12402	01	Northern NJ	1.051	1.206	1.077
12402	99	Rest of New Jersey	1.031	1.125	1.077
04202	05	New Mexico	0.981	0.947	1.054
13202	01	Manhattan, NY	1.063	1.263	1.137
13202	02	NYC Suburbs/Long I., NY	1.050	1.278	1.335
13202	03	Poughkpsie/N NYC Suburbs, NY	1.013	1.074	0.945
13292	04	Queens, NY	1.047	1.233	1.351
13282	99	Rest of New York	0.993	0.964	0.492
05535	00	North Carolina	0.972	0.960	0.664
03302	01	North Dakota ****	0.957	1.000	0.453
00883	00	Ohio	0.996	0.961	1.230
04302	00	Oklahoma	0.960	0.927	0.671
00835	01	Portland, OR	1.003	1.016	0.542
00835	99	Rest of Oregon	0.974	0.968	0.542
12502	01	Metropolitan Philadelphia, PA	1.015	1.084	1.619
12502	99	Rest of Pennsylvania	0.990	0.958	1.101
09202	20	Puerto Rico	0.907	0.845	0.249
14402	01	Rhode Island	1.015	1.071	1.089
00880	01	South Carolina	0.976	0.952	0.482
03402	02	South Dakota****	0.946	1.000	0.424
10302	35	Tennessee	0.976	0.945	0.566
04402	31	Austin, TX	0.988	0.995	0.859
04402	20	Beaumont, TX	0.978	0.937	1.131
04402	09	Brazoria, TX	1.014	0.967	1.070
04402	11	Dallas, TX	1.009	1.001	0.969
04402	28	Fort Worth, TX	0.999	0.982	0.966
04402	15	Galveston, TX	1.000	0.985	1.100
04402	18	Houston, TX	1.012	0.992	1.131
04402	99	Rest of Texas	0.974	0.943	0.936
03502	09	Utah	0.975	0.953	1.059
14502	50	Vermont	0.973	1.002	0.523
00904	00	Virginia	0.988	0.978	0.692
09202	50	Virgin Islands	0.998	0.994	1.007
00836	02	Seattle (King Cnty), WA	1.020	1.098	0.785
00836	99	Rest of Washington	0.991	0.991	0.770
00884	16	West Virginia	0.968	0.912	1.279
00951	00	Wisconsin	0.988	0.966	0.476
03602	21	Wyoming ***	0.964	1.000	1.052
03602	21	Wyoming	1.000	0.842	0.889

* Indicates multiple contractors.

** 2011 work GPCI reflects the 1.500 floor in Alaska.

*** Frontier States: For 2011, these states will receive the higher of the standard PE GPCI value or a minimum value of 1.000.

Appendix B: Locality Lookup Chart

Carrier Number	Locality Number	State	Fee Schedule Area	Counties
10102	00	ALABAMA	STATEWIDE	ALL COUNTIES
00831	01	ALASKA	STATEWIDE	ALL COUNTIES
03102	00	ARIZONA	STATEWIDE	ALL COUNTIES