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644th Meeting of the Health Services Cost Review Commission

July 22, 2026

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 pm)

CLOSED SESSION
12:00 pm

1. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Second Closed Session on May 13, 2026; Public and Closed Meetings on June 10, 2026

Specific Matters

For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2695N TidalHealth Peninsula Regional Medical Center
2670A University of Maryland Medical Center- 2nd Extension Request
2698A Johns Hopkins Health System

1. Docket Status – Cases Open

2699A University of Maryland Medical Center
2700A University of Maryland Medical Center
2701R Brook Lane

2. Final Staff Recommendation Request to Access HSCRC Confidential Data: Johns Hopkins Bloomberg School of Public Health

Informational Subjects

3. Sickle Cell Presentation

Subjects of General Applicability

4. Report from the Executive Director
    a. Update on Medicare Fee-For-Service Savings

b. Policy Calendar

5. Draft Recommendation: Update to The Accounting and Budget Manual
6. Final Recommendation: Global Budget Carve Out
7. Final Recommendation: Update Factor with Adjustments for Individual Market Stabilization and Uncompensated Care
8. Hearing and Meeting Schedule

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As an advance notice, the Commission will not hold a meeting in August 2026.

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Application for an Alternative Method of Rate Determination

University of Maryland Medical Center

July 22, 2026

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
UNIVERSITY OF MARYLAND MEDICAL	*	DOCKET:	2026
CENTER	*	FOLIO:	2509
BALTIMORE, MARYLAND	*	PROCEEDING:	2699A

I. INTRODUCTION

On June 2, 2026, University of Maryland Medical Center ("Hospital") filed a renewal application for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital is requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ transplant and blood and bone marrow transplants. The Hospital requests that the Commission approve the arrangement for one year beginning July 1, 2026.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. ("FPI"), which is a subsidiary of the University of Maryland Medical System. FPI will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract. FPI maintains it has been active in similar types of fixed fee contracts for several years, and that FPI is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been unfavorable, however performance has been favorable past years. According to the Hospital, the losses under this arrangement can be attributed to several extraordinary outlier cases. Staff believes that absent these cases, the Hospital can again achieve favorable experience under this arrangement. However, if the experience under the arrangement during the next year continues to be unfavorable, staff will not recommend further approval.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with Aetna Health, Inc. for solid organ transplant and blood and bone marrow transplants. for one year beginning July 1, 2026. The Hospital must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
UNIVERSITY OF MARYLAND MEDICAL	*	DOCKET:	2026
CENTER	*	FOLIO:	2510
BALTIMORE, MARYLAND	*	PROCEEDING:	2700A

I. INTRODUCTION

On June 2, 2026, University of Maryland Medical Center ("Hospital") filed a renewal application for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital is requesting approval to continue to participate in a global price arrangement with OptumHealth Care Solutions, Inc. for solid organ transplant and blood and bone marrow transplants. The Hospital requests that the Commission approve the arrangement for one year beginning July 1, 2026.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. ("FPI"), which is a subsidiary of the University of Maryland Medical System. FPI will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

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The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

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The Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract. FPI maintains it has been active in similar types of fixed fee contracts for several years, and that FPI is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospital can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with OptumHealth Care Solutions, Inc. for solid organ transplant and blood and bone marrow transplants for one-year beginning July 1, 2026. The Hospital must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Final Staff Recommendation for Access to the HSCRC Confidential Patient Level Data Request from Johns Hopkins University, Bloomberg School of Public Health

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a Final Recommendation for Commission consideration at the July 22, 2026 Public Commission Meeting.

SUMMARY STATEMENT

Johns Hopkins University (JHU), in collaboration with Brown University, requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient and Outpatient) to support a federally-funded study evaluating Maryland's 2019 law requiring all local jails to provide medications for opioid use disorder (MOUD). The NIDA-funded project will assess how expanded MOUD availability in jails affects post-release treatment engagement, opioid-related health outcomes, health care utilization, overdose, and recidivism. The staggered rollout of MOUD programs across Maryland jails offers a natural experiment to evaluate program effectiveness and examine differences across facilities, communities, and demographic groups. Access to HSCRC data will enable analysis of hospitalization patterns, overdose-related encounters, and continuity of care after release. These findings will help determine whether expanded MOUD access reduces overdose risk, improves treatment outcomes, and supports statewide public health goals.

This data request is for Calendar Years 2019–2026. CRISP is linking HSCRC and administrative data from Maryland courts and providing JHU with de-identified study files for analysis. Risks relate primarily to potential breaches of confidentiality; however, JHU maintains extensive safeguards, including encrypted storage, role-based access, secure virtual desktop environments, and compliance with NIST SP 800-171. The identifiable information used for the linkage will remain with CRISP. All study data will be stored within JHU's secure research enclave and destroyed according to NIST SP 800-88 guidelines at project completion, with a Certification of Destruction submitted to HSCRC.

BACKGROUND

The purpose of this request is to enable CRISP-assisted linkage of individuals identified in publicly available Maryland Electronic Courts (MDEC) data to HSCRC's confidential inpatient and outpatient discharge datasets for Calendar Years 2019–2026. The linked data are necessary to evaluate post-release health care utilization and continuity of MOUD, overdose-related hospital and emergency department encounters, health outcomes including fatal overdose, variations across demographic and geographic groups, and differences in outcomes related to the timing and strength of MOUD implementation in Maryland jails. Maryland's 2019 law requiring all local jails to offer methadone, buprenorphine, and naltrexone, alongside screening, counseling, and reentry coordination, was implemented in stages across facilities, creating a natural opportunity to examine program effectiveness, community health impacts after release, and operational factors influencing implementation.

For linkage, the study team will provide CRISP with publicly available MDEC data containing personally identifiable information (PII). CRISP will replace all identifiers with encrypted study IDs and return only de-identified HSCRC data to JHU. No PII will be accessible to investigators. Risks center on potential re-identification if encrypted data were improperly accessed. JHU mitigates this through strong security controls, including secure virtual desktops, firewalls, encrypted storage, multi-factor authentication, and role-based access, all in compliance with NIST, HIPAA, and Maryland requirements. This study provides significant public health value by clarifying how statewide MOUD expansion influences overdose prevention, continuity of care, and health equity. Findings will support evidence-based decision-making for policymakers, correctional partners, and public health agencies.

Johns Hopkins University, Bloomberg School of Public Health received IRB approval and MDH Strategic Data Initiative (SDI) approval on July 1, 2026.

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REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee included representatives from the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to assist HSCRC staff in making recommendations for approval to the Commission at its monthly public meeting:

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee voted unanimously to give Johns Hopkins University, Bloomberg School of Public Health access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request from Johns Hopkins University, Bloomberg School of Public Health for access to the confidential inpatient and outpatient discharge data for Calendar Years 2019 through 2026 be approved.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

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Draft Recommendation:

Accounting and Budget Manual Updates

Effective October 1, 2026

July 22, 2026

This is a draft recommendation for Commission consideration at the July 22, 2026, Public Commission Meeting. Please submit comments on this draft to the Commission by August 12, 2026, via email to Wayne Nelms at Wayne.Nelms2@Maryland.gov

P: 410.764.2605 4160 Patterson Avenue | Baltimore, MD 21215 hscrc.maryland.gov

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Relative Value Units for Labor and Delivery Services

On November 6, 2025, the HSCRC staff convened a dedicated workgroup to review and update the Labor & Delivery Relative Value Units (RVUs) and guidelines for this rate center. The work group comprised key industry stakeholders, including representatives from Maryland Hospitals, the Maryland Hospital Association, Health Insurance Companies, and Hospital Consultants.

The workgroup concluded that the state's technical instructions must be revised to align with recent updates issued by the Centers for Medicare & Medicaid Services (CMS).

Adopting these updated guidelines is critical for several key reasons:

- **Regulatory Alignment and Compliance:** Aligning Maryland's technical instructions with CMS standards ensures consistency with national federal coding and billing frameworks. This prevents regulatory friction and ensures that state reporting metrics remain accurate and comparable on a national scale.
- **Equitable and Accurate Reimbursement:** Labor and Delivery services have evolved significantly with advancements in clinical practice and resource utilization. Updating the guidelines ensures that hospital reimbursement accurately reflects the modern intensity, time, and resources required by clinical staff, thereby protecting the financial viability of maternal health services.
- **Standardization Across Payers:** By involving hospitals, payers, and consultants in the consensus process, these updated guidelines establish a clear, standardized methodology. This transparency reduces administrative burden, minimizes billing disputes, and streamlines the claims review process across all private and public insurance providers.

Additional Accounting and Budget Manual Updates

The HSCRC also engaged I^3 Healthcare Consulting in a multi-year project to assist staff with modernizing the Annual Filing process. The overall goal of the Annual Filing Modernization (AFM) project was to obtain additional information about the operational costs at regulated hospitals to better improve HSCRC oversight. The AFM project consisted of the following workstreams: 1) Physician Allocation; 2) Cost Center Alignment; 3) Overhead Reallocation; 4) Annual Filing Submission; and 5) Revisions to the Accounting and Budget Manual. This Recommendation addresses the Revisions to the Accounting and Budget Manual.

First drafted in the late 1970s and last updated in 2024, the Accounting and Budget Manual (the Manual) has undergone periodic updates over the years. This latest revision focuses on three key objectives:

- **Streamlining Content:** Removing outdated and irrelevant information.
- **Filling Gaps:** Integrating new or missing details.
- **Improving Usability:** Enhancing how readers navigate, view, and search the manual.

A summary of changes to the Manual are as follows:

Section 200 (Chart of Accounts)	Updated language contained in the Anesthesiology section
Section 400 (Reporting Requirements)	Updated the requirements for specific reports and reformatted the section
Section 500 (Reporting Instructions)	Provided an overview of reports, and removed detailed reporting instructions
Section 700 (Appendix D)	Updated language contained in the Labor & Delivery section
Appendix B (Hospital List)	Updated the list of regulated hospitals and added additional reporting details
Appendix C (Cost Center Codes)	Added additional reporting details

Staff Recommendation

1. The Commission approves the revisions to the Accounting and Budget Manual. These revisions are specific to CMS guidelines and the current practices at the HSCRC.

2. The revisions to the Accounting and Budget Manual be effective **October 1, 2026.**

Section 200
Chart of Accounts

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PREFACE

A Chart of Accounts is a listing of account titles, used in the compilation of financial data.

An outline of the required Chart of Accounts for hospitals is presented in this section with a description of the nature and content of each account required to be used and reported. It is recognized, however, that it is impossible to develop a Chart of Accounts that will fulfill all the requirements of all hospitals. Many hospitals will not require the detailed information provided for the Chart of Accounts; others may require even more detailed classification. The Chart of Accounts is designed to provide the basis for a minimum standard of uniform accounting and reporting which will meet the needs of management, regulators, planners, and others.

Hospitals are required to use for reporting purposes all revenue and expense accounts which have capitalized titles.

CONTRACTUAL ADJUSTMENTS - VOLUNTARY

Any difference between a patient's charge and the payment received by the hospital which is as the result of a contract between the hospital and a third-party payor, employee, or employee group whereby the hospital agrees to accept less than approved charges as payment for services rendered shall be charged to Contractual Adjustments - Voluntary. This account shall not include any monies which are as the result of contractual adjustments mandated by Commission approved rate orders. It should additionally be noted that such monies shall not be charged to accounts in such a way as to increase charges to any other patient or payor.

For example, if the Commission approved charge is $100 and the contractual allowance to the patient as the result of a voluntary agreement is $90 and the hospital receives $85, then $10 shall be charged to Contractual Adjustments - Voluntary and $5 shall be charged as a bad debt.

Also, for example, if the approved charge for a service is $200 and the Medicaid- Commission approved discount would result in a normal payment of $188, but that the hospital and Medicaid have entered into an agreement which allows for a payment by Medicaid of $175, then $12 shall be charged to account 5920 and $13 shall be charged to Contractual Adjustments – Voluntary.

HSCRC UNCOMPENSATED CARE FUND

This account is charged with the amount of patient charges paid into, or received from, the HSCRC Uncompensated Care Fund. This account is used to calculate the proper Net Patient Revenue of the reporting hospital

CHARITY/UNCOMPENSATED CARE

Charity/Uncompensated Care-Hill-Burton
Charity/Uncompensated Care-Other

This account is charged with the differential between the amount based on the hospital's full established rates, of charity/uncompensated care patients' bills for hospital services and the amount (if any) to be received from such patients in payment for such services. This differential should be credited directly to the appropriate Accounts Receivable account, rather than to a Contractual Adjustment account, as such charity/uncompensated care discounts are readily determinable. Charges billed and uncollected for medically unnecessary services are not recognized by the Commission, as charity or uncompensated care and should not be charged to these accounts. Amounts resulting from medically unnecessary services should be charged to Administrative, Courtesy and Policy Discounts and Adjustments,

When the hospital receives lump-sum grants or subsidies (rather than specific payments for individual patient's bills) from government or voluntary agencies for the care of medically indigent patients, the amount of the lump-sum or grant or subsidy must be credited to "Restricted Donations and Grants for Indigent Care.

In order to distinguish properly between patients whose uncollectible bills should be considered as charity/uncompensated care write-off and patients whose uncollectible bills should be considered as bad debts, all patients should be classified at the time of admittance, or as soon after as it is possible, being charity/uncompensated (full or partial) paying patients. There may be some instances in which, because of complications unforeseen at the time of admission, the charges made to a patient turn out to be considerably greater than anticipated, and the patient is unable to pay the full amount. In such cases, the patient would be reclassified as a charity/uncompensated care patient, and the charges attributable to the unforeseen complications would be considered charity service. Uncollectible charges made to patients classified as paying patients - except for contractual adjustments, policy discounts and administrative adjustments - should be treated as credit losses, i.e., as bad debts.

PATIENT CARE AND OTHER OPERATING EXPENSE ACCOUNTS-DESCRIPTION

The following pages contain detailed descriptions of the functions or types of activities to be included in each cost center, the name and definition of the applicable standard unit of measure and the data source of the standard unit of measure.

The Standard Unit of Measure must be maintained as defined and tabulated on an actual basis for all cost centers. The data source must be utilized as defined in each account description, for example, the laboratory units must be maintained by the laboratory cost center and may not be obtained from a hospital's billing system.

Standard Unit of Measure

The Standard Unit of Measure is required to provide a uniform statistic for measuring costs. The Standard Unit of Measure for revenue-producing cost centers (Daily Hospital, Ambulatory, and Ancillary Services) attempts to measure the volume of services rendered to patients (productive output). For non-revenue producing cost centers, the Standard Unit of Measure attempts to measure the volume of support services rendered. The Standard Unit of Measure provides a method of determining unit cost and revenue to facilitate cost and revenue comparisons among peer group health facilities.

Standard Units of Measure should not be confused with allocation statistics used to allocate cost of non-revenue producing cost centers to each other and to the revenue-producing centers.

TABLE OF STANDARD UNITS OF MEASURE

This table of Standard Units of Measure has been developed as a quick reference source. For a detailed description of the units of measure, please refer to the appropriate cost center description in this section.

Service Type	Cost Center	Standard Unit of Measure
Daily Hospital Services		
	Medical/Surgical Acute	Number of Patient Days
	Pediatric Acute	Number of Patient Days
	Psychiatric Acute	Number of Patient Days
	Psychiatric Adult - Specialty - Hospitals	Number of Patient Days
	Psychiatric Child/Adolescent - Specialty Hospitals	Number of Patient Days
	Psychiatric Geriatric - Specialty Hospitals	Number of Patient Days
	Obstetrics Acute	Number of Patient Days
	Adolescent Dual Diagnosed – Specialty Hospital	Number of Patient Days
	Definitive Observation	Number of Patient Days
	Medical/Surgical Intensive Care	Number of Patient Days
	Coronary Care	Number of Patient Days
	Pediatric Intensive Care	Number of Patient Days
	Neo-Natal Intensive Care	Number of Patient Days
	Pediatric Step Down	Number of Patient Days
	Pediatric Specialty	# of Procedures
	Burn Care	Number of Patient Days
	Psychiatric Intensive Care	Number of Patient Days
	Other Intensive Care	Number of Patient Days
	Normal Newborns	Number of Normal Deliveries
	Premature Nursery	Number of Premature Patient Days
	Rehabilitation	Number of Patient Days
	Psychiatric Long-Term Care	Number of Patient Days
	Chronic Care	Number of Patient Days
	Residential Care	Number of Patient Days

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Service Type	Cost Center	Standard Unit of Measure
Ambulatory Services		
	Emergency Services	RVUs
	Clinic Services	RVUs
	Clinic Services Primary	RVUs
	Observation Service	Number of Hours
	Ambulance Service Rebundled	RVUs
	Psychiatric Day and Night Care Services	Number of Visits
	Free Standing Emergency Services	Number of Visits
	Same Day Surgery	Number of Patients
	Ambulatory Surgery Procedure	RVUs
	Operating Room – Clinic	Minutes
Ancillary Services		
	Labor and Delivery Services	RVUs
	Operating Room	Number of Surgery Minutes
	Ambulatory Surgery Services	Number of Surgery Minutes
	Anesthesiology	Number of Anesthesia Minutes
	Medical Supplies Sold	EIPA
	Drugs Sold	EIPA
	Laboratory Services	RVUs
	Blood	RVUs
	Electrocardiography	RVUs
	Interventional Cardiovascular	RVUs
	Radiology-Diagnostic	RVUs
	CT Scanner	RVUs
	MRI Scanner	RVUs
	Lithotripsy	Number of Procedures
	Radiology-Therapeutic	RVUs
	Nuclear Medicine	RVUs
	Respiratory Therapy	RVUs
	Pulmonary Function Testing	RVUs
	Electroencephalography	RVUs
	Physical Therapy	RVUs
	Occupational Therapy	RVUs
	Speech-Language Pathology	RVUs
	Recreational Therapy	Number of Treatments

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Service Type	Cost Center	Standard Unit of Measure
Ancillary Services (Con't)		
	Audiology	RVUs
	Other Physical Medicine	Number of Treatments
	Psychiatric/Psychological Services	Number of Treatments
	Renal Dialysis	Number of Treatments
	Organ Acquisition	Number of Treatments
	Leukopheresis	RVUs
	Hyperbaric Chamber	Hours of Treatment
	Transurethral Microwave Thermo Therapy	# of Procedures
	Individual Therapies	Hours
	Group Therapies	Hours
	Family Therapies	Hours
	Activity Therapy	Hours
	Other Therapies	Hours
	Electro-convulsive Therapy	Treatments
	Psychological Testing	Hours
	Education	Hours
Unregulated Services		
	Skilled Nursing Care	Number of Patient Days
	Free Standing Clinic	Number of Visits
	Home Health Services	Number of Visits
	Laboratory-Non Pat.	RVUs
	Renal Dialysis-Outpatient	Number of Treatments
	Physicians-Part B Services	Number of FTE's
	Certified Nurse Anesthetist	Number of CNA Minutes
Other Operating Expenses		
Research		
	Research	Number of Research Projects
Education		
	Nursing Education	Average Number of Nursing Students
	Post-Graduate Teaching Program	Number of FTE Students
	Other Health Profession Education	Average Number of Students
	Community Health Education	Number of Participants

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General Services		
	Dietary Services	Number of Patient Meals
	Cafeteria	Equivalent Number of Meals Served
	Laundry and Linen	Number of Dry and Clean Pounds Processed
	Social Services	Admissions
	Housing	Average Number of Persons Housed
	Plant Operations and Maintenance	Number of Gross Square Feet
	Ambulance Services	Number of Occasions of Service
	Parking	Number of Parking Spaces
	Housekeeping	Hours Assigned
	Central Services and Supply	EIPA
	Pharmacy	EIPA
	Organ Acquisition Overhead	Number of Organs transplanted + # of allogeneic stem cells transplant procedures
Fiscal Services		
	General Accounting	EIPD
	Patient Accounts	Number of Patient Days Plus Outpatient Visits
Administrative Services		
	Hospital Administration	EIPD
	Purchasing and Stores	EIPD
Medical Care Administration		
	Medical Records	Number of Inpatient Discharges plus 1/8 of Total Visits for Emergency Services, Clinic Services, Psychiatric Day Care Services, Freestanding Clinic Services and Freestanding Emergency Services
	Medical Staff Administration	EIPD
	HSCRC Regulated Physicians Part B Services (Non-Medicare)	Number of FTEs
	Physician Support Services	Number of FTEs
	Nursing Administration	Hours of Nursing Services Personnel

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Service Type	Cost Center	Standard Unit of Measure
	Depreciation and Amortization	Not Applicable
	Leases and Rentals	Not Applicable
	Insurance-Hospital and Professional Malpractice	Not Applicable
	Insurance - Other	Not Applicable
	Licenses and Taxes (Other than Income Taxes)	Not Applicable
	Interest-Short Term	Not Applicable
	Interest-Long Term	Not Applicable

DAILY HOSPITAL SERVICES EXPENSES

MEDICAL/SURGICAL ACUTE

Function

Medical/Surgical Acute Care Units provide care to patients on the basis of physicians' orders and approved nursing care plans. Additional activities include, but are not limited to, the following:

> Serving and feeding of patients; collecting sputum, urine, and feces samples; monitoring of vital life signs: operating of specialized equipment related to this function; preparing of equipment and assisting physicians during patient examination and treatment; changing of dressings and cleaning of wounds and incisions: observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed: observing patients for reaction to drugs; administering specified medication: infusing fluids, including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Medical/Surgical acute patients. Included as direct expenses are salaries and wages, employee benefits, professional fees, (non-physician) supplies (non-medical and surgical) purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as the day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PEDIATRIC ACUTE

Function

Pediatric Acute Care Units provide care to Pediatric patients (Children less than 14 years) in Pediatric nursing units on the basis of Physicians' orders and approved nursing care plans. Additional activities include, but are not limited to, the following:

> Serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment and assisting of physicians during patient examination and treatment: changing of dressings and cleaning of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing the patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Pediatric patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Units of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PSYCHIATRIC ACUTE - ACUTE/GENERAL HOSPITALS

Function

Psychiatric Acute Care Units provide care to patients admitted, to acute/general hospitals, for diagnosis as well as treatment on the basis of physicians' orders and approved nursing care plans. The units are staffed with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Additional activities include, but are not limited to the following:

> Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Psychiatric patients in acute/general hospitals. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PSYCHIATRIC ADULT - SPECIALTY HOSPITALS

Function

Psychiatric Adult Care Units provide care to adult patients between the ages of 18 and 64; admitted for diagnosis as well as treatment to private psychiatric hospitals on the basis of physicians' orders and approved nursing care plans. The units are staff with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Additional activities include, but are not limited to the following:

> Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to adult Psychiatric patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PSYCHIATRIC CHILD/ADOLESCENT - SPECIALTY HOSPITALS

Function

Psychiatric Child/Adolescent Care Units provide care to patients under the age of 18, admitted for diagnosis as well as treatment to private psychiatric hospitals on the basis of physician's orders and approved nursing care plans. The units are staffed with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Additional activities include, but are not limited to the following:

> Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to child or adolescent Psychiatric patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PSYCHIATRIC GERIATRIC-SPECIALTY HOSPITALS

Function

Psychiatric Geriatric Care Units provide care to geriatric patients, 65 years of age or older, admitted for diagnosis as well as treatment to private psychiatric hospitals on the basis of physicians' orders and approved nursing care plans. The units are staff with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Additional activities include, but are not limited to the following:

> Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to geriatric Psychiatric patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

OBSTETRICS ACUTE

Function

Obstetrics Acute Care Units provide care to the mother following delivery on the basis of physicians' orders and approved nursing care plans is provided in the Obstetrics Acute Care Unit. Additional activities include, but are not limited, to the following:

> Instruction of mothers in postnatal care and care of newborn; serving and feeding of patients; collecting of sputurn, urine and feces samples; monitoring vital life signs; operating specialized equipment related to this function; preparing equipment and assist physicians in changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering patients' call signals; keeping patients' rooms (personal effects) in order.

Description

The cost center contains the direct expenses incurred in providing daily bedside care to Obstetric patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered a day of admission and counts as one patient day. **A maternity patient in the Labor/Delivery ancillary area at the daily census may not be included in the census count of the Obstetrics Acute Care or other routine care unit unless the patient has occupied an inpatient routine bed at some time since admission. Absent extenuating circumstances, maternity patients are not admitted to this unit prior to delivery.**

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PSYCHIATRIC ADOLESCENT NEUROPSYCHIATRY - SPECIALTY HOSPITALS

Function

Psychiatric Adolescent Neuropsychiatry Unit provide care to adolescent patients who are dual diagnosed; i.e., are diagnosed as mentally retarded/developmentally disabled and are also diagnosed with a psychiatric disorder. The units are staffed with nursing personnel specially trained to care for dual diagnosed patients. Additional activities include, but are not limited to the following:

Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to child or adolescent Psychiatric patients who are mentally retarded/developmentally disabled in addition to being diagnosed with a psychiatric disorder. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

DEFINITIVE OBSERVATION

Function

Definitive Observation is the delivery of care to patients requiring care more intensive than that provided in the acute care areas, yet not sufficiently intensive required to admission to an intensive care area. Patients admitted to this cost center are generally transferred there from an intensive care unit after their condition has improved.

The unit is staffed with specially trained nursing personnel and contains monitoring and observation equipment for intensified, comprehensive observation and care. Additional activities include, but are not limited to the following:

> Serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs operating specialized equipment and assisting physicians during patient examination and treatment; changing dressing and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reactions to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Definitive Observation patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The number of days shall be taken from daily census counts.

Reporting Schedule

Schedule D

MEDICAL/SURGICAL INTENSIVE CARE

Function

A Medical/Surgical Intensive Care Unit provides patient care of a more intensive nature than that provided to the Medical and Surgical Acute patients. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support equipment for patients who, because of shock, trauma, or threatening conditions, require intensified comprehensive observation and care. Additional activities include, but are not limited to, the following:

> Serving and feeding of patients: collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including IVs and blood; answering of patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing intensive daily bedside care to Medical/Surgical Intensive Care patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs, if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

CORONARY CARE

- Myocardial Infarction
- Pulmonary Care
- Heart Transplant
- Other Coronary Care

Function

The delivery of care of a more specialized nature than that provided to the usual Medical, Surgical, and Pediatric patient is provided in the Coronary Care Unit. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open heart surgery or threatening conditions require intensified, comprehensive observation and care. Additional activities include, but are not limited to, the following:

> Serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medications; infusing fluids including IVs and blood; answering patients' call signals; keeping patients rooms (personal effects) in order.

Description

These cost centers contain the direct expenses incurred in providing intensive daily bedside care to Coronary Care patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs, if done in-house) on principal equipment other direct expenses and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to each of these units, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The Number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PEDIATRIC INTENSIVE CARE

Function

A Pediatric intensive care unit provides care to children less than 14 years of age of a more intensive nature than the usual Pediatric Acute level. The units are staffed with specially trained personnel and contain monitoring and specialized support equipment for patients who, because of shock, trauma, or threatening conditions, require intensified, comprehensive observation and care. Additional activities include, but are not limited to, the following:

> Serving and feed of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including IVs and blood; answering patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Pediatric Intensive Care patients. Included in these direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, maintenance costs (maintenance contracts or bio-medical engineers, if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Patients Days

Report patient days of care for all patients admitted to this unit unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered as a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

NEO-NATAL INTENSIVE CARE

Function

A Neo-Natal Intensive Care Unit provides care to newborn infants that are of a more intensive nature than care provided in newborn acute units. Care is provided on the basis of physicians' orders and approved nursing care plans. The units are staffed with specially trained nursing personnel and contain specialized support equipment for treatment of those newborn infants who require intensified, comprehensive observation and care. Additional activities include, but are not limited to the following:

> Feeding infants; collecting sputum, urine and feces samples; monitoring vital life signs; operating specialized equipment needed for this function; preparing equipment and assisting physicians during infant examination and treatment; changing dressings or assisting physicians in changing dressings and cleansing wounds and incisions; bathing infants, observing patients for reaction to drugs; and administering specified medication; infusing fluids including IV's and blood.

Description

This cost center contains the direct expenses incurred in providing intensive daily bedside care to Neo-Natal Intensive Care patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, maintenance costs (maintenance contracts or bio-medical engineers, if done in-house) on principal equipment, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

BURN CARE

Function

A Burn Care Unit provides care to severely burned patients that are of a more intensive nature than the usual acute nursing care provided in medical and surgical units. Burn units are staffed with specially trained nursing personnel and contain specialized support equipment for burn patients who require intensified, comprehensive observation and care. Additional activities include, but are not limited to:

> Serving and feeding of patients: collecting sputum, urine and feces samples; monitoring vital life signs; operating specialized equipment needed for this function: preparing equipment and assisting physicians during patient examination and treatment; changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping them into and out of bed; observing patients for reactions to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering patients' call signals; and keeping patients' room in order.

Description

This cost center contains the direct expenses incurred in providing intensive daily bedside care to Burn Care Patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PSYCHIATRIC INTENSIVE CARE - SPECIALTY HOSPITALS

Function

Psychiatric Intensive Care Units provide care to psychiatric patients which are of a more intensive nature than the usual nursing care provided in routine patient care units in private psychiatric hospitals. The units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who, because of shock, trauma, or threatening conditions, require intensified, comprehensive observation and care. Additional activities include, but are not limited to, the following:

Serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment and assisting physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Psychiatric Intensive Care patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

OTHER INTENSIVE CARE

Shock Trauma
Oncology

Function

Other Intensive Care Units provide patient care of a more intensive nature than that to the Medical and Surgical Acute patients. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support equipment for patients who require intensified comprehensive observation and care. Included are those units not required to be included in other specific intensive care cost centers. The Shock Trauma Unit and Oncology Unit as University of Maryland Hospital and the Oncology unit at the Johns Hopkins Hospital are included in this account. Additional activities include, but are not limited to the following:

Serving and feeding of patients: collecting sputum, urine and feces samples; monitoring vital life signs; operating specialized equipment and assisting physicians during patient examinations and treatment; changing dressings and cleansing wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients for reaction to drugs; administering specified medication; infusing fluids including I.V.'s and blood; answering patients' call signals; keeping patients' rooms (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing intensive daily bedside care to Other Intensive Care patients in those units not required to be included in other specific Intensive Care cost centers. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

NEWBORN NURSERY

Function

Daily care for newborn infants (including "Boarder" babies) is provided in Newborn Nursery Units on the basis of physicians' orders and approved nursing care plans. Additional activities include, but are not limited to, the following:

Feeding infants; collecting sputum, urine and feces samples; monitoring vital life signs; operation of specialized equipment related to this function; preparation of equipment and assistance of physician during infant examination and treatment; changing or assisting physician in changing of dressing and cleansing of wounds and incisions; bathing infants; observing patients for reaction to drugs; administering specified medication; infusing fluids, including I.V.'s and blood.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Newborn Nursery patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Newborn Patient Days

Report patient days of care for all infant patients (including "boarder" babies) admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered a day of admission and counts as one newborn patient day.

Data Source

The number of newborn nursery patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PREMATURE NURSERY

Function

Daily care for premature infants [infants born at any time through the 37th week of gestation (259 days)] is provided in these nursery units on the basis of physicians' orders and approved nursing care plans. Additional activities include, but are not limited to the following:

> Feeding infants; collecting sputum, urine and feces samples: monitoring vital life signs; operating specialized equipment needed for this function; preparing equipment and assisting physicians during infant examination and treatment; changing dressings or assisting physicians in changing dressings and cleansing wounds and incisions; bathing infants; observing patients for reactions to drugs; administering specified medication; infusing fluids, including I.V.'s and blood.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to Premature Nursery patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Newborn Patient Days

Report patient days of care for all infant patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered a day of admission and counts as one newborn patient day.

Data Source

The number of newborn patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

SKILLED NURSING CARE

Medicare-Certified
Medicare-Non-Certified

Function

Skilled Nursing Care is provided to patients on the basis of physicians' orders and approved nursing care plans and consists of care in which the patients require convalescent and/or restorative services at a level less intensive than the Medical, Surgical and Pediatric acute care requirements. This center is sometimes referred to as Extended Care. Additional activities include but are not limited to:

> Serving and feeding of patients; collecting of sputum. urine, and feces samples; monitoring of vital life signs; operating of specialized equipment and assisting physicians during patients' examinations and treatment; changing of dressings and cleaning of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; answering of patients' call signals; keeping patients' room (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to patients requiring extended skilled nursing care usually lasting 30 days or more. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge of death. If both admission, and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule UR

REHABILITATION

Function

The Rehabilitation unit provides care to physically disabled persons requiring coordinated, comprehensive services to enable them to achieve functional goals. Rehabilitation is provided through an integrated program of medical and other services under professional supervision. Additional activities may include but are not limited to:

> Serving and feeding of patients; collecting of sputum, urine, and feces samples; monitoring of vital life signs; operating of specialized equipment and assisting physicians during patients' examinations and treatment; changing of dressings and cleaning wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication: answering of patients' call signals; keeping patients' room (personal effects) in order.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to patients requiring physical rehabilitation services. Included as direct expenses are salaries and wage, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission, and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

PSYCHIATRIC LONG TERM CARE

Function

Medical care nursing services and intensive supervision of chronic mentally ill, mentally disordered, or other mentally incompetent persons is rendered in the Psychiatric Long Term Care Unit.

Description

This cost center contains the direct expenses incurred in providing daily care to Psychiatric Long-Term patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees. (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occurs on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Not Applicable

CHRONIC CARE

Function

Chronic care is the delivery of care to patients requiring constant medical and nursing care by reason of chronic illness or infirmity: or patients who have a chronic disability amenable to rehabilitation. Patients admitted to this unit require close monitoring and observation and continued skilled nursing services. The condition of patients admitted to this unit necessitates care too complex to be provided in a skilled Nursing Facility.

Description

This cost center contains the direct expenses incurred in providing daily bedside care to chronic patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission, and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Schedule D

RESIDENTIAL CARE

Function

Residential Care is the provision of safe, hygienic, sheltered living for residents not capable of fully independent living. Regular and frequent, but not continuous, medical and nursing services are provided. Also included is self-care. Self-care units provide supportive, restorative, and preventive health care for ambulatory patients who are capable of caring for themselves under the supervision of a professional nurse. The unit is used by recovering patients who are making the transition to discharge or by patients who are undergoing tests and medical evaluation who require a minimal amount of nursing supervision. These patients generally eat in a central dining facility and do not require bedside nursing care.

Description

This cost center contains the direct expense incurred in providing residential care to patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Patient Days

Report patient days of care for all patients admitted to this unit, unless discharged or left against medical advice prior to daily census counts. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Data Source

The number of patient days shall be taken from daily census counts.

Reporting Schedule

Not Applicable

AMBULATORY SERVICE EXPENSES

EMERGENCY SERVICES

Emergency Room

Other Emergency Services

Function

Emergency Services provide emergency services to the ill and injured who require immediate medical or surgical care on an unscheduled basis. (See Appendix D for definition of services)

Description

This cost center contains the direct expenses incurred in providing services in the Emergency Department. Direct expenses included are: salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses.

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (See Appendix D of this manual)

Data Source

The number of Relative Value Units shall be the actual count maintained by Emergency Services.

Reporting Schedule

Schedule D

CLINIC SERVICES

Function

Clinics provide organized diagnostic, preventive, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients. Additional activities include, but are not limited to the following:

> Participating in community activities designed to promote health education; assisting in administration of physical examinations and diagnosing and treating ambulatory patients having illness which respond quickly to treatment; referring patients who require prolonged or specialized care to appropriate other services; assigning patients to doctors in accordance with clinic rules; assisting and guiding volunteers in their duties; making patients' appointments through required professional service functions.

Description

The cost centers contain the direct expenses incurred in providing clinic services to ambulatory patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical-surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Relative Value Units

Clinic Relative Value Units as developed by the Health Services Cost Review Commission. A count of visits must also be maintained and reported on Schedule V2. Visits made by clinic patients to ancillary cost centers are not included here but are accumulated in the appropriate ancillary cost center.

Data Source

The number of Relative Value Units shall be the actual count maintained by the formally organized clinic within the hospital.

Reporting Schedule

Schedule D

OBSERVATION

FUNCTION

Observation services are those services furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient. Such services must be ordered and documented in writing as to time and method (FAX, telephone, etc.), given by a medical staff practitioner. Observation services may or may not be provided in a distinct area of the hospital. Notwithstanding the location of the service, all expenses, revenue, statistics, and price compliance must be included in the report of the Observation center. Extended recovery time for scheduled ambulatory surgery patients should be included in the reporting of the Same Day Surgery center. Additional activities include, but are not limited to the following:

Monitoring of vital life signs; collecting sputum, urine, and feces; operating of specialized equipment and assisting physicians during patient examination and treatment; changing of dressings and cleaning of wounds and incisions; observing and recording the emotional stability of patients; observing patients for reaction to drugs; administrating specified medication; and infusing fluids including I.V.s and blood.

Description

This cost center contains the direct expenses incurred in providing bedside care to observation patients. Included as direct expenses are: salaries and wages, employee benefits, non-physician professional fees, non-medical/surgical supplies, purchased services, and other direct expenses and transfers.

Standard Unit of Measure: Hours

Report the number of hours commencing at the time a valid order for observation is made and ending when a valid order to cease observation is made. This service usually does not exceed one day. Some patients may, however, require a second day of observation services. Only in rare and exceptional circumstances should reasonable and necessary observation services span more than 48 hours. The minimum observation time is one hour; any partial hours are rounded to the nearest full hour.

Data Source

The number of hours shall be the total of the actual count of clock hours of observation services provided.

Reporting Schedule

Schedule D

AMBULANCE SERVICES-REBUNDLED

Function

This cost center provides round-trip ambulance services for hospital inpatients from the hospital to the facility of a third-party provider of non-physician diagnostic or therapeutic services. An ambulance is defined as a vehicle that is specifically designed for transporting patients; contains a stretcher, linens, first aid supplies, oxygen equipment and other lifesaving equipment required by State or local laws; and is staffed with personnel trained to provide first aid treatment.

Lifting and placing patient into and out of an ambulance; transporting patients to and from the third party provider.

Description

The cost center contains the direct expenses incurred in providing roundtrip ambulance service to inpatients. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased service, other direct expenses, and transfers.

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by Ambulance Services Cost Center.

Reporting Schedule

Schedule D

PSYCHIATRIC DAY AND NIGHT CARE SERVICES

Function

The Psychiatric Day and Night Care Services provides intermittent care to patients either during the day with the patient returning to his home each night or during the evening and night hours with the patient performing his usual daytime functions.

Description

This cost center contains all the direct expenses of maintaining Psychiatric Day and Night Care Services. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Visits

A visit is each registration of a patient in a formally organized Psychiatric Day and Night Care unit of the hospital. Multiple services performed in the Psychiatric Day and Night Care unit during a single registration, e.g., (encounters with two or more physicians, two or more occasions of services, any combination of one or more encounters and occasions of service) are recorded as one visit.

Data Source

The number of visits shall be the actual count maintained by the Psychiatric Day and Night Care Services Unit.

Reporting Schedule

Schedule D

FREE STANDING EMERGENCY SERVICES

Free Standing Emergency Services provide emergency treatment to the ill and injured who require immediate medical or surgical care on an unscheduled basis at locations other than hospital. Additional activities include, but are not limited to the following:

> Comforting patients; maintaining aseptic conditions; assisting physicians in performance of emergency care; monitoring of vital life signs; applying or assisting physician in applying bandages; coordinating the scheduling of patient through required professional service functions; administering specified medications; and infusing fluids, including I.V.'s and blood.

Description

This cost center contains the direct expenses incurred in providing emergency treatment to the ill and injured. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Visits

A visit is each registration of a patient in the free-standing emergency service unit. Multiple services performed in the free-standing emergency services unit during a single registration, e.g., (encounters with two or more physicians, two or more occasions of service, any combination of one or more encounters and occasions of service) are recorded as one visit. Services provided to emergency patients in ancillary cost centers are not included here but are included in the applicable ancillary cost center.

Data Source

The number of visits shall be the actual count maintained by the Free Standing Emergency Service.

Reporting Schedule

Schedule D

FREE STANDING CLINIC SERVICES

Function

Free Standing Clinics provide organized diagnostic, preventive, curative, rehabilitative and educational services on a scheduled basis to ambulatory patients at locations other than the hospital campus. Additional activities include, but are not limited to, the following:

> Participating in community neighborhood activities designed to promote health education, assisting in administration of physical examinations and diagnosing and treating ambulatory patients having illness which respond quickly to treatment; referring to appropriate other services; assigning patients to doctors in accordance with clinic rules; assisting and guiding volunteers in their duties; making patients appointments through required professional service functions.

Description

This cost center contains the direct expenses incurred in providing clinic services to ambulatory patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), other expenses and transfers.

Standard Unit of Measure: Number of Visits

A visit is each registration of a patient in a free-standing clinic of the hospital. Multiple services performed in a free-standing clinic during a single registration, e.g., (encounters with two or more physicians, two or more occasions of service, any combination of one or more encounters and occasions of service) are recorded as one visit.

Data Source

The number of visits shall be taken from the actual count maintained by the free-standing clinics.

Reporting Schedule

Schedule UR

HOME HEALTH SERVICES

Function

Home Health Services is the provision of care to patient normally at their place of residence. Activities such as the following functions may be performed for patients outside the hospital, nursing care, intravenous therapy, respiratory therapy, electro-cardiology, physical therapy, occupational therapy, recreational therapy, speech pathology, social service, dietary, and housekeeping.

Description

This cost center contains the direct expenses incurred in providing care to patients normally at their place of residence. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, travel to and from the patient's residence, other direct expenses, and transfers.

Standard Unit of Measure: Number of Resident Visits

A home health visit is a personal contract in the place of residence of a patient made for the purpose of providing a service by a member of the staff of the home health agency or by others under contract or arrangement with the home health agency. If a visit is made simultaneously by two or more persons from the home health agency to provide a single service, for which one person supervises or instructs the other, it is counted as one visit (see Example 1). If one person visits the patient s home more than once during a day to provide services, each visit is recorded as a separate visit (see Example 2). If a visit is made by two or more persons from the home health agency for the purpose of providing separate and distinct types of services, each is recorded - i.e., two or more visits (see Example 3). Example 1 - If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, one visit is counted. Example 2 - If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, two visits are counted. However, if the nurse visits the patient in the morning to dress a wound and replace a catheter, one visit is counted. Example 3 - If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, two visits are counted.

Data Source

The number of resident visits shall be the actual count obtained from Home Health Services.

Reporting Schedule

Schedule UR

SAME DAY SURGERY SERVICES

Function

Same Day Surgery Services are provided by specially trained personnel preceding and immediately following same day surgery including monitoring of patients while recovering from anesthesia. Patients requiring more than six hours of recovery time as a result of a major diagnostic procedure are also considered Same Day Surgery patients. Additional services include, but are not limited to the following:

> Registering same day surgery patients. Comforting same day surgery patients in the recovery room and maintaining aseptic techniques, monitoring vital life signs, operating specialized equipment related to this function; administering specified medication, observing patient's condition until all effects of the anesthesia have passed; preparing patients for their release.

Description

This cost center contains the direct expenses incurred in registering patients, preparing patients for surgery or major diagnostic procedures and monitoring of patients while recovering from anesthesia. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, and other direct expenses.

Standard Unit of Measure: Number of Same Day Surgery Patients

A Same Day Surgery patient is defined as a surgical patient who is registered for same day surgery, or a patient who is registered for a major diagnostic procedure who requires, due to the effect of the procedure, more than six hours of recovery time, and who is not subsequently admitted to the hospital.

Data Source

The number of same day surgery patients shall be an actual count maintained by the Same Day Surgery cost center.

Reporting Schedule

Schedule D

ANCILLARY SERVICES EXPENSES

LABOR AND DELIVERY SERVICES

Function

Labor and Delivery services are provided by specially trained personnel to patients in Labor and Delivery, including prenatal care in labor and delivery, including prenatal care in labor assistance in delivery, post-natal care in recovery, and minor gynecological procedures, if performed in the Delivery suite. Additional activities include, but are not limited to, the following:

> Comforting patients in the labor and delivery and recovery rooms; maintaining aseptic techniques; preparing for deliveries and surgery; cleaning up after deliveries to the extent of preparation for pickup and disposal of used linen, gloves, instruments, utensils, equipment, and waste; arranging sterile setup for deliveries and surgery; preparing patient for transportation to delivery and recovery room; enforcing safety rules and standards; monitoring of patients while in recovery.

Description

The cost center contains the direct expenses incurred in providing care to maternity patients in labor, delivery, and recovery rooms. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

Maryland Relative Value Units as determined by the Health Services Cost Review Commission (See Appendix D of this manual). Relative value units for unlisted procedures cannot be estimated and reported to the Commission.

Data Source

The number of Relative Value Units shall be an actual count obtained from medical records, or as maintained by the Labor and Deliver unit.

Reporting Schedule

Schedule D

OPERATING ROOM

General Surgery
Open Heart Surgery
Neurosurgery
Orthopedic Surgery
Kidney Transplant
Other Organ Transplants
Recovery Room
Other Operating Room Services

Function

Surgical Services are provided to inpatients, and outpatients, if the hospital uses a common operating room for both inpatients and outpatients by physicians and specially trained nursing personnel who assist physicians in the performance of surgical and related procedures during and immediately following surgery. Additional activities include, but are not limited to the following:

> Comforting patients in the operating room and recovery room; maintaining aseptic techniques; scheduling operations in conjunction with surgeons, assisting surgeon during operations; preparing for operations; cleaning up after operations to the extent of preparation for pickup and disposal of used linen, gloves, instruments utensils, equipment and waste; assisting in preparing patients for surgery; inspecting, testing and maintaining special equipment related to this function; preparing patients for transportation to recovery room; counting of sponges, needles and instruments used during operation; enforcing safety rules and standards; monitoring of vital life signs; observing patient's condition until all effects of the anesthesia have passed; preparing patient for transportation to acute care or intensive care units.

Description

These cost centers contain the direct expenses incurred in providing surgical services to patients and monitoring of patients while recovering from anesthesia. When a common operating room is used for both inpatients and outpatients, the direct costs for both is to remain in this cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased supplies, maintenance costs (maintenance contracts or bio-medical engineers, if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Surgery Minutes

Surgery minutes are the difference between starting time and ending time defined as follows: Starting time is the beginning of anesthesia administered in the operating room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating room. Ending time is the end of the anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient in the recovery room is not to be counted.

Data Source

The number of surgery minutes shall be an actual count obtained from the operating room log.

Reporting Schedule

Schedule D

AMBULATORY SURGERY SERVICES

Function

Ambulatory Surgery Services are those surgical services provided to outpatients in a discrete outpatient surgical suite by specially trained nursing personnel who assist physicians in the performance of surgical and related procedures both during and immediately following surgery. Additional activities include, but are not limited to, the following:

> Comforting patients in the operating room; maintaining aseptic techniques; scheduling operations in conjunction with surgeons; assisting surgeon during operations; preparing for operations; cleaning up after operations to the extent of preparation for pickup and disposal of used linen, gloves, instruments, utensils equipment, and waste; arranging sterile setup for operation; assisting in preparing patient for surgery; inspecting, testing and maintaining special equipment related to this function; preparing patient for transportation to recovery room; continuing sponges, needles, and instruments used during operation; enforcing safety rules and standards; monitoring patient while recovering from anesthesia.

Description

This cost center contains the direct expenses associated with a separately identifiable outpatient surgery room. When a common operating room is used for both inpatients and outpatients, the direct costs for both must be accumulated in the "Operating Room". Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical and surgical), purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Surgery Minutes

Surgery minutes are the difference between starting time and ending time defined as follows: The starting time is the beginning of anesthesia administered in the operating room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating room. Ending time is the end of anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient in the recovery room is not to be counted.

Data Source

The number of surgery minutes shall be an actual count obtained from the surgery room operating log.

Reporting Schedule

Schedule D

OPERATING ROOM – CLINIC

Function

Surgical services are provided to clinic patients in operating and procedure rooms by physicians assisted by specially trained nursing personnel. Additional activities include, but are not limited to the following:

Comforting patients in the operating or procedure room immediately following surgery; preparing for operations and maintaining aseptic techniques; assisting surgeon during operations; cleaning up after operations; enforcing safety rules and standards; monitoring of vital life signs; and observing patient's condition until all effects of anesthesia have passed.

Description

The cost center contains the direct expenses incurred in-providing surgical services to clinic patients and monitoring of patients while recovering from anesthesia. Included as direct expenses are: non-physician salaries and wages, employee benefits, and professional fees, non-medical surgical supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Surgery Minutes

Surgery minutes is the difference between starting and ending time defined as follows: The starting time is the beginning of anesthesia administered in the operating or procedure room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating or procedure room. Ending time is the end of anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient outside of the operating or procedure room is not counted.

Data Source

The number of surgery minutes shall be the actual count maintained by either the operating room log or the appropriate clinic personnel.

Reporting Schedule

Schedule D

ANESTHESIOLOGY

Function

Anesthesia services are rendered in the hospital by, or under the direction of, either a physician trained in anesthesia or the operating surgeon. Bedside anesthesiology encompasses the administration of anesthesia and sedation for procedures performed outside the traditional operating room, often in intensive care units (ICUs) or other specialized settings. Hospitals must have policies and procedures addressing who may provide anesthesia services in each setting, ensuring compliance with both regulations and recognized standards of anesthesia care.

Description

This cost center contains the direct costs incurred in the administering of anesthesia exclusive of the costs of professional services of physicians and/or certified nurse anesthetists and the appropriate physician supervision. Included as direct expenses are salaries and wages, employee benefits, professional fees (other than physicians and certified nurse anesthetists), supplies, oxygen, gases, purchased services, other direct expenses and transfers. Hospitals that provide anesthesia services must adhere to the Conditions of Participation for Anesthesia Services set by the Centers for Medicare & Medicaid Services (CMS).

Standard Unit of Measure: Number of Anesthesia Minutes

Anesthesia minutes are defined as the difference between starting time and ending time defined as follows: Starting time is the beginning of anesthesia administered in the operating room or bedside. Ending time is the end of anesthesia. The time the anesthesiologist spends with the patient in the recovery room is not to be counted. When anesthesia is administered in Labor and Delivery, such anesthesia minutes shall be counted.

Data Source

The number of anesthesia minutes shall be an actual count maintained by the Anesthesiology cost center.

Reporting Schedule

Schedule D

CERTIFIED NURSE ANESTHETISTS

Function

Anesthesia services are rendered in the hospital by a physician or certified nurse anesthetists under the direction of either a physician trained in anesthesia or the operating surgeon.

Description

This cost center contains salaries, wages and fringe benefits of the certified nurse anesthetists and the physician's supervision costs associated with the administering of anesthesia by certified nurse anesthetists.

Standard Unit of Measure:
Number of Certified Nurse Anesthetists Minutes

Certified Nurse Anesthetist minutes are defined as the difference between starting time and ending time defined as follows: Starting time is the beginning of anesthesia administered by a certified nurse anesthetist in the operating room. Ending time is the time of anesthesia. The time the nurse anesthetist spends with the patient in the recovery room is not to be counted. When anesthesia is administered by a certified nurse anesthetist in the Labor and Delivery Room such certified nurse anesthetist minutes shall be counted.

Data Source

The number of certified nurse anesthetists' minutes shall be an actual count maintained by the Anesthesiology cost center.

Reporting Schedule

Schedule UR

MEDICAL SUPPLIES SOLD

Medical Supplies-Billable

Medical Supplies-Non-Billable

Description

The Medical Supplies Sold cost center is used for the accumulation of the invoice cost of all disposable medical and surgical supplies and equipment used in daily hospital service centers, ambulatory service centers and certain ancillary service centers (Labor and Delivery and Delivery Services, Operating Room, Ambulatory Surgery, Speech-Language Pathology, and Audiology, Interventional Radiology/Cardiovascular, Occupational Therapy, and Physical Therapy). The invoice/inventory cost of non-chargeable disposable supplies and equipment issued by the Central Services and Supplies cost center to patient care cost centers shall be maintained in this cost center. If such items are purchased by patient-care cost center, the invoice cost of preparing and issuing medical and surgical supplies and equipment must be accumulated in the Central Services and Supplies cost center. The cost of reusable (non-disposable) medical and surgical supplies must be accounted for in the Central Services and Supplies cost center. The applicable portion of such overhead will be allocated to this cost center during the cost allocation process.

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

Gross Patient Revenue x Inpatient Admissions (excl. nursery)
Gross Inpatient Revenue

Data Source

Gross Patient Revenue and Gross Inpatient Revenue shall be obtained from the General Ledger. Inpatient Admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule D

DRUGS SOLD

Drugs-Billable
Drugs-Non-Billable

Description

The Drugs Sold cost center is used for the accumulation of the invoice cost of all pharmaceuticals and intravenous solutions used, excluding drugs incident radiology. The cost of drugs incident to radiology, i.e. contrast media etc are to be transferred to the using cost center. The invoice/inventory cost of non-chargeable drugs (pharmaceuticals and I.V. solutions) issued by the Pharmacy to other cost centers shall be maintained in this cost center. If such items are purchased by the using cost centers, the cost of those items must be transferred to this cost center. The overhead cost of preparing and issuing drugs must be accumulated in the Pharmacy cost center The applicable portion of such overhead will be allocated to this cost center during the cost allocation process.

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

Gross Patient Revenue x Inpatient Admissions (Excl. Nursery)
Gross Inpatient Revenue

Data Source

Gross Patient Revenue and Gross Inpatient Revenue shall be obtained from the general ledger. Inpatient Admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule D

LABORATORY SERVICES-REGULATED

Chemistry
Hematology
Immunology (Serology)
Microbiology (Bacteriology)
Procurement and Dispatch
Urine and Feces
Other Clinical Laboratories
Cytology
Histology
Autopsy
Other Pathological Laboratories
Blood-Whole
Blood-Plasma
Blood-Other
Blood Storing and Processing

Function

These cost centers perform diagnostic and routing clinical laboratory tests and diagnostic and routine laboratory tests on tissues and cultures necessary for the diagnosis and treatment of hospital patients. (That is, test on specimens drawn at the hospital.) Additional activities include, but are not limited to, the following:

> Transporting specimens from nursing floors and operating rooms; drawing of blood samples; caring for laboratory animals and equipment; mortuary operation; autopsy; maintenance of quality control standards; preparation of samples for testing.

This cost center also procures and collects whole blood, recruit's donors; processes, preserves stores and issues blood after it has been procured. Additional activities include, but are not limited to the following:

Plasma fractionation; freezing and thawing blood; and maintaining inventory control.

Description

These cost centers contain the direct expenses incurred in the performance of laboratory tests necessary for diagnosis and treatment of hospital patients and diagnostic; routine clinical laboratory tests on tissues and cultures; procuring blood; recruiting donors, processing, storing and issuing whole blood after it has been procured. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts. or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses, and transfers.

This cost center also contains the direct expenses incurred in procuring and drawing blood, recruiting and paying donors; processing, storing and issuing whole blood after it has been procured. Included as direct expenses are: salaries and wages employee benefits, professional fees (non-physician), supplies,

purchased services, other direct expenses and transfers. Include in this cost center the cost of spoiled or defective blood; and the service fee charged by out-side blood sources, whether or not the blood is replaced. Do not include in this cost center the expenses incurred in performing tests on blood (i.e., typing, cross-matching, etc.). These expenses must be charged to Laboratory Services. Do not include in this amount the expenses incurred for blood derivatives. These expenses must be charged to pharmacy. The cost of blood (amount paid or fair market value) is charged to this center, or an inventory account if applicable rather than debited to revenue or cleared through an agency account. When blood is purchased, cost is the amount paid. When blood is donated, cost is its fair market value at the date of donation, and an offsetting credit is made to Donated Blood. If replacement is received by a hospital blood bank, the original amount charged the patient is debited to this cost center and credited to the patient's account (Accounts and Notes Receivable). If replacement blood is received by the hospital from the supplier is debited to the amount due to the supplier (Accounts Payable) and credited to the patient's account (Accounts and Notes Receivable).

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be an actual count maintained by the laboratory.

Reporting Schedule

Schedule D

LABORATORY SERVICES - NON-PATIENT

Function

These cost centers perform diagnostic and routine clinical laboratory tests and diagnostic and routine laboratory tests on tissues and cultures necessary for the diagnosis and treatment of non-hospital patients. (That is, tests on specimens not drawn at the hospital.)

This cost center contains the direct expenses incurred in the performance of laboratory tests necessary for diagnosis and treatment and diagnostic and routine on tissues and cultures for non-hospital patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) or principal equipment, other direct expenses, and transfers.

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be an actual count maintained by the laboratory.

Reporting Schedule

Schedule UR

ELECTROCARDIOGRAPHY

Function

This cost center operates specialized equipment to (1) Record graphically electromotive variations in actions of the heart muscle; (2) Record graphically the direction and magnitude of the electrical forces of the heart's action, (3) Record graphically the sounds of the heart for diagnostic purposes; (4) Imaging; (5) Cardioversion; and/or (6) Tilt Table. Additional activities include, but are not limited to, the following:

> Explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from patient; a patient may remove electrodes and remit recording data from home when appropriate.

This cost center contains the direct expenses incurred in performing electrocardiographic examinations, as well as up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Cost of contrast material is included in this cost center.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be an actual count maintained by the Electrocardiography cost center.

Reporting Schedule

Schedule D

INTERVENTIONAL RADIOLOGY/CARDIOVASCULAR

Function

The Interventional Radiology/Cardiovascular Department provides special diagnostic, therapeutic, and interventional procedures that include the use of imaging techniques to guide catheters and other devices through blood vessels and other pathways of the body.

Description

This cost center shall contain the direct expenses incurred in providing the above function as well as patient registration and up to six hours of recovery time. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), purchased services, maintenance cost (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers. (Disposable D26, Medical Supplies Sold). Cost of contrast material is included in the minute value and should not be assigned separately.

Standard Unit of Measure

IRC minutes are the difference between starting time and ending time plus one minute for each technical Imaging service performed as defined by American Medical Association's (AMA) Current Procedural Terminology (CPT) (i.e. add and additional minute to the start and stop time for each radiology CPT. Start and ending times are defined as follows: Starting time is the beginning of the procedure if general anesthesia is on administered; or the beginning of general anesthesia or conscious sedation administered in the procedure room. Ending time is the removal of the needle or catheter if general anesthesia is not administered; or the end of general anesthesia. In instances where general anesthesia is administered the time the anesthesiologist spends with the patient following the end of the procedure is not to be counted. Sheath removal and hemostasis is considered part of recovery and is not to be counted. Average procedural times are permitted so long as they are validated annually.

Data Source

The number of IRC minutes shall be the actual count maintained by the Interventional Radiology/Cardiovascular Department.

Reporting Schedule

Schedule D

RADIOLOGY-DIAGNOSTIC

Ultrasonography

Radiology-Diagnostic-Other

Function

This cost center provides diagnostic radiology services as required for the examination and care of patients under the direction of a qualified radiologist. Diagnostic radiology services include the patient registration, taking, processing, examining and unofficial interpretation by a non-physician or other qualified medical staff of radiology services defined below, and up to six hours of recovery time. Radiology examinations for this Cost Center include general diagnostic radiology, ultrasound, fluoroscopy and mammography and exclude Computed Tomography, Magnetic Resonance Imaging (MRI and MRA), Radiation Therapy, Nuclear Medicine, and Interventional Radiology/Cardiovascular and Radiology procedures with a surgical component. Additional activities include, but are not limited to, the following:

Consultation with patients and attending physicians; radioactive waste disposal, storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing diagnostic radiology services. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (including Drugs incident to Radiology, i.e. contrast media) etc. purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Radiology Relative Values issued by the Health Services Cost Review Commission. (See Appendix D of this manual.)

Data Source

The number of Relative Value Units shall be the actual count maintained by the Radiology-Diagnostic cost center.

Reporting Schedule

Schedule D

CT SCANNER

Function

The CT Scanner function uses computerized tomography imaging in order to diagnose abnormalities.

Description

This cost center shall contain the direct expenses incurred in providing CT scans, patient registration and up to six hours of recovery time. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, (including Drugs incident to Radiology, i.e. contrast media), purchased services, equipment, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the CT Scanner cost center.

Reporting Schedule

Schedule D

MRI SCANNER

Function

The MRI Scanner function uses magnetic resonance imaging in order to diagnose abnormalities.

Description

This cost center shall contain the direct expenses incurred in providing MRI scans, patient registration and up to six hours of recovery time. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician) supplies, (including Drugs incident to Radiology, i.e. contrast media) etc., purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the MRI Scanner cost center.

Reporting Schedule

Schedule D

LITHOTRIPSY

Function

The Lithotripsy (Extracorporeal Shock Wave Lithotripsy) function provided a non-invasive procedure by which renal and ureteral calculi are pulverized using electrohydraulic shockwaves.

Description

This cost center shall contain the direct expenses incurred in providing Lithotripsy services with up to six hours of recovery time. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Procedures

The procedure is defined as a treatment session. A treatment session may consist of 500 to 1500 shocks. Count only those procedures for which a charge is made.

Data Source

The number of procedures shall be the actual count maintained by the Lithotripsy cost center.

Reporting Schedule

Schedule D

RADIATION-THERAPEUTIC

Function

This cost center provides radiation therapy services as required for the care and treatment of patients under the direction of a qualified radiation oncologist. Therapeutic radiology services include consultation, patient education, physician planning, simulation, dosimetry planning, blocking and shaping, quality assurance, treatment delivery, image guidance, on-treatment assessment, and follow up. Therapeutic radiation may be delivered using a variety of radiation sources including external photon beams, external live radiation source, intracavitary live radiation source, implantable live radiation source, intraoperative radiation, and particle beam therapy. The most common radiation therapy modalities include but are not limited to 3-D conformal treatment ("3-D"), Intensity Modulated Radiation Therapy ("IMRT"), Image Guided Radiation Therapy ("IGRT"), Stereotactic Radiosurgery ("SRS"), Stereotactic Body Radiation Therapy ("SBRT"), brachytherapy, and intraoperative radiation therapy ("IORT"). Details and descriptions of radiation therapy services and terminology can be found on the websites of the Centers for Medicare and Medicaid Services, the National Cancer Institute, and the American Society for Radiation Oncology.

Description

This cost center includes the direct expenses incurred in providing therapeutic radiology services. Included in these direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, facility costs, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Therapeutic Radiology RVUs were assigned using the 2015 CMS Physician Fee Schedule, technical component or global RVUs. The RVU Assignment Protocol is detailed in Appendix D Standard Unit of Measure References.

Data Source

The number of RVUs shall be the actual count maintained by the Therapeutic Radiology cost center.

Reporting Schedule

Schedule D

TRANSURETHRAL MICROWAVE THERMOTHERAPY

Function

This cost center provides Transurethral Microwave Thermotherapy services as required for the care and treatment of patients under the direction of a qualified urologist.

Description

This cost center contains the direct expenses incurred in providing Transurethral Microwave Thermotherapy services. Included in these direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Number of Procedures

Data Source

The number of procedures shall be the actual count maintained by the Transurethral Microwave Thermotherapy cost center.

Reporting Schedule

Schedule D

NUCLEAR MEDICINE

Nuclear Medicine-Diagnostic

Nuclear Medicine-Therapeutic

Function

This cost center provides diagnosis and treatment by injectable or ingestible radioactive isotopes as required for the care and treatment of patients under the direction of a qualified physician. Additional activities include, but are not limited to, the following:

Consultation with patients and attending physician; radioactive waste disposal; storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing nuclear medicine services to patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the Nuclear Medicine Cost Center.

Reporting Schedule

Schedule D

RESPIRATORY THERAPY

Respiratory Therapy is the administration of oxygen and certain potent drugs through inflation of positive pressure and other forms of rehabilitative therapy as prescribed by physicians. This function is performed by specially trained personnel who initiate, monitor, and evaluate patient performance, cooperation and ability during testing procedures. Additional activities include, but are not limited, to the following:

> Assisting physician in performance of emergency care; reviving and maintaining patients' vital life signs; maintaining open airways, breathing and blood circulation; maintaining aseptic conditions; transporting equipment to patients' bedsides; observing and instructing patients during therapy; visiting all assigned patients to ensure that physicians' orders are being carried out; inspecting and testing equipment; enforcing safety rules; and calculating test results.

Description

This cost center contains the direct expenses incurred in the administration of oxygen and other forms of therapy through inhalation. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be the actual count maintained by the Respiratory Therapy cost center.

Reporting Schedule

Schedule D

PULMONARY FUNCTION TESTING

Function

This cost center tests patients through measurement of inhaled and exhaled gases and analysis of blood, and evaluation of the patient's ability to exchange oxygen and other gases. This function is performed by specially trained personnel who initiate, monitor and evaluate patient performance, cooperation, and ability during testing procedures.

Description

This cost center contains the direct expenses incurred in the performance of patient and laboratory testing necessary for diagnostic and treatment of pulmonary disorders. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be an actual count maintained by the Pulmonary Function Testing cost center.

Reporting Schedule

Schedule D

ELECTROENCEPHALOGRAPHY

Function

This cost center provides diagnostic electroencephalography services. Specialized equipment is used to record electromotive variations in brain waves and to record electrical potential variation for diagnosis of muscular and nervous disorders. Additional activities include, but are not limited to, the following:

Wheeling portable equipment to patient's bedside; explaining test procedures to patient; operating specialized equipment; attaching and removing electrodes from patients.

Description

This cost center contains the direct expenses incurred in providing diagnostic electroencephalography services to patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, and other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Diagnostic Neurology Relative Values as determined by the Health Services Cost Review Commission (See Appendix D of this manual.)

Data Source

The number of Relative Value Units shall be the actual count maintained by the Electroencephalography cost center.

Reporting Schedule

Schedule D

PHYSICAL THERAPY

Electromyography

Function

The Physical Therapy cost center provides physical or corrective treatment of bodily or mental conditions by the use of physical chemical and other properties of heat, light, water, electricity, sound, massage, therapeutic exercise under the direction of a physician and/or registered physical therapist. The physical therapist provides evaluation, treatment planning, instruction and consultation. Activities include, but are not limited to the following:

> Application of manual and electrical muscle tests and other evaluative procedures; formulation and provision of therapeutic exercise and other treatment programs; organizing and conducting physical therapy programs upon physician referral or prescription: instructing and counseling patients, relatives, or other personnel; consultation with other health workers concerning a patient's total treatment program; assistance by aides to patients in preparing for treatment and performance of routine housekeeping activities of the physical therapy service.

Description

This cost center contains the direct expenses incurred in maintaining a physical therapy program. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Include the direct costs associated with electromyography for reporting purposes.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted modalities or for procedures should be reasonably estimated on the basis of other comparable modalities or procedures.

Data Source

The number of Relative Value Units shall be the actual count maintained by the Physical Therapy cost center.

Reporting Schedule

Schedule D

OCCUPATIONAL THERAPY - ACUTE/GENERAL HOSPITALS

Function

Occupational Therapy is the supplication of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Specific occupational therapy services include, but are not limited to, education and training in activities of daily living (ADL); the design, fabrication, and the application of splints; sensorimotor activities; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; therapeutic activities enhanced functional performance; prevocational evaluation and training; and consultation concerning the adaptation of physical environments for the handicapped. These services are provided to individuals or groups.

Description

This cost center contains the direct expenses incurred in maintaining an occupational therapy program in acute/general hospitals. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Relative Value Units as determined by the Health Services Cost Review Commission (see Appendix D of this manual).

Data Source

The number of Relative Value Units shall be obtained from an actual count maintained by the Occupational Therapy cost center.

Reporting Schedule

Schedule D

SPEECH-LANGUAGE PATHOLOGY

Function

The Speech-Language Pathology cost center provides evaluation and treatment to persons with impaired speech, language, cognitive-communication, or swallowing function. Speech-Language Pathology includes evaluation, treatment, and establishing plans of care to address areas of need. Specific Speech-Language Pathology services, which shall be implemented or supervised by a licensed speech-language pathologist, include but are not limited to diagnostic assessment and evaluation, treatment, and continued evaluation/periodic re-evaluation.

Diagnostic assessment and evaluation includes clinical appraisal of speech (articulation, voice, fluency, motor speech disorders), deglutition (clinical bedside dysphagia exams and instrumental dysphagia assessments, such as flexible endoscopic examination of swallowing or modified barium swallow studies), language competencies (expressive and receptive language domains), and underlying processes (speech perception, visual perception, motor skills, cognitive skills, memory, attention, etc.) through standardized and informal tests, and hearing screening. Treatment includes planning and conducting treatment programs on an individual or group basis, to develop, restore, improve or augment functional skills of persons disabled in the processes of speech, deglutition, language and/or underlying processes. Continued evaluation/periodic re-evaluation includes both standardized and informal procedures to monitor progress and verify current status.

Additional activities may include but are not limited to preparation of written diagnostic evaluative and special reports; provisions of extensive counseling and guidance individuals and their families; and maintaining specialized equipment utilized in evaluation and treatment such as assistive communication devices and speech prostheses.

Description

This cost center contains the direct expenses incurred in maintaining a Speech-Language Pathology Cost Center. Any expenses related to the sale of speech prostheses or other communication aids and disposable medical supplies must not be included here but accounted for in Medical Supplies Sold cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

Speech- Language pathology RVUs as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted modalities or for procedures should be estimated based on other comparable modalities or procedures.

Data Source

The number of Relative Value Units shall be the actual count maintained by the Speech-Language Pathology cost center.

Reporting Schedule

Schedule D

RECREATIONAL THERAPY - ACUTE/GENERAL HOSPITALS

Function

Recreational Therapy services include the employment of sports, dramatics, arts and other recreational programs to stimulate the patient's recovery rate. Additional activities include, but are not limited to the following:

Conducting and organizing instrumental and vocal musical activities and directing activities of volunteers in respect to these functions.

Description

This cost center contains the direct expenses incurred in maintaining a program of recreational therapy in acute/general hospitals. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Treatments

Count each procedure for which a separate charge is made as one treatment.

Data Source

The number of treatments shall be obtained from an actual count maintained by the Recreational Therapy cost center.

Reporting Schedule

Schedule D

AUDIOLOGY

Function

The Audiology cost center provides and coordinates services to person's age newborns through geriatrics. Audiology evaluates individuals with auditory and vestibular complaints or symptoms (including, but not limited to, impaired hearing, tinnitus, dizziness, imbalance, sound intolerance, delayed speech and language, auditory processing problems, poor educational performance, or failed hearing and/or balance screening results), and aid in the diagnosis of vestibular disease/falls risk leading to vestibular rehabilitation. Audiology diagnoses hearing loss, identifies auditory disorders, and determines the possible etiology of auditory disorders.

Conducted evaluations include, case history (including previous assessments and diagnoses, diagnostic impressions, and management planning); physical examination of the ears and cranial nerve function, gait, and posture; qualitative and/or quantitative classification of communication abilities; assessment and impact of tinnitus and/or decreased sound tolerance; behavioral (psychometric or psychophysical), physical, and electrophysiological tests of hearing, auditory function, balance and vestibular function, and auditory processing that result in the formation of a diagnosis and subsequent management and treatment planning.

Audiologists collaborate with other healthcare providers, patients and their caregivers to integrate information, test results, and treatment recommendations to develop a comprehensive needs assessment for medical, educational, psychosocial, vocational, or other services. They also design and implement programs to prevent the onset or progression of hearing loss and identify individuals exposed to potentially adverse conditions.

Description

This cost center contains the direct expenses incurred in maintaining an Audiology program. The expense related to the sale of hearing aids and disposable medical supplies must not be included here but accounted for in the Medical Supplies Sold cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Audiology Relative Value Units (RVU) as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted services or procedures should be estimated based on other comparable modalities or procedures.

Data Source

The **number** of RVU shall be obtained from an actual count maintained by the Audiology Cost Center.

Reporting Schedule

Schedule D

OTHER PHYSICAL MEDICINE

Function

Other Physical Medicine includes educational and therapeutic activities related to the treatment, habilitation and rehabilitation of patients with neuromuscular and musculoskeletal impairments. Such activities are those not required to be included in the Physical Therapy, Occupational Therapy, Speech Pathology, Recreational Therapy, and Audiology cost centers.

Description

This cost center contains the direct expenses incurred in providing physical medicine activities not specifically required to be included in another cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of treatments

Count each procedure for which a separate charge is made as one treatment.

Data Source

The number of treatments shall be obtained from an actual count maintained by the Other Physical Medicine cost center.

Reporting Schedule

Schedule D

PSYCHIATRIC/PSYCHOLOGICAL SERVICES - SPECIALTY HOSPITALS

Individual Therapy
Group Therapy
Family Therapy
Education
Psychological Testing
Electroconvulsive Therapy
Activity Therapy
Other Psychiatric/Psychological Therapies

Function

This cost center provides psychiatric and psychological services such as individual, group and family therapy to adults, adolescents and families; education; psychological testing; and electroconvulsive therapy.

Description

This cost center contains the direct expenses incurred in providing psychiatric and psychological services. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Hours/Treatments

Count each hour for which the service is provided. For group sessions, count one half hour for each patient participating per hour treatment. For education count one hour per patient for each hour of education. For Electroconvulsive Therapy count treatments.

Data Source

The number of hours/treatments shall be obtained from an actual count maintained by this service.

Reporting Schedules

Individual Therapy	Schedule D
Group Therapy	Schedule D
Family Therapy	Schedule D
Education	Schedule D
Psychological Testing	Schedule D
Electroconvulsive Therapy	Schedule D
Activity Therapy	Schedule D
Other Therapies	Schedule D

RENAL DIALYSIS - INPATIENT

Hemodialysis
Peritoneal Dialysis
Patient Dialysis Training
Other Dialysis

Function

Renal Dialysis is the process of cleaning the blood by the use of an artificial kidney machine or other method. Additional activities include, but are not limited to, the following:

Wheeling portable equipment to patients' bedside; explaining procedures to patient; operating dialysis equipment, inspecting, testing and maintaining special equipment.

Description

This cost center contains the direct expenses incurred in the Inpatient Renal Dialysis cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Treatments

Count each treatment for which separate charge is made as one treatment regardless of the length of treatment.

Data Source

The number of treatments shall be the total actual count maintained by the Renal Dialysis cost center.

Reporting Schedule

Schedule D

RENAL DIALYSIS - OUTPATIENT

Hemodialysis - Outpatient
Peritoneal Dialysis - Outpatient
Patient Dialysis Training
Home Dialysis
Other Dialysis - Outpatient

Function

Renal Dialysis is the process of cleaning the blood by the use of an artificial kidney machine or other method. Additional activities include, but are not limited to, the following:

> Wheeling portable equipment to patients' bedside; explaining procedures to patient; operating dialysis equipment, inspecting, testing and maintaining special equipment.

Description

This cost center contains the direct expenses incurred in the Renal Dialysis cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, other direct expenses and transfers.

This cost center contains the direct expenses incurred in the Outpatient Renal Dialysis cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Treatments

Count each treatment for which separate charge is made as one treatment regardless of the length of treatment.

Data Source

The number of treatments shall be the total actual count maintained by the Outpatient Renal Dialysis cost center.

Reporting Schedule

Schedule UR

ORGAN ACQUISITION

Function

This cost center accumulates the costs of acquisition, storage, and preservation of all solid organs and allogeneic stem cells. This cost center also collects all hospital and physician costs associated with living donor and recipient pre-transplant outpatient services, and recipient and living donor inpatient medical evaluations.

Description

The Organ Acquisition cost center is used for the accumulation of the direct expenses incurred in acquiring, storing, and preserving human solid organs and allogeneic stem cells. The expenses include organ harvesting costs, organ transportation, organ preservation, as well as the cost of all hospital and physician inpatient and outpatient services provided to live donors and recipients in anticipation of a transplant. Such expenses include: hospital costs (but not physicians' costs) associated with harvesting of organs and stem cells from live donors; physician and hospital costs associated with the excision of organs from cadavers; organ importation and transportation costs; organ preservation costs; transplant registry fees; laboratory tests (including tissue typing of receipts and donors); general medical evaluation of recipients and donors (including medical evaluation and management services provided by physicians in their offices); inpatient hospital and physician services associated with the medical evaluation of recipients before admission for transplantation; and the inpatient hospital and physician services associated with the medical evaluation of living donors before admission for harvesting of the organ or stem cells. (The salary, wages, and employee benefits of the transplant coordination staff are excluded)

The direct costs exclusively identified with a specific transplanted organ or stem cells will be allocated to that organ. Other direct costs not identified with a specific transplanted organ or stem cells shall be allocated appropriately to all transplanted organs by organ type. The approved hospital overhead and mark-up shall be allocated to all transplanted organs and stem cells to develop patient charges.

Standard Unit of Measure: Number of Organs Transplanted plus Number of Allogeneic Stem Cells Transplant Procedures

Count each organ transplanted as one and each allogeneic stem transplant procedure.

Data Source

The number of organs transplanted and allegeneic stem cell procedures will be the actual count maintained by the organ acquisition cost center.

Reporting Schedule

Schedule D

OTHER ANCILLARY SERVICES

Leukopheresis
Hyperbaric Chamber

Function

Other Ancillary Services includes services of Leukopheresis and Hyperbaric Chamber. A leukopheresis program is designed to extract blood derivatives from suitable donors for the treatment of various types of cancer. A Hyperbaric Chamber provides treatment for: gas gangrene, decompression sickness, chronic refractory osteomyelitis, soft tissue neurosis and osteomyelitis and compressed skin graft.

Description

This cost center contains the direct expenses incurred in the operation of a leukopheresis center and a hyperbaric chamber. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure:

Leukopheresis: Relative Value Units as established by the Health Services Cost Review Commission. (See Appendix D of this manual.)

Hyperbaric Chamber: Count each hour of patient treatment as one unit.

Data Source

The Relative Value Units for Leukopheresis shall be the count maintained by the Leukopheresis center. The hours of treatment for Hyperbaric Chamber shall be the count maintained by the Hyperbaric Chamber center.

Reporting Schedule

Leukopheresis: Schedule D
Hyperbaric Chamber: Schedule D

RESEARCH

Function

This cost center administers, manages and carries on research projects funded by outside donations, grants and/or the hospital. Additional activities include:

Maintenance of animal house and administration of specific research projects.

Description

This cost center contains the direct expenses incurred in carrying on research in the hospital. Separate cost centers must be maintained for each research activity for which separate accounting is required, either by a grant agreement, contract, or because of restrictions made upon donations. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Research Projects

A research project is any project which was active during the fiscal year.

Data Source

The number of research projects shall be the actual count of active projects maintained by the Research or General Accounting cost center.

Reporting Schedule

Schedule F

PART B PHYSICIANS

Description

Prior to June 30,1985, Medicare paid hospitals for hospital-based physicians as Part A services. Consequently, the HSCRC had two sets of rates for some services, traditional Part A rates and rates for hospital-based physicians. Beginning July 1, 1985, Medicare began paying hospital-based physicians separately. This resulted in the Maryland legislature changing our enabling statute, Health General, Section 19- 201Definitions 1 €(1)(v), to say that physician services that the HSCRC had approved rates on June 30, 1985, were hospital services and the HSCRC continued to have rate setting jurisdiction over them as Part A hospital services. Hospitals were allowed to opt out of HSCRC jurisdiction for these physician services. Almost all hospitals opted out, however some did not.

For those hospitals that did not opt out, data is collected for the creation of rates, though these rates and revenues associated with them are not included in hospital GBRs.

For details of the non-Part B Physicians rate centers for these three, please see Electrocardiography, Emergency Services, and Laboratory Services within this document.

Standard Unit of Measure: RVUs

Relative Value Units as established by the Health Services Cost Review Commission.

Reporting Schedule

Data for these rate centers is not collected as part of the Annual Cost Reports of Revenues, Expenses, and Volumes. Cost data is not collected. Revenue and RVU data for participating hospitals is collected by the HSCRC monthly through the experience data submissions.

EDUCATION EXPENSES

NURSING EDUCATION

Registered Nurses

Licensed Vocational (Practical) Nurses

Function

Hospitals may either operate a School of Nursing or provide clinical training activities for student nurses when the degree is issued by a college or university. Nursing Education is a school for educating Registered Nurses and/or Licensed Vocational (Practical) Nurses. Additional activities include, but are not limited to, the following:

> Selecting qualified nursing students; providing education in theory and practice conforming to approved standards; maintaining personnel records; counseling of students regarding professional, personal and educational problems; selecting faculty personnel; assigning and supervising students in giving nursing care to selected patients; and administering aptitude and other tests for counseling and selecting purposes.

Description

This cost center shall be used to record the direct expenses incurred in, or providing clinical facilities for, the education of Registered Nurses and/or Licensed Vocational (Practical) Nurses. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Nursing Students

The number of Nursing Students in the Nursing Education cost center is defined as the average number of students enrolled during the year.

Data Source

The average number of Nursing Students in this educational program shall be the actual count maintained by the Nursing Education cost center.

Reporting Schedule

Schedule F

POSTGRADUATE MEDICAL EDUCATION - TEACHING PROGI

Approved Teaching Program
Non-Approved Teaching Program

Function

A Postgraduate Medical Education Teaching Program provides an organized program of postgraduate medical clinical education to interns and residents. To be approved, a medical internship or residency training program must be approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. To be approved, intern or residency programs in the field of dentistry in a hospital osteopathic hospital must have the approval of the council on Dental Education of the American Dental Association. Additional activities include, but are not limited to the following:

Selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, and educational problems; and assigning and supervising students.

Description

This cost center shall be used to record the direct expenses incurred in providing an approved organized program of postgraduate medical clinical education. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services. Other direct expenses and transfers. All salaries and stipends paid to interns and residents in approved and non-approved teaching programs must be reflected in this cost center, in the "Salaries and Wages" natural expense classification (.07).

Standard Unit of Measure: Number of FTE Students

The number of FTE students in Postgraduate Medical Education Program is defined as the sum of the actual individual contracted residents and interns multiplied by the percentage of the Base Year that the residents and interns worked at the hospital. Residents and interns are to be reported in two categories: eligible, all authorized interns and residents prior to the first year of their first general specialty board eligibility, up to a maximum of five years, and who are not able to practice their specialty and ineligible, residents after the first year of their first general specialty board eligibility, who can practice their specialty or have been out of medical school more than 5 years.

Data Source

The number of FTE students in the educational program shall be the actual count maintained by the program or general accounting.

Reporting Schedule

Schedule F

OTHER HEALTH PROFESSION EDUCATION

School of Medical Technology
School of X-Ray Technology
School of Respiratory Therapy
Administrative Intern Program
Medical Records Librarian

Function

Other Health Profession Education is the provision of organized programs of medical clinical education other than for nurses (RN and LVN) doctors, and the provision of organized education programs for administrative interns and externs, Medical Records Librarians and other health professionals. Additional activities include, but are not limited to, the following:

> Selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and educational problems; selecting faculty personnel; assigning and supervising students in giving medical care to selected patients; and administering aptitude and other tests for counseling and selection purposes.

Description

These cost centers contain the direct expenses relative to operating health education programs other than nursing and postgraduate medical programs, such as a School of Medical Technology, and other non-in-service education programs such as those listed above. A separate cost center should be established for each program. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Students

The number of students in Other Health Profession Education Programs is defined as the average number of students enrolled during the year.

Data Source

The average number of students in such programs shall be the actual count maintained by each such program.

Reporting Schedule

Schedule F

COMMUNITY HEALTH EDUCATION

Function

Community Health Education is the coordination, development, and presentation of community social and health education programs such as colostomy education, cardiopulmonary resuscitation (CPR) training, anti-smoking campaign, geriatric education, and childbirth training.

Such programs may be presented in the health facility or in community settings to former patients, families of patients, and other interested persons.

Description

This cost center contains the direct expenses incurred by the health facility in coordinating, developing, and presenting social and health education programs to the community. This cost center would not include cost incurred in the presentation of such information to patients. Any fees collected to offset the cost of community education programs is to be credited to Community Health Education Revenue.

Standard Unit of Measure: Number of Participants

Count each person attending one session of the community education program as one participant, regardless of the length of session.

Data Source

The number of participants must be the actual count maintained by the Community Education cost center.

Reporting Schedule

Schedule F

GENERAL SERVICES

DIETARY SERVICES

Function

Dietary Services includes the procurement, storage, processing and delivery of food and nourishment to patients in compliance with Public Health Regulations and physician's orders. Additional activities include, but are not limited to, the following: teaching patients and their families nutrition and modified diet requirements; determining patient food preferences as to type and method of preparation; preparing selective menus for various specific diet requirements; preparing or recommending a diet manual, approved by the medical staff, for use by physicians and nurses; and delivering and collecting food trays for meals and nourishments.

Description

This cost center contains the direct expenses incurred in preparing and delivering food to patients. Infant formula must be charged to the using cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. Also included is Dietary Service's share of common costs of the Cafeteria and Dietary Services cost center. Examples of common costs include salaries of cooks who prepare food for both cost centers, common food costs, common administrative costs, etc. These common costs shall be accumulated in a sub-account of this cost center and distributed (preferably on a monthly basis) to the Dietary and Cafeteria cost centers, based upon the ratio of number of meals served in each cost center. A detailed explanation of the method to be used in computing the number of meals served in the cafeteria is included in the explanation of the Cafeteria Standard Unit of Measure.

Standard Unit of Measure: Number of Patient Meals

Count only regularly scheduled meals (3, 4 or 5 meal schedule) and exclude snacks and fruit juices served between regularly scheduled meals. Also excluded are tube feedings and infant formula.

Data Source

The number of patient meals must be the actual count of patient meals maintained by the Dietary cost center.

Reporting Schedule

Schedule C

CAFETERIA

Function

Cafeteria includes the procurement, storage, processing, and delivery of food to employees and other non-patients in compliance with Public Health Regulations.

Description

This cost center contains all directly identifiable expenses incurred in preparing and delivering food to employees and other non-patients. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, other direct expenses and transfers. Also included is the cafeteria's share of common costs of the Cafeteria and Dietary Services cost centers, which are accumulated in a sub-account of Dietary Services and distributed, preferably on a monthly basis. The cost of edible supplies for vending machines served by the health facility must be included in this cost center.

Standard Unit of Measure: Equivalent Number of Meals Served

To obtain an equivalent meal in a pay cafeteria, divide total cafeteria revenue by the average selling price of a full meal. The average full meal should include meat, potato, vegetable, salad, beverage and dessert. When there is a selection of entrees, desserts and so forth that are available at different prices, use an average in calculating the selling price of a full meal. Count a free meal served as a full meal.

Data Source

Cafeteria revenue must be taken from the general ledger.

Reporting Schedule

Schedule E

LAUNDRY AND LINEN

Function

Laundry and Linen performs the storing, issuing, mending, washing and processing of in-service linens. The services include uniforms, special linens and disposable linen substitutes.

Description

This cost center shall contain the direct expenses incurred in providing laundry and linen services for hospital use, including student, non-paid workers, and employee quarters. Cost of disposable linen must be recorded in this cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Dry and Clean Pounds Processed

Record the weight of linen processed (laundered and dried) plus the equivalent weight of disposable linen substitutes used. Linen is weighed after it has been cleaned and processed. Include uniforms and linen from personnel quarters and employee housing. If linen is not weighed, a conversion from pieces to pounds is allowed. If soiled linen is weighed, divide by 1.1.

Data Source

The number of dry and clean pounds processed (laundered and dried) must be taken from actual counts maintained in the Laundry and Linen cost center. If the hospital uses an outside laundry services, the number of dry and clean pounds processed must be maintained and reported.

Reporting Schedule

Schedule C

SOCIAL SERVICES

Function

The Social Services cost center obtains, analyzes, and interprets social and economic information to assist in diagnosis, treatment and rehabilitation of patients. These services include counseling of staff, patients in case units and group units; participation in development of community social and health programs and community education. Additional activities include, but are not limited to, the following:

> Interviewing patients and relatives to obtain social history relevant to medical problems and planning; interpreting problems of social situations as they relate to medical conditions and/or hospitalization; arranging for post discharge care of chronically ill; collecting and revising information on community health and welfare resources. In private psychiatric hospitals, the function and expenses associated with this service is limited to those involving administration and supervision of social service functions.

Description

This cost center contains the direct expense incurred in providing social services to patients. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Admissions

Record the total number of admissions (excl. nursery) to the hospital.

Data Source

The number of admissions shall be taken from daily patient census counts.

Reporting Schedule

Schedule C

Section 200
Chart of Accounts

HOUSING

- Employee Housing
- Non-Paid Worker Housing
- Student Housing

Function

Housing is the provision of living quarters to hospital employees and non-paid workers; and maintenance of residence for students, including interns and residents, participating in education programs carried on by the hospital.

Description

This cost center shall contain the direct expenses incurred in providing living quarters for hospital employees; non-paid workers; and students involved in educational programs carried on by the hospital. Expenses of on-call room shall be included in this cost center. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Average Number of Persons Housed

Record the number of persons housed each month, regardless of the number of days each person is in the facility. Accumulate the monthly totals and divide by 12 to obtain the average number of persons housed.

Data Source

The average number of persons housed shall be determined from the record of employees housed maintained in the Housing cost center.

Reporting Schedule

Schedule E

PLANT OPERATIONS AND MAINTENANCE

Plant Operations
Plant Maintenance
Grounds
Security
Energy

Function

Plant Operations and Maintenance includes the maintenance and service of utility systems such as heat, light, water, air conditioning, and air treatment (include the expenses incurred for the purchase of electricity, fuel, water, and steam); the maintenance and repair of buildings, parking facilities, and equipment; painting; elevator maintenance; vehicle maintenance; performance of minor renovation of buildings and equipment and maintenance of grounds of the institution, such as landscaped and paved areas, streets on the property, sidewalks, fenced areas and fencing, external recreation areas, and parking facilities. Additional activities include, but are not limited to the following:

> Trash disposal; boiler operation and maintenance; service and maintenance of water treatment facilities; drainage systems and utility transmission systems including all maintenance performed under contract; technical assistance on equipment purchases and installation; coordinating construction; establishing priorities for repairs and utility projects; maintaining the safety and well-being of hospital patients, employees, visitors and protection of the hospital facilities.

Description

This cost center shall contain the direct expenses incurred in the operation and maintenance of the hospital plant and equipment. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, utilities (except telephone and telegraph), other direct expenses and transfers.

Standard Unit of Measure: Amount of Gross Square Feet

Gross square feet are defined as the total floor area of the hospital facility including common areas (hallways, stairways, elevators, lobbies, closets, etc.).

Data Source

The amount of gross square feet shall be taken from current blueprints of the hospital facility or from actual measurement if blueprints are not available.

Reporting Schedule

Schedule C

AMBULANCE SERVICES

Function

This cost center provides ambulance service to the ill and injured who require medical attention on a scheduled and unscheduled basis, with the exception of those ambulance services determined to be Part A hospital services. Additional activities include, but are not limited to, the following:

> Lifting and placing patients into and out of an ambulance; transporting patients to and from the hospital: first aid treatment administered by a physician or paramedic prior to arrival at the hospital.

Description

The cost center contains the direct expense incurred in providing ambulance service to the ill and injured. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Occasions of Service

Ambulance service provided a patient is counted as one occasion of service regardless of special services rendered at the point of pickup or during transport. For example, the administration of oxygen and first aid during the pickup and delivery of the patient would not be counted as a separate occasion of service.

Data Source

The number of occasions of service shall be the actual count maintained by Ambulance Services.

Reporting Schedule

Schedule E

PARKING

Function

Parking includes the provision of parking facilities to patients, physicians, employees and visitors.

Description

This cost center shall contain the direct expenses of parking facilities owned and/or operated by the hospital. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Parking Spaces

For parking structures and parking lots, count the number of parking spaces.

Data Source

The number of parking spaces shall be taken from blueprints of the parking area, or based on actual count if blueprints are not available.

Reporting Schedule

Schedule E

HOUSEKEEPING

Function

This cost center is responsible for the care and cleaning of the interior physical plant, including the care (washing, waxing, stripping) of floors, walls, ceilings, partitions, windows (inside and outside), furniture (stripping, disinfecting and making beds upon discharge), fixtures excluding equipment) and furnishings and emptying of room trash containers, as well as the costs of similar services purchased from outside organizations.

Description

This cost center shall contain the direct expenses incurred for maintaining general cleanliness and sanitation throughout the hospital and other areas serviced (such as student and employee quarters). Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Hours Assigned to Maintain General Cleanliness and Sanitation

The number of hours assigned is the time it assigned to maintain general cleanliness and sanitation of the interior floor area routinely serviced by housekeeping personnel.

Data Source

The number of hours assigned to maintain general cleanliness and sanitation should be taken from the hospitals records.

Reporting Schedule

Schedule C

CENTRAL SERVICES AND SUPPLIES

Function

Central Services and Supplies prepares and issues medical and surgical supplies and equipment to patients and to other cost centers. Additional activities include, but are not limited to, the following:

> Requisitioning and issuing of appropriate supply items required for patient care; preparing sterile irrigating solutions; collecting, assembling, sterilizing, and redistributing reusable items; cleaning, assembling, maintaining, and issuing portable apparatuses.

Description

This cost center contains the direct expenses incurred in preparing and issuing medical and surgical supplies and equipment to other cost centers and to patients. Also included is the expense related to reusable medical and surgical items. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies (non-medical and surgical), reusable medical and surgical supplies, purchased services, other direct expenses and transfers. The invoice cost of all disposable (non-reusable) medical and surgical supplies shall be recorded or transferred to Medical Supplies Sold. For a further discussion refer to Section 100.515 of this manual.

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

$$\frac{\text{Gross Patient Revenue}}{\text{Gross Inpatient Revenue}} \times \text{Inpatient Admissions (Excl. Nursery)}$$

Data Source

Gross Patient Revenue and Gross Inpatient Revenue shall be obtained from the general ledger. Inpatient admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule C

PHARMACY

Function

The Pharmacy procures, preserves, stores, compounds, manufactures packages, controls, assays, dispenses, and distributes medications (including I.V. solutions) for inpatients and outpatients under the jurisdiction of a licensed pharmacist. Pharmacy services include the maintaining of separate stocks of commonly used items in designated areas. Additional activities include, but are not limited to, the following:

> Development and maintenance of formulary established by the medical staff; consultation and advice to medical staff and nursing staff on drug therapy; adding drugs to I.V. solutions; determining incompatibility of drug combinations; stocking of floor drugs and dispensing machines.

Description

This cost center contains the direct expenses incurred in maintaining a pharmacy under the jurisdiction of a licensed pharmacist. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. The invoice cost of pharmaceuticals and intravenous solutions shall be recorded or transferred to Drugs Sold (Account 7150). (For a further discussion refer to Section 100.516 of this manual.)

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

Gross Patient Revenue x Inpatient Admissions (Excl. Nursery)

Gross Inpatient Revenue

Data Source

Gross patient revenue and gross inpatient revenue shall be obtained from the general ledger. Inpatient admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule C

ORGAN ACQUISITION OVERHEAD

Function

This cost center accumulates the direct costs of Transplant Coordination staff.

Description

The Organ Acquisition Overhead cost center contains the direct expenses of the transplant coordination staff. Included as direct expenses are salaries and wages, employee benefits.

Standard Unit of Measure: Number of Organs Transplanted plus Number of Allogeneic Stem Cells Transplant Procedures

Count each organ transplanted and each allegeneic stem cell procedure as one.

Data Source

The number of organs transplanted and allegeneic stem cell procedures will be the actual count maintained by the organ acquisition cost center.

Reporting Schedule

Schedule C

FISCAL SERVICES

GENERAL ACCOUNTING

Function

This cost center performs general accounting (i.e., non-patient billing and accounting) activities of the hospital such as the preparation of ledgers, budgets and financial reports, payroll accounting, accounts payable accounting, plant and equipment accounting, inventory accounting, non-patient accounts receivable accounting (tuition, sales to other institutions), etc.

Description

This cost center shall include the direct expenses incurred in providing the general accounting requirements of the hospital. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchases services, other direct expenses and transfers.

Standard Unit of Measure: Equivalent Inpatient Days

Gross Patient Revenue x Inpatient Days (Excl. Nursery)

Gross Inpatient Revenue

Data Source

Gross patient revenue and gross inpatient revenue shall be obtained from the general ledger. Inpatient days shall be obtained from daily census counts.

Reporting Schedule

Schedule C

PATIENT ACCOUNTS, ADMITTING, AND REGISTRATION

Patient Accounting
Credit and Collection
Cashiering
Inpatient Admitting
Emergency Room Registration
Clinic Registration
Referred Ambulatory Registration
Other Outpatient Registration

Function

The processing of patient charges, including processing charges to patients' accounts, preparing claims, extending credit, collecting accounts receivable, cashiering, and other patient-related billing and accounting activities, is handled by this cost center. Additional activities include interviewing patients and others relative to the extension of credit, checking references and use of outside collection agencies. The admitting of inpatients for hospital services including filling out admission forms, scheduling admission times, accompanying patients to room or service areas after admission and arrangement of admission details is performed by this cost center. All outpatient registration activities are also included here, including emergency, clinic, and referred patients.

Description

This cost center shall include the direct expenses incurred in patient-related credit, billing, and accounting activities; inpatient admitting; and outpatient activities registration. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Number of Patient Days Plus Outpatient Visits

Report patient says of care for all patients (excluding nursery) based on daily census. Include the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day. An outpatient visit is each registration of an outpatient in Emergency Services, Clinic Services, Psychiatric Day and Night Care Services, Free Standing Clinic Services, and Home Health Services; and the registration of referred ambulatory patients.

Data Source

The number of patient days shall be taken from daily census counts. The number of visits shall be the actual count maintained by Emergency Services, Clinic Services, Renal Dialysis, Psychiatric Day and Night Care Services, Free Standing Clinic Services, and Home Health Services.

Reporting Schedule

Schedule C

ADMINISTRATIVE SERVICES

HOSPITAL ADMINISTRATION

- Office of Hospital Administrator
- Governing Board
- Public Relations
- Spiritual Care
- Communications
- Personnel
- Management Engineering
- Health Sciences Library
- Auxiliary Groups
- Fund Raising

Function

Hospital Administration performs overall management and administration of the institution. This function also includes the following activities: public relations, spiritual care, communications, personnel management engineering, health sciences library, auxiliary groups, and fund raising. The function of cost centers 8615 through 8621 are described on the following pages.

Description

This cost center contains the direct expenses associated with the overall management and administration of the institution including those of the Governing Board. The expenses associated with furnishing information for public use in maintaining the hospital's position in the community must be included here. The expenses associated with spiritual care (chaplaincy), communications, personnel, management engineering, health sciences library, auxiliary groups and fund raising must be included here. Care should be taken to ascertain that all costs included in this cost center do not properly belong in a different cost center. For example, expenses chargeable to hospital administration do not include legal fees incurred in connection with the purchase of property (which should be capitalized). Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Equivalent Inpatient Days (EIPD)

Gross Patient Revenue x Inpatient Days (Excl. Nursery)

Gross Inpatient Revenue

Data Source

Gross patient revenue and gross inpatient revenue shall be obtained from the general ledger. Inpatient days shall be obtained from daily census counts.

Reporting Schedule

Schedule C

COMMUNICATIONS

Function

The Communications cost center operates the communications systems within and outside the hospital, including the telephone system, radio and telemetry communications systems, public address systems, closed-circuit television, messenger services and mail processing.

Description

This cost center shall include the direct expenses incurred in carrying on communications (both in and out of the hospital), including the telephone switchboard and related telephone services, messenger activities, internal information systems and mail services. Specific expenses include postage and telephone company charges for equipment and monthly services. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. For reporting purposes, the costs of patient telephones will be transferred to Schedule E6, Patient Telephones.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C

PERSONNEL

Function

Personnel provides adequate staffing of hospital departments and maintain employee satisfaction and morale. Activities include recruitment, employee selection, salary and wage administration, employee health services, fringe benefit program administration, and the premium paid, over the applicable hospital employee costs per hour plus fringe benefits, for temporary personnel procured from non-related temporary help agencies.

Description

This cost center shall be used to record the direct expenses incurred in carrying out the personnel function of the hospital. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. Direct expenses incurred in this center and the temporary personnel premium paid will be reported in Hospital Administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C

MANAGEMENT ENGINEERING

Function

Management Engineering is an administrative service which assists hospital administrators in performing their managerial functions by providing specialized knowledge and skills in the mathematical, physical and social sciences, together with the principles and methods of engineering analysis, development and implementation. Management Engineering performs a wide variety of services including, but not limited to, the following: productivity analysis and improvement; cost containment; planning and control procedures; systems analysis and design; facilities layout; computer sciences and operations research.

Description

This cost center contains the direct expenses incurred by the management engineering function. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. The direct expenses incurred in this cost center will be reported with Hospital Administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C

HEALTH SCIENCES LIBRARY

Function

The Health Sciences Library procures, stores, indexes, classifies, annotates and abstracts books, catalogs, journals and other related published materials principally for medical staff use and reviews library records for completeness and compliance with established standards.

Description

This cost center contains the direct expenses incurred in maintaining a health sciences library. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C

AUXILIARY GROUPS

Function

Costs incurred in connection with hospital-related auxiliary groups including coordinator of auxiliary group activities and special meetings or auxiliary groups conducted by the hospital are maintained in this cost center.

Description

This cost center contains the direct expenses incurred in connection with hospital auxiliary or volunteer groups. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses, and transfers. The direct expenses incurred in this cost center will be reported with Hospital Administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C

FUND RAISING

Function

Fund Raising carries on fund-raising activities such as special luncheons and other meetings and special mailings.

Description

This cost center contains the direct expenses associated with fund raising (both restricted and unrestricted). Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. The direct expenses incurred in this center will be reported with Hospital Administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule C

PURCHASING AND STORES

Function

Purchasing and Stores includes the procuring of supplies, equipment and services necessary to hospital operations, the receipt of supplies and materials from vendors and their routing and distribution to specific using areas and the receipt and central storage of all non-pharmaceutical supplies and materials prior to their issue to using departments. Additional activities include, but are not limited to, the following:

Receipt and processing of requisitions; monitoring of perpetual supply items; obtaining of quotes from selected vendors; and monitoring of receipt of supplies.

Description

This cost center shall contain the direct expenses incurred in providing supplies, equipment and services necessary to hospital operations. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Equivalent Inpatient Days (EIPD)

$$\frac{\text{Gross Patient Revenue}}{\text{Gross Inpatient Revenue}} \times \text{Inpatient Days (Excl. Nursery)}$$

Data Source

Gross patient revenue and inpatient revenue shall be obtained from the general ledger. Inpatient days shall be obtained from daily census counts.

Reporting Schedule

Schedule C

MEDICAL STAFF ADMINISTRATION

MEDICAL RECORDS

Function

Medical Records includes the maintenance of a records system for the use, transportation, retrieval, storage and disposal of patient medical records; and the production of indices, abstracts and statistics for hospital management and medical staff uses. This function also includes tumor registry activities.

Description

This cost center contains the direct expenses incurred in maintaining the medical records function. Also, costs associated with microfilming of medical records shall be included in this account. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure

Number of Inpatient Discharges (excluding nursery) plus one-eighth of total visits for Emergency Services, Clinic Services, Psychiatric Day and Night Care Services, Free Standing Clinic Services and Free-Standing Emergency Services.

Data Source

The number of visits shall be the actual count maintained by the Emergency Services, Clinic Services, Psychiatric Day and Night Care Services, Free Standing Clinic Services and Free-Standing Emergency Services cost centers. The number of discharges shall be the actual count maintained by Medical Records.

Reporting Schedule

Schedule C

MEDICAL STAFF ADMINISTRATION

Medical Photography and Illustration
Medical Staff Administration-Other

Function

This cost center is used to record certain general expenses associated with medical staff administration, such as the salary and related expenses of the Chief of Medical Staff and assigned non-physician employees. This cost center also provides medical photography and illustration services for other cost centers of the hospital. The cost center also includes the function of infection control program.

Description

This cost center contains the expenses associated with medical staff administration and medical photography and illustration and infection control programs. Interns and residents' salaries (or stipends) must not be included here, but rather in the Post Graduate Medical Education-Teaching Program. Compensation paid to physicians (other than Chief of the Medical Staff) must not be included here. Refer to Section 100.552 for the proper distribution of physician compensation. Included as direct expenses are salaries and wages, employee benefits, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Equivalent Inpatient Days (EIPD)

Gross Patient Revenue x Inpatient Days (Excl. Nursery)
Gross Inpatient Revenue

Data Source

Gross patient revenue and gross inpatient revenue shall be obtained from the general ledger, inpatient days will be obtained from daily census counts.

Reporting Schedule

Schedule C

PHYSICIANS PART B SERVICES (REGULATED)

Function

This cost center is used to report the professional component expenses associated with services to non-Medicare hospital patients provided by regulated hospital-based physicians.

Description

This cost center contains professional component expenses associated with regulated hospital-based physicians in accordance with the procedures of section 100.55. Professional component expenses include the applicable percentage of professional fees and of salaries and employee benefits. Interns and Residents' salaries (or stipends) must not be included here but rather in the Post Graduate Medical Educational-Teaching Program.

Standard Unit of Measure: Number of FTEs

The number of FTEs in regulated Physicians Part B Services is defined as the sum of the actual on-site hours worked divided by 2080.

Data Source

The number of FTEs in regulated Physicians Part B Services shall be the actual count maintained by general accounting.

Reporting Schedule

Schedule P2

PHYSICIANS PART B SERVICES (UNREGULATED)

Function

This cost center is used to report the expenses associated with provided by unregulated physicians employed by the hospital.

Description

This cost center contains expenses associated with the provision of unregulated services by physicians reimbursed by the hospital. Expenses include salaries, wages, and employee benefits. Interns and Residents' salaries, (or stipends) must not be included here but rather in the Post Graduate Medical Education-Teaching Program.

Standard Unit of Measure: Number of FTEs

The number of FTEs in unregulated Physicians Part B Services is defined as the sum of the actual hours worked divided by 2080.

Data Source

The number of FTEs in unregulated Physicians Part B Services shall be the actual count maintained by general accounting.

Reporting Schedule

Schedule UR

PHYSICIAN SUPPORT SERVICES

Function

This cost center is used to report the expenses associated with services to hospital patients provided by physician support personnel, Physician Assistants, and Certified Nurse Practitioners when employed by the hospital and not billing patients for their services.

Description

This cost center contains the expenses associated with physician support personnel. Physician Support Services expenses include wages and salaries and employee benefits.

Standard Unit of Measure: Number of FTEs

The number of FTEs in Physician Support Services is defined as the sum of the actual on-site hours worked divided by 2080.

Data Source

The number of FTEs in Physician Support Services shall be the actual count maintained by general accounting.

Reporting Schedule

Schedule P3

NURSING ADMINISTRATION

In-service Education-Nursing
Nursing Administration-Other

Function

Nursing Administration performs the administration and supervision of the nursing function in the hospital including scheduling and transfer of nurses among the services and units, nursing staff supervision, evaluation and discipline. This cost center also includes continuing education of hospital-employed nursing personnel, (i.e., RNs, LPNs, aides, and orderlies) including regularly scheduled classes, in-house seminars and special training sessions.

Description

This cost center shall contain the direct expenses associated with nursing administration and with conducting a nursing in-service education program. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. Supervisors assigned to specific cost centers shall be included in those cost centers on a direct basis. The salaries, wages and fringe benefits paid float personnel shall be recorded in the cost center in which they work. This may be done directly, or they may be recorded originally in the Float Nursing Personnel cost center and distributed (preferably at the end of each payroll period) to using cost centers based upon hours worked. If the latter method is used, all salaries, wages and fringe benefits of float personnel must be transferred out of the "Float" Nursing Personnel cost center. Any idle time would be allocated together with actual hours worked. Scheduling and other administrative functions relative to float personnel are considered costs of Nursing Administration. If hospital employees in other nursing activities, their salaries, wages and fringe benefits shall be separated based upon number of hours spent in each activity and distributed to the appropriate cost centers, preferably after each payroll period. This cost center shall not include costs related to in service student time. These costs must remain in the cost center in which the student works.

Standard Unit of Measure: Hours of Nursing Service Personnel

The hours of nursing service personnel shall include RNs, LPNs, aides, orderlies and other under the supervision of Nursing Administration.

Data Source

The hours of nursing personnel shall be calculated from payroll data.

Reporting Schedule

Schedule C

UNASSIGNED EXPENSES

DEPRECIATION AND AMORTIZATION
- Land Improvements
- Buildings and Improvements
- Leasehold Improvements
- Fixed Equipment
- Intangibles
- Movable Equipment

Functions

Depreciation and Amortization is a cost center for recording depreciation and amortization expenses on land improvements, buildings and improvements, leasehold improvements, fixed equipment, intangibles and movable equipment.

Depreciation

This cost center contains depreciation and amortization expenses on land improvements, buildings and improvements, leasehold improvements, fixed equipment, intangibles and movable equipment. All such expenses must remain in this cost center.

Standard Unit of Measure

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

LEASES AND RENTALS

- Land
- Buildings and Improvements
- Fixed Equipment
- Movable Equipment

Function

Leases and Rentals is a center for the recording of leases and rental expenses on land, buildings and improvements, fixed equipment and movable equipment.

Description

This cost center contains all lease and rental expenses relating to land, building and improvements, fixed equipment and movable equipment. All lease and rental expenses are to remain in this cost center.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

INSURANCE - HOSPITAL AND PROFESSIONAL MALPRACTICE

Function

This cost center is used to record all hospital and professional malpractice insurance expenses.

Description

This cost center contains the expense incurred in maintaining hospital and professional liability insurance policies.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

INSURANCE-OTHER

Function

This cost center is used to record all insurance expenses except malpractice insurance, UIC, Workman's Compensation and employee benefit insurance.

Description

This cost center contains the expenses incurred in maintaining all insurance policies except professional and hospital malpractice insurance, UIC, Workman's Compensation and employee benefit insurance. For example, fire, theft, employee fidelity bonds, liability (non-professional), property damage, auto, boiler, and business interruption would be included here.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

LICENSES AND TAXES (OTHER THAN INCOME TAXES)

Function

This cost center is used to record all business license expenses incidental to the operation of the hospital, all other license expense, and all taxes (other than on income).

Description

This cost center contains the business license expense, other license expense (including unassigned permits), tax expense which are incidental to the operating of the hospital. Fees paid to a city and/or county (or other governmental unit except the State Tax Board) for doing business in city and/or county must be recorded in this cost center.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

INTEREST - SHORT TERM

Function

This cost center is used to record all interest incurred on borrowings for working capital purposes.

Description

This cost center contains the interest expense relating to borrowings for hospital operations. Interest incurred on mortgage notes and other borrowings for the acquisition of equipment must not be included in this cost center. Interest on borrowings during construction phases must be treated in accordance with Section 100.286 of this manual.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

INTEREST - LONG TERM

Function

This cost center contains all interest incurred on capital, mortgages and other loans for the acquisition of property, plant and equipment.

Description

This cost center contains all interest expense incurred on capital, mortgages, and other loans for the acquisition of property, plant, and equipment. This includes the interest on the current portion of long-term debt.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

MEDICAL CARE REVIEW

PSRO

Other Medical Care Review

Function

This cost center is used to record the expenses incurred in the conducting of ongoing evaluation of the quality of care given and includes periodic review of the utilization of the bed facilities, and of the diagnostic, nursing therapeutic resources of the hospital, with respect to both the availability of these resources to all patients in accordance with their medical need and the recognition of the medical practitioner's responsibility for the costs of health care. This review should cover necessity of admission, length of stay, level of care, quality of care, utilization of ancillary services, professional services furnished, effectiveness of discharge planning and the availability and alternate use of out of hospital facilities and services. Three review programs may be included in this center: Pre-admission screening, concurrent review (including admission certification and continued stay review) and retrospective medical care evaluation studies. The review committee should include medical staff, hospital administration, nurses and home health planners.

Description

This cost center contains the expenses associated with medical care review programs. Included as direct expenses are salaries and wages, employee benefits, supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule UA

HOLDING ACCOUNTS

CENTRAL PATIENT TRANSPORTATION

Function

Central Patient Transportation is the transporting of patients between services in and about the hospital. This does not include the transportation of patients to the hospital. This control cost center is provided for those hospitals wishing to identify the cost of this service. However, all costs in this cost center must be transferred to the appropriate Ancillary Services Cost Center for reporting purposes.

Description

This cost center shall contain the direct expenses incurred in central patient transportation only if there is an established central patient transportation cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. These costs shall be reclassified to Ancillary Services Cost Centers. See Section 100.519 for a further discussion.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Applicable Ancillary Services Cost Centers.

NURSING FLOAT PERSONNEL

Function

To record the expenses of nursing personnel who work in more than one cost center on a "float" basis.

Description

The expenses of nursing personnel who work in more than one cost center on a "float" basis must be recorded in the cost center in which they work. This may be done directly, or may be recorded originally in this account and distributed (preferably at the end of each payroll period) to using cost centers based upon hours worked in each cost center. Any expenses attributable to nursing float personnel, including on call and standby must be distributed based upon actual hours worked by the individual nurses during the applicable payroll period. Scheduling and other administrative functions relative to float personnel are considered costs of nursing administration.

Standard Unit of Measure:

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Appropriate D Schedules

EMPLOYEE BENEFITS

Function

This cost center may be used to record payroll-related employee benefits. This cost center is provided for those hospitals wishing to identify the cost of this service. However, all costs in this cost center must be closed out for reporting purposes to the other functional cost centers as specified in sub-section .513 of section 100.

Description

This cost center is a holding account for payroll-related employee benefits expense. Included in payroll-related employee benefits are FICA, SUI, vacation, holiday, and sick leave, group health insurance, group life insurance, pension and retirement, and workmen's compensation insurance.

Standard Unit of Measure:

No unit of measure is prescribed since this cost center must have a zero balance for reporting purposes.

Data Source

Not Applicable

Reporting Schedule

Schedule C

Schedule D

Schedule E

Schedule F

Schedule P2

Schedule P3

Schedule P4

Schedule OADP

DATA PROCESSING

Function

The Data processing cost center performs the operation of the hospital's electronic data processing system, including input, storage and safeguarding of data, operating data processing equipment, data processing job scheduling, distributing output and identifying and solving hardware and software problems.

Description

This cost center shall contain the costs incurred in operating an electronic data processing center. Included as direct expenses are salaries and wages, employee benefits, professional fees, supplies, purchased services, other direct expenses and transfers. Expenses incurred in the operation of terminals of the EDP center throughout the hospitals shall be included in the Data Processing cost center. However, outside service bureau costs directly chargeable to a specific routine or ancillary service cost center shall be included in that specific cost center in the "Purchased Services - Data Processing" natural classification (.75). Outside service bureau costs benefiting more than one cost center shall be included in the Data Processing cost center.

Standard Unit of Measure

Not Applicable

Data Source

Not Applicable

Reporting Schedule

Schedule OADP
Schedule C
Schedule D
Schedule E
Schedule F

NON-OPERATING REVENUE AND EXPENSE

Non-Operating revenue and expenses include those revenues and expenses not directly related to patient care, related patient services, or the sale of related goods. The following items are indicated:

GAINS OR LOSSES ON SALE OF HOSPITAL PROPERTY

This account is credited for gains and debited for losses arising as a result of the disposal of hospital property.

Reporting Schedule

UNRESTRICTED CONTRIBUTIONS

All contributions, donations, legacies, and bequests, which are made to the hospital without restrictions by the donors, must be credited to this account. When a hospital receives contributions in significant amounts, such contributions should be clearly described and fully disclosed in the income statement.

Reporting Schedule

DONATED SERVICES

Many hospitals receive donated services of individuals. Fair value of donated services must be recorded when there is the equivalent of an employer-employee relationship and an objective basis for valuing such services. The value of services donated by organizations may be evidenced by a contractual relationship which may provide the basis of valuation. Donated Services are most likely to be recorded in a hospital operated by a religious group. If members of the religious group are not paid (or are paid less than the fair value of the services rendered) the lay-equivalent value of their services (or the difference between lay-equivalent value of services rendered and compensation paid) must be recorded as the expense in the cost center in which the service was rendered with the credit to this account.

Reporting Schedule

Various Schedules

INCOME, GAINS AND LOSSES FROM UNRESTRICTED INVESTMENTS

Income, and gains and losses from investments of unrestricted funds must be recorded in this account.

Reporting Schedule

UNRESTRICTED INCOME FROM ENDOWMENT FUNDS

This account is credited with the unrestricted revenue and net realized gains on investments of endowment funds.

Reporting Schedule

UNRESTRICTED INCOME AND OTHER RESTRICTED FUNDS

This account is credited with the revenue and net realized gains on investments of restricted funds (other than endowment funds) if the income is available for unrestricted purposes.

Reporting Schedule

TERM ENDOWMENT FUNDS BECOMING UNRESTRICTED

When restricted endowment funds become available for unrestricted purposes, they must be reported in this account.

Reporting Schedule

TRANSFERS FROM RESTRICTED FUNDS FOR NON-OPERATING REVENUE

This account reflects the amounts of transfers from restricted funds to match non-operating expenses in the current period for restricted fund activities.

Reporting Schedule

DOCTORS' PRIVATE OFFICE RENTAL REVENUE

This account is credited with the revenue earned from rental of office space and equipment to physicians and other medical professionals for use in their private practice.

Reporting Schedule

Schedule E

OFFICE AND OTHER RENTAL REVENUE

This account is credited with rentals received from other than doctors, other medical professionals and other non-retail rental activities for office space located in the hospital and for other rental of property, plant and equipment not used in hospital operations.

Reporting Schedule

Schedule E

RETAIL OPERATIONS REVENUE

This account must be credited with revenue earned from other retail operations such as gift shop, barber shop, beauty shop, drug store, or newsstand located in space owned by the hospital.

Reporting Schedule

Schedule E

OTHER NON-OPERATING REVENUE

This account is credited with non-operating revenue not specifically required to be included in the above accounts, including unrestricted tax revenue and funds appropriated by governmental entities.

Reporting Schedule

DOCTORS' PRIVATE OFFICE RENTAL EXPENSES

This account contains the expenses incurred in connection with the rental of office space and equipment to physicians, and other medical professionals for use in their private practice.

Reporting Schedule

Schedule E

OFFICE AND OTHER RENTAL EXPENSE

This cost center contains the expenses incurred in connection with the rental to other than physicians, other medical professionals and non-retail rental activities.

Reporting Schedule

Schedule E

RETAIL OPERATIONS EXPENSE

This cost center contains the expense incurred in connection with retail operations such as gift shop, barber shop, drug store, beauty shop or newsstand.

Reporting Schedule

Schedule E

OTHER NON-OPERATING EXPENSES

This cost center contains non-operating expenses not specifically required to be included in the above accounts.

Reporting Schedule

EXTRAORDINARY ITEMS

Cost Centers should be used to segregate extraordinary items from the results of ordinary operations and to disclose the nature thereof. Each hospital is to follow "Generally Accepted Accounting Principles" (GAAP) to determine when items are to be considered extraordinary.

Reporting Schedule

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APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
DIAGNOSTIC RADIOLOGY

Preface

This document provides a reference for standard units of measure for Ancillary and Ambulatory services provided.

Diagnostic Radiology, Ultrasound, and Vascular

Approach

Diagnostic-Radiology Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the Non-Facility Practice Expenses (PE) RVU. ("RVU Assignment Protocol")

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only (such as treatment codes), the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g., CMS Status Code "C")
    a. CPT 70170, 74190, 74235, 74300, 74301, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74450, 74470, 744885, 74740, 74742, 75801, 75803, 75805, 75807, 75810, 75894, 75952, 75954, 75956, 75957, 75958, 75959, 75970, 76930, 76932, 76940, 76941, 76945 and 76975 did not have a published RVU in the MPFS. As these codes are reported with a surgical code, these procedures should be reported under Interventional Radiology/Cardiovascular.
    b. CPT 74420 did not have a published RVU in the MPFS. The work group agreed the work activity associate with this code is similar to CPT 74415. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 74420.
    c. CPT 74445 did not have a published RVU in the MPFS. The work group agreed that this code is priced similar to CPT 74415 by various state Medicaid agencies. Given the similarity in pricing it was determined the same RVU should be applied to CPT 74445.
    d. CPT 74775 did not have a published RVU in the MPFS. The group agreed that this code is priced similar to CPT 74455 by various state Medicaid agencies. Given the similarity

in pricing it was determined the same RVU should be applied to CPT 74775. Note: 74455 is moving to IRC but its federal RVU was used for 74775.

e. CPT 76001 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 76000. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 76001.
f. CPT 76125 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 76120. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 76125.
g. CPT 76140 did not have a published RVU in the MPFS. This code is a professional fee and weighted at 0.
h. CPT 76496, 76499 and 76999 did not have a published RVU in the MPFS. As these codes are for unlisted procedures, the group agreed these codes should be considered "By Report" and RVUs should be developed using the guidelines below.
i. CPT 76998 does not have a published RVU in the MPFS. As this service is for guidance, the group agreed to mirror fluoroscopic guidance CPT 76000 (11 RVUs).
j. CPT 77061 did not have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 77063. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77061.
k. CPT 77062 did have a published RVU in the MPFS. The group agreed the work activity associated with this code is similar to CPT 77063. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77062.
l. CPT 77065 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 26 RVUs to mirror HCPCS code G0206.
m. CPT 77066 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 34 RVUs to mirror HCPCS code G0204.
n. CPT 77067 did not have a published RVU per the MPFS. This code is not valid for Medicare reporting purposes as Medicare requires a HCPCS code for this service. Therefore, RVUs will be established at 28 RVUs to mirror HCPCS code G0202.
o. CPT 93315, 93317 and 93318 did not have a published RVU in the MPFS. The group agreed that these codes should be reported under the Electrocardiology section of Appendix D.
p. CPT 93895 did not have a published RVU in the MPFS. This service is non-covered by Medicare and should be developed "By Report" following the protocol listed below.
q. CPT 93998 did not have a published RVU in the MPFS. As this code are for unlisted procedures, the group agreed these codes should be considered "By Report" and RVUs should be established using the guidelines below.
r. HCPCS code C9744 did not have a published RVU in the MPFS. This code is similar to CPT 76705; however, testing time is approximately double. A factor of 1.88 to account for additional testing time will be applied to the RVU value for CPT 76705 and will be assigned 34 RVUs (1.88 x 18= 33.84).
s. HCPCS R0070 and R0075 did not have a published RVU in the MPFS. The group agreed that these codes were not diagnostic and therefore were excluded from Appendix D.

3. CPT/HCPCS codes for which the published RVU did not make sense,
    a. G0365 is a level II HCPCS associated with other vessel mapping services. To allow flexibility for reporting this service to all payers, it will be listed as "By Report."

Services with Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 that accompany a surgical CPT have been labeled as Interventional Radiology/Cardiovascular (IRC) and should be reported via the IRC rate center. When a Radiology CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as IRC, and the associated costs of the procedure are to be reclassified to the IRC cost center.

Labor & Delivery Imaging

CPT codes that are listed in both Radiology and Labor & Delivery (e.g., Obstetrical Ultrasound) are to be charged based on where performed and the personnel performing the procedure. Procedures performed by Radiology staff are to be charged through Radiology and procedures performed by Labor & Delivery staff are to be charged through Labor & Delivery

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the FY 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided

compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e., 1XXXX – 6XXXX) and being performed in the imaging suite, these services are not "By Report", they are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVUs will be strictly tied to the CPT code.No additional RVUs are to be added to portable procedures regardless of when or where the service is performed.
All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any Radiology- Diagnostic examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU

CPT CODE	DESCRIPTION	RVU's
70010	Myelography, posterior fossa, supervision and interpretation only	IRC
70015	Cisternography, positive contrast, supervision and interpretation only	26
70030	Radiological exam, eye, for detection of foreign body	5
70100	Radiological exam, mandible, partial, less than four views	7
70110	Radiological exam, mandible, complete, minimum four views	7
70120	Radiological exam, Mastoids, less than three views per side	7
70130	Radiological exam, Mastoids complete, minimum of three views per side	10
70134	Radiological exam, Internal auditory meati, complete	10
70140	Radiological exam, Facial bones, less than three views	5
70150	Radiological exam, Facial Bones complete, minimum of three views	8
70160	Radiological exam, Nasal bones, complete, minimum of three views	7
70170	Dacryocystography, Nasolacrimal duct, radiological supervision and interpretation	IRC
70190	Radiological exam, Optic foramina	7
70200	Radiological exam, Orbits, complete, minimum of four views	8
70210	Radiological exam, Sinuses, paranasal, less than three views	6
70220	Radiological exam, Sinuses, paranasal complete, minimum of three views	7
70240	Radiological exam, Sella turcica	6

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CPT CODE	DESCRIPTION	RVU's
70250	Radiological exam, Skull, less than four views	7
70260	Radiological exam, Skull complete, minimum of four views	8
70300	Radiological exam, Teeth, single view	2
70310	Radiological exam, Teeth partial examination, less than full mouth	8
70320	Radiological exam, Teeth complete, full mouth	11
70328	Temporomandibular joint, open and closed mouth, unilateral	6
70330	bilateral	10
70332	Temporomandibular joint arthrography, radiological supervision and interpretation	IRC
70350	Cephalogram (orthodontic)	3
70355	Orthopantogram	3
70360	Neck, soft tissue examination	5
70370	Pharynx or larynx, including fluoroscopy	17
70371	complete dynamic pharyngeal and speech evaluation by cine or video recording	13
70380	Salivary gland for calculus	7
70390	Sialography, supervision and interpretation only	IRC
71010	Radiological exam, chest, single view, frontal	4
71015	Radiological exam, chest, stereo, frontal	5
71020	Radiological exam, chest, 2 views, frontal & lateral	5
71021	Radiological exam, chest, 2 views, frontal & lateral w, apical lordotic procedure	6
71022	Radiological exam, chest, 2 views, frontal & lateral w, oblique projections	7
71023	Radiological exam, chest, 2 views, frontal & lateral, w, fluoroscopy	12
71030	Radiological exam, chest, complete, minimum of 4 views	7
71034	Radiological exam, chest, complete, minimum of 4 views, w, fluoroscopy	17
71035	Radiological exam, chest, special views, (e.g., lateral, decubitus, Bucky studies)	7
71100	Radiological exam, Ribs, unilateral, 2 views	6
71101	Radiological exam, Ribs, unilateral, including posteroanterior chest, minimum of 3 views	6
71110	Radiological exam, Ribs, bilateral, 3 views	7
71111	Radiological exam, Ribs, bilateral, including posteroanterior chest, minimum of 4 views	9
71120	Radiological exam, Sternum, minimum of 2 views	5
71130	Sternoclavicular joint or joints, minimum of 3 views	7
72020	Radiological exam, spine, single view, specify level	4
72040	Radiological exam, spine, cervical, 2 or 3 views	6

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CPT CODE	DESCRIPTION	RVU's
72050	Radiological exam, spine, cervical, 4 or 5 views	8
72052	Radiological exam, spine, cervical, 6 or more views	11

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CPT CODE	DESCRIPTION	RVU's
72070	Radiological exam, spine, thoracic, 2 views	6
72072	Radiological exam, spine, thoracic, 3 views	7
72074	Radiological exam, spine, thoracic, minimum 4 views	8
72080	Radiological exam, spine, thoracolumbar junction, minimum 2 views (to report thoracolumbar junction one view see CPT 72020)	5
72081	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis eval); one view	7
72082	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis eval); 2 or 3 views	13
72083	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis eval); 4 or 5 views	14
72084	Radiological exam, spine, entire thoracic & lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis eval); minimum 6 views	17
72100	Radiological exam, spine, lumbosacral, 2 or 3 view(s)	7
72110	Radiological exam, spine, lumbosacral, minimum 4 views	9
72114	Radiological exam, spine, lumbosacral, complete, including bending views, minimum of 6 views	13
72120	Radiological exam, spine, lumbosacral, bending views only, 2 or 3 views	8
72170	Radiological exam, pelvis, 1 or 2 view(s)	6
72190	Radiological exam, pelvis, minimum 3 view(s)	8
72200	Radiological exam, sacroiliac joints, less than three views	5
72202	Radiological exam, sacroiliac joints, 3 or more views	7
72220	Radiological exam, sacrum and coccyx, minimum of two views	5
72240	Myelography, cervical, supervision and interpretation only	IRC
72255	Myelography, thoracic, supervision and interpretation only	IRC
72265	Myelography, lumbosacral, supervision and interpretation only	IRC
72270	Myelography, entire spine canal, supervision and interpretation only	IRC
72275	Epidurography, radiological supervision and interpretation (includes 77003)	IRC

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CPT CODE	DESCRIPTION	RVU's
72285	Discography, cervical or thoracic, radiological supervision and interpretation	IRC
72295	Discography, lumbar, radiological supervision and interpretation	IRC
73000	Radiological exam, clavicle, complete	5
73010	Radiological exam, scapula complete	6
73020	Radiological exam, shoulder, one view	4
73030	Radiological exam, shoulder, complete, minimum 2 views	5
73040	Radiological exam, shoulder, arthrography, supervision and interpretation only	IRC
73050	Radiological exam, acromioclavicular joints, bilateral, w, or w, o weighted distraction	7
73060	Radiological exam, humerus, minimum two views	6
73070	Radiological exam, elbow, 2 views	5
73080	Radiological exam, elbow complete, minimum of three views	6
73085	Radiologic examination, elbow, arthrography, radiological supervision and interpretation	IRC
73090	Radiological exam, forearm, 2 views	5
73092	Radiological exam, forearm, upper extremity, infant, minimum of 2 views	5
73100	Radiological exam, wrist, 2 views	6
73110	Radiological exam, wrist complete, minimum of 3 views	7
73115	Radiological examination, wrist, arthrography, radiological supervision and interpretation	IRC
73120	Radiological exam, hand, minimum of 2 views	5
73130	Radiological exam, hand minimum of 3 views	6
73140	Radiological exam, finger(s), minimum of 2 views	7
73501	Radiological exam, hip, unilateral, w, pelvis when performed; 1 view	6
73502	Radiological exam, hip, unilateral, w, pelvis when performed; 2 to 3 views	8
73503	Radiological exam, hip, unilateral, w, pelvis when performed; minimum 4 views	10
73521	Radiological exam, hips, bilateral, w, pelvis when performed; 2 views	8
73522	Radiological exam, hips, bilateral, w, pelvis when performed; 3 to 4 views	9
73523	Radiological exam, hips, bilateral, w, pelvis when performed; minimum of 5 views	11
73525	Radiologic examination, hip, arthrography, radiological supervision and interpretation	IRC
73551	Radiological exam, femur, 1 view	5
73552	Radiological exam, femur, minimum 2 views	6
73560	Radiological exam, knee, 1 or 2 views	6
73562	Radiological exam, knee, 3 views	7
73564	Radiological exam, knee, complete, 4 or more views	8
73565	Radiological exam, both knees, standing, anteroposterior	8

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CPT CODE	DESCRIPTION	RVU's
73580	Radiological exam, knee, arthrography, supervision and interpretation only	IRC
73590	Radiological exam, tibia and fibula, 2 views	6
73592	Radiological exam, tibia and fibula, lower extremity, infant, minimum of two views	5
73600	Radiological exam, ankle, 2 views	6
73610	Radiological exam, ankle complete, minimum of 3 views	6
73615	Radiological examination, ankle, arthrography, radiologic supervision and interpretation	IRC
73620	Radiological exam, foot, 2 views	5
73630	Radiological exam, foot, complete, minimum of 3 views	6
73650	Radiological exam, calcaneus, minimum of 2 views	5
73660	Radiological exam, toe(s), minimum of 2 views	6
74000	Radiological exam, abdomen, single anteroposterior view	4
74010	Radiological exam, abdomen, anteroposterior and additional oblique and cone views	7
74020	Radiological exam, abdomen, complete, including decubitus and, or erect views	7
74022	Radiological exam, complete acute abdomen series, including supine, erect, and, or decubitus views, single view chest	8
74190	Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation	IRC
74210	Radiological exam, pharynx and, or cervical esophagus	17
74220	Radiological exam, esophagus	18
74230	Swallowing function, with cineradiography, videoradiography	28
74235	Removal of foreign body(s), esophageal, with use of balloon catheter, radiologic supervision and interpretation	IRC
74240	Radiological exam, gastrointestinal tract, upper, w, or w, o delayed films, without KUB with and without delayed films, with KUB	22
74241	Radiological exam, gastrointestinal tract w, or w, o delayed films, with KUB	23
74245	Radiological exam, gastrointestinal tract, upper, w, small intestines, includes multiple serial images	35
74246	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high-density barium, effervescent agent, with or without glucagon, with or without delayed films, without KUB	26
74247	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high-density barium, effervescent agent, with or without glucagon, with or without delayed films, with KUB	30
74249	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high-density barium, effervescent agent, with or without glucagon, with or without delayed films, without KUB; w, small intestine follow-through	39

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CPT CODE	DESCRIPTION	RVU's
74250	Radiological exam, small intestines, includes multiple serial images	22
74251	Radiological exam, small intestines, includes multiple serial images via enteroclysis tube	108
74260	Duodenography hypotonic	89
74270	Radiological exam, colon, barium enema w, or w, o KUB	32
74280	Radiological exam, colon; air contrast with specific high-density barium, w, or w, o glucagon	46
74283	Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (e.g., meconium ileus)	30
74290	Cholecystography, oral contrast	15
74300	Cholangiography and, or pancreatography; intraoperative, radiological supervision and interpretation	IRC
74301	additional set intraoperative, radiological supervision and interpretation	IRC
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	IRC
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	IRC
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	IRC
74340	Introduction of long gastrointestinal tube (e.g., Miller-Abbott) with multiple fluoroscopies and films	IRC
74355	Percutaneous placement of enteroclysis tube, radiological supervision and interpretation	IRC
74360	Intraluminal dilation of strictures and, or obstructions (eg esophagus) radiological supervision and interpretation	IRC
74363	Percutaneous transhepatic dilation of biliary duct structure w, or w, o placement of stent, radiological supervision & interpretation	**IRC**
74400	Urography (pyelography), intravenous, w, or w, o KUB, w or w, o tomography	IRC
74410	Urography, infusion, drip technique and, or bolus technique	24
74415	Urography, infusion, drip technique and, or bolus technique, with nephrotomography	31
74420	Urography, retrograde, w, or w, o KUB	31
74425	Urography, antegrade (pyleostogram, nephrostogram, loopogram) supervision and interpretation only	IRC
74430	Cystography, contrast or chain, minimum of 3 views, supervision and interpretation only	IRC
74440	Vasography, vesiculography, epididymography, radiological supervision and interpretation only	IRC
74445	Corpora cavernosography, radiological supervision and interpretation	31
74450	Urethrocystography, retrograde, radiological supervision and interpretation only	IRC

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CPT CODE	DESCRIPTION	RVU's
74455	Urethrocystography, voiding, radiological supervision and interpretation only	IRC
74470	Radiological exam, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation only	IRC
74485	Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretation	IRC
74710	Pelvimetry, with or without placental localization	5
74740	Hysterosalpingogram, supervision and interpretation only	IRC
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation	IRC
74775	Perineogram (e.g., vaginogram, for sex determination or extent of anomalies)	18
75600	Aortography, thoracic, without serialography, radiological supervision and interpretation	IRC
75605	Aortography, thoracic, by serialography, radiological supervision and interpretation	IRC
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	IRC
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	IRC
75658	Angiography, brachial, retrograde, radiological supervision and interpretation	IRC
75705	Angiography, spinal, selective, radiological supervision and interpretation	IRC
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	IRC
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	IRC
75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	IRC
75731	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	IRC
75733	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	IRC
75736	Angiography, pelvic, selective or supraselective, radiological supervision and interpretation	IRC
75741	Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation	IRC
75743	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation	IRC
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	IRC
75756	Angiography, internal mammary, radiological supervision and interpretation	IRC
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	IRC
75801	Lymphangiography, extremity only, unilateral, radiological supervision and interpretation	IRC
75803	Lymphangiography, extremity only, bilateral, radiological supervision and interpretation	IRC
75805	Lymphangiography, pelvic, abdominal, unilateral, radiological supervision and interpretation	IRC

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CPT CODE	DESCRIPTION	RVU's
75807	Lymphangiography, pelvic, abdominal, bilateral, radiological supervision and interpretation	IRC
75809	Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation	IRC
75810	Splenoportography, radiological supervision and interpretation	IRC
75820	Venography, extremity, unilateral, radiological supervision and interpretation	IRC
75822	Venography, extremity, bilateral, radiological supervision and interpretation	IRC
75825	Venography, caval, inferior, with serialography, radiological supervision and interpretation	IRC
75827	Venography, caval, superior, with serialography, radiological supervision and interpretation	IRC
75831	Venography, renal, unilateral, selective, radiological supervision and interpretation	IRC
75833	Venography, renal, bilateral, selective, radiological supervision and interpretation	IRC
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation	IRC
75842	Venography, adrenal, bilateral, selective, radiological supervision and interpretation	IRC
75860	Venography, venous sinus (eg, , petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	IRC
75870	Venography, superior sagittal sinus, radiological supervision and interpretation	IRC
75872	Venography, epidural, radiological supervision and interpretation	IRC
75880	Venography, orbital, radiological supervision and interpretation	IRC
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation	IRC
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation	IRC
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation	IRC
75891	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation	IRC
75893	Venous sampling through catheter, with or without angiography (eg, for, for parathyroid hormone, renin), radiological supervision and interpretation	IRC
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	IRC

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CPT CODE	DESCRIPTION	RVU's
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	IRC
75901	Mechanical removal of pericatheter obstructive material (eg, fibrin, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation	IRC
75902	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation	IRC
75952	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation	IRC
75953	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery, aneurysm, pseudoaneurysm, dissection, radiological supervision and interpretation	IRC
75954	Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation	IRC
75956	Endovascular repair of descending thoracic aorta (eg, aneurysm, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	IRC
75957	Endovascular repair of descending thoracic aorta (eg, aneurysm, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	IRC
75958	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	IRC
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	IRC
75970	Transcatheter biopsy, radiological supervision and interpretation	IRC
75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary, genitourinary system, abscess), radiological supervision and interpretation	IRC

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CPT CODE	DESCRIPTION	RVU's
75989	Radiological guidance (, US or CT) for percutaneous drainage (e.g., abscess, specimen collection) w, placement of catheter, radiological supervision and interpretation	IRC
76000	Fluoroscopy (separate procedure- other than 71034 or 71023) up to 1 hour physician or other qualified health care professional time (e.g., cardiac fluoroscopy)	11
76001	Fluoroscopy, more than 1 hour physician or other qualified health care professional time, assisting a non-radiological physician or other qualified health care professional (e.g., Nephrosto-lithotomy, ERCP, bronchoscopy, transbronchial biopsy)	11
76010	Radiologic exam from nose to rectum for foreign body, single view, child	5
76080	Radiological exam, abscess, fistula or sinus tract study, radiological supervision and interpretation	8
76098	Radiological exam, surgical specimen	2
76100	Radiologic exam, single plane, body section (eg. tomography) other than w, urography	17
76101	Radiological examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	27
76102	Radiological examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral	39
76120	Cineradiography, videography, except where specifically included	18
76125	Cineradiography, videography to complement routine examination	18
76140	Consultation on x-ray examination made elsewhere, written report	0
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; not requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	By Report
76499	Unlisted diagnostic radiographic procedure (see guidelines)	By Report

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CPT CODE	DESCRIPTION	RVU
76506	Echoencephalography, real time w, image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities) including A-mode encephalography as secondary component were indicated	24
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter	23
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only, performed during the same patient encounter	14
76512	Ophthalmic ultrasound, diagnostic; B-scan (w, or w, o superimposed non-quantitative A-scan) performed during the same patient encounter	11
76513	Ophthalmic anterior segment ultrasound, diagnostic; immersion (water bath) B-scan or high resolution biomicroscopy performed during the same patient encounter	17
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness) performed during the same patient encounter	1
76516	Ophthalmic biometry by ultrasound, echography, A-scan	13
76519	Ophthalmic biometry by ultrasound, echography, A-scan w, intraocular lens power calculation	15
76529	Ophthalmic ultrasonic foreign body localization	13
76536	Ultrasound soft tissue of head and neck (thyroid, parathyroid, parotid), real-time w, image documentation	25
76604	Ultrasound chest (includes mediastinum) real-time w, image documentation	17
76641	Ultrasound breast, unilateral, real-time w, image documentation includes axilla when performed; complete	20
76642	Ultrasound breast, unilateral, real-time w, image documentation includes axilla when performed; limited	15
76700	Ultrasound, abdominal, real-time w, image documentation; complete	23
76705	Ultrasound, abdominal, real-time w, image documentation; limited (i.e., single organ, quadrant, follow-up)	18
76706	Ultrasound, abdominal aorta, real time w/ image documentation, screening study for abdominal aortic aneurysm (AAA)	19
76770	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time w, image documentation; complete	22
76775	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time w, image documentation; limited	8
76776	Ultrasound, transplanted kidney, real time & duplex doppler w, image documentation;	34

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CPT CODE	DESCRIPTION	RVU
76800	Ultrasound, spinal canal and contents	23
76801	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, first trimester (<14 wks 0 days) transabdominal approach; single or first gestation	21
76802	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, first trimester (<14 wks 0 days) transabdominal approach; each additional gestation	6
76805	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, after first trimester (> or = 14 wks 0 days) transabdominal approach; single or first gestation	26
76810	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic examination, transabdominal approach; each addt'l gestation	12
76811	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic exam, transabdominal approach; single or first gestation	24
76812	Ultrasound, pregnant uterus, real-time w, image documentation, fetal and maternal eval, plus detailed fetal anatomic exam, transabdominal approach; each additional gestation	32
76813	Ultrasound, pregnant uterus, real-time w, image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	17
76814	Ultrasound, pregnant uterus, real-time w, image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation	8
76815	Ultrasound, pregnant uterus, real-time w, image documentation, limited (eg fetal heartbeat, placental location, fetal position and, or qualitative amniotic fluid volume), 1 or more fetus	15
76816	Ultrasound, pregnant uterus, real-time w, image documentation, follow-up (eg re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach , per fetus	20
76817	Ultrasound, pregnant uterus, real-time w, image documentation; transvaginal	17
76818	Fetal biophysical profile; w, non-stress testing	20
76819	Fetal biophysical profile; w, o non-stress testing	14
76820	Doppler velocimetry, fetal; umbilical artery	6

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CPT CODE	DESCRIPTION	RVU
76821	Doppler velocimetry, fetal; middle cerebral artery	16
76825	Echocardiography, fetal, cardiovascular system, real-time w, image documentation (2D); w, or w, o M-mode recording	55
76826	Echocardiography, fetal, cardiovascular system, real-time w, image documentation (2D); w, or w, o M-mode recording; follow-up or repeat study	35
76827	Doppler Echocardiography, fetal pulsed wave and, or continuous wave w, spectral display; complete	13
76828	Doppler Echocardiography, fetal pulsed wave and, or continuous wave w, spectral display; follow-up or repeat study	7
76830	Ultrasound, transvaginal	25
76831	Endovaginal introduction of the saline enhanced endometrium	IRC
76856	Ultrasound pelvic (non-obstetric) real time w, image documentation; complete	21
76857	Ultrasound pelvic (non-obstetric) real time w, image documentation; limited or follow-up (e.g., follicles)	7
76870	Ultrasound scrotum and contents	10
76872	Ultrasound, transrectal	17
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning	26
76881	Ultrasound, extremity, non-vascular, real-time w, image documentation; limited; complete	25
76882	Ultrasound, extremity, non-vascular, real-time w, image documentation; anatomic specific	3
76885	Ultrasound, infant hips, real-time w, image documentation; dynamic; (requiring physician or other healthcare prof. manipulation)	31
76886	Ultrasound, infant hips, real-time w, image documentation; limited; static; (NOT requiring physician or other healthcare prof. manipulation)	22
76930	US guided aspiration of pericardium	IRC
76932	US guided endomyocardial biopsy	IRC
76936	US scan to localize and therapeutically compress a pseudo-aneurysm	IRC
76937	US guided for vascular access requiring US eval., of potential access sites, vessel patency, visualization of vascular needle entry w, permanent recording and reporting	IRC

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CPT CODE	DESCRIPTION	RVU
76940	US guidance for & monitoring of parenchymal tissue ablation	IRC
76941	US guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	IRC
76942	US guidance for needle placement (eg. Biopsy, aspiration, injection, localization device), imaging supervision and interpretation	IRC
76945	US guidance for chorionic villus sampling, imaging supervision and interpretation	IRC
76946	US guidance for amniocentesis, imaging supervision and interpretation	IRC
76948	US guidance for aspiration of ova, imaging supervision and interpretation	IRC
76965	US guidance for interstitial radioelement application	IRC
76970	Ultrasound study follow-up (specify)	21
76975	Gastrointestinal endoscopic ultrasound, supervision and interpretation	IRC
76977	US bone density measurement and interpretation, peripheral site(s); any method	1
76998	Ultrasonic guidance, intraoperative	11
76999	Unlisted ultrasonic procedure (e.g., diagnostic)	By Report
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	IRC
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) ** NOTE surgical &, or injection codes listed depends on anatomical location	IRC
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)	IRC
77053	Mammary ductogram or galactogram, single ducts, radiological supervision and interpretation	11
77054	Mammary ductogram or galactogram, multiple ducts, radiological supervision and interpretation	15
77061	Digital breast tomosynthesis; unilateral	7
77062	Digital breast tomosynthesis; bilateral	7
77063	Screening digital breast tomosynthesis; bilateral (list separately in addition to code for primary procedure)	7

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CPT CODE	DESCRIPTION	RVU
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	26
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	34
77067	Screening mammography, bilateral (2 view study of each breast), including computer-aided detection (CAD) when performed	28
77071	Manual application of stress performed by physician or other qualified healthcare professional for joint radiography; including contralateral joint if indicated	9
77072	Bone age studies	4
77073	Bone length studies (orthoroentgenogram)	6
77074	Radiologic examination, osseous survey, limited (eg. for metastasis)	12
77075	Radiologic examination, osseous survey; complete (axial and appendicular skeleton)	17
77076	Radiologic examination, osseous survey, infant	17
77077	Joint survey, single view, one or more joints (specify)	6
77080	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)	9
77081	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; appendicular skeleton (e.g., hips, pelvis, spine)	5
77085	Dual-energy X-ray absorptiometry (DXA) bone density study, 1 or more sites; appendicular skeleton (e.g., hips, pelvis, spine) including vertebral fracture assessment	11
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	7

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CPT CODE	DESCRIPTION	RVU
93880	Duplex scan of extracranial vessels complete bilateral study	46
93882	Duplex scan of extracranial vessels, unilateral or limited study	29
93886	Transcranial doppler study of the intracranial arteries; complete	65
93888	Transcranial doppler study of the intracranial arteries; limited	35
93890	Transcranial doppler study of the intracranial arteries; vasoreactivity study	66
93892	Transcranial doppler study of the intracranial arteries; emboli detection w, o intravenous microbubble injection	76
93893	Transcranial doppler study of the intracranial arteries; emboli detection w, intravenous microbubble injection	81
93895	Quantitative carotid intima media thickness and carotid atheroma eval; bilateral	
93922	Limited bilateral non-invasive physiologic study of Upper or Lower extremities arteries; (eg, for lower extremity: ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle, brachial indices at distal posterior tibial and anterior tibial, dorsalis pedis arteries w, transcutaneous oxygen tension measurement at 1-2 levels	21
93923	Complete bilateral non-invasive physiologic studies of Upper or Lower extremities arteries; 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurement at 3 or more levels, or single level study with provocative functional maneuvers (eg, measurements with postural provocative test, or measurements with reactive hyperemia)	32
93924	Non-Invasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing (i.e. bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle, brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study	41
93925	Duplex scan of lower extremity arteries or arterial bypass grafts, complete bilateral study	62

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CPT CODE	DESCRIPTION	RVU
93926	Duplex scan of lower extremity arteries or arterial bypass grafts, unilateral or limited study	36
93930	Duplex scan of upper extremity arteries or arterial bypass grafts, complete bilateral study	47
93931	Duplex scan of upper extremity arteries or arterial bypass grafts, unilateral or limited study	29
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	46
93971	Duplex scan of lower extremity veins including responses to compression and other maneuvers, unilateral or limited study	28
93975	Duplex scan of arterial inflow or venous outflow of abdominal, Pelvic and, or scrotal contents and, or retroperitoneal organs; complete study	63
93976	Duplex scan of arterial inflow or venous outflow of abdominal, Pelvic and, or scrotal contents and, or retroperitoneal organs; limited study	35
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature or bypass grafts, complete study	43
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature or bypass grafts, unilateral or limited study27	27
93980	Duplex scan of arterial inflow and venous outflow of penile vessels, complete study	17
93981	Duplex scan of arterial inflow and venous outflow of penile vessels, follow-up or limited study	15
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording analysis of pressure and waveform tracings, interpretation and report	9

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CPT CODE	DESCRIPTION	RVU
93990	Duplex scan of hemodialysis access including arterial inflow, body of access and venous outflow	38
93998	Unlisted noninvasive vascular diagnostic study	By Report
C9744	Ultrasound, abdominal, with contrast	34
G0365	Vessel mapping of vessels for hemodialysis access	By Report
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema (Medicare reporting only)	46
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema (Medicare reporting only)	46
G0121	Colorectal cancer screening: colonoscopy on individual not meeting criteria for high risk (Medicare reporting only)	53
G0130	Single energy x-ray absorptiometry (sexa) bone density study, on ore more sites, appendicular skeleton (peripheral) (e.g.,, radius, wrist, heel) (Medicare reporting only)	6
G0202	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed (Medicare reporting only)	28
G0204	Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral (Medicare reporting only)	34
G0206	Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral (Medicare reporting only)	26
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206) (Medicare reporting only)	7

Nuclear Medicine

Approach

Nuclear Medicine Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the Non-Facility Practice Expense (PE) RVU. ("RVU Assignment Protocol")

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.

2. CPT codes that do not have RVUs listed in the MPFS (e.g., CMS Status Code "C")
    a. CPTs 78099, 78199, 78299, 78399, 78499, 78599, 78699, 78799 and 78999 did not have a published RVU in the MPFS. As these codes are for an unlisted procedure, RVUs should be developed "By Report" following the protocol below in the section "CPT Codes without an Assigned RVU Value."
    b. CPT 78267 did not have a published RVU in the MPFS. Due to its similarity to CPT 78270 in time and resources, it was assigned 26 RVUs.
    c. CPT 78268 did not have a published RVU in the MPFS. As time and resources used are about one-half of CPT 78267, it was assigned 13 RVUs.
    d. CPT 78282 did not have a published RVU in the MPFS. CMS APC weights for this code are similar to other gastrointestinal codes that are assigned approximately 2.5 RVUs per the MPFS, it was assigned 25 RVUs.
    e. CPT 78351 did not have a published RVU in the MPFS. Due to its similarity to CPT 78350 in time and resources, it was assigned 6 RVUs.
    f. CPT 78414 did not have a published RVU in the MPFS. Due to its similarity to CPT 78320 in assigned CMS APC weights, it was assigned 52 RVUs.
    g. CPTs 0331T and 0332T are new technology CPTs and did not have published RVUs in the MPFS. 0331T will mirror 78453 (74 RVUs) as workload is comparable and 0332T will mirror 78452 (115 RVUs) due to comparable workload.

h. CPTs 78459, 78491, 78492, 78608, 78609, 78811, 78812, 78813, 78814, 78815 and 78816 did not have a published RVU in the MPFS. The workgroup agreed that two (2) RVUs per minute for average testing plus an additional one (1) RVU per minute to account for machine cost and other resources is a reasonable basis for establishing RVUs for PET scans for a total of 3 RVUs per minute as follows:

CPT CODE	AVERAGE TESTING TIME	RVUS
78459	240 minutes	720
78491	80 minutes	240
78492	150 minutes	450
78608	120 minutes	360
78609	120 minutes	360
78811	90 minutes	270
78812	120 minutes	360
78813	150 minutes	450
78814	120 minutes	360
78815	145 minutes	435
78816	165 minutes	495

3. CPT/HCPCS codes for which the published RVU did not make sense
   a. CPT 38792 did not have a published non-facility RVU, the facility RVU was used.

Services with both a HCPCS for Medicare and CPT for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 that accompany a surgical CPT have been labeled as Interventional Radiology/Cardiovascular (IRC) and should be reported via the IRC rate center . If a NUC CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC), and the associated costs of the procedure are to be reclassified to the IRC cost center. (This is minimal for Nuclear Medicine.)

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are to be charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e., 1xxxx-6xxxx) and being performed in the imaging suite, these services are not "By Report"; they are to be reported via IRC. There is one exception to this rule – see Sentinel Node information below

Sentinel Node Injection

CPT 38792, although in the surgical series of CPT, will be kept in the NUC rate center with its associated RVUs of 6.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug, including radiopharmaceuticals, is considered a routine part of any NUC examination. Radiopharmaceuticals and sedation and pain reducing agents may be used with these procedures. These drugs should NOT be included in the RVU of the exam and are to be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU

CPT	Description	RVU
38792	Injection procedure, radioactive tracer for identification of sentinel node	6
78012	Thyroid uptake, single or multiple quantitative measurements including stimulation, suppression, or discharge, when performed.	21
78013	Thyroid imaging (including vascular flow, when performed)	50

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78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurements(s) (including stimulation, suppression, or discharge, when performed)	63
78015	Thyroid carcinoma metastases imaging; limited area (e.g., neck/chest only)	55
78016	Thyroid carcinoma metastases imaging; limited area (e.g., neck/chest only) w/additional studies (eg, urinary recovery)	73

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CPT	Description	RVU
78018	Thyroid carcinoma metastases imaging; whole body	79
78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	16
78070	Parathyroid planar imaging (including subtraction, when performed)	76
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	87
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	98
78075	Adrenal imaging, cortex and/or medulla	119
78099	Unlisted endocrine procedure, diagnostic nuclear medicine	By Report
78102	Bone marrow imaging; limited area	42
78103	Bone marrow imaging; multiple areas	54
78104	Bone marrow imaging; whole body	61
78110	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling	26
78111	Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); multiple samplings	24
78120	Red cell volume determination (separate procedure); single sampling	24
78121	Red cell volume determination (separate procedure); multiple samplings	26
78122	Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)	22
78130	Red cell survival study;	40
78135	Red cell survival study; differential organ/tissue kinetics (e.g., splenic and/or hepatic sequestration)	94
78140	Labeled red cell sequestration, differential organ/tissue (e.g., splenic and/or hepatic)	31
78185	Spleen imaging only, with or without vascular flow	56
78190	Kinetics, study of platelet survival, with or without differential organ/tissue localization	99
78191	Platelet survival study	40
78195	Lymphatics and lymph node imaging	87
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	By Report
78201	Liver imaging; static only	49
78202	Liver imaging; with vascular flow	52

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CPT CODE	DESCRIPTION	RVU's
78205	Liver imaging (SPECT);	52
78206	Liver imaging (SPECT); with vascular flow	86
78215	Liver and spleen imaging; static only	50
78216	Liver and spleen imaging; with vascular flow	29
78226	Hepatobiliary system imaging, including gallbladder when present;	86
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	118
78230	Salivary gland imaging;	44
78231	Salivary gland imaging; with serial images	30
78232	Salivary gland function study	23
78258	Esophageal mobility	55
78261	Gastric mucosa imaging	62
78262	Gastroesophageal reflux study	61
78264	Gastric emptying study (e.g., solid, liquid, or both)	87
78265	Gastric emptying study (e.g., solid, liquid, or both); with small bowel transit	102
78266	Gastric emptying study (e.g., solid, liquid, or both); with small bowel and colon transit, multiple days	123
78267	Urea breath test, C-14 (isotopic); acquisition for analysis	26
78268	Urea breath test, C-14 (isotopic); analysis	13
78270	Vitamin B-12 absorption study (e.g., Schilling test); without intrinsic factor	26
78271	Vitamin B-12 absorption study (e.g., Schilling test); with intrinsic factor	23
78272	Vitamin B-12 absorption study combined, with and without intrinsic factor	25
78278	Acute gastrointestinal blood loss imaging	88
78282	Gastrointestinal protein loss	25
78290	Intestine imaging (e.g., ectopic gastric mucosa, Meckel's localization, volvulus)	87
78291	Peritoneal-venous shunt patency test (e.g., LeVeen, Denver shunt)	62

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CPT CODE	DESCRIPTION	RVU's
78299	Unlisted gastrointestinal procedure, diagnostic Nuclear Medicine	By Report
78300	Bone and/or joint imaging; limited area	44
78305	Bone and/or joint imaging: multiple areas	56
78306	Bone and/or joint imaging; whole body	61
78315	Bone and/or joint imaging; 3 phase study	87
78320	Bone and/or joint imaging; tomographic (SPECT)	52
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	6
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	6
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	By Report
78414	Determination of central c-v hemodynamics (non-imaging) (e.g., ejection fraction with probe technique) with or without pharmacologic intervention or exercise, single or multiple determinations	52
78428	Cardiac shunt detection	42
78445	Non-cardiac vascular flow imaging (i.e., angiography, venography)	46
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)	80
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 redistribution and/or rest reinjection	115
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); singe study, at rest or stress (exercise or pharmacologic)	74
78454	Myocardial perfusion imaging, planar (including 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	108
78456	Acute venous thrombosis imaging, peptide	79
78457	Venous thrombosis imaging, venogram; unilateral	40

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CPT CODE	DESCRIPTION	RVU's
78458	Venous thrombosis imaging, venogram; bilateral	47
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation	720
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	47
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	45
78469	Myocardial imaging infarct avid, planar; tomographic SPECT with or without quantification	53
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	53
78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification	64
78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction with or without quantification	37
78483	Cardiac blood pool imaging (planar) first pass technique; multiple studies, at rest or with stress (exercise and/or pharmacologic) wall motion study plus ejection fraction with or without quantification	50
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	240
78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest or stress	450
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	49
78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (list separately in addition to code for primary procedure)	6
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	By Report

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CPT CODE	DESCRIPTION	RVU's
78579	Pulmonary ventilation imaging (e.g., aerosol or gas)	47
78580	Pulmonary perfusion imaging (e.g., particulate)	59
78582	Pulmonary ventilation (e.g., aerosol or gas) and perfusion imaging	82
78597	Quantitative differential pulmonary perfusion, including imaging when performed	49
78598	Quantitative differential pulmonary perfusion and ventilation (e.g., aerosol or gas), including imaging when performed	77
78599	Unlisted respiratory procedure, diagnostic nuclear medicine	By Report
78600	Brain imaging, less than 4 static views;	48
78601	Brain imaging, less than 4 static views; with vascular flow	55
78605	Brain imaging, minimum 4 static views;	51
78606	Brain imaging, minimum 4 static views; with vascular flow	87
78607	Brain imaging, tomographic (SPECT)	86
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	360
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	360
78610	Brain imaging, vascular flow only	47
78630	Cerebrospinal fluid flow, imaging (not including introduction of material); cisternography	89
78635	Cerebrospinal fluid flow, imaging (not including introduction of material;) ventriculography	91
78645	Cerebrospinal fluid flow, imaging (not including introduction of material); shunt evaluation	87
78647	Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic (SPECT)	90
78650	Cerebrospinal fluid leakage detection and localization	88
78660	Radiopharmaceutical dacryocystography	45

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CPT CODE	DESCRIPTION	RVU's
78699	Unlisted nervous system procedure, diagnostic nuclear medicine	By Report
78700	Kidney imaging morphology	44
78701	Kidney imaging morphology; with vascular flow	55
78707	Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention	54
78708	Kidney imaging morphology; with vascular flow and function, single study, with pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic)	34
78709	Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (e.g., angiotensin converting enzyme inhibitor and/or diuretic)	87
78710	Kidney imaging morphology; tomographic (SPECT)	50
78725	Kidney function study, non-imaging radioisotopic study	26
78730	Urinary bladder residual study (List separately in addition to code for primary procedure)	18
78740	Ureteral reflux study (radiopharmaceutical voiding cystogram)	56
78761	Testicular imaging with vascular flow	52
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	By Report
78800	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area	46
78801	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); multiple areas	65
78802	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging	82
78803	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)	85
78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging	150
78805	Radiopharmaceutical localization of inflammatory process; limited area	43
78806	Radiopharmaceutical localization of inflammatory process; whole body	85
78807	Radiopharmaceutical localization of inflammatory process; tomographic (SPECT)	85
78808	Injection procedure for radiopharmaceutical localization by non-imaging probe study, intravenous (e.g., parathyroid adenoma)	11
78811	Positron emission tomography (PET) imaging; limited area (e.g., chest, head/neck)	270

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CPT CODE	DESCRIPTION	RVU's
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	360
78813	Positron emission tomography (PET) imaging; whole body	450
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (e.g., chest, head/neck)	360
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	435
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	495
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	By Report
79005	Radiopharmaceutical therapy, by oral administration	14
79101	Radiopharmaceutical therapy, by intravenous administration	14
79200	Radiopharmaceutical therapy, by intracavitary administration	15
79300	Radiopharmaceutical therapy, by interstitial radioactive colloid administration	IRC
79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	23
79440	Radiopharmaceutical therapy, by intra-articular administration	14
79445	Radiopharmaceutical therapy, by intra-articular particulate administration	IRC
79999	Radiopharmaceutical therapy, unlisted procedure	By Report
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment	74
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment with tomographic SPECT	115

Radiology Therapeutic

Approach

Therapeutic Radiology Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. The descriptions of codes in this section of Appendix D were obtained from the 2015 edition of the Current Procedural Terminology (CPT) manual and the 2015 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2015 Medicare Physician Fee schedule (MPFS). RVUs were assigned using the Non-Facility Practice Expense (PE) RVU. ("RVU Assignment Protocol")

The RVUs reported in the 2015 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only (such as treatment codes), the single RVU reported will be used.
        b. CPT codes considered professional only (such as weekly treatment management and physician planning), are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS.
        a. CPT 77387 did not have a published RVU in the MPFS. The RVU work group agreed the work activity associated with this code is similar to CPT 77014. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77387.
        b. CPT codes 77424 and 77425 did not have published RVUs in the MPFS. The RVU work group agreed the work activity associated with these codes is similar to CPT 77787. Given the similarity of the work activity, it was determined the same RVU should be applied to CPTs 77424 and 77425.
        c. CPT 77520 did not have a published RVU in the MPFS. The code does have an OPPS APC relative value weight, and it is valued the same as CPTs 77385 and 77386. It was determined the RVUs for 77385 and 77386 should be applied to CPT 77520.
        d. CPT 77522, 77523, and 77525 did not have published RVUs in the MPFS. These codes are in the same family of services as CPT 77520. The codes have an OPPS APC with a relative value weight 2.112 times greater than the APC for CPT 77520. It was determined CPT codes 77522, 77523, and

77525 should each have the same RVU which is calculated by multiplying 2.112 to the RVU of CPT 77520.

e. CPT 77402 did not have a published RVU in the MPFS. This is a code where Medicare's hospital-based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6003. The RVU work group used the same RVU for G6003 for CPT 77402.
f. CPT 77407 did not have a published RVU in the MPFS. This is a code where Medicare's hospital-based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6007. The RVU work group used the same RVU for G6007 for CPT 77407.
g. CPT 77412 did not have a published RVU in the MPFS. This is a code where Medicare's hospital-based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6011. The RVU work group used the same RVU for G6011 for CPT 77412.
h. CPT 77371 did not have a published RVU in the MPFS, and it was determined there was not a similar CPT for benchmarking. Table 1 provides the methodology employed to assign RVUs of 378 to CPT 77371.

Table 1: CPT 77371 RVU Assessment

CPT 77371 Gamma Knife Treatment Delivery RVU Assignment

a. Step One, Determine a base CPT: CPT 77385 and 77386 were used as a base to which the work associated with CPT 77371 could be compared and extrapolated. CPT 77385 and 77386 each have a RVU of 11.15

b. Step Two, Determine the comparative work components for the CPT in question (77371). These are the work components for which the relative workload will be evaluated against the base CPTs 77385 and 77386.

Component	Weighting	Weighting Methodology
Initial Set-up	65%	The setup for SRS treatment is 4Xs the work effort of an IMRT setup - criticality of coordinate system - application of frame
Treatment	20%	It takes on average 3Xs the amount of time to deliver an SRS Cobalt Based treatment vs. IMRT
QA	7.50%	The QA process is 50% less work effort than with IMRT
Resources	7.50%	The treatment delivery is managed by the Medical Physics personnel as compared to therapists for IMRT delivery. Physicists are 2Xs the resource intensity as IMRT therapists

c. Step Three, Extrapolate the RVU value

	Initial S/U	Treatment	QA	Resources			
Weighting	65%	20%	7.50%	7.50%			
Base RVU	11.15	11.15	11.15	11.15			
Multiplier	4	3	0.5	2	**Sum**	**Multiplier**	**RVUs**
Total RVUs	28.99	6.69	0.42	1.67	**37.77**	**10**	**378**

4. CPT codes for which the published RVU did not make sense,
    a. CPT 77333 had a RVU that did not seem reasonable as compared to CPT 77332 and 77334, which are in the same family of codes and clinical services. It was determined the RVU for CPT 77333 should be the average value of CPT codes 77332 and 77334.

CPT Codes without an Assigned RVU Value

An effort was made to assign RVUs to all codes that were effective in 2015. In the case of CPT codes listed as 'By Report', hospitals should assign RVUs based on the time and resource intensity of the service provided compared to like services in the department.

For new codes developed and reported by CMS after the 2015 reporting, these codes are considered to be "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

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RADIOLOGY THERAPEUTIC

CPT Code	Procedure	RVU
77014	Computed tomography guidance for placement of radiation therapy fields	20
77280	Therapeutic radiology simulation-aided field setting; simple	66
77285	Intermediate	104
77290	Complex	120
77293	Respiratory motion management (list separately in addition to code for primary procedure)	101
77295	3-Dimensional radiotherapy plan, including dose-volume histograms	74
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	By Report
	MEDICAL RADIATION PHYSICS, DOSIMETRY, TREATMENT DEVICES AND SPECIAL SERVICES	

CPT Code	Procedure	RVU
77300	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	9
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	425
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)	20
77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)	37
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	32
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)	41
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	56
77321	Special teletherapy port plan, particles, hemibody, total body	12

APPENDIX D
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CPT Code	Procedure	RVU
77331	Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician	5
77332	Treatment devices, design and construction; simple, (simple block, simple bolus)	15
77333	Treatment devices, design and construction; intermediate, (multiple blocks, stents, bite blocks, special bolus)	20
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)	25
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of therapeutic radiologist, reported per week of therapy	21
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan	79
77370	Special medical radiation physics, consultation	32
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	378
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	297
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	377
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	112
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	112
77387	Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed	20
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices	By Report
Radiation Treatment delivery (77401–77416) recognizes the technical component and the various energy levels.		

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RADIATION TREATMENT DELIVERY

Radiation Treatment delivery (77401–77416) recognizes the technical component and the various energy levels.

CPT Code	Procedure	RVU
77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	6
77402	Radiation treatment delivery, > MeV; simple	45
77407	Radiation treatment delivery, >1 MeV; intermediate	72
77412	Radiation treatment delivery, >1 MeV; complex	77

CLINICAL TREATMENT MANAGEMENT

CPT Code	Procedure	RVU
77417	Therapeutic radiology port film(s)	3
77422	High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking	9
77423	High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	18
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session	147
77425	Intraoperative radiation treatment delivery, electrons, single treatment session	147
77470	Special treatment procedure (e.g., total body irradiation, hemibody irradiation, per oral, vaginal cone irradiation)	13
77999	Unlisted procedure, therapeutic radiology treatment management	By Report

PROTON TREATMENT DELIVERY

CPT Code	Procedure	RVU
77520	Proton treatment delivery, simple, without compensation	112
77522	Proton treatment delivery, simple, with compensation	235
77523	Proton treatment delivery, intermediate	235
77525	Proton treatment delivery, complex	235

APPENDIX D
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RADIOLOGY THERAPEUTIC

HYPERTHERMIA

Hyperthermia treatments as listed in this section include external (superficial and deep), interstitial and intracavitary. Radiation therapy when given concurrently is listed separately.

Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy. It may be induced by a variety of sources, e.g., microwave, ultrasound, low energy radio-frequency conduction, or by probes.

Physics planning and interstitial insertion of temperature sensors, and use of external or interstitial heat generating sources are included.

CPT Code	Procedure	RVU
77605	Hyperthermia, externally generated; deep (i.e., heating to depths greater than 4 cm)	183
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators	266
77615	Hypothermia generated by interstitial probe(s); more than 5 interstitial applicators	252
77620	Hyperthermia generated by intracavitary probe(s)	105

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RADIOLOGY THERAPEUTIC

CLINICAL BRACHYTHERAPY

Clinical brachytherapy requires the use of either natural or manmade radioelements applied into or around a treatment field of interest. The supervision of radioelements and dose interpretation are performed solely by the therapeutic radiologist.

Definitions

(Sources refer to intracavitary placement or permanent interstitial placement; ribbons refer to temporary interstitial placement.)

Simple	Application with one to four sources/ribbons.
Intermediate	Application with five to ten sources/ribbons.
Complex	Application with greater than ten sources/ribbons.

CPT Code	Procedure	RVU
77750	Infusion or instillation of radioelement solution	31
77761	Intracavitary radiation source application; simple	53
77762	Intracavitary radiation source application; intermediate	61
77763	Intracavitary radiation source application; complex	79
77776	Interstitial radiation source application; simple	64
77777	Interstitial radiation source application; intermediate	54
77778	Interstitial radiation source application; complex	80
77785	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel	46
77786	Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels	90
77787	Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels	147
77789	Surface application of radioelement	17
77790	Surface application of radiation source	12
77799	Unlisted procedure, Clinical brachytherapy	By Report

Electrocardiography

The Electrocardiography Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. These Relative Value Units will be used as the standard unit of measure related to the output of the Electrocardiography Center.

Electrocardiography (EKG) is a transthoracic interpretation of the electrical activity of the heart over a period of time. The EKG cost center operates specialized equipment to (1) Record graphically electromotive variations in actions of the heart muscle; (2) Record graphically the direction and magnitude of the electrical forces of the heart's action, (3) Record graphically the sounds of the heart for diagnostic purposes; (4) Imaging; (5) Cardioversion; and/or (6) Tiltable. Additional activities include, but are not limited to, the following:

Explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from patient; a patient may remove electrodes and remit recording data from home when appropriate.

Description

This cost center contains the direct expenses incurred in performing electrocardiographic examinations, as well as up to six hours of recovery time. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Cost of contrast material is included in this cost center.

Code	Description (CQ)	RVUs
92960	Cardioversion, elective, electrical conversion of arrhythmia; external	45
92960	Cardioversion in addition to TEE 5 RVUs. Also report TEE separately with 60 RVUs	5
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	12
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	30
93024	Ergonovine provocation test	30
93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	30
93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report	5
93225	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; recoding (includes connection, recording, and disconnection)	10

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ELECTROCARDIOGRAPHY

Code	Description (CQ)	RVUs
93226	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; scanning analysis with report	50

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ELECTROCARDIOGRAPHY

Code	Description (CQ)	RVUs
93270	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30-day period of time; recording (includes connection, recording, and disconnection)	10
93278	Signal-averaged electrocardiography (SAECG), with or without ECG	30
93279	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 pacemaker system	15
93280	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 pacemaker system	15
93281	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; multiple lead pacemaker system	15
93282	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	20
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	20
93284	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; multiple lead implantable cardioverter-defibrillator system	20
93285	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; implantable loop recorder system	20
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system	15
93287	Single, dual or multiple lead implantable cardioverter-defibrillator system	15

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Code	Description (CQ)	RVUs
93288	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system	15
93289	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	20
93290	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	20
93291	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; Implantable loop recorder system, including heart rhythm derived data analysis	20
93292	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	30
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	15
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	20
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	20
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	45
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	20
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	60
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	45
93308	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording, when performed, follow-up or limited study	20

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Code	Description (CQ)	RVUs
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	60
3315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	90
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	10
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	8
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	5
93350	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	60
93352	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)	1
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention. A standard tilt table evaluation of 45 minutes or less qualifies for 60 RVUs. A complex tilt table evaluation of greater than 45 minutes qualifies for 90 RVUs. Evaluation time includes the time necessary to prepare the patient for the evaluation and any post evaluation services.	60/90
93701	Bioimpedance, thoracic, electrical	5
93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)	15
93740	Temperature gradient studies	By Report
93745	Initial set-up and reprogramming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data-to-data repository, patient instruction in wearing system and patient reporting of problems or events	30
93750	Interrogation of Ventricular Assist Device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, recovery), with programming, if performed, and report	15

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Code	Description (CQ)	RVUs
93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only	10
93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report	30
93799	Unlisted cardiovascular services or procedure (AICD Reprogramming)	By Report
G0166	External Counterpulsation, per treatment session	By Report

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Contrast Codes

Code	Description (CQ)	RVUs
C8921	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies, complete	45 (93303) + 1 for contrast = 46 RVUs
C8922	Transthoracic echocardiography with contrast or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study	20(93304) + 1 for contrast = 21 RVUs
C8923	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler	45 (93307) + 1 for contrast = 46 RVUs
C8924	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	20 (93308) + 1 for contrast = 21 RVUs
C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording), including probe placement, image acquisition, interpretation and report	60 (93312) + 1 for contrast= 61 RVUs
C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies, including probe placement, image acquisition, interpretation, and report	90 (93315) + 1 for contrast = 91 RVUs
C8927	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	By Report
C8928	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time image documentation (2D), includes M-mode recoding, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	60 (93350) + 1 for contrast = 61 RVUs
C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	60 (93306) + 1 for contrast = 61 RVUs

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Codes Intentionally Omitted from List

93313	Placement of transesophageal probe only
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only.
93316	Placement of transesophageal probe only
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only.
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
C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report, including performance of continuous electrocardiographic monitoring, with physician supervision

Electroencephalography

Approach

Electroencephalography Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The description of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2107 Medicare Physician Fee Schedule (MPFS) released November 2, 2016. RVUs were assigned using the Non-Facility Practice Expense (PE) RVU. ("RVU Assignment Protocol")

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUS listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        i. CPT codes that are considered technical only, the single RVU reported will be used.
        ii. CPT considered professional only are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS (e.g., CMS Status Code "C")
    a. CPT 95824 did not have a published RVU in the MPFS. This CPT is infrequently reported by hospitals and will be listed "By Report."
    b. CPT 95941 did not have a published RVU in the MPFS. This procedure is not reported to Medicare but may be utilized for other payers. This CPT (1 hour of time) will be reported at 3 RVUs, mirroring 94940 (which is for 15 minutes) because physician is not 1:1 with patient.
    c. CPT 95943, 94965, 94966 and 95967 did not have a published RVU in the MPFS. These CPTs will be assigned "By Report." As this procedure is not currently being provided by hospitals. When hospitals do provide this service, RVUs shall be assigned following the protocol below in the section "CPT Codes without an Assigned RVU Value."
    d. CPT 94951 did not have a published RVU in the MPFS. This CPT is infrequently reported by hospitals and will be listed "By Report."
    e. HCPCS codes G0398, G0399 and G0400 did not have published RVUs as they are for hospital use only. These procedures will mirror CPT 95806 at 30 RVUs.
3. CPT/HCPCS codes for which the published RVU did not make sense.
    a. There were not deviations from published RVUs when present.

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Services with both a HCPCS for Medicare and CPT for NonMedicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

Unattended and Home Sleep Studies

The RVUs for these services assumes the patients are coming to the hospital before and/or after the procedure to be hooked up/educated on equipment and unhooked/discharged from equipment. These RVUs do not relate to the portion of the service occurring without staff and/or at the patient's home.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report." When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVUs will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any EEG examination, however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

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CPT Code	Description	RVU
95782	Polysomnography: younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	251
95783	Polysomnography: younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	285
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time	36
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone)	12
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	27
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	103
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement)	30

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95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	113
95808	Polysomnography: any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	155

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CPT Code	Description	RVU
95810	Polysomnography: age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	140
95811	Polysomnography: age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist	148
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	75
95813	Electroencephalogram (EEG) extended monitoring; greater than 1 hour	90
95816	Electroencephalogram (EEG); including recording awake and drowsy	85
95819	Electro-encephalogram (EEG); including recording awake and asleep	101
95822	Electroencephalogram (EEG); recording in coma or sleep only	89
95824	Electroencephalogram (EEG); cerebral death evaluation only	By Report
95827	Electroencephalogram (EEG); all night recording	170
95829	Electrocorticogram at surgery (separate procedure)	445
95830	Insertion by physician or other qualified health care professional of sphenoidal electrodes for electroencephalographic (EEG) recording	62
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	9
95832	Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side	9
95833	Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands	11
95834	Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands	15
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	5
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side	4
95857	Cholinesterase inhibitor challenge test for myasthenia gravis	15
95860	Needle electromyography; 1 extremity with or without related paraspinal areas	20
95861	Needle electromyography; 2 extremities with or without related paraspinal areas	26
95863	Needle electromyography; 3 extremities with or without related paraspinal areas	33
95864	Needle electromyography; 4 extremities with or without related paraspinal areas	39
95865	Needle electromyography; larynx	17
95866	Needle electromyography; hemidiaphragm	19
95867	Needle electromyography: cranial nerve supplied muscle(s), unilateral	15
95868	Needle electromyography: cranial nerve supplied muscles, bilateral	20
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)	20
95870	Needle electromyography: limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	20
95872	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied	12
95873	Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	15
95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)	15

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CPT Code	Description	RVU
95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	16
95885	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	11
95886	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)	13
95887	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)	12
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report;	19
95907	Nerve conduction studies; 1-2 studies	12
95908	Nerve conduction studies; 3-4 studies	16
95909	Nerve conduction studies; 5-6 studies	19
95910	Nerve conduction studies; 7-8 studies	25
95911	Nerve conduction studies; 9-10 studies	28
95912	Nerve conduction studies; 11-12 studies	28
95913	Nerve conduction studies; 13 or more studies	31
95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	11
95922	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt	14
95923	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential	27
95924	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	18
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	31
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	30
95927	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head	31
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	37
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	39
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash	31
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing	13
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method (for ultrasonography, see 76500 et seq.)	13
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs	83

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CPT Code	Description	RVU
95939	Central motor evoked potential study (transcranial motor stimulation); upper and lower limbs	108
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	3
95941	Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	3
95943	Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change	By Report
95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (e.g., 8 channel EEG) recording and interpretation, each 24 hours	71
95951	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (e.g., for pre-surgical localization), each 24 hours	By Report
95953	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended	73
95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (e.g., thiopental activation test)	92
95955	Electroencephalogram (EEG) during nonintracranial surgery (e.g., carotid surgery)	45
95956	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse	404
95957	Digital analysis of electroencephalogram (EEG) (e.g., for epileptic spike analysis)	56
95958	Wada activation test for hemispheric function, including electroencephalographic (EEG) monitoring	99
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	40
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	25
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)	By Report
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)	By Report
95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	By Report

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CPT Code	Description	RVU
95970	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	19
95971	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	14
95972	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	17
95974	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour	59
95975	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	32
95978	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programing; first hour	71
95979	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programing; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	31
95980	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	4

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CPT Code	Description	RVU
95981	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	9
95982	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	15
95999	Unlisted neurological or neuromuscular diagnostic procedure	By Report
G0398	Home sleep test/type 2 portable (Medicare reporting only)	30
G0399	Home sleep test/type 3 portable (Medicare reporting only)	30
G0400	Home sleep test/type 4 portable (Medicare reporting only)	30
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)	3

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Physical Therapy & Occupational Therapy

The descriptions in this section of Appendix D were obtained from the 2003 edition of the Current Procedural Terminology (CPT) manual, and the 2003 edition of the Healthcare Common Procedure Coding System (HCPCS). Some of the codes are designed with time as a multiple. For example, code 97032, "Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes." While other codes are silent on time. For example, code 29105, "Application of long arm splint (shoulder to hand)."

The review committee has elected to assign all Relative Value Units (RVU's) in this section of Appendix D, based on time. That decision required converting CPT non-time-based codes to time-based codes. The time increment selected was 15 minutes. **The 15-minute increments used in this Appendix D are subject to the Medicare 8-minute rule.** (For the benefit of the reader, all applicable PT and OT codes are grouped, per CPT definition, as either "NON-TIME" or "TIME" codes. However, for CPT codes under "NON-TIME", it is implicit that the service is provided in time multiples, as defined by the review committee. For emphasis the phrase "(*per HSCRC: each 15 minutes*)" has been added to the CPT description).

Hospitals may want to contact MHA for billing suggestions

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Other considerations:

1. Supply costs are included in the HSCRC rate per RVU. There is one exception, which is noted under CPT code 29580.
2. The CPT codes reviewed account for the majority of services provided in PT & OT. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as "by report" by the individual institution.
3. CPT codes are in a process of constant revision and as such providers should review their institution's use of CPT codes and stay current with proper billing procedures.
4. The RVU's listed in this section of Appendix D are time based. The time increments are in 15-minute multiples. HSCRC expects providers to round up/down for services, when not provided in exactly a 15-minute multiple. For example, services that are:
   a. 8 to 22 minutes = 15 minutes,
   b. 23 to 37 minutes = 30 minutes,
   c. 38 to 52 minutes = 45 minutes,
   d. 53 to 67 minutes = 60 minutes, etc.
5. Time increments used in this section of Appendix D are for direct patient time. Direct patient time is billable. Time spent for set-up, documentation of service, conference, and other non-patient contact is not billable.
6. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support services provided.

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PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

NON-TIME-BASED CODES

CPT code	Description	RVU
29105	Application of long arm splint (shoulder to hand) (Per HSCRC: each 15 minutes).	12
29125	Application of short arm splint (forearm to hand); static (per HSCRC: each 15 minutes).	10
29126	Application of short arm splint (forearm to hand); dynamic (per HSCRC: each 15 minutes).	12
29130	Application of finger splint; static (Per HSCRC: each 15 minutes).	8
29131	Application of finger splint; dynamic (Per HSCRC: each 15 minutes).	10
29505	Application of long leg splint (thigh to ankle or toes) (per HSCRC: each 15 minutes).	12
29515	Application of short leg splint (calf to foot) (Per HSCRC: each 15 minutes).	10
29580	Strapping; Unna boot (per HSCRC: each 15 minutes. Per HSCRC: charge for unna boot separately).	6
64550	Application of surface (transcutaneous) neurostimulator (per HSCRC: each 15 minutes. Per HSCRC, to be used for initial Ten's application only).	5
90901	Biofeedback training by any modality (exception see 90911) (per HSCRC: each 15 minutes).	6
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry (e.g., Incontinence) (per HSCRC: each 15 minutes).	7
96110	Developmental testing limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. (Per HSCRC: each 15 minutes).	9
97001	Physical Therapy evaluation (per HSCRC: each 15 minutes).	12

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

CPT code	Description	RVU
97002	Physical Therapy re-evaluation (per HSCRC: each 15 minutes).	9
97003	Occupational Therapy evaluation (per HSCRC: each 15 minutes).	12
97004	Occupational Therapy re-evaluation (per HSCRC: each 15 minutes).	9
97010	(Per HSCRC: not reportable) Application of a modality to one or more areas; hot or cold packs.	0
97012	Application of a modality to one or more areas: traction, mechanical (per HSCRC: each 15 minutes).	4
97014	(Per HSCRC: not reportable) Application of a modality to one or more areas; electrical stimulation (unattended).	0
97016	Application of a modality to one or more areas; Vasopneumatic devices (per HSCRC each 15 minutes).	3
97018	Application of a modality to one or more areas; Paraffin bath (per HSCRC: each 15 minutes).	2
97022	Application of a modality to one or more areas; Whirlpool, (per HSCRC: each 15 minutes).	3
97039	Unlisted modality (specific type and time if constant attendance), (per HSCRC: RVU assigned should be for a 15-minute increment)	by report
97139	Unlisted therapeutic procedure (specify), (per HSCRC: RVU assigned should be for a 15-minute increment).	By report

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

CPT Code	Description	RVU
NON-TIME-BASED CODES		
97150	Therapeutic procedure(s), group (2, 3, or 4 patients). Therapeutic procedure(s), group (5 or more patients). (Per HSCRC: each 15 minutes).	3 per patient 2 per patient
97601	Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (e.g., high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers). Including topical application(s) wound assessment, and instruction(s) for ongoing care, per session. (Per HSCRC: each 15 minutes).	12
97602	(Per HSCRC: not reportable) Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s). Wound Assessment and instruction(s) for ongoing care, per session.	0
97799	Unlisted physical medicine rehabilitation service or procedure (per HSCRC; RVU assigned should be for a 15-minute increment).	By report

HCPCS Code	Description	RVU
NON-TIME-BASED CODES		
G0281	Electrical stimulation (unattended), to one or more areas, for Chronic Stage III and Stage IV pressure ulcers, arterial ulcers, Diabetic ulcers, and Venous stasis ulcers not demonstrating Measurable signs of healing after 30 days of conventional care, as Part of a therapy plan of care. (Per HSCRC: each 15 minutes).	4
G0282	Electrical stimulation (unattended), to one or more areas for wound care other than described in G0281 (per HSCRC: each 15 minutes).	4

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STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

HCPCS Code	Description	RVU
NON-TIME-BASED CODES		
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.	3
G0295	(Per HSCRC: not reportable) Electromagnetic Stimulation, to one or more areas.	0

CPT Code	Description	RVU
TIME BASED CODES – (direct one to one patient contact)		
96111	Developmental testing, extended (includes assessment of motor, language, social adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour.	48
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes.	4
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes.	5
97034	Application of a modality to one or more areas; Contrast baths, each 15 minutes.	3
97035	Application of a modality to one or more areas; Ultrasound. Each 15 minutes.	3
97036	Application of a modality to one or more areas; hubbard tank. Each 15 minutes.	4
97110	Therapeutic procedure, one or more areas, each 15 minutes, therapeutic exercises to develop strength and endurance, range of motion and flexibility.	6

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

CPT Code	Description	RVU
TIME BASED CODES – (direct one to one patient contact)		
97112	Therapeutic procedure, one or more areas; each 15 minutes, neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.	6
97113	Therapeutic procedure, one or more areas; each 15 minutes, aquatic therapy with therapeutic exercises.	6
97116	Therapeutic procedure, one or more areas, each 15 minutes, gait training (includes stair climbing).	6
97124	Therapeutic procedure, one or more areas; each 15 minutes, massage including effleurage, 66enture66co and/or tapotement (stroking, compression percussion), (Supplement HSCRC description: The clinician uses massage to provide muscle relaxation, increase localized circulation, soften scar tissue, or mobilize mucous secretions in the lung via tapotement and/or percussion).	4
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes.	6
97504	Orthotic(s) fitting and training, upper extremity (ies), lower extremity (ies), and/or trunk, each 15 minutes.	6
97520	Prosthetic training, upper and/or lower extremities each 15 minutes.	5
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes.	7
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes.	5

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT)

CPT Code	Description	RVU
TIME BASED CODES – (direct one to one patient contact)		
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes.	5
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.	6
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one-on-one contact by provider, each 15 minutes.	5
97542	Wheelchair management/propulsion training, each 15 minutes.	5
97545	Work hardening – conditioning, initial 2 hours.	40
97546	Work hardening – conditioning; each additional hour. (List separately in addition to code for primary procedure).	20
97703	Checkout for orthotic/ prosthetic use, established patient, each 15 minutes.	5
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes (Supplemental HSCRC description: includes such tests as BTI, isokinetic tests, vision test with equipment, Etc.)	12

Respiratory Therapy & Pulmonary Function Testing

Respiratory Therapy and Pulmonary Function Testing encompass services that respiratory care practitioners and specially trained pulmonary function teams provide. In keeping with the principles in the Medicare Hospital Manual §210.10, when a respiratory therapist or pulmonary function technologist provides these services, they are reportable as respiratory or pulmonary services, ~~and~~ in accordance with the Code of Maryland Regulations (COMAR) for scope of service. If a nurse or other health care team member provides the services, they are considered a component of the patient day or visit, and they are not separately reportable.

Approach

Respiratory Therapy (RES) and Pulmonary Function (PUL) Relative Value Units (RVUs) were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2018 edition of the Current Procedural Terminology (CPT) manual and the 2018 edition of the Healthcare Common Procedure Coding System (HCPCS). In addition, for those services requiring usage of an "unlisted" CPT code, the task force developed a description for the service. In assigning RVUs, the task force used the procedure minutes established in the 2012 AARC Uniform Reporting Manual as a reference with a ratio of 1 minute = 1 RVU. RVUs were then assigned using the following protocol ("RVU Assignment Protocol").

RVU Assignment Protocol

The AARC Uniform Reporting Manual has established minutes for respiratory therapy services. The AARC established minutes based on the mean and median time to perform the service within patient categories of Adult, Pediatric and Neonatal. The median number of minutes in the adult category ~~will has~~ been used as the basis for RVUs as adults are the majority patient population that receives respiratory therapy and pulmonary function services. All exceptions have been noted.

4. CPT codes that were not assigned in accordance with the AARC median:
    a. CPT 33946 [Extracorporeal membrane oxygenation {ECMO/extracorporeal life support (ECLS)} provided by physician; initiation, veno-venous] and CPT 33947 [Extracorporeal membrane oxygenation {ECMO/extracorporeal life support (ECLS)} provided by physician; initiation, veno-arterial] do not have any associated AARC minutes. These services require 1,820 minutes of staff time per initial day on average per the task force. 1,820 RVUs have been assigned.
    b. CPT 33948 [Extracorporeal membrane oxygenation {ECMO/extracorporeal life support (ECLS)} provided by physician; daily management, each day, veno-venous] and CPT 33949 [Extracorporeal membrane oxygenation {ECMO/extracorporeal life support (ECLS)} provided by physician; daily management, each day, veno-arterial] do not have any associated AARC minutes. These services require 1,440 minutes of staff time per subsequent day on average per the task force. 1,440 RVUs have been assigned.
    c. CPT 36410 [Venipuncture, age 3 years or older] is assigned 15 minutes by the AARC. However, this procedure is typically "packaged" by Medicare and will be assigned zero (0) RVUs.

d. CPT 36416 [Collection of capillary blood specimen (egg, finger, heel, ear stick)] has a median of 17.5 AARC minutes. However, as this is a lab service, RVUs will not be assigned. The code will remain in Appendix D and will be referenced as a lab service. The task force also noted that Medicare requests hospitals not separately report this service.

e. CPT 92950 [Cardiopulmonary resuscitation (egg, in cardiac arrest)] has a median of 40 AARC minutes. This service typically involves includes two (2) respiratory therapists. Therefore, the task force agreed the AARC minutes would be doubled and 80 RVUs would be assigned.

f. CPT 93463 [Pharmacologic agent administration (egg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after, and repeat pharmacologic agent administration, when performed (list separately in addition to code for primary procedure)] has a median of 15.5 AARC minutes for Nitric Oxide Delivery- System Calibration and 30 AARC minutes for Nitric Oxide Delivery- Set up. The task force agreed that the minutes would be combined and 46 RVUs would be assigned. This code is sometimes referred to as a "Vaso-active challenge" test and is only used when support is provided by a respiratory therapist in the Cath Lab. This service is bundled into Inhaled Nitric Oxide Therapy, code 94799, daily reportable service, is used when provided in non-Cath lab, typically intensive care settings.

g. CPT 93503 [Insertion and placement of flow directed catheter (egg, Swan-Ganz) for monitoring purposes] does not have any associated AARC minutes. The task force indicated that this service is currently not performed in Maryland and is a physician service. Therefore zero (0) RVUs will be assigned.

h. CPT 94002 [Ventilation assists and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day] has a median of 30 AARC minutes. This service has many component services within the AARC listing. The task force agreed to assign 250 RVUs for adults and 300 RVUs for neonates based on the combined amount of time spent on direct and indirect ventilator activities/support for patients. This service bundles all services provided to ventilator patients including but not limited to mobility, transports, spontaneous mechanics, patient assessments and system checks, etc. into a once daily reportable service.

i. CPT 94003 [Ventilation assists and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, subsequent day] has a median 15 AARC minutes. This service has many component services within the AARC listing. The task force agreed to assign 250 RVUs for adults and 300 RVUs for neonates based on the combined amount of time spent on direct and indirect ventilator activities/support for patients. This service bundles all services provided to ventilator patients including but not limited to mobility, transports, spontaneous mechanics, patient assessments and system checks, etc., into a once daily reportable service.

j. CPT 94004 [Ventilation assists and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day] did not have assigned AARC minutes. This service is specific to a nursing facility. Therefore, zero (0) RVUs will be assigned.

k. CPT 94005 [Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (egg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more] did not have assigned AARC minutes. This service is performed on patients at home or a rest home. Therefore, zero (0) RVUs will be assigned.

l. CPT 94014 [Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, period recalibration and review and interpretation by a physician or other qualified health care professional] and 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] did not have assigned AARC minutes. These services are rarely performed currently, therefore, the task force agreed these codes should be reported as "By Report."

m. CPT 94016 [Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional] did not have assigned AARC minutes. This is a physician only service, therefore zero (0) RVUs will be assigned.

n. CPT 94150 [Vital capacity, total (separate procedure)] did not have assigned AARC minutes. The task force briefly discussed this code and agreed that the current 18 RVUs per Appendix D are still valid. Therefore, 18 RVUs will be assigned to this code. See note regarding SEPARATE PROCEDURES.

o. CPT 94250 [Expired gas collection, quantitative, single procedure (separate procedure)] did not have assigned AARC minutes. This code is similar in time and resources to CPT 94400. Therefore, 30 RVUs will be assigned. See note regarding SEPARATE PROCEDURES.

p. CPT 94375 [Respiratory flow volume loop] did not have assigned AARC minutes. This procedure is bundled into spirometry therefore zero (0) RVUs will be assigned.

q. CPT 94450 [Breathing response to hypoxia (hypoxia response curve)] has 60 AARC minutes. This code will be assigned 30 RVUs as it is more similar to CPT 94400 [Breathing response to CO2, CO2 response curve].

r. CPT 94453 [High altitude simulation test (HAST), with interpretation and report by a physician or other qualified health care professional; with supplemental oxygen titration] did not have assigned AARC minutes. This service is similar to CPT 94452 (45 RVUs) and therefore will be assigned 45 RVUs.

s. CPT 94617 [Exercise test for bronchospasm, including pre-and post-spirometry, electrocardiographic recording(s), and pulse oximetry] did not have assigned AARC minutes. This service is similar to deleted CPT 94620 [Exercise-Induced Bronchospasm Challenge] with median minutes of 71 therefore, 71 RVUs will be assigned.

t. CPT 94618 [Pulmonary stress testing (egg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed] did not have assigned AARC minutes. This code was similar to deleted CPT 94620 [Shuttle Walk Test] with median minutes of 30 therefore, 30 RVUs will be assigned.

u. CPT 94621 [Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings] has 30 AARC minutes. This code will be assigned 90 minutes as complex pulmonary stress testing should be higher than the simple pulmonary stress testing RVUs.

v. CPT 94640 [Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device] is reportable once per encounter. An encounter starts when the patient enters the facility and ends when the patient leaves the facility. The time involved with this service varies with each patient and is considerably different between an inpatient and outpatient; as such, there is a different RVU based upon patient classification. An inpatient may receive on average of 6 treatments per day with each treatment requiring 20 minutes of clinical care time. An average stay for these patients may be 4 days. Calculation: 6 treatments x 20 minutes per treatment x 4 days = 480 minutes. An outpatient receives on average 2 treatments per day with each treatment requiring 20 minutes of clinical care time. Calculation: 2 treatments x 20 minutes per treatment = 40 minutes/RVUs.

w. CPT 94642 [Aerosol inhalation of Pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis] did not have AARC minutes. This procedure is about 60 minutes in duration. Therefore, 60 RVUs will be assigned.

~~x.~~ CPT 94660 [Continuous positive airway pressure ventilation (CPAP), initiation and management] did not have AARC minutes. This service requires an average of six separate respiratory therapist visits per day with an average of 20 minutes each. Therefore, 120 RVUs will be assigned to this code. This service is inclusive of respiratory therapist time. Home equipment used only in the absence of respiratory therapist time is not reportable.

y. CPT 94662 [Continuous negative pressure ventilation (CNP), initiation and management] did not have AARC minutes. This service requires an average of six separate respiratory therapist visits per day with an average of 20 minutes each. Therefore, 120 RVUs will be assigned to this code.

z. CPT 94669 [Mechanical chest wall oscillation to facilitate lung function, per session] did not have AARC minutes. This procedure is approximately 30 minutes in duration. Therefore, the task force agreed to assign 30 RVUs to this code. This is not to be reported with CPT 94667 [Manipulation chest wall; Initial demonstration] and CPT 94668 [Manipulation chest wall; Subsequent demonstration].

aa. CPT 94680 [Oxygen uptake, expired gas analysis; rest and exercise, direct, simple] did not have AARC minutes. This procedure is approximately 75 minutes in length. Therefore, 75 RVUs will be assigned to this code.

bb. CPT 94681 [Oxygen update, expired gas analysis; including CO2 output, percentage oxygen extracted] did not have AARC minutes. This procedure is similar to CPT 94621 [Pulmonary Stress Testing, complex…] in time and resources, which is assigned 90 RVUs. Therefore, 90 RVUs will be assigned to this code.

cc. CPT 94727 [Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes] did not have AARC minutes. This procedure is similar to CPT 94726 (Plethysmography for determination of lung volumes and when performed, airway resistance) in time and resources, which is assigned 19 RVUs. Therefore, 19 RVUs will be assigned to this code.

dd. CPT 94750 [Pulmonary compliance study (egg, plethysmography, volume and pressure measurements] did not have AARC minutes. This procedure is approximately 30 minutes in length. Therefore, 30 RVUs will be assigned to this code.

ee. CPT 94761 [Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (egg, during exercise)] has a median of 20 AARC minutes. The task force agreed that 20 RVUs was not sufficient for this procedure as this typically takes 30 minutes. Therefore 30 RVUs will be assigned to this code.

ff. CPT 94762 [Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)] has a median of 20 AARC minutes. The task force agreed that 20 RVUs was not sufficient for this procedure as this typically takes 30 minutes as it is a separate procedure that includes downloading and reporting. Therefore 30 RVUs will be assigned to this code. See note regarding SEPARATE PROCEDURES.

gg. CPT 94770 [Carbon dioxide, expired gas determination by infrared analyzer] has a median of 7 AARC minutes. The task force referenced applicable to bedside end tidal CO2 procedures and agreed that 7 RVU was not sufficient for this procedure it typically takes 40 minutes. Therefore, 40 RVUs will be assigned to this code.

hh. CPT 94774 [Pediatric home apnea monitoring event recording including respiratory rate, pattern, and heart rate per 30-day period; includes monitor attachment, download of data, review, interpretation, and preparation of a report by a physician or other qualified health care professional] did not have AARC minutes. This code will be assigned zero (0) RVUs as this is a global CPT not to be used by hospitals.

ii. CPT 94775 [Pediatric home apnea monitoring event recording including respiratory rate, patter, and heart rate per 30-day period; monitor attachment only (includes hook-up, initiation of recording and disconnection)] did not have AARC minutes. This service is currently not being reported. The task force agreed that this should remain in Appendix D for future reporting and RVUs should be established “By Report.”

jj. CPT 94776 [Pediatric home apnea monitoring event recording including respiratory rate, patter, and heart rate per 30-day period; monitoring, download of information, receipt of transmission(s) and analyses by computer only] did not have AARC minutes. This code will be assigned zero (0) RVUs as the patient is not present at the hospital.

kk. CPT 94777 [Pediatric home apnea monitoring event recording including respiratory rate, patter, and heart rate per 30-day period; review, interpretation, and preparation of report only by a physician or other qualified health care professional] did not have AARC minutes. This code will be assigned zero (0) RVUs as this is a physician service.

ll. CPT 9780 [Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes] did not have AARC minutes. Per the AMA description, this procedure is 60 minutes. Therefore, 60 RVUs will be assigned.

mm. CPT 94781 [Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report each additional full 30 minutes (List separately in addition to code for primary procedure)] did not have AARC minutes. Per the AMA description, this procedure is 30 minutes. Therefore, 30 RVUs will be assigned.

nn. CPT 99406 [Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes] did not have AARC minutes. Per the AMA description, this service is up to 10 minutes. Therefore, 10 RVUs will be assigned.

oo. CPT 99407 [Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes] did not have AARC minutes. Per the AMA description, this service is 10 minutes or greater. Based on discussion from clinical staff, the task force agreed that this service is approximately 20 minutes. Therefore, 20 RVUs will be assigned.

pp. CPT 99464 [Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn] has a median of 35 AARC minutes. The task force referenced applicable time and support and agreed that 35 minutes was not sufficient. After discussion, the task force agreed that this procedure requires approximately 60 minutes. Therefore, 60 RVUs will be assigned.

qq. HCPCS G0237 [Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)] did not have AARC minutes. Per the AMA description, this service is each 15 minutes. Therefore, 15 RVUs, for each 15 minutes, will be assigned.

rr. HCPCS G0238 [Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)] did not have AARC minutes. Per the AMA description, this service is each 15 minutes. Therefore, 15 RVUs, for each 15 minutes, will be assigned.

ss. HCPCS G0239 [Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)] did not have AARC minutes. The ratio of care team provider to patient is ~~often~~ generally 1:4 and sessions last one hour. Therefore, 15 RVUs (60 minutes/4 patients) will be assigned.

tt. HCPCS G0424 [Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day] did not have AARC minutes. The ratio of care team provider to patient is often 1:4 and sessions last one hour. The first and last sessions typically requires one-on-one time. Therefore, 18 RVUs (60 minutes/4 patients plus additional time to account for the first and last sessions) will be assigned.

SERVICES WITHOUT AN ASSIGNED CPT CODE

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
RESPIRATORY THERAPY & PULMONARY FUNCTION TESTING

Various respiratory services do not have assigned CPT codes. These services will be included in Appendix D under CPT 94799. For all other usage of 94799, the RVU is "by report" and will require development based on minutes of staff time required.

a. Aerosol Therapy-

    a. Continuous aerosol mist= 30 RVUs/day. Note: Daily oxygen is bundled with this service.

    b. Continuous nebulization- non-bronchodilator= 250 RVUs/day. Used for continuous nebulization of non-bronchodilator medications, includes pulmonary vasodilator medications, antibiotics, or any non-bronchodilator nebulized medication administered.

    Patients receiving more than one of the types of aerosol therapies listed above report the highest complexity service I.e.) Cont Aerosol mist + Cont Neb-BD: Report ONLY Cont Neb-BD, I.e.) Cont Neb-BD + Cont Neb-Non-BD: Report ONLY Cont Neb-non-BD. A second less complex aerosol therapy is bundled into the highest complexity service.

b. Arterial blood sampling via indwelling catheter – This service is bundled with other services and not to be reported separately.

c. Gas Therapies –

    a. High Flow Oxygen – This procedure requires an average of six ~~checks~~ patient visits per day with an average of 20 minutes per check. Therefore, 120 RVUs/day will be assigned to this code.

    b. Inhaled Nitric Oxide – Therapeutic gas administration for the treatment of Pulmonary Hypertension and other related conditions in patients who have this condition or related disease processes primarily in newborns and adults who exhibit signs of Pulmonary Hypertension. May also be used to treat reperfusion injury as in patients who have received heart and/or lung transplants. The task force agreed this service is similar in time and resources to CPT 94002 [Ventilation assist and management] therefore 250 RVUs/day will be assigned.

    c. Alternative Gases- The administration of gases or mixtures of gases other than the traditional administration of oxygen or medical air. Administration requires procuring special equipment, special expertise, and additional time in providing this gas and systems to patients. Examples of these gases are Helium, Helium oxygen measures, Carbon dioxide and mixtures, and Nitrogen gas mixtures excluding Nitric Oxide. The task force agreed this service is similar in time and resources as High Flow Oxygen therefore 120 RVUs/day will be assigned.

    d. Oxygen – This is all-inclusive rate for oxygen that is not high flow nasal cannula oxygen. The task force assigned 20 RVUs per day based on the average amount of minutes required for this service. This service may not be reported with CPT 94799 [Aerosol Therapy]. Daily care and cleaning of transtracheal oxygen catheter is not to be separately reported.

d. Bedside pulmonary mechanics – Non-vent- Used only for spontaneous breathing, non-ventilator patients, as a diagnostic measure of respiratory muscle strength, volumes, and capacities. Includes, not limited to, negative inspiratory force, tidal volume, and minute volumes. This must be performed stand-alone to be reported. The task force recommended using the AARC median minutes of 15. Therefore 15 RVUs will be assigned.

e. Generation of Non-Emergent NIV patient compliance study – The task force recommended using the AARC median minutes of 15. Therefore 15 RVUs will be assigned.

f. Incentive spirometry – This service is not to be reported separately; generally, is performed by nursing and it does not meet the requirements of the spirometry CPT 94010. This is assigned zero (0) RVUs.

g. Comprehensive Patient Assessment- The process of gathering and evaluating data from a complete medical record, consultations, physiologic monitors, that does not lead to the immediate administration of another respiratory service/treatment. This service is not intended to be used for routine Respiratory Assess and Treat order and must be specifically ordered and provided stand alone. There is a maximum of once/day allowed. This service is approximately 20 minutes in duration, therefore, 20 RVUs will be assigned.

h. Manual ventilation – This cannot be reported with ventilator or rapid response service. The task force recommended keeping this service weighted at 15 RVUs per quarter hour.

i. Nasopharyngeal airway- This service is bundled with other services and not separately reportable. This is assigned zero (0) RVUs.

j. Peak flow/spirometry monitoring – This service is bundled with other services and not separately reportable. This is assigned zero (0) RVUs.

k. Mini broncho alveolar lavage (BAL) – This is for stand-alone usage only and would not be ~~charged~~ reported in addition to another bedside procedural assist. The task force recommended ~~used~~ using the AARC median minutes of 30. Therefore 30 RVUs will be assigned.

   This activity describes the collection of a non-bronchoscopic bronchoalveolar lavage to obtain fluid specimen for the diagnosis of ventilator associated pneumonia.

l. Bedside Procedural Assistance – This is used when respiratory therapists assist physicians or other authorized providers with complex bedside procedures including but not limited to bedside bronchoscopy, laryngoscopy, endoscopy, lung biopsy, chest tube insertion, percutaneous tracheostomy, A-line insertion, peripherally inserted central catheter (PICC), thoracentesis, cricothyrotomy, central line insertion pulmonary artery catheter setup, and hemodynamic monitoring/measurements. The task force assigned 30 minutes for this service based on the average amount of support time. Therefore 30 RVUs will be assigned.

m. Rapid response –This service is reportable once per rapid response event and may not be used in combination with Cardiopulmonary Resuscitation. These events typically require an average of 30 minutes of support. Therefore 30 RVUs will be assigned.

n. Bedside Sleep Apnea Screening- The application of an Impedance Monitoring system to assess a patient's ventilatory pattern with periodic evaluation of patient. When in hospital bedside sleep apnea screenings are performed by inpatient respiratory therapists as a separate service, average amount of support time 30 minutes. Therefore 30 RVUs will be assigned.

o. Speech Services-The task force agreed certain services are reportable via the Speech Therapy rate center/assigned zero (0) RVUs

   a. Placement/Removal of Assistive Speech Value

   b. Transdiaphragmatic pressure

p. Subsequent Patient Assessment- Limited patient assessments are bundled with associated procedures and therefore zero (0) RVUs will be assigned.

q. Tracheostomy Tube Care- This service cannot be charged with ventilator daily charges. For non-vent patients, the task force agreed this procedure is approximately 20 minutes. Therefore 20 RVUs will be assigned. Initial placement, daily care, and removal of tracheostomy button are bundled with this service.

~~r.~~ Transcutaneous Monitoring- Transcutaneous (existing, applied, or measured across the depth of the skin) oxygen/carbon dioxide monitoring. A method of measuring the oxygen/carbon dioxide in the blood by attaching electrodes to the skin which contain heating coils to raise the skin temperature and increase blood flow at the surface. This is similar in support time to 94770 [end tidal CO2 procedure] assigned 40 RVUs. Therefore 40 RVUs will be assigned.

s. Ventilator services- The following services are considered a component of ventilator services and not separately reportable/assigned zero (0) RVUs and are bundled into the daily vent management service.

    a. Ambulation
    b. Endotracheal tube re-stabilization and positioning
    c. Extubation of Airway
    d. FRC determination during mechanical ventilation
    e. Maximal inspiratory and expiratory pressure (also bundled with Pulmonary Function Testing)
    f. Monitor cuff pressure/care
    g. Placement or change of in-line suction catheter
    h. Prone positioning
    i. Spontaneous breathing trial and/or screen
    j. Static pressure/volume loop (also bundled with Pulmonary Function Testing)
    k. Therapeutic ventilator maneuver (recruitment maneuver)
    l. Transport/MRI ventilator use during – invasive Mechanical Ventilation
    m. Ventilator circuit change – invasive mechanical ventilation
    n. Work of breathing

CPT Codes with Bundled Procedures

CPT codes from 2018 with a surgical component have been assigned a zero (0) RVU value. If a RES or PUL CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC), and the associated costs of the procedure/service are to be reclassified to the IRC cost center. (This is minimal for Respiratory/Pulmonary Services.)

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2018 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above, where possible, using the most current AARC Uniform Reporting Manual. For codes that are not listed in the AARC Uniform Reporting Manual, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of descriptions and the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

Separate Procedures

These are codes that include the parenthetical statement "separate procedure". The inclusion of this statement indicates that the procedure can only be reported when it is performed stand-alone. A "separate procedure" should not be reported when performed along with another procedure in an anatomically related region through the same skin incision or orifice, or approach.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVUs will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and other medical equipment are part of hospital room and board and are not separately reportable and should not be assigned separately.

Drugs are NOT a routine part of any Resp/Pulm examination. These drugs should NOT be included in the RVU of the exam and are to be ~~billed~~ reported separately through the pharmacy. Drugs should not be assigned an RVU.

CPT	Description	RVU [1]
31500	INTUBATION, ENDOTRACHEAL, EMERGENCY PROCEDURE	25
31502	TRACHEOTOMY TUBE CHANGE PRIOR TO ESTABLISHMENT OF FISTULA TRACT	22
31505	LARYNGOSCOPY, INDIRECT, DIAGNOSTIC (SEPARATE PROCEDURE)	0 See Procedure Assist
31720	CATHETER ASPIRATION (SEPARATE PROCEDURE); NASOTRACHEAL	15
33946	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) PROVIDED BY PHYSICIAN; INITIATION, VENO-VENOUS	1820/day
33947	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) PROVIDED BY PHYSICIAN; INITIATION, VENO-ARTERIAL	1820/day

APPENDIX D
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CPT	Description	RVU [1]
33948	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) PROVIDED BY PHYSICIAN; DAILY MANAGEMENT, EACH DAY, VENO-VENOUS	1440/day
33949	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) PROVIDED BY PHYSICIAN; DAILY MANAGEMENT, EACH DAY, VENO-ARTERIAL	1440/day
36410	VENIPUNCTURE, AGE 3 YEARS OR OLDER, NECESSITATING THE SKILL OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (SEPARATEPROCEDURE), FOR DIAGNOSTIC OR THERAPEUTIC PURPOSES (NOT TO BE USED FORROUTINE VENIPUNCTURE)	Report via Lab
36416	COLLECTION OF CAPILLARY BLOOD SPECIMEN (EG, FINGER, HEEL, EAR STICK)	Report via Lab
36600	ARTERIAL PUNCTURE, WITHDRAWAL OF BLOOD FOR DIAGNOSIS	15
36620	ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING, MONITORING OR TRANSFUSION (SEPARATE PROCEDURE); PERCUTANEOUS	30
92950	CARDIOPULMONARY RESUSCITATION (EG, IN CARDIAC ARREST)	80/ session
93463	PHARMACOLOGIC AGENT ADMINISTRATION (EG, INHALED NITRIC OXIDE, INTRAVENOUS INFUSION OF NITROPRUSSIDE, DOBUTAMINE, MILRINONE, OR OTHERAGENT) INCLUDING ASSESSING HEMODYNAMIC MEASUREMENTS BEFORE, DURING, AFTER AND REPEAT PHARMACOLOGIC AGENT ADMINISTRATION, WHEN PERFORMED (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) NOTE: CATH LAB ONLY	46
93503	INSERTION AND PLACEMENT OF FLOW DIRECTED CATHETER (EG, SWAN-GANZ) FOR MONITORING PURPOSES	0 See Procedural Assistance

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CPT	Description	RVU [1]
94002	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUMEPRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, INITIAL DAY [This service includes all services provided to ventilator patients including but not limited to mobility, transport, spontaneous mechanics, patient/system checks, etc.]	250/day-adult, 300/day-Neonates
94003	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY [This service includes all services provided to ventilator patients including but not limited to mobility, transport, spontaneous mechanics, patient/system checks, etc.]	250/day-adult, 300/day-Neonates
94004	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; NURSINGFACILITY, PER DAY	0
94005	HOME VENTILATOR MANAGEMENT CARE PLAN OVERSIGHT OF A PATIENT (PATIENTNOT PRESENT) IN HOME, DOMICILIARY OR REST HOME (EG, ASSISTED LIVING) REQUIRING REVIEW OF STATUS, REVIEW OF LABORATORIES AND OTHER STUDIES AND REVISION OF ORDERS AND RESPIRATORY CARE PLAN (AS APPROPRIATE), WITHIN A CALENDAR MONTH, 30 MINUTES OR MORE	0
94010	SPIROMETRY, INCLUDING GRAPHIC RECORD, TOTAL AND TIMED VITAL CAPACITY, EXPIRATORY FLOW RATE MEASUREMENT(S), WITH OR WITHOUT MAXIMAL VOLUNTARY VENTILATION	25
94011	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	30
94012	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS, BEFORE AND AFTER BRONCHODILATOR, IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	38

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CPT	Description	RVU [1]
94013	MEASUREMENT OF LUNG VOLUMES (IE, FUNCTIONAL RESIDUAL CAPACITY [FRC], FORCED VITAL CAPACITY [FVC], AND EXPIRATORY RESERVE VOLUME [ERV]) IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	33
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 REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTHCARE PROFESSIONAL	BY REPORT
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)	BY REPORT
94016	PATIENT-INITIATED SPIROMETRIC RECORDING PER 30-DAY PERIOD OF TIME; REVIEW AND INTERPRETATION ONLY BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	0
94060	BRONCHODILATION RESPONSIVENESS, SPIROMETRY AS IN 94010, PRE- AND POST-BRONCHODILATOR ADMINISTRATION	37
94070	BRONCHOSPASM PROVOCATION EVALUATION, MULTIPLE SPIROMETRIC DETERMINATIONS AS IN 94010, WITH ADMINISTERED AGENTS (EG, ANTIGEN[S], COLD AIR, METHACHOLINE)	84
94150	VITAL CAPACITY, TOTAL (SEPARATE PROCEDURE)	18
94200	MAXIMUM BREATHING CAPACITY, MAXIMAL VOLUNTARY VENTILATION	12
94250	EXPIRED GAS COLLECTION, QUANTITATIVE, SINGLE PROCEDURE (SEPARATE PROCEDURE)	30
94375	RESPIRATORY FLOW VOLUME LOOP	0
94400	BREATHING RESPONSE TO CO2 (CO2 RESPONSE CURVE)	30
94450	BREATHING RESPONSE TO HYPOXIA (HYPOXIA RESPONSE CURVE)	30

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CPT	Description	RVU [1]
94452	HIGH ALTITUDE SIMULATION TEST (HAST), WITH INTERPRETATION AND REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL;	45
94453	HIGH ALTITUDE SIMULATION TEST (HAST), WITH INTERPRETATION AND REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; WITH SUPPLEMENTAL OXYGEN TITRATION	45
94610	INTRAPULMONARY SURFACTANT ADMINISTRATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL THROUGH ENDOTRACHEAL TUBE	30
94617	EXERCISE TEST FOR BRONCHOSPASM, INCLUDING PRE- AND POST-SPIROMETRY, ELECTROCARDIOGRAPHIC RECORDING(S), AND PULSE OXIMETRY	71
94618	PULMONARY STRESS TESTING (EG, 6-MINUTE WALK TEST), INCLUDING MEASUREMENT OF HEART RATE, OXIMETRY, AND OXYGEN TITRATION, WHEN PERFORMED	30
94621	PULMONARY STRESS TESTING; COMPLEX (INCLUDING MEASUREMENTS OF CO2 PRODUCTION, O2 UPTAKE, AND ELECTROCARDIOGRAPHIC RECORDINGS)	90
94640	PRESSURIZED OR NONPRESSURIZED INHALATION TREATMENT FOR ACUTE AIRWAY OBSTRUCTION FOR THERAPEUTIC PURPOSES AND/OR FOR DIAGNOSTIC PURPOSES SUCH AS SPUTUM INDUCTION WITH AN AEROSOL GENERATOR, NEBULIZER, METERED DOSE INHALER OR INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) DEVICE	480 per inpatient admission 40 per outpatient admission
94642	AEROSOL INHALATION OF PENTAMIDINE FOR PNEUMOCYSTIS CARINII PNEUMONIATREATMENT OR PROPHYLAXIS	60
94644	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION FOR ACUTE AIRWAY OBSTRUCTION; FIRST HOUR	34

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CPT	Description	RVU [1]
94645	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION FOR ACUTE AIRWAY OBSTRUCTION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) MAX 4	28
94660	CONTINUOUS POSITIVE AIRWAY PRESSURE VENTILATION (CPAP), INITIATION AND MANAGEMENT	120/day
94662	CONTINUOUS NEGATIVE PRESSURE VENTILATION (CNP), INITIATION AND MANAGEMENT	120/day
94664	DEMONSTRATION AND/OR EVALUATION OF PATIENT UTILIZATION OF AN AEROSOL GENERATOR, NEBULIZER, METERED DOSE INHALER OR IPPB DEVICE	15/day
94667	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND VIBRATION TO FACILITATE LUNG FUNCTION; INITIAL DEMONSTRATION AND/OR EVALUATION	30
94668	MANIPULATION CHEST WALL, SUCH AS CUPPING, PERCUSSING, AND VIBRATION TO FACILITATE LUNG FUNCTION; SUBSEQUENT [This includes services provided by the Inexsufflator – Cough Assist and other products providing the same function.]	25
94669	MECHANICAL CHEST WALL OSCILLATION TO FACILITATE LUNG FUNCTION, PER SESSION	30
94680	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST AND EXERCISE, DIRECT, SIMPLE	75
94681	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; INCLUDING CO2 OUTPUT, PERCENTAGE OXYGEN EXTRACTED	90
94690	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST, INDIRECT (SEPARATE PROCEDURE)	60
94726	PLETHYSMOGRAPHY FOR DETERMINATION OF LUNG VOLUMES AND, WHEN PERFORMED, AIRWAY RESISTANCE	19
94727	GAS DILUTION OR WASHOUT FOR DETERMINATION OF LUNG VOLUMES AND, WHEN PERFORMED, DISTRIBUTION OF VENTILATION AND CLOSING VOLUMES	19

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CPT	Description	RVU [1]
94728	AIRWAY RESISTANCE BY IMPULSE OSCILLOMETRY	15
94729	DIFFUSING CAPACITY (EG, CARBON MONOXIDE, MEMBRANE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	20
94750	PULMONARY COMPLIANCE STUDY (EG, PLETHYSMOGRAPHY, VOLUME AND PRESSURE MEASUREMENTS)	30
94760	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; SINGLE DETERMINATION	8
94761	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; MULTIPLE DETERMINATIONS (EG, DURING EXERCISE)	30
94762	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; BY CONTINUOUS OVERNIGHT MONITORING (SEPARATE PROCEDURE)	30
94770	CARBON DIOXIDE, EXPIRED GAS DETERMINATION BY INFRARED ANALYZER	40/day
94772	CIRCADIAN RESPIRATORY PATTERN RECORDING (PEDIATRIC PNEUMOGRAM), 12-24HOUR CONTINUOUS RECORDING, INFANT	34
94774	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORYRATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; INCLUDES MONITOR ATTACHMENT, DOWNLOAD OF DATA, REVIEW, INTERPRETATION, ANDPREPARATION OF A REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	0
94775	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITORATTACHMENT ONLY (INCLUDES HOOK-UP, INITIATION OF RECORDING AND DISCONNECTION)	By Report

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CPT	Description	RVU [1]
94776	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITORING, DOWNLOAD OF INFORMATION, RECEIPT OF TRANSMISSION(S) AND ANALYSES BY COMPUTER ONLY	0
94777	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; REVIEW, INTERPRETATION AND PREPARATION OF REPORT ONLY BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	0
94780	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NURSING OBSERVATION AND CONTINUOUS RECORDING OF PULSE OXIMETRY, HEART RATE AND RESPIRATORY RATE, WITH INTERPRETATION AND REPORT; 60 MINUTES	60
94781	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NURSING OBSERVATION AND CONTINUOUS RECORDING OF PULSE OXIMETRY, HEARTRATE AND RESPIRATORY RATE, WITH INTERPRETATION AND REPORT; EACH ADDITIONAL FULL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	30
94799	ALTERNATIVE GAS THERAPY The administration of gases or mixtures of gases other than the traditional administration of oxygen or medical air. Administration requires procuring special equipment, special expertise, and additional time in providing this gas and systems to patients. Examples of these gases are Helium, Helium oxygen measures, Carbon dioxide and mixtures, and Nitrogen gas mixtures excluding Nitric Oxide.	120/day
94799	BEDSIDE PULMONARY MECHANICS Used for spontaneously breathing, non-vented patients, as a diagnostic measurement of respiratory muscle strength, volumes, and capacities. Includes, not limited to negative inspiratory force, tidal volume, and minute volumes. May have more than one session per day; each session may include multiple different measurements.	15

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CPT	Description	RVU [1]
94799	CONTINUOUS NEBULIZATION-NON-BRONCHODILATOR Used for continuous nebulization of non-bronchodilator medications, includes pulmonary vasodilator medications, antibiotics, or any non-bronchodilator nebulized medication administered.	250/day
94799	CONTINUOUS AEROSOL MIST W/ OR W/OUT OXYGEN The initial application of equipment to supply and maintain a continuous aerosol mist, with or without increased oxygen concentration (FIO2), to a patient, using a face mask, tracheostomy mask, T-piece, hood, or other device. Includes the periodic evaluation of the system supplying and maintaining a continuous aerosol mist with or without increased oxygen (FIO2) to a patient. The aerosol may be heated or cool. Daily oxygen is bundled into this service.	30/day
94799	GENERATION OF NON-EMERGENT NIV PATIENT COMPLIANCE STUDY This activity describes the evaluation, application, and monitoring of a patient, using a non-invasive portable ventilator, as a means in determining oxygenation/ventilation requirements during resting, ambulation, and walking/exercise to quantify the required ventilation needs with daily life activities.	15
94799	HIGH FLOW OXYGEN THERAPY Heated, humidified high flow nasal cannula (HFNC, aka: HFO, HFT) that can deliver up to 100% heated and humidified oxygen at a flow rate that meets or exceeds patient demand	120/day
94799	INHALED NITRIC OXIDE Therapeutic gas administration for the treatment of Pulmonary Hypertension and other related conditions in patients who have this condition or related disease processes primarily in newborns and adults who exhibit signs of Pulmonary Hypertension. May also be used to treat reperfusion injury as in patients who have received heart and/or lung transplants	250/day
94799	COMPREHENSIVE PATIENT ASSESSMENT The process of gathering and evaluating data from a patient's complete medical record, consultations, physiological monitors and bedside observations (that does not lead to the immediate administration of a treatment). This must be specifically ordered and may only be charged once per day.	20/day
94799	MANUAL VENTILATION Intermittent manual compression of a gas-filled reservoir bag to force gases into a patient's lungs to maintain and support oxygenation and carbon dioxide elimination during apnea or hypoventilation. Can't be reported with ventilator and rapid response.	15/qtr hr

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CPT	Description	RVU [1]
94799	MINI BRONCHO ALVEOLAR LAVAGE (BAL) This activity describes the collection of a non-bronchoscopic bronchoalveolar lavage to obtain fluid specimen for the diagnosis of ventilator associated pneumonia.	30
94799	NASOPHARNGEAL TUBE CARE A curved flexible endotracheal tube to be slotted down one nostril to open a channel between the nostril and nasopharynx, to sit behind the tongue, that can be used in an emergency (egg, unconscious patient), or for long-term purposes to create a patient airway.	~~10~~ 0
94799	OXYGEN THERAPY The initial application and periodic monitoring of equipment supplying and maintaining continuous increased oxygen concentration (FIO2) to a patient using a cannula, simple oxygen mask, non-rebreather mask or enturi-type mask. This excludes high flow oxygen therapy and cannot be reported with Continuous Aerosol therapy.	20/day
94799	RAPID RESPONSE Used when respiratory therapy is part of a multidisciplinary team of clinicians who bring critical care expertise and interventions directly to patients with early signs of deterioration. Use ONCE per rapid response event. DO NOT USE in combination with Cardiopulmonary Resuscitation. Regardless of number of therapists present	30
94799	TRACH TUBE CARE The routine care of a tracheostomy tube and tracheostomy site. Not reportable for ventilator patients.	20
94799	TRANSCUTANEOUS MONITORING Transcutaneous (existing, applied, or measured across the depth of the skin) oxygen/carbon dioxide monitoring. A method of measuring the oxygen/carbon dioxide in the blood by attaching electrodes to the skin which contain heating coils to raise the skin temperature and increase blood flow at the surface	40/day
94799	Bedside Sleep Apnea Screening The application of an Impedance Monitoring system to assess a patient's ventilatory pattern with periodic evaluation of patient	30
~~94799~~	~~Nasopharyngeal airway~~	~~0~~
94799	UNLISTED PULMONARY SERVICE OR PROCEDURE	BY REPORT
94799	Bedside Procedure Assist- Used for assistance during separate complex bedside procedures performed by authorized prescribers (physicians, PAs, NPs). Examples include, not limited to, bedside laryngoscopy/bronchoscopy/ endoscopy/ lung biopsy, chest tube insertion, bedside percutaneous trach, A-line insertion, peripherally inserted central catheter (PICC), thoracentesis, cricothyrotomy, central line insertion,	30

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CPT	Description	RVU [1]
	hemodynamic monitoring/measurements, or other invasive diagnostic or therapeutic, or emergency procedure.	
95012	NITRIC OXIDE EXPIRED GAS DETERMINATION	15
99406	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTERMEDIATE, GREATER THAN 3 MINUTES UP TO 10 MINUTES	10
99407	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTENSIVE, GREATER THAN 10 MINUTES	20
99464	ATTENDANCE AT DELIVERY (WHEN REQUESTED BY THE DELIVERING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL) AND INITIAL STABILIZATION OF NEWBORN	60
G0237	THERAPEUTIC PROCEDURES TO INCREASE STRENGTH OR ENDURANCE OF RESPIRATORY MUSCLES, FACE TO FACE, ONE ON ONE, EACH 15 MINUTES (INCLUDES MONITORING)	15
G0238	THERAPEUTIC PROCEDURES TO IMPROVE RESPIRATORY FUNCTION, OTHER THAN DESCRIBED BY G0237, ONE ON ONE, FACE TO FACE, PER 15 MINUTES (INCLUDES MONITORING)	15
G0239	THERAPEUTIC PROCEDURES TO IMPROVE RESPIRATORY FUNCTION OR INCREASE STRENGTH OR ENDURANCE OF RESPIRATORY MUSCLES, TWO OR MORE INDIVIDUALS (INCLUDES MONITORING)	15
G0424	PULMONARY REHABILITATION, INCLUDING EXERCISE (INCLUDES MONITORING), ONE HOUR, PER SESSION, UP TO TWO SESSIONS PER DAY	18

Leukopheresis

Leukopheresis Relative Values as developed by the Johns Hopkins Hospital, reproduced below, shall be used to determine the units related to the output of the Leukopheresis cost center.

Procedure	Unit Value
Leukopheresis Run	
Granulocytes	15.6
Other Pheresis Runs	
Random Platelets	1.0
Matched Platelets	10.9
Therapeutic	5.0
Special	4.0

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
LABOR AND DELIVERY

Labor and Delivery

Labor and Delivery Service

The Labor and Delivery Relative Value Units were developed by a task force which included clinical and financial representatives of Maryland hospitals and HSCRC staff. These relative value units will be used as the standard unit of measure related to the output of the Labor and Delivery Revenue Center.

All time reflects standard of 1 RVU=15 minutes of direct RN care. Charges made to Labor and Delivery RVUs must reflect entire procedure or event occurring in the Obstetrical suite without duplication, support or charges to other areas using RVUs, minutes, or hours per patient day at the same time. As an example, a short stay D&C cannot be charged RVUs plus OR minutes; a sonogram cannot be charged RVUs to Labor and Delivery and to Radiology. Each institution should designate where a procedure is to be charged based on where that procedure is performed. For any Labor and Delivery OR suite procedure, RVUs or Minutes may be charged, but not both.

Primary Obstetrical Procedures:

These procedures include physical assessment, pregnancy history, and vital signs. Delivery procedures are excluded. RVUs are assigned on the basis of RN time only in relation to these procedures. Charges for these Obstetrical charges (See section to follow entitled: L & D Observation/Triage services.)

1RVU=15 minutes of direct RN care

Procedures	RVUs
Amniocentesis – Diagnostic	3
Biophysical Profile with NST	5
Biophysical Profile w/o NST	4
Cervical Cerclage	10
Dilation & Curettage (D&C)	9
Dilation and Evacuation (D&E)	9
Doppler Flow Evaluation	1
External Cephalic Versions	10
*Minor OR procedure, w/o delivery	8
*Major OR procedure, w/o delivery	38
Non-Stress Test, Fetal	5
Oxytocin Stress Test	5
Periumbilical Blood Sampling (PUBS)	18(+4w/multiples)
Periumbilical Blood Sampling (PUBS) double set up w/OR	2
Ultrasound, OB (performed and read by Obstetrics personnel only)	By Report

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LABOR AND DELIVERY

*The classification of minor and major procedures is related to the complexity of the case and the nursing workload required for patient care. The lists below are examples of procedures in each category, but the classification is not limited to these examples.

Minor:	Major:
Cerclage insertion or removal	Bladder repair
Incision and Drainage (I&D)	Bowel repair
Needle membrane	Hernia repair
Tubal ligation	Hysterectomy
Wound care	Oophorectomy

*"Minor" surgery is any invasive operative procedure in which only skin or mucous membranes and connective tissue is resected, e.g., vascular cutdown for catheter placement, implanting pumps in subcutaneous tissue. Also included are procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar in combination with a "minor" surgical procedure, e.g., the placement of electrodes into the CNS through reflected skin and a burr hole in the cranium, so long as the dura is not resected.

*"Major" surgery is any invasive operative procedure in which extensive resection is performed, e.g., a body cavity is entered, organs are removed, or normal anatomy is significantly altered. In general, if a mesenchymal barrier is opened (pleurum, peritoneum, meninges) or an extensive orthopedic procedure is involved, the surgery is considered "major". For surgical procedures that do not clearly fall in the above categories, the chance for significant inadvertent infection of the surgical site is to be a primary consideration.

DELIVERY Procedures:

The following procedures are primarily inpatient services, however if any are performed on an outpatient basis hospital should apply the most appropriate CPT codes.

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Procedures: (SELECT ONLY ONE):	RVUs
Fetal Demise/Genetic Termination 2nd or 3rd Trimester	30
Fetal Demise/Genetic Termination 2nd or 3rd Trimester w/Epidural	36
Delivery outside the hospital, prior to arrival	12
Vaginal Delivery (No anesthesia, uncomplicated)	24
Vaginal Delivery w/Vacuum/Forceps Assistance	26
Vaginal Delivery w/Epidural Anesthesia	30
Vaginal Delivery w/Epidural w/Forceps/Vacuum Assistance	32
Vaginal Delivery after prior C-section (VBAC)	32
Cesarean Section, non-emergent	18
Cesarean Section, non-emergent w/minor surgery	20
Cesarean Section, non-emergent w/major surgery	31
Cesarean Section, emergent/urgent	37
Cesarean Section, emergent/urgent, w/minor surgery	39
Cesarean Section, emergent/urgent, w/major surgery	61

The definition of Emergent and Non-emergent is based on timing also known as the "decision to incision time". An emergent procedure is where the absence of immediate medical attention could result in severe life threatening or possibly disabling conditions to the patient or fetus and is performed within 30 minutes of the physician's decision. An urgent procedure is one that requires prompt attention but does not pose an immediate threat to life or health. It could become emergent if not diagnosed or treated in a timely manner, but where the patient's condition is stable enough to tolerate a short delay beyond the 30-munte decision-to-incision window.

Non-emergent services are those provided for stable maternal and fetal conditions that do not require immediate or rapid intervention. These services are planned or scheduled and are not associated with expected rapid clinical deterioration.

OBSTETRICAL ADD ON TO DELIVERY Procedures:

These are procedures that are performed in addition to the core procedures listed above:

Procedure	RVUs
Amnioinfusion	6
Double Set-Up/Failed Forceps/Vacuum	2
Intrauterine Pressure Catheter Monitoring (IUPC)	2
Induction/Augmentation w/delivery	4
Multiple Birth: Twins	6
Multiple Birth: Triplets	9
Multiple Birth: Quads	12
Neonatal Resuscitation (APGAR < 6 @ 1 minute; PH < 7.2)	4

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POSTPARTUM OBSTETRICAL SURGICAL Procedures:

The following procedures are listed to capture RVUs for postpartum obstetrical surgeries that occur after an episode of delivery, vaginal or cesarean section. Please refer to page 2 for the definition and examples of minor and major procedures.

Procedures **(SELECT ONLY ONE)**:

Surgery, Additional minor, non-emergent	8
Surgery, Additional major, non-emergent	19
Surgery, Additional minor, emergent/urgent	16
Surgery, Additional major, emergent/urgent	38

MISCELLANEOUS PROCEDURES

	RVUs
Circumcision (even if performed in Nursery)	3
Oocyte Retrieval	10
Gamete Intrafallopian Tube Transfer (GIFT)/Tubal Embryo Transfer	16

ASSESSMENT/TRIAGE and OBSERVATION Services:

Hospitals should determine the most appropriate level of Assessment/Triage, the use of Observation, and Maternal Intensive Care; then apply the most appropriate observation and/or evaluation and management code depending on the physician order.

	RVUs
Services:	
Assessment/Triage Services	1

Assessment/Triage services may include but are not limited to performing a health and physical assessment, pregnancy history and vital signs.

	RVUs
Outpatient Maternal Observation	1 per hour (15 min direct RN time per hour)

Observation is a valid clinical service. The primary purpose of observation services in L&D is to determine whether the patient should be admitted as an inpatient. The service includes the use of a hospital bed and periodic monitoring, by the facility's nursing or other staff, deemed reasonable and necessary to evaluate the patient's condition to determine whether she should be admitted. This service may not be reported concurrently with Outpatient Maternal Intensive Care (MIC).

Outpatient Maternal Observation minutes should be rounded up to the nearest full hour. This should be interpreted to mean that 30 minutes = 0 RVUs, 31 minutes = 1 RVU, 75 minutes = 1 RVU, etc.

Some common examples of providing observation and triage services included but not limited to are:

1) Labor evaluation
2) Cervical ripening
3) Fetal monitoring
4) Motor Vehicle Accident
5) IV hydration

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L & D MATERNAL INTENSIVE CARE (MIC) **RVUs:**

Outpatient Maternal Intensive Care	2 RVUs per hour (30 min direct RN time per hour)

This category is reserved for patients requiring on-going intensive nursing care. This category may be charged only during the period of intensive interventions. (Note: Patients who have been admitted and require on-going intensive nursing care should be reported with the applicable inpatient care room and board rate and not Maternal Intensive Care). Examples of disease processes with designated pharmaceutical and or nursing interventions are listed below but the examples are not all inclusive. This service may not be reported concurrently with Maternal Observation. MIC hours can be used for postpartum outpatients. When a postpartum patient requires MIC and does not meet admission criteria then MIC hours should be charged.

Once a patient has been admitted (whether ante or post-partum), there cannot be hourly charges on the same day as the admission (and subsequent days) because the patient is already receiving patient day charges.

Diagnoses:
Cardiac Disease
Bleeding Disorders
Disseminated Intravascular Coagulation (DIC)
Diabetes Mellitus
Hypertensive Disorder of Pregnancy (HDP)
Preterm labor
Multisystem Disorders
Asthma

Examples of pharmaceuticals and nursing care necessary for MIC include but are not limited to the following:

Pharmaceutical:
Magnesium Sulfate
Ritodrine
Terbutaline (repeated SQ doses)
Aminophylline
Insulin IV Drip
Apresoline
Heparin Sulfate
Phenytoin Sodium (Dilantin)
Pitocin
Nifedipine
Labetalol
AZT Drip
IVIG Drip

Nursing Care:
Blood Transfusions (> 2 units)
Nebulizer Therapy
Invasive Hemodynamic Monitoring
Conscious Sedation procedures
- a) PUBS
- b) Fetal surgery
- c) Fetal exchange transfusion

Ventilation Therapy
Labor/Delivery care on another unit

Interventional Radiology/Cardiovascular

Definition of IRC

The Interventional Cardiovascular Services (IVC) rate center is re-named Interventional Radiology/Cardiovascular to better reflect both interventional radiologic and interventional cardiovascular services. The Interventional Radiology/Cardiovascular Department provides special diagnostic, therapeutic, and interventional procedures that include the use of imaging techniques to guide catheters and other devices through blood vessels and other pathways of the body. When these procedures are performed in the operating room and charged with operating room minutes, hospitals may not charge IRC minutes in addition to operating room minutes. All Medical/Surgical supplies utilized in these cases will be billed for separately through the MedSurg Supplies (MSS) rate center.

Assigning RVUs

RVUs are assigned based either on the actual clock minutes it takes to perform the procedure—similar to the assignment of Operating Room minutes or the average minutes it takes to perform the procedure based on an annual time study. Procedures with a separately billable imaging component are assigned a single RVU for the imaging component. It is assumed that the costs associated with the imaging component are already included in the IRC rate center and therefore should not generate additional revenue. A single RVU is reported for the imaging component so that, when appropriate, an imaging CPT code can be included in the coding of the case. In practice, this means hospitals may want to assign in their charge description master a value of one, representing one RVU, to each imaging component associated with an interventional procedure.

Start and Stop Times

The definition of start and stop time for procedures performed in IRC mirrors the definition used in the operating room.
Starting time is:

- The beginning of the procedure if general anesthesia is not administered, or
- The beginning of general anesthesia or conscious sedation administered in the procedure room

Ending time is:

- Removal of the needle or catheter, if general anesthesia is not administered, or
- The end of general anesthesia.

Six hours of recovery time is included in the minute value. The time the anesthesiologist spends with the patient in the recovery room is not counted. Sheath removal and hemostasis is considered part of recovery and is not to be counted.

The cost of sedation and pain reducing drugs used to make a procedure more easily tolerated are not included in the IRC rate center. The time it takes to administer the drugs is accounted for in counting the procedure minutes. Revenue and expenses associated with the drug itself are billed and reported through the Pharmacy rate center.

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Clinic Services

Clinic services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services may be provided to inpatients; for example, if specialized staff from the clinic must provide care to an inpatient at the patient's bedside.

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Labor and Delivery, Electroencephalography, Echocardiography, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, or Speech Therapy, are to be reported in those specific rate centers.

Clinic services may include either one or both of the following two components: an evaluation and management (E/M) visit and/or non-surgical procedure(s).

Approach

Clinic Relative Value Units (RVUs) were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of the codes in this section of Appendix D were obtained from the 2022 edition of the Current Procedural Terminology (CPT) manual and the 2022 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2022 Medicare Physician Fee Schedule (MPFS) released December 15, 2021, and then assigned using the following protocol.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, the psychotherapy CPT of 90832 shown below has a NON-FAC PE RVU of 0.48. 0.48 * 10 = 4.8. 4.8 rounded = 5. 5 is the proposed RVU.

		NON-FAC

HCPCS	MOD	DESCRIPTION	PE RVU
90832		Psytx w pt 30 minutes	0.48

Here is another example where there is a TC modifier. In this case, the Corneal Topography CPT of 92025 shown below has a NON-FAC PE RVU for TC modifier of 0.50. 0.50 * 10 = 5.0. 5.0 rounded = 5. 5 is the proposed RVU.

HCPCS	MOD	DESCRIPTION	NON-FAC PE RVU
92025		Corneal topography	0.70
92025	TC	Corneal topography	0.50
92025	26	Corneal topography	0.20

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.
2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.
3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.
4) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.
    - If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

PART 1: EVALUATION AND MANAGEMENT (E/M) COMPONENT

CLINICAL CARE TIME

The evaluation and management portion of the clinic visit is based on a 5-point visit level scale. The amount of clinical care time provided to the patient during the E/M portion of the visit determines the visit level. Clinical care time is the combined total amount of time that each non-physician clinician spends treating the patient (such as nurses, medical technicians, residents, and other staff employed by the hospital clinic). The time does not necessarily have to be face-to-face with the patient, but the patient must be present in the department, except during specific times when telehealth (i.e., virtual) services are permitted. The time spent by physicians, and other non-physician providers (NPP), who bill professionally for their services is not included. It is possible for multiple clinic personnel to be providing CCT to the same patient simultaneously. Therefore, in each time interval, the hospital may record and report CCT greater than the actual clock time that as elapsed.

Both direct and indirect patient care may be included in CCT. Direct patient care will always be included in CCT. Indirect patient care may be included when the skills of a clinician are required to provide the care. Direct patient care includes tasks or procedures that involve face-to-face contact with the patient. These tasks may include specimen retrieval, administration of medications (when not separately charged), family support, patient teaching, and transportation of patients requiring nurse or other clinical personnel whose cost is assigned to the Clinic. Indirect patient care includes tasks or procedures that do not involve face-to-face contact with the patient but are related to their care. These tasks may include arranging for admission, calling for lab results, calling a report to another unit, documentation of patient care, and reviewing prior medical records.

EXAMPLES OF SERVICES INCLUDED IN E/M COMPONENT

The following are examples of services performed by nursing and other clinical staff that may be included in CCT provided during the E/M portion of a clinic visit. The list is not all-inclusive and is only meant as a guide.

- Patient evaluation and assessment
- Patient education and skills assessment
- Patient counseling
- Patient monitoring that does not require equipment or a physician order (different from observation)
- Skin and wound assessment
- Wound cleansing and dressing changes
- Application of topical medications
- Transporting of patient when it requires the skill of a clinician
- Coordination of care and discharge planning that requires the skill of a clinician

EXAMPLES OF SERVICES EXCLUDED FROM E/M COMPONENT

Services that do not require the skills of a clinician should be excluded from CCT. Examples of excluded activities are listed below. The list is not all-inclusive and is only meant as a guide.

- Patient waiting time
- Time spent on the phone with a payer
- Time spent securing payment authorization
- Chart set-up, room preparation
- Appointment setting
- Calling in prescriptions and entering orders and/or charges

TELEMEDICINE

Per the May 4, 2020, HSCRC memo:
https://hscrc.maryland.gov/Documents/TELEHEATH%20MEMO%20AND%20ADDENDUM.pdf

For services provided real-time in an audio-visual format or for telephonic/audio only services when an audio-visual format is not accessible by the patient: where the service is provided by non-physician providers who cannot bill a professional fee for their services; where the service provided utilizes the same staffing structure as face-to-face; and where the only difference is that the patient is at home vs. at the hospital receiving services; in these instances, hospitals are to use the existing Appendix D to report and charge for the service with the exact same RVUs and pricing as face-to-face visits.
In instances where a patient receives the telehealth services from an outside provider who bills a professional fee for the services rendered, such as a physician, the hospital shall not report nor charge an E/M visit or charge for other services, procedures, or therapies provided to the patient by non-physician clinicians who cannot bill a professional fee. The only instance when a hospital clinic fee or other fee for telehealth services can be charged is when the only telehealth services rendered are those provided solely by providers that cannot bill for their service

Until the end of the federal public health emergency (PHE), the temporary guidance provided related to telemedicine services will remain in effect. At the conclusion of the federal PHE, additional guidance will be provided to hospitals regarding the reporting of these services.

PROFESSIONAL SERVICES ONLY VISIT

In instances where a patient sees only an *outside provider,* the hospital may only report a Level one E/M visit regardless of the amount of time a patient spends with the outside provider. An outside provider is a physician or other provider who bills professionally. A level one E/M visit may also be reported when a patient is seen by clinic personnel and CCT totals 1-10 minutes, as per the E/M visit level guidelines below.

INTERNAL GUIDELINES

The RVUs for each visit level remain the same across every clinic. However, each clinic within a hospital is expected to develop and maintain a set of internal guidelines to standardize the amount of CCT required to perform common E/M services in the clinic. Hospitals are expected to conduct in-service programs to assure that new and existing clinic staff understand the guidelines and apply them fairly and consistently. The over-riding consideration is that there must be a "reasonable" relationship between the intensity of resource use and the assigned visit level.

The clinic's internal guidelines should include a typical time range for all the commonly performed services in that clinic. The time range allows for the circumstances of the visit and judgment of the clinician, while maintaining a degree of uniformity among clinicians. The guidelines are not expected to dictate a definitive time value for every service that could be performed in a clinic. Instead, their purpose is to provide an average time frame for commonly performed procedures. The format and content are at the facility's discretion. For example, taking vital signs: 5 minutes.

VISIT LEVELS

The minutes and RVUs for each of the five levels of an E/M visit are:

	New/Established	Minutes	RVUs
Level 1	99211	0-10	2
Level 2	99202/99212	11-25	3
Level 3	99203/99213	26-45	4
Level 4	99204/99214	46-90	5
Level 5	99205/99215	>90	6

HCPCS code G0463 can be used for Medicare billing with the above assigned RVUs.

Consultation codes (such as CPT 99242) or prolonged E/M codes (such as CPT 99354) are for professional services and should not be used for facility services. Only E/M codes (99202-99215 and G0463) should be used for facility E/M visits.

If codes for preventive (such as CPT 99387) or other specific services will be used, the RVUs should be based on the minute-to-RVU logic shown above. For example, if CPT 99387 typically takes 45 minutes, then 4 RVUs should be used, etc. Codes are noted as "E/M" on the table of RVUs if they are to be based on the minute-to-RVU logic above.

Code	Description	RVU	Rationale
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	1	Based on prior BR
G0463	Hospital outpatient clinic visit for assessment and management of a patient	E/M	Match RVUs as stated above
Q0091	Screening Papanicolaou smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	0	Included as an E/M component
Q0111	Wet mounts, including preparations of vaginal, cervical, or skin specimens	LAB	Report in Lab rate center

PART II: SERVICES AND NON-SURGICAL PROCEDURES

Each section includes tables with CPT codes, descriptions, and RVU values. This manual is not meant to give direction or interpretation to Medicare or other payer billing or coding rules. Moreover, it is the goal of every work group that recommends revisions to RVUs that the revised system may be as impervious as possible to future changes in billing rules and correct coding guidelines. Codes below are grouped in subsections and are in CPT code order with numeric and new technology codes listed before alpha-numeric codes. COVID-19 related services are listed at the end.

When a service has By Location (BL) instead of a relative value unit (RVU) assigned to it, this means that the service may be provided in multiple areas of the hospital based on hospital protocols, patient condition, and other factors. The RVU for the service should be assigned based on the respective rules for the location. For example, and the list below is not all-inclusive:

- If the service is provided in an Operating Room (OR), OR minutes should be used.
- If the service is provided in an Imaging Suite, Interventional Radiology Cardiovascular (IRC) minutes should be used.

- If the service is provided in an outpatient clinic or other outpatient area where scheduled services are provided that is not an operating room or imaging suite, Operating Room-Clinic (ORC) minutes should be used. For any services where ORC minutes are indicated, but the hospital does not have an ORC rate, the hospital should report the service under the Clinic (CL) rate center using a BR RVU.

TRANSFUSIONS

RVUs for transfusion of blood or blood components (36430) will be assigned based on the number of hours. Stratifying by the number of units transfused was rejected because the resources consumed in the transfusion of units vary by patient diagnosis and type of product. The timing of the transfusion begins and ends with the start and stop of the transfusion, and/or resolution of any reaction to the blood product. Any fraction of the first hour can be reported as a full hour, subsequent hours are subject to simple rounding rules (i.e., must be 30 minutes or more).

Code	Description	RVU	Rationale
36430	Transfusion, blood, or blood components, first hour (0-90 min)	11	MPFS
36430	Transfusion, blood or blood components, two hours (91-150 min)	16	MPFS base RVU plus add-on of 5 RVUs for each additional hour (11 was slightly less than prior value of 12 and add-on of 5 is slightly less than prior add-on of 6)
36430	Transfusion, blood or blood components, three hours (151-210 min)	21	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, four hours (211-270 min)	26	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, five hours (271-330 min)	31	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, six hours (331-390 min)	36	MPFS base plus add-on of 5 RVUs for each additional hour

Code	Description	RVU	Rationale
36430	Transfusion, blood or blood components, seven hours (391-450 min)	41	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, eight hours (451-510 min)	46	MPFS base plus add-on of 5 RVUs for each additional hour
36455	Exchange transfusion, blood; other than newborn	21	Resources like 180 minutes of blood transfusion

VENOUS PROCEDURES

RVUs for therapeutic apheresis and photopheresis were based on prior established By Report RVUs in use by hospitals and kept consistent with the Outpatient Prospective Payment System (OPPS) relationship weights. Note that these services are NOT the same as pheresis services that appear in the LAB rate center.

Code	Description	RVU	Rationale
36511	Therapeutic apheresis; for white blood cells	50	Prior BR average RVUs
36512	Therapeutic apheresis; for red blood cells	50	Prior BR average RVUs
36513	Therapeutic apheresis; for platelets	50	Prior BR average RVUs
36514	Therapeutic apheresis; for plasma pheresis	50	Prior BR average RVUs
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	150	Base code for apheresis adjusted based on OPPS relationship (weight of CPT 36516 approximately 3x weight of CPT 36511)
36522	Photopheresis, extracorporeal	150	Consistency with CPT 36516
36591	Collection of blood specimen from a completely implantable venous access device	8	MPFS
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified	9	MPFS
36593	Declotting by thrombolytic agent of implanted vascular access device or catheter	10	MPFS

Code	Description	RVU	Rationale
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	9	MPFS
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	9	MPFS

IMMUNIZATIONS

Code	Description	RVU	Rationale
90460	Immunization administration through 18 years of age via any route of administration, with counseling by qualified health care professional; first or only component of each vaccine or toxoid administered	3	MPFS
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/ toxoid)	3	MPFS
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/ toxoid)	2	MPFS
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/ toxoid)	3	MPFS
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/ toxoid)	2	MPFS
G0008	Administration of influenza virus vaccine	3	Consistency with CPT 90471
G0009	Administration of pneumococcal vaccine	3	Consistency with CPT 90471
G0010	Administration of hepatitis B vaccine	3	Consistency with CPT 90471

PSYCHIATRY (EXCLUDES PARTIAL HOSPITALIZATION – PHP)

In instances where a patient only sees an outside provider who bills professionally, the hospital may only report two RVUs regardless of the amount of time a patient spends with the outside provider. Two RVUs corresponds to a level one E/M visit that is used to report the facility component of an E/M visit when a clinic patient is seen only by an outside provider. (*See Professional Service Only Visit under Part II: E/M Component.*) The following RVUs are to be assigned only when the service is performed by a non-physician provider who does not bill professionally for the service.

Code	Description	RVU	Rationale
90785	Interactive complexity	1	MPFS
90791	Psychiatric diagnostic evaluation	12	MPFS
90792	Psychiatric diagnostic evaluation with medical services	15	MPFS
90832	Psychotherapy, 30 minutes with patient	5	MPFS
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	5	MPFS
90834	Psychotherapy, 45 minutes with patient	6	MPFS
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	6	MPFS
90837	Psychotherapy, 60 minutes with patient	9	MPFS
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	9	Consistency with CPT 90837
90839	Psychotherapy for crisis; first 60 minutes	9	MPFS
90840	Psychotherapy for crisis; each additional 30 minutes	5	MPFS
90845	Psychoanalysis	6	MPFS
90846	Family psychotherapy (without the patient present), 50 minutes	4	MPFS
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	4	MPFS
90849	Multiple-family group psychotherapy	4	MPFS
90853	Group psychotherapy (other than of multiple-family group)	2	MPFS

Code	Description	RVU	Rationale
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	2	MPFS
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital (Amytal) interview)	BR	No volumes
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	5	MPFS
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	10	MPFS
90880	Hypnotherapy	8	MPFS
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	0	Not a hospital service
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	0	Not a hospital service
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	0	Not a hospital service
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	0	Not a hospital service

Code	Description	RVU	Rationale
G0176	Activity therapy, such as music, dance, art, or play therapies, not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	PDC	Report in PHP rate center
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	PDC	Report in PHP rate center
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	BR	Services may vary by hospital
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	BR	Services may vary by hospital
H0001	Alcohol and/or drug assessment	12	Consistency with CPT 90791
H0004	Behavioral health counseling and therapy, per 15 minutes	3	Based on prior BR
H0005	Alcohol and/or drug services; group counseling by a clinician	2	Consistency with CPT 90853
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education	6	Consistency with CPT 90853 x 3hrs
H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)	9	Based on prior BR

Code	Description	RVU	Rationale
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	9	Based on prior BR
H0032	Mental health service plan development by non-physician	PDC	Report in PHP rate center
H0035	Mental Health Partial Hospitalization, treatment, less than 24 hours	PDC	Report in PHP rate center
H0047	Alcohol and/or other drug abuse services, not otherwise specified	BR	Unlisted service

BIOFEEDBACK TRAINING

No RVUs were assigned to these services (e.g., CPT 90901. 90912, and 90913). These services are reportable via the rehabilitation (Physical and Occupational Therapy) rate centers.

OPHTHALMOLOGY

Ophthalmology is a section where the MPFS RVUs for many services included equipment and overhead and required adjustment.

Code	Description	RVU	Rationale
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	4	Based on E&M value
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	4	Based on E&M value
92012	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient	4	Based on E&M value
92014	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment	4	Based on E&M value

Code	Description	RVU	Rationale
	program; comprehensive, established patient, 1 or more visits		
92015	Determination of refractive state	2	MPFS
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	OR	Report in OR rate center
92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited	OR	Report in OR rate center
92020	Gonioscopy	4	MPFS
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report	5	MPFS
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., Restrictive, or paretic muscle with diplopia) with interpretation and report	8	MPFS
92065	Orthoptic training	10	MPFS
92071	Fitting of contact lens for treatment of ocular surface disease	4	MPFS
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., Tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopi 3 or 7 equivalent)	5	MPFS
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	8	MPFS

Code	Description	RVU	Rationale
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	11	MPFS
92100	Serial tonometry with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)	2	Based on hospital BR as MPFS value is equipment intense
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	4	MPFS
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	4	MPFS
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	5	MPFS
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation	6	MPFS
92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral	3	MPFS
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with	2	MPFS

Code	Description	RVU	Rationale
	interpretation and report, unilateral or bilateral		
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral	2	Based on hospital BR as no MPFS value
92230	Fluorescein angioscopy with interpretation and report	0	Not a hospital service
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral	4	Based on hospital BR as MPFS value is equipment intense
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral	2	Based on hospital BR as MPFS value is equipment intense
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral	6	Based on hospital BR as MPFS value is equipment intense
92250	Fundus photography with interpretation and report	5	MPFS
92260	Ophthalmodynamometry	4	MPFS
92265	Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report	12	MPFS
92270	Electro-oculography with interpretation and report	20	MPFS
92273	Electroretinography (ERG), with interpretation and report; full field (i.e., ffERG, flash ERG, Ganzfeld ERG)	27	MPFS
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)	16	MPFS
92283	Color vision examination, extended, e.g., anomaloscope or equivalent	13	MPFS
92284	Dark adaptation examination with interpretation and report	13	MPFS
92285	External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up	6	MPFS

Code	Description	RVU	Rationale
	photography, slit lamp photography, goniophotography, stereophotography)		
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis	5	MPFS
92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	14	Based on hospital BR as MPFS value is equipment intense
92499	Unlisted ophthalmological service or procedure	BR	Unlisted service
95930	Visual evoked potential (VEP) checkerboard or flash testing central nervous system except glaucoma, with interpretation and report	EEG	Report in EEG rate center

OTORHINOLARYNGOLOGIC SERVICES

Code	Description	RVU	Rationale
92504	Binocular microscopy	7	MPFS
92511	Nasopharyngoscopy with endoscope	SLP	Report in Speech Language Pathology rate center

REHABILITATION SESSIONS AND OTHER SERVICES

Code	Description	RVU	Rationale
93668	Peripheral arterial disease (PAD) rehabilitation, per session	4	MPFS
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	PT/OT	Report in PT/ OT rate center
93750	Interrogation of ventricular assist device (VAD), in person, with qualified health care professional analysis of device parameters (e.g., drivelines, alarms, power	EKG	Report in EKG rate center

Code	Description	RVU	Rationale
	surges), review of device function (e.g., flow and volume status, septum status, recovery), with programming, if performed, and report		
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ration (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	E/M	Align with E&M RVUs
93797	Qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	3	MPFS
93798	Qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	5	MPFS
94625	Qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	15	MPFS
94626	Qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	16	MPFS
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	1	Based on hospital BR as no MPFS value
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)	3	MPFS
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)	3	MPFS
G0239	Therapeutic procedures to improve respiratory function or increase strength or	4	MPFS

Code	Description	RVU	Rationale
	endurance of respiratory muscles, two or more individuals (includes monitoring)		
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session	3	Consistency with CPT 93797
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session	5	Consistency with CPT 93798

ALLERGY TESTING/IMMUNOTHERAPY

Code	Description	RVU	Rationale
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	1	MPFS
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests	2	MPFS
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests	5	MPFS
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	2	MPFS
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests	1	MPFS

Code	Description	RVU	Rationale
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	4	MPFS
95044	Patch or application test(s) (specify number of tests)	1	MPFS
95052	Photo patch test(s) (specify number of tests)	2	MPFS
95056	Photo tests	BR	No volumes
95060	Ophthalmic mucous membrane tests	BR	No volumes
95065	Direct nasal mucous membrane test	8	MPFS
95076	Ingestion challenge tests (sequential and incremental ingestion of test items, e.g., food, drug, or other substance); initial 120 minutes of testing	19	MPFS
95079	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug, or other substance); each additional 60 minutes of testing	10	MPFS
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	0	Not a hospital service
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	0	Not a hospital service
95180	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, equine serum)	19	MPFS
95199	Unlisted allergy/clinical immunologic service or procedure	BR	Unlisted service

ENDOCRINOLOGY

Code	Description	RVU	Rationale
95249	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording	**7**	Equipment intense; OPPS APC weight more appropriate

Code	Description	RVU	Rationale
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; qualified health care professions (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording	**7**	Consistency with CPT 95249, patient vs provider equipment not a factor
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report	0	Not a hospital service

ELECTROMYOGRAPHY

No RVUs were as assigned to these services (e.g., CPT 95874). These services are reportable via the Electroencephalography (EEG) rate center.

GENETIC COUNSELING

Code	Description	RVU	Rationale
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	2	Service equivalent to E/M charges, various increments determined value

PSYCHOLOGICAL ASSESSMENTS, TESTING, AND INTERVENTIONS

Code	Description	RVU	Rationale
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgement, [e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities]), by qualified health care professional, both face-to-face time with the	8	MPFS

Code	Description	RVU	Rationale
	patient and time interpreting test results and preparing the report; first hour		
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgement, [e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities]), by qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour	5	MPFS
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	SLP or PT/OT	Report in SLP or PT/OT rate center
96130	Psychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	8	MPFS
96131	Psychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour	6	MPFS
96132	Neuropsychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical	12	MPFS

Code	Description	RVU	Rationale
	decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour		
96133	Neuropsychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour	9	MPFS
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method; first 30 minutes	7	MPFS
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method; each additional 30 minutes	7	MPFS
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	10	MPFS
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes	10	MPFS
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	1	MPFS
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)	6	MPFS
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	4	MPFS

Code	Description	RVU	Rationale
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	1	MPFS
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	1	MPFS
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	1	MPFS
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	4	MPFS
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	2	MPFS
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	7	MPFS
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes	3	MPFS

DRUG ADMINISTRATION AND DELIVERY

Code	Description	RVU	Rationale
95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed	6	Equipment intense; RVU is in line with prior By Report values
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	8	MPFS
96361	Intravenous infusion, hydration; each additional hour	3	MPFS
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour	18	MPFS

Code	Description	RVU	Rationale
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis; each additional hour	4	MPFS
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis; additional sequential infusion of a new drug/substance, up to 1 hour	7	MPFS
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion	4	MPFS
96369	Subcutaneous infusion for therapy or prophylaxis; initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	18	Consistency with CPT 96365
96370	Subcutaneous infusion for therapy or prophylaxis; each additional hour	4	Consistency with CPT 96366
96371	Subcutaneous infusion for therapy or prophylaxis; additional pump set-up with establishment of new subcutaneous infusion site(s)	6	Consistency with CPT 95990
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	2	MPFS
96373	Therapeutic, prophylactic, or diagnostic injection; intra-arterial	4	MPFS
96374	Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug	10	MPFS
96375	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug	4	MPFS
96376	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility	1	MPFS
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection	4	MPFS
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	7	Drug intense; OPPS APC weight more appropriate

Code	Description	RVU	Rationale
96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	7	Drug intense; OPPS APC weight more appropriate
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	7	Drug intense; OPPS APC weight more appropriate
96406	Chemotherapy administration; intralesional, more than 7 lesions	7	Consistency with CPT 96405
96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug	10	Consistency with CPT 96374
96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug	4	Consistency with CPT 96375
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	18	Consistency with CPT 96365
96415	Chemotherapy administration, intravenous infusion technique; each additional hour	4	Consistency with CPT 96366
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	18	Consistency with CPT 96413
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour	1	Consistency with CPT 96376
96420	Chemotherapy administration, intra-arterial; push technique	BL	Invasive service
96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour	BL	Invasive service
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour	BL	Invasive service
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	BL	Invasive service

Code	Description	RVU	Rationale
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	BL	Invasive service
96446	Chemotherapy administration into peritoneal cavity via indwelling port or catheter	BL	Invasive service
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	BL	Invasive service
96521	Refilling and maintenance of portable pump	6	Consistency with CPT 95990
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	6	Consistency with CPT 95990
96523	Irrigation of implanted venous access device for drug delivery systems	3	Based on hospital BR as MPFS value is equipment intense
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	6	Based on hospital BR as MPFS value is too high
96549	Unlisted chemotherapy procedure	BR	Unlisted service
C8957	Intravenous infusion for therapy/ diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable of implantable pump	18	Consistency with CPT 96413
G0498	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/other outpatient visit at the conclusion of the infusion	18	Consistency with CPT 96416
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of	0	Bundled service with the biologic

Code	Description	RVU	Rationale
	genetically modified autologous CAR-T cells, per day		
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	18	Consistency with CPT 96413
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	9	Based on hospital BR as no MPFS value
0663T	Scalp cooling, mechanical; placement of device, monitoring, and removal of device	12	Based on hospital BR as no MPFS value

PHOTODYNAMIC THERAPY/DERMATOLOGY

Code	Description	RVU	Rationale
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day	BR	No volumes
96570	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes	3	MPFS
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes	2	MPFS
96900	Actinotherapy (ultraviolet light)	7	MPFS
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality	2	MPFS
96904	Whole body integumentary photography, for monitoring of high-risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	6	Based on hospital BR as MPFS value is equipment intense

Code	Description	RVU	Rationale
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	2	Based on hospital BR as MPFS value is equipment intense
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	2	Based on hospital BR as MPFS value is equipment intense
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	BR	No volumes
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	BR	No volumes
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	BR	No volumes
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	BR	No volumes
96999	Unlisted special dermatological service or procedure	BR	Unlisted service

ACTIVE WOUND CARE MANAGEMENT

No RVUs were as assigned to these services (e.g., CPT 97597). These services are reportable via the rehabilitation (Physical and Occupational Therapy) rate centers. Clinic staff costs should be reallocated to the therapy rate centers for appropriate matching of revenue and expense.

MEDICAL NUTRITION THERAPY AND DIABETES MANAGEMENT

Code	Description	RVU	Rationale
97802	Medical nutrition therapy; initial assessment and intervention, individual,	5	MPFS

Code	Description	RVU	Rationale
	face-to-face with the patient, each 15 minutes		
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	5	MPFS
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes	2	MPFS
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	7	MPFS
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	2	MPFS
G0270	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	5	MPFS
G0271	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes	2	MPFS
0403T	Preventative behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day	4	Consistency with CPT G0109 x2

ACCUPUNCTURE AND CHIROPRACTIC

Code	Description	RVU	Rationale
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	5	MPFS

Code	Description	RVU	Rationale
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	3	MPFS
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	7	MPFS
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	5	MPFS
98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved	4	MPFS
98926	Osteopathic manipulative treatment (OMT); 3-4 body regions involved	6	MPFS
98927	Osteopathic manipulative treatment (OMT); 5-6 body regions involved	7	MPFS
98928	Osteopathic manipulative treatment (OMT); 7-8 body regions involved	8	MPFS
98929	Osteopathic manipulative treatment (OMT); 9-10 body regions involved	9	MPFS
98940	Chiropractic manipulation treatment (CMT); spinal, 1-2 regions	3	MPFS
98941	Chiropractic manipulation treatment (CMT); spinal, 3-4 regions	4	MPFS
98942	Chiropractic manipulation treatment (CMT); spinal, 5 regions	5	MPFS
98943	Chiropractic manipulation treatment (CMT); extraspinal, 1 or more regions	3	MPFS

EDUCATION AND TRAINING

Code	Description	RVU	Rationale
98960	Education and training for patient self-management by a qualified, nonphysician	7	Consistency with CPT G0108

Code	Description	RVU	Rationale
	health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient		
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	2	Consistency with CPT G0109
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	2	Consistency with CPT G0109

NON-FACE-TO-FACE AND NON-MEDICAL SERVICES

Code	Description	RVU	Rationale
98966	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion	0	Professional service
98967	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an	0	Professional service

Code	Description	RVU	Rationale
	assessment and management service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion		
98968	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion	0	Professional service
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	0	Professional service
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	0	Professional service
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	0	Professional service
98975	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	5	MPFS
98976	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or	0	Not a regulated service

Code	Description	RVU	Rationale
	programmed alert(s) transmission to monitor respiratory system, each 30 days		
98977	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	0	Not a regulated service
98980	Remote therapeutic monitoring treatment management services, qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	0	Not a regulated service
98981	Remote therapeutic monitoring treatment management services, qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes	0	Not a regulated service
99078	Qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)	0	Not a regulated service
99441	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion	0	Professional service

Code	Description	RVU	Rationale
99442	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion	0	Professional service
99443	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion	0	Professional service
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	0	Not a regulated service
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a E/M	0	Not a regulated service

Code	Description	RVU	Rationale
	service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion		

SUBSTANCE ABUSE SERVICES

Code	Description	RVU	Rationale
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	2	MPFS
99407	Smoking and tobacco use cessation counseling; intensive, greater than10 minutes	3	MPFS
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	0	Not a regulated service
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	0	Not a regulated service

COVID-19-RELATED CODES

Codes will continue to be added as COVID-19 treatments are identified.

Code	Description	RVU	Rationale
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose	3	Consistency with CPT 90471
0003A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; third dose	3	Consistency with CPT 90471
0004A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; booster dose	3	Consistency with CPT 90471
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	3	Consistency with CPT 90471
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose	3	Consistency with CPT 90471
0013A	Immunization administration by intramuscular injection of severe acute	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; third dose		
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose	3	Consistency with CPT 90471
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; second dose	3	Consistency with CPT 90471
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; single dose	3	Consistency with CPT 90471
0034A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; booster dose	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
0041A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; first dose	3	Consistency with CPT 90471
0042A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; second dose	3	Consistency with CPT 90471
0051A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; first dose	3	Consistency with CPT 90471
0052A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; second dose	3	Consistency with CPT 90471
0053A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; third dose	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
0054A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; booster dose	3	Consistency with CPT 90471
0064A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25mL dosage; booster dose	3	Consistency with CPT 90471
0071A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2mL dosage, diluent reconstituted, tris-sucrose formulation; first dose	3	Consistency with CPT 90471
0072A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2mL dosage, diluent reconstituted, tris-sucrose formulation; second dose	3	Consistency with CPT 90471
0073A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: third dose	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
0081A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: first dose	3	Consistency with CPT 90460
0082A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: second dose	3	Consistency with CPT 90460
0094A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, booster dose	3	Consistency with CPT 90471
M0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for who vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 component(s), includes injection and post administration monitoring	4	Consistency with CPT 96372 X 2

Code	Description	RVU	Rationale
M0222	Intravenous injection, bebtelovimab, includes injection and post administration monitoring	18	Consistency with CPT 96365
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	22	Consistency with CPT 96365 plus CPT 96368
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring	22	Consistency with CPT 96365 plus CPT 96368
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	22	Consistency with CPT 96365 plus CPT 96368
M0247	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring	18	Consistency with CPT 96365
M0249	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose	0	Inpatient procedure
M0250	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose	0	Inpatient procedure

GASTROENTEROLOGY

All GI services (codes 91000-91299) will be reported through the operating room center. (See the Surgical Procedure section for more information.)

PART III: SURGICAL PROCEDURES

Any surgical procedures performed in a clinic should be reported via the Operating Room-Clinic (ORC) cost center, and associated surgical costs allocated to the ORC rate center (excluding the exceptions listed in more detail below.) Surgical procedures are defined as all procedures corresponding to CPT codes from 10000 to 69999 (surgery), 91000 to 91299 (gastroenterology), and 93000 to 93050 (cardiography).

A few rate centers include a limited number of surgical procedures with CPT codes between 10000 and 69999 that have already been assigned RVUs relative to other procedures in that cost center. For the most part, the RVU values and reporting of these procedures will remain unchanged. The procedures and how they should be reported are:

- *Clinic*-Specimen Collection via VAD (CPT 36591), Declotting (CPT 36593), and Blood Transfusions (CPT 36430) have been assigned Clinic RVUs and should be reported as clinic revenue.

- *Delivery*-Non-Stress Tests, amniocentesis, external versions, cervical cerclages, dilation and curettage/evacuation and curettage, hysterectomies, deliveries, etc. Continue to report via DEL by assigned RVUs.

- *Interventional Cardiology*-certain IRC procedures have surgical CPT codes are defined in the IRC rate center with RVUs. Hospitals should continue to report using those IRC RVUs until instructed otherwise.

- *Laboratory*-Venipuncture/Capillary punctures. These procedures are part of the E/M component of a clinic visit. If a hospital chooses to code and report them separately in the clinic, the RVU is zero. If a phlebotomist comes to the clinic to do the procedure, the revenue and expenses are allocated to LAB.

- *Lithotripsy* -Procedures will continue to be reported in the LIT cost center as the number of procedures.

- *Occupational and Physical Therapy*-Splinting, Strapping and Unna Boot application (CPT codes 29105-29590) continue to report with assigned PT/OT RVUs.

- *Radiation Therapy*-Stereotactic Radiosurgery (61793). Continue to report with assigned RAT RVUs.

- *Speech Therapy*-Laryngoscopy (31579). Continue to report via STH by assigned RVUs.

CAPTURING MINUTES FOR SURGICAL PROCEDURES PERFORMED IN CLINIC

The counting of minutes for surgical procedures performed in clinics is different than the rules in the operating room Chart of Accounts [See Operating Room Chart of Accounts.]

Clinicians need to document procedure stop and start times in the medical record unless the hospital is using average times. It is not necessary to keep a log like the one kept in the Operating Room (OR) to document the minutes of each procedure. Unlike in the OR, clinic staff may enter and leave the room during a procedure. Please reference additional information in this section regarding reporting of actual minutes (included vs. excluded minutes).

As an alternative to reporting actual minutes, hospitals may report procedures using average times that are "hard coded". To report average procedure times, hospitals should conduct time studies to find the average time it takes to perform common procedures and periodically verify these average times. Please reference additional information in this section regarding reporting of average minutes (included vs. excluded minutes).

ACTIVITIES INCLUDED IN PROCEDURE TIME

For surgical procedures performed in the clinic, some activities that are integral to the procedure may not be typically thought of as included in the time of the procedure. The following lists of included and excluded activities are examples to guide the decision of which activities to include and exclude from the timing of surgical procedures performed in clinics. These lists are not all-inclusive but should be used as a guide when reporting minutes for these services.

INCLUDED ACTIVITIES

When the following activities are integral to a procedure, the time it takes to perform the activity should be included in the procedure time. These services are all above and beyond the actual performance of the surgical service, i.e., "cut to close". Many of these examples apply directly to wound care but should also be applied to all surgical procedures performed in the clinic. The overriding consideration is that the minutes associated with the procedure along with the minutes associated with clinical care time spent preparing the recovering the patient are reportable surgical minutes.

- Positioning of the patient in preparation for the procedure
- Removal of dressing/casting/Unna boot (i.e., whatever covers the wound)
- Cleansing of wound
- Wound measurement and assessment
- Applications of topical/local anesthetic
- Application of topical pharmaceuticals and dressing post procedure
- Monitored time when waiting for anesthetic to become effective
- Taking vital signs
- Monitored time when waiting for cast to dry

Monitored time post procedure when waiting for recovery from anesthetic

EXCLUDED ACTIVITIES

The time it takes to perform the following activities should not be included in the procedure time.

- Waiting time in general
- Teaching
- Non-monitored time when waiting for topical and/or local anesthetic to become effective
- Non-monitored time when waiting for cast to dry
- Non-monitored time post procedure when waiting for recovery from anesthetic

Ambulance Services-Rebundled

The Ambulance Service-Rebundled relative value units listed below were developed by the Health Services Cost Review Commission. They will be used as the standard unit of measure to determine the charges for round-trip ambulance services for hospital inpatients from the hospital to the facility of a third-party provider of a non-physician diagnostic or therapeutic services.

Basic Ambulance Service

Service	Relative Value Units
Base Charge	112.5
Per Mile	1.5
Downtown - Per Hour	37.5
Overtime Premium (Night, Weekend, etc.)	15

Advance Ambulance Service

Service	Relative Value Units
Base Charge	225
Per Mile	3.0
Downtime - Per Hour	75
Overtime Premium (Night, Weekend, etc.)	30

Speech Therapy

The Speech Therapy (ST) relative value units (RVUs) were developed with the aid of the industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions in this section of Appendix D were obtained from the 2024 edition of the Current Procedural Terminology (CPT) manual, and the 2024 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2024 Medicare Physician Fee Schedule (MPFS) released December 15, 2023, and then assigned using the following protocol. For the new 2024 CPT codes we used the 2024 Medicare Physician Fee Schedule (MPFS) released December 13, 2023.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value is used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, treatment of speech CPT of 92507 has a NON-FAC PE RVU of 0.94. 0.94 * 10 = 9.4. 9.4 rounded = 9. 9 is the proposed RVU.

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.

a. 92521 Evaluation of speech fluency did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92522 Evaluation of speech sound production which is 13 RVUs.

b. 92537 Caloric vestibular test, bithermal did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92141540 basic vestibular evaluation which is 17 RVUs.

c. 92538 Caloric vestibular test, monothermal did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92537 Caloric vestibular test, bithermal rounded down which is 17 divided by 2= 8.5 rounded down to 8.

d. 92550 Tympanometry and reflex threshold measurements did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) = 5 RVUs.

e. 92557 Comprehensive audiometry threshold did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92553 Pure tone audiometry (13 RVUs) and CPT 92556 Speech audiometry threshold (13 RVUs) = 26 RVUs.

f. 92579 Visual reinforcement audiometry did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92552 Pure tone audiometry which is 11 RVUs.

g. 92588 Distortion product evoked otoacoustic emissions, comprehensive did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it should be set at double CPT 92587 Distortion product evoked otoacoustic emissions, limited 3*2 = 6 RVUs.

h. 92611 Motion Fluoroscopic evaluation did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92612 Flexible endoscopic evaluation 46 divided by 2 = 23 RVUs.

i. 97129 Mirror PT/OT- Therapeutic interventions, initial 15 minutes did not seem reasonable in comparison to other codes. It was determined to mirror 97110 (Therapeutic Exercises) and 97112 (neuromuscular re-ed) which are both 4 RVUs.

j. 97130 Mirror PT/OT- Therapeutic interventions, additional 15 minutes did not seem reasonable in comparison to other codes. It was determined to mirror 97110 (Therapeutic Exercises) and 97112 (neuromuscular re-ed) which are both 4 RVUs.

3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

a. 92630 Auditory rehabilitation, prelingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

4) For RVUs converting CPT non-time-based codes time-based codes. The time increment selected was 15 minutes. The 15-minute increments used in this Appendix D are subject to the Medicare 8-minute rule. The phrase *"(per HSCRC: each 15 minutes)"* has been added to the CPT description for emphasis.

a. 97150 Therapeutic procedures, group it was determined to use the MPFS RVU of 2 as the base and then double for each 15-minute increment.

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Time	RVU
08-22 MINUTES	2
23-37 MINUTES	4
38-52 MINUTES	6
53-67 MINUTES	8

5) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.

•If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

Other considerations:

1. Routine supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply (such as TEP, passey-muir speaking valve) and disposable medical supplies costs are billable as MSS.
3. Durable Medical Equipment (DME) for inpatient services is billable as MSS. However, DME provided to outpatients are not regulated by HSCRC, and all applicable payor DME billing requirements would apply.
4. The CPT codes reviewed account for most services provided in ST. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as "by report" by the individual institution and use the RVU assignment protocols listed above.
5. CPT codes are in a process of constant revision and as such providers should review their institution's use of CPT codes and stay current with proper billing procedures.
6. Time increments used in this section of Appendix D are for direct patient time. Direct patient time spent evaluating and treating the patient is billable. Time spent on set-up, documentation of service, conference, and other non-patient contact is not reportable or billable.
7. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support the services provided.

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
31575	Laryngoscopy, flexible; diagnostic	28	Non-Time Based	MPFS
31579	Laryngoscopy, flexible or rigid telescopic, with stroboscope	38	Non-Time Based	MPFS
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	9	Non-Time Based	MPFS
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	4	Non-Time Based	MPFS
92511	Nasopharyngoscopy with endoscope (separate procedure)	29	Non-Time Based	MPFS
92519	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp) and ocular (ovemp)	15	Non-Time Based	MPFS
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)	18	Non-Time Based	MPFS
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	13	Non-Time Based	Mirror CPT 92522 Based on resources
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	13	Non-Time Based	MPFS
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)	29	Non-Time Based	MPFS
92524	Behavioral and qualitative analysis of voice and resonance	13	Non-Time Based	MPFS
92526	Treatment of swallowing dysfunction and/or oral function for feeding	12	Non-Time Based	MPFS
92537	Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation in each ear for a total of four irrigations)	17	Non-Time Based	Mirror CPT 92540 Based on resources

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92538	Caloric vestibular test with recording, bilateral; monothermal (i.e., one irrigation in each ear for a total of two irrigations)	8	Non-Time Based	Set at half of CPT 92537 (rounded down) Based on CPT Description and resources
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	17	Non-Time Based	MPFS
92542	Positional nystagmus test, minimum of 4 positions, with recording	4	Non-Time Based	MPFS
92546	Sinusoidal vertical axis rotational testing	35	Non-Time Based	MPFS
92550	Tympanometry and reflex threshold measurements	5	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) Based on CPT Description and resources
92552	Pure tone audiometry (threshold); air only	11	Non-Time Based	MPFS
92553	Pure tone audiometry (threshold); air and bone	13	Non-Time Based	MPFS
92555	Speech audiometry threshold	8	Non-Time Based	MPFS
92556	Speech audiometry threshold; with speech recognition	13	Non-Time Based	MPFS
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	26	Non-Time Based	Combination of CPT 92553 (13) + CPT 92556 (13) Based on CPT Description and resources
92567	Tympanometry (impedance testing)	3	Non-Time Based	MPFS
92568	Acoustic reflex testing, threshold	2	Non-Time Based	MPFS
92579	Visual reinforcement audiometry (vra)	11	Non-Time Based	Mirror CPT 92552 Based on resources

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92582	Conditioning play audiometry	24	Non-Time Based	MPFS
92584	Electrocochleography	23	Non-Time Based	MPFS
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	3	Non-Time Based	MPFS
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	6	Non-Time Based	Set at double CPT 92587 Based on resources
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	8	Non-Time Based	MPFS
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	24	Non-Time Based	MPFS
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	17	Non-Time Based	MPFS
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	22	Non-Time Based	MPFS
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	14	Non-Time Based	MPFS
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	9	Time-Based	MPFS
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	9	Non-Time Based	MPFS

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	18	Time-Based	MPFS
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	7	Time-Based	MPFS
92609	Therapeutic services for the use of speech-generating device, including programming and modification	15	Non-Time Based	MPFS
92610	Evaluation of oral and pharyngeal swallowing function	12	Non-Time Based	MPFS
92611	Motion fluoroscopic evaluation of swallowing function by cine or videorecording	23	Non-Time Based	Set at half of CPT 92612 Based on resources
92612	Flexible endoscopic evaluation of swallowing by cine or video recording	46	Non-Time Based	MPFS
92614	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording	31	Non-Time Based	MPFS
92616	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording	47	Non-Time Based	MPFS
92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	8	Non-Time Based	MPFS
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	12	Time-Based	MPFS

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92630	Auditory rehabilitation; prelingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	6	Non-Time Based	MPFS
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	15	Non-Time Based	MPFS
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	18	Non-Time Based	MPFS
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	14	Non-Time Based	MPFS
92700	Unlisted otorhinolaryngological service or procedure	By Report	Non-Time Based	Unlisted Code
95992	Canalith repositioning procedure(s) (e.g., epley maneuver, semontmaneuver), per day	5	Non-Time Based	Mirror PT/OT
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by boston diagnostic aphasia examination) with interpretation and report, per hour	11	Time-Based	MPFS
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	3	Non-Time Based	MPFS

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	10	Time-Based	MPFS
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure)	6	Time-Based	MPFS
96125	Standardized cognitive performance testing (e.g., ross information processing assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	13	Time-Based	MPFS
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	4	Time-Based	Mirror PT/OT
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	5	Time-Based	Mirror PT/OT

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	4	Time-Based	Mirror PT/OT
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)	4	Time-Based	Mirror PT/OT
97150	Therapeutic procedure(s), group (2 or more individuals) (per HSCRC: each 15 minutes)	2 +	Non-Time Based	Mirror PT/OT (Starting with 2 and then doubling based on time)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	7	Time-Based	Mirror PT/OT
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes	6	Time-Based	MPFS

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (list separately in addition to code for primary service)	2	Time-Based	MPFS
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	4	Time-Based	MPFS
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	9	Time-Based	Mirror PT/OT
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	7	Time-Based	Mirror PT/OT
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	11	Time-Based	Mirror PT/OT

Audiology

The Audiology relative value units (RVUs) were developed with the aid of the industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions in this section of Appendix D were obtained from the 2024 edition of the Current Procedural Terminology (CPT) manual, and the 2024 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2023 Medicare Physician Fee Schedule (MPFS) released December 15, 2022, and then assigned using the following protocol. For the new 2024 CPT codes we used the 2024 Medicare Physician Fee Schedule (MPFS) released December 13, 2023.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, basic vestibular evaluation CPT of 92540 has a NON-FAC PE RVU of 1.69. 1.69 * 10 = 16.9. 16.9 rounded = 17. 17 is the proposed RVU.

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.

a. 92537 Caloric vestibular test, bithermal did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92540 basic vestibular evaluation which is 17 RVUs.

b. 92538 Caloric vestibular test, monothermal did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92537 Caloric vestibular test, bithermal rounded down which is 17 divided by 2= 8.5 rounded down to 8.

c. 92550 Tympanometry and reflex threshold measurements did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) = 5 RVUs.

d. 92557 Comprehensive audiometry threshold did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92553 Pure tone audiometry (13 RVUs) and CPT 92556 Speech audiometry threshold (13 RVUs) = 26 RVUs.

e. 92570 Acoustic immittance testing did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) plus 2 RVUs for decay testing= 7 RVUs.

f. 92579 Visual reinforcement audiometry did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92552 Pure tone audiometry which is 11 RVUs.

g. 92588 Distortion product evoked otoacoustic emissions, comprehensive did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it should be set at double CPT 92587 Distortion product evoked otoacoustic emissions, limited 3*2 = 6 RVUs.

3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

a. 92630 Auditory rehabilitation, prelingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

b. 92633 Auditory rehabilitation, postlingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

4) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.

•If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

Other considerations:

1. Routine supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply costs and disposable medical supplies are billable as M/S supplies.
3. Durable Medical Equipment (DME) for inpatient services is billable as M/S supplies. However, DME provided to outpatients are not regulated by HSCRC, and all applicable payor DME billing requirements would apply.
4. The CPT codes reviewed account for most services provided in audiology. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as "by report" by the individual institution and use the RVU assignment protocols listed above.
5. CPT codes are in a process of constant revision and as such providers should review their institution's use of CPT codes and stay current with proper billing procedures.

6. Time increments used in this section of Appendix D are for direct patient time. Direct patient time spent evaluating and treating the patient is billable. Time spent on set-up, documentation of service, conference, and other non-patient contact is not reportable or billable.
7. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support services provided.

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92511	Nasopharyngoscopy with endoscope (separate procedure)	29	Non-Time Based	MPFS
92512	Nasal function studies (e.g., rhinomanometry)	0	Non-Time Based	Zero RVUs. Not SLP/AUD.
92516	Facial nerve function studies (egg, electroneuronography)	17	Non-Time Based	MPFS
92517	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp)	15	Non-Time Based	MPFS
92518	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; ocular (ovemp)	15	Non-Time Based	MPFS
92519	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp) and ocular (ovemp)	15	Non-Time Based	MPFS
92537	Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation in each ear for a total of four irrigations)	17	Non-Time Based	Mirror CPT 92540 Based on resources
92538	Caloric vestibular test with recording, bilateral; monothermal (i.e., one irrigation in each ear for a total of two irrigations)	8	Non-Time Based	Set at half of CPT 92537 (rounded down) Based on CPT Description and resources

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	17	Non-Time Based	MPFS
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	3	Non-Time Based	MPFS
92542	Positional nystagmus test, minimum of 4 positions, with recording	4	Non-Time Based	MPFS
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	2	Non-Time Based	MPFS
92545	Oscillating tracking test, with recording	2	Non-Time Based	MPFS
92546	Sinusoidal vertical axis rotational testing	35	Non-Time Based	MPFS
92547	Use of vertical electrodes (list separately in addition to code for primary procedure)	3	Non-Time Based	MPFS
92548	Computerized dynamic posturography sensory organization test (cdp-sot), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report	7	Non-Time Based	MPFS
92549	Computerized dynamic posturography sensory organization test (cdp-sot), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (mct) and adaptation test (adt)	6	Non-Time Based	MPFS

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92550	Tympanometry and reflex threshold measurements	5	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) Based on CPT Description and resources
92551	Screening test, pure tone, air only	0	Non-Time Based	Zero RVUs. Screening/No Charge/Part of Clinic Visit performed during visit
92552	Pure tone audiometry (threshold); air only	11	Non-Time Based	MPFS
92553	Pure tone audiometry (threshold); air and bone	13	Non-Time Based	MPFS
92555	Speech audiometry threshold	8	Non-Time Based	MPFS
92556	Speech audiometry threshold; with speech recognition	13	Non-Time Based	MPFS
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	26	Non-Time Based	Combination of CPT 92553 (13) + CPT 92556 (13) Based on CPT Description and resources
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	1	Non-Time Based	Typically used for newborn screenings. See DEL rate center when appropriate.
92562	Loudness balance test, alternate binaural or monaural	14	Non-Time Based	MPFS
92563	Tone decay test	10	Non-Time Based	MPFS
92565	Stenger test, pure tone	6	Non-Time Based	MPFS
92567	Tympanometry (impedance testing)	3	Non-Time Based	MPFS
92568	Acoustic reflex testing, threshold	2	Non-Time Based	MPFS
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	7	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) + 2 RVUs for decay testing

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92571	Filtered speech test	9	Non-Time Based	MPFS
92572	Staggered spondaic word test	14	Non-Time Based	MPFS
92575	Sensorineural acuity level test	6	Non-Time Based	MPFS
92576	Synthetic sentence identification test	12	Non-Time Based	MPFS
92577	Stenger test, speech	6	Non-Time Based	MPFS
92579	Visual reinforcement audiometry (vra)	11	Non-Time Based	Mirror CPT 92552 Based on resources
92582	Conditioning play audiometry	24	Non-Time Based	MPFS
92583	Select picture audiometry	16	Non-Time Based	MPFS
92584	Electrocochleography	23	Non-Time Based	MPFS
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	3	Non-Time Based	MPFS
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	6	Non-Time Based	Set at double CPT 92587 Based on resources
92590	Hearing aid examination and selection; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92591	Hearing aid examination and selection; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92592	Hearing aid check; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92593	Hearing aid check; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92594	Electroacoustic evaluation for hearing aid; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92595	Electroacoustic evaluation for hearing aid; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92596	Ear protector attenuation measurements	6	Non-Time Based	MPFS
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	24	Non-Time Based	MPFS
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	17	Non-Time Based	**MPFS**
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	22	Non-Time Based	MPFS
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	14	Non-Time Based	MPFS
92620	Evaluation of central auditory function, with report; initial 60 minutes	14	Time-Based	MPFS
92621	Evaluation of central auditory function, with report; each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	11	Time-Based	MPFS
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	8	Non-Time Based	MPFS

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CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	12	Time-Based	MPFS.
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92630	Auditory rehabilitation; prelingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92633	Auditory rehabilitation; postlingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	6	Non-Time Based	MPFS
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	15	Non-Time Based	MPFS
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	18	Non-Time Based	MPFS
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	14	Non-Time Based	MPFS
92700	Unlisted otorhinolaryngological service or procedure	By Report	Non-Time Based	Unlisted Code
V5240	Dispensing fee, contralateral routing system, binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital

Laboratory Services

Approach

The descriptions of codes in this section of Appendix D were obtained from the 2014 edition of the Current Procedural Terminology (CPT) manual, and the 2014 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning relative value units (RVU's) to laboratory codes, an effort was made to maintain consistency across laboratory sections. RVU assignments were developed considering Medicare fee schedule, technician time, reagent costs, and supply costs. Future assignments of RVU's should take existing assignments to similar CPT codes into consideration as well as the Medicare fee schedule, technician's time, reagent costs, and supply costs, the methodology used in performing the test. Since the cost of supplies for each test was considered when the RVU's were developed, hospitals may not bill separately for any laboratory supplies.

CPT Codes without an Assigned RVU Value

By Report Some CPT codes in the appendix are rarely used or have significant range in reagent supply costs and have not been assigned RVUs; they are labeled "by report". In addition, new CPT codes may be added in the years following this revision that will not have assigned RVUs. In the case a laboratory performs a test that does not have assigned RVUs, or a test that is not listed, the lab will select an appropriate CPT code and assign a reasonable value based on the above criteria (existing assignments to similar CPT codes, technician's time, reagent and supply costs, and the methodology used in performing the test). The laboratory reporting such tests to the HSCRC must maintain adequate documentation of the rationale used in assigning the RVU. In the case of a CPT code covering multiple tests with varying resources, the hospital is allowed to assign different RVU values as long as they maintain the documentation of the rationale.

Non-Regulated; Professional Services
CPT codes that describe the interpretation of results are considered professional, not technical services and are valued at zero RVUs, or labeled "non-regulated". Professional services are considered physician services, not regulated hospital services, and should not be reported to the HSCRC.

Professional Component of Service Referred to Outside Laboratory
According to the *Medicare Claims Processing Manual,* a clinical diagnostic laboratory may refer a specimen to an independent laboratory (one separate from a physician's office or hospital) for testing. When the hospital obtains laboratory services for patients under arrangements with clinical laboratories or other hospital laboratories, only the originating hospital can bill for the arranged services.

By providing the services under arrangement, it is as if the initiating laboratory has performed the service themselves; therefore, can bill for the complete service provided (including those codes stating "with interpretation"). Also from Medicare, "where a referring laboratory prepares a specimen before transfer to a reference laboratory these preparatory services are considered integral part of the testing process and the costs of such services are included in the charge for the total testing service."

For example, a specimen is collected at the hospital, prepared and sent out to the reference laboratory for testing and interpretation. The reference laboratory has an arrangement with the hospital to provide such services and bills the hospital appropriately. The reference laboratory does not bill the patient or the patient's insurance. The hospital bills the patient/insurance for the testing that has been completed. In this appendix, services, such as 88291, that include both a professional and technical component and are typically performed by an outside laboratory are labeled "By Report."

Non-Regulated; Autopsy Service (CPT Codes 88000-88099)
Autopsy, CPT code 88020, is labeled "not reportable"-meaning no value may be reported to the HSCRC for this service. Do not report Autopsy RVU's to the HSCRC.

General Advice

- The HSCRC system is a revenue reporting and payment system; it does not dictate billing rules. Hospitals should adhere to the billing requirements of CMS and exhibit good billing practices as defined by the OIGs Model Compliance Plan.
- The RVU assigned to a test will be the same regardless of whether the analysis is performed at the hospital's laboratory or sent to another laboratory.
- Additional RVUs have not been allotted for STAT testing or for specimen dispatch; this is regarded as overhead expense.
- The RVUs are assigned per reported test, do not bill double the RVU's when a test is run in multiple times on the same sample.
- If a procedure has multiple CPT codes, the hospital may report all applicable CPT codes.
- No RVUs have been allotted for calculated tests such as INR, albumin/globin ratios, etc.
- Simple confirmatory testing should not generate additional reported RVUs. For example, sulfosalicylic acid used to confirm abnormal protein from urine dipstick would not warrant additional RVUs.
- More complex reflex testing that is performed based on initial test results would generate additional RVU's. Reflex testing to a more definitive assay includes such things as: anti-body panel following a positive anti-body screen; IgM anti-hepatitis A after a positive anti-hepatitis A; Western blot testing after a positive HIV anti-body assay; phase contrast platelet count used to test a low automated platelet count. Hospitals must obtain an additional physician's order or follow established policies for reflex testing.

- Regarding CMS/AMA Panels, the hospital laboratory should bill tests as a defined panel even if the tests are ordered individually.
- Do not use a code with a general or miscellaneous description when a specific code is available.
- Phlebotomy is a billable laboratory procedure. In order to bill for this service, the lab must perform the phlebotomy and report all expenses such as personnel and supplies associated with this service.
- Point of Care Testing is also a billable laboratory procedure. Revenue and expenses for point of care testing must be reported as a laboratory service.
- Lab testing cannot be billed as a supply charge; a laboratory CPT code must be used.

- Therapeutic apheresis has been moved from the laboratory rate center to the clinic rate center.

- Bone and Tissue have moved from the laboratory rate center to the supply rate center.

Regulated vs. Unregulated Laboratory Services

HSCRC rules govern inpatient services as defined by Medicare, and outpatient services performed at the hospital. Any sample collected on regulated hospital premises is part of this regulated system and must be reported when the patient is still an inpatient or presents as an outpatient. If a patient is discharged a test ordered through the laboratory system is considered regulated within the first 14 days post-discharge for Medicare patients and at discharge for all other patients.

This includes samples referred to other reference labs. Under Medicare guidelines, when a hospital provides and/or refers laboratory services for patients under arrangements with clinical laboratories or other hospital laboratories, only the originating hospital can bill for the arranged services (per the Medicare Claims Processing Manual). By providing the services under arrangement, it is as if the initiating laboratory has performed the service and can therefore bill for the complete service provided.

Samples received by a hospital laboratory from other sources, e.g., doctors' offices, other laboratories, are not part of HSCRC regulated activity. Similarly, samples that are collected or tested by hospital employees stationed away from hospital property are not regulated. The costs associated with these services should not be included in regulated expenses reported to the HSCRC.

Blood Bank

Blood Products are described by HCPCS codes. In establishing RVU's for the new HCPCS codes, individual values for existing basic blood products (whole blood, red blood cells, fresh frozen plasma, and platelets) were combined with individual values for existing manipulations to blood products (washing, rejuvenation, leukoreduction, irradiation, etc.) to build the corresponding RVUs for the new HCPCS Codes.

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CPT Code	Description	RVU
Venous/Capillary		
36415	Collection of venous blood by venous puncture	8
	[see also G0001]	
36416	Capillary blood collect (eg, finger, heel, ear stick)	6
	[see also G0001]	
Therapeutic Apheresis		
36511	Therapeutic apheresis-WBC	0
36512	Therapeutic apheresis-RBC	0
36513	Therapeutic apheresis-platelets	0
36514	Therapeutic apheresis-Plasma	0
Organ or Disease Oriented Panels		
80047	Basic Metabolic panel (calcium, ionized)	11
80048	Basic Metabolic panel (with Calcium)	11
80050	General Health Panel	Depends on tests
80051	Electrolyte panel	8
80053	Comprehensive metabolic panel (with C02, AST)	15
80055	Obstetric Panel	Depends on tests
80061	Lipid panel	19
80069	Renal function panel	12
80074	Acute Hepatitis Panel	90
80076	Hepatic Function Panel (with Total Protein)	11
Drug Testing		
80100	Drug screen, multiple classes	By report
80101	Drug screen, each drug or class	8
80102	Drug confirmation	25
80103	Tissue prep for drug analysis	By report
80104	Drug screen, multiple drug classes other than chromatographic method, each procedure	By Report

Therapeutic Drug Assays

CPT Codes	Description	RVU
80150	Amikacin, assay	15
80152	Amitriptyline	30
80154	Benzodiazepines	30
80155	Caffeine	15
80156	Carbamazepine, total	15
80157	Carbamazepine, free	15
80158	Cyclosporine	20
80159	Clozapine	30
80160	Desipramine	30
80162	Digoxin	15
80164	Dipropylacetic acid (valproic acid)	15
80166	Doxepin	30
80168	Ethosuximide	15
80169	Everolimus	30
80170	Gentamicin	15
80171	Gabapentin	15
80172	Gold	40
80173	Haloperidol	30
80174	Imipramine	30
80175	Lamotrigine	15
80176	Lidocaine	15
80177	Levatiracetam	15
80178	Lithium	15
80180	Mycophenolate (Mycophenolic Acid)	20
80182	Nortriptyline	30
80183	Oxcarbazepine	15
80184	Phenobarbital	15
80185	Phenytoin, total	15
80186	Phenytoin, free	15
80188	Primidone	30

CPT Codes	Description	RVU
80190	Procainamide	15
80192	Procainamide with metabolites	30
80194	Quinidine	15
80195	Sirolimus	30
80196	Salicylate	15
80197	Tacrolimus	30
80198	Theophylline	15
80199	Tiagabine	30
80200	Tobramycin	15
80201	Topiramate	15
80202	Vancomycin	15
80203	Zonisamide	15
80299	Quantitation of drug not specified	By report

Evocative/Suppression Testing

80400	ACTH stimulation panel, adrenal insufi.	30
80402	ACTH stimulation panel, 21 hydro insuff.	100
80406	ACTH stim panel, 3 beta-hydroxy insuff	80
80408	Aldosterone suppression eval panel	80
80410	Calcitonin stimul panel	90
80412	Corticotropic releas horm stim panel	270
80414	Chorionic gonads stim panel, testosterone	90
80415	Estradiol response panel	90
80416	Renin stimulation panel, renal vein	90
80417	Renin stimulation panel, peripheral vein	30
80418	Pituitary evaluation panel	608
80420	Dexamethasone supression panel	94
80422	Glucagon tolerance panel, insulinoma	57

CPT Code	Description	RVU
80424	Glucagon tolerance panel, pheochrom	180
80426	Gonadotropin hormone panel	160
80428	Growth hormone stimulation panel	128
80430	Growth hormone suppression panel	140
80432	Insulin induced C-peptide suppression	110
80434	Insulin tolerance panel, ACTH insuff	101
80435	Insulin tolerance panel, GH deficiency	180
80436	Metyrapone Panel	80
80438	TRH stimulation panel, 1 hour	45
80439	TRH stimulation panel, 2 hours	60
80440	TRH stimulation panel, hyperprolactin	60

Consultations (Clinical Pathology)

80500	Clinical pathology consultation; limited	0
80502	Clinical pathology consultation; comprehensive	0

Urinalysis

81000	Urinalysis, nonauto, w/scope	9
81001	Urinalysis, auto, w/scope	9
81002	Urinalysis, nonauto w/o scope	4
81003	Urinalysis, auto, w/o scope	4
81005	Urinalysis, qualitative or semiquant	9
81007	Urine bacteria screen, non-culture	4
81015	Microscopic exam of urine only	5
81020	Urinalysis, glass test	By report
81025	Urine pregnancy test, visual color comparison	10
81050	Urine, timed, volume measurement	2
81099	Unlisted urinalysis procedure	By report

Chemistry

CPT Code	Description	RVU
81161	DMD (dystrophin) (eg. Duchenne/Becker muscular dystrophy) deletion analysis and duplication analysis if performed	By Report
81200	ASPA gene analysis, common variants	By Report
81201	ASPC gene analysis, full gene sequence	By Report
81202	APC gene analysis, known familial variance	By Report
81203	APC gene analysis, duplication/deletion variants	By Report
81205	BCKDHB gene analysis, common variants	By Report
81206	BCR/ABL1 tranlocation analysis; major breakpoint qual or quant	By Report
81207	BCR/ABL1 tranlocation analysis; minor breakpoint qual or quant	By Report
81208	BCR/ABL1 translocation analysis; another breakpoint qual or quant	By Report
81209	BLM gene analysis, 2281 del6ins7 variant	By Report
81210	BRAF, gene analysis, V60E variant	By Report
81211	BRCA1, BRCA gene analysis; full sequence analysis and common duplication/deletion variance in BRCA	By Report
81212	184del AG, 5385insC, 617dellT variants	By Report
81213	Uncommon duplication/deletion variants	By Report
81214	BRCA1 gene analysis, full sequence and common duplication/deletion variants	By Report
81215	Known familial variant	By Report
81216	BRCA2 gene analysis, full sequence analysis	By Report
81217	Known familial variant	By Report
81220	CFTR gene analysis; common variants	By Report
81221	Known familial variant	By Report
81222	Duplication/deletion variants	By Report
81223	Full gene sequence	By Report
81224	Introl 8 poly-T analysis	By Report
81225	CYP2C19, gene analysis, common variants	By Report
81226	CYP2D6, gene analysis, common variants	By Report
81227	CYP2C9, gene analysis, common variants	By Report
81228	Cytogenomic contitutional microarray analysis; interrogation of genomic regions for copy number variants	By Report
81229	Interrogation of genomic regions for copy number and single nucleotide polymorphism variants of chromosomal abnormalities	By Report

CPT Code	Description	RVU
81235	EGFR gene analysis, common variants	By Report
81240	F2 gene analysis, 20210G>A variant	By Report
81241	F5 gene analysis, Leiden variant	By Report
81242	FANCC gene analysis, common variant	By Report
81243	FMR1 gene analysis; evaluation to detect abnormal alleles	By Report
81244	FMR1 gene analysis; characterization of alleles	By Report
81245	FLT3 gene analysis, internal tandem duplication variants	By Report
81250	G6PC gene analysis, common variants	By Report
81251	GBA gene analysis, common variants	By Report
81252	GJB2 gene analysis, full gene sequence	By Report
81253	GJB2 gene analysis, known familial variants	By Report
81254	GJB6 gene analysis, common variants	By Report
81255	HEXA gene analysis, common variants	By Report
81256	HFE gene analysis, common variants	By Report
81257	HBA1/HBA2, gene analysis, for common deletions or variant	By Report
81260	IKBKAP gene analysis, common variants	By Report
81261	IGH@, gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology	By Report
81262	IGH@, gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology	By Report
81263	IGH@, variable region somatic mutation analysis	By Report
81264	IGK@, gene rearrangement analysis, evaluation to detect abnormal clonal population	By Report
81265	Comparative analysis using Short Tandem Repeat markers; patient and comparative specimen	By Report
+81266	Comparative analysis using Short Tandem Repeat markers; each additional specimen	By Report
81267	Chimerism analysis, post transplantation specimen, includes comparison to previously performed baseline analyses, without cell selection	By Report
81268	Chimerism analysis, post transplantation specimen, includes comparison to previously performed baseline analyses; with cell selection	By Report
81270	JAK2 gene analysis, p. Val617Phe variant	By Report

CPT Code	Description	RVU
81275	KRAS gene analysis, variants in codons 12 and 13	By Report
81280	Long QT syndrome gene analysis; full sequence analysis	By Report
81281	Long QT syndrome gene analysis; known familial sequence variant	By Report
81282	Long QT syndrome gene analysis; duplication/deletion variants	By Report
81287	MGMT (o-6 methylguaninej-DNA methyltransferase) (eg, glioblastoma multiforma), methylation analysis	By Report
81290	MCOLN1 gene analysis, common variants	By Report
81291	MTHFR gene analysis, common variants	By Report
81292	MLH1 gene analysis; full sequence analysis	By Report
81293	MLH1 gene analysis; known familial variants	By Report
81294	MLH1 gene analysis; duplication/deletion variants	By Report
81295	MSH2 gene analysis; full sequence analysis	By Report
81296	MSH2 gene analysis, known familial variants	By Report
81297	MSH2 gene analysis; duplication/deletion variants	By Report
81298	MSH6 gene analysis, full sequence analysis	By Report
81299	MSH6 gene analysis; known familial variants	By Report
81300	MSH6 gene analysis; duplication /deletion variants	By Report
81301	Microsatellite instability analysis of markers for mismatch repair deficiency, if performed	By Report
81302	MECP2 gene analysis; full sequence analysis	By Report
81303	MECP2 gene analysis; known familial variant	By Report
81304	MECP2 gene analysis; duplication/deletion variant	By Report
81310	NPM1 gene analysis, exon 12 variants	By Report
81315	PML/RARalpha translocation analysis; common breakpoints, qualitative or quantitative	By Report
81316	PML/RARalpha translocation analysis; single breakpoint, qualitative or quantitative	By Report
81317	PMS2 gene analysis; full sequence analysis	By Report
81318	PMS2 gene analysis; known familial variant	By Report
81319	PMS2 gene analysis, duplication deletion variant	By Report

CPT Code	Description	RVU
81321	PTEN gene analysis; full sequence analysis	By Report
81322	PTEN gene analysis, known familial variant	By Report
81323	PTEN gene analysis; duplication/deletion variant	By Report
81324	PMP22 gene analysis; full sequence analysis	By Report
81325	PMP22 gene analysis; known familial variant	By Report
81326	PMP22 gene analysis; duplication/deletion variant	By Report
81330	SMPD1 gene analysis, common variants	By Report
81331	SNRPN/UBE3A methylation analysis	By Report
81332	SERPINA1, gene analysis, common variants	By Report
81340	TRB@, gene rearrangement analysis to detect abnormal clonal population(s), using amplification methodology	By Report
81341	TRB@, gene rearrangement analysis to detect abnormal clonal population(s), using direct probe methodology	By Report
81342	TRG@, gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	By Report
81350	UGT1A1, gene analysis, common variants	By Report
81355	VKORC1, gene analysis, common variants	By Report
81370	HLA Class I and II typing, low resolution; complete	By Report
81371	HLA Class I and II typing, low resolution; one focus	By Report
81372	HLA Class I typing, low resolution; complete	By Report
81373	HLA Class I typing, low resolution, one locus	By Report
81374	HLA Class I typing, low resolution, one antigen equivalent	By Report
81375	HLA Class II typing, low resolution; HLA-DRB1/3/4/5 and- DQB1	By Report
81376	HLA Class II typing, low resolution; one locus	By Report
81377	HLA Class II typing, low resolution; one antigen equivalent, each	By Report
81378	HLA Class I and II typing, high resolution, LA-A, -B, -C and -DRB1	By Report
81379	HLA Class I typing, high resolution; complete	By Report
81380	HLA Class I typing, high resolution; one focus	By Report

CPT Code	Description	RVU
81381	HLA Class I typing, high resolution; one allele or allele group	By Report
81382	HLA Class II typing, high resolution; one locus, each	By Report
81383	HLA Class II typing, high resolution; one allele or allele group each	By Report
81400	Molecular pathology procedure, Level 1	By Report
81401	Molecular pathology procedure, Level 2	By Report
81402	Molecular pathology procedure, Level 3	By Report
81403	Molecular pathology procedure, Level 4	By Report
81404	Molecular pathology procedure, Level 5	By Report
81405	Molecular pathology procedure, Level 6	By Report
81406	Molecular pathology procedure, Level 7	By Report
81407	Molecular pathology procedure, Level 8	By Report
81408	Molecular pathology procedure, Level 9	By Report
81479	Unlisted molecular pathology procedure	By Report
81500	Oncology, biochemical assays of two proteins, utilizing serum, with menopausal status, algorithm reported as a risk score	By Report
81503	Oncology, biochemical assays of five proteins, utilizing serum, algorithm reported as a risk score	By Report
81504	Oncology (tissue or origin), microarray gene expression profiling of >2000 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm, reported as tissue similarity scores	By Report
81506	Endocrinology, biochemical assays of seven analytes, utilizing serum of plasma, algorithm reporting a risk score	By Report
81507	Fetal aneuploidy (trisomy 21, 18, and 13) DNA dequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy.	By Report
81508	Fetal congenital abnormalities, biochemical assays of two proteins, utilizing maternal serum, algorithm reported as a risk score	By Report
81509	Fetal congenital abnormalities, biochemical assays of three proteins, utilizing maternal serum, algorithm reported as a risk score	By Report

CPT Code	Description	RVU
81510	Fetal congenital abnormalities, biochemical assays of three analytes, utilizing maternal serum, algorithm reported as a risk score	By Report
81511	Fetal congenital abnormalities, biochemical assays of four analytes, utilizing maternal serum, algorithm reported as a risk score	By Report
81512	Fetal congenital abnormalities, biochemical assays of five analytes, utilizing maternal serum, algorithm reported as a risk score	By Report
81599	Unlisted multianalyte assay with alorithmic analysis	By Report
82000	Acetaldehyde, blood	19
82003	Acetaminophen	15
82009	Keytone body(s); qualitative	5
82010	Keytone body(s); quantitative	13
82013	Acetylcholinesterase assay	30
82016	Acylcarnitines; qualitative	50
82017	Acylcarnitines; quantitative	130
82024	Adrenocorticotropic hormone (ACTH)	30
82030	Adenosine, 5- monophosphate, cyclic	25
82040	Albumin, serum	2
82042	Albumin urine/other, quantitative	10
82043	Microalbumin, urine, quantitative	15
82044	Microalbumin, semiquant. (Reagent strip)	5
82045	Microalbumin, semiquant, ischemia modified	By Report
82055	Alcohol (ethanol) except breath	15
82075	Alcohol (ethanol) breath	20
82085	Aldolase	15
82088	Aldosterone	25
82101	Alkaloids, urine, quantitative	By Report
82103	Alpha -I-antitrypsin, total	15
82104	Alpha- I-antitrypsin phenotype	40
82105	Alpha- fetoprotein, serum	15
82106	Alpha- fetoprotein; amniotic	15
82107	Alpha- fetoprotein; AFP-L3 fraction isoform and total AFP	By Report
82108	Aluminum	40

CPT Codes	Description	RVU
82120	Amines, vaginal fluid, qualitative	30
82127	Amino acids, single, qualitative	30
82128	Amino acids, multiple, qualitative, each specimen	30
82131	Amino acids, single, quantitative, each specimen	60
82135	Aminolevulinic acid, delta (ALA)	26
82136	Amino acids, 2–5 amino acids, quantitative	120
82139	Amino acids, 6 or more, quantitative	150
82140	Ammonia	20
82143	Amniotic fluid scan	120
82145	Amphetamine or metamphetamine	25
82150	Amylase	6
82154	Androstanediol glucuronide	47
82157	Androstenedione	25
82160	Androsterone assay	25
82163	Angiotensin II	20
82164	Angiotensin II converting enzyme (ACE)	20
82172	Apolipoprotein	15
82175	Arsenic	40
82180	Ascorbic acid (Vitamin C), blood	25
82190	Atomic absorption spec, each analyta	40
82205	Barbiturates, not elsewhere specified	25
82232	Beta-2 microglobulin	15
82239	Bile acids, total	25
82240	Bile acids, cholylglycine	25

CPT Codes	Description	RVU
82247	Bilirubin, total	6
82248	Bilirubin, direct	6
82252	Bilirubin, fecal, qualitative	8
82261	Biotinidase, each specimen	75
82270	Blood, occult; feces, 1–3 simultaneous deterim	5
	[see also G0107 for screening]	
82271	Blood, occult, other sources, qualitative	4
82272	Blood, occult, qual, feces, single specimen	4
82274	Blood, occult, immunoassay, 1–3 determinations	25
82286	Bradykinin	10
82300	Cadmium	40
82306	Calcifediol (25-OH Vitamin D-3)	15
82308	Calcitonin	30
82310	Calcium, total	2
82330	Calcium, ionized	15
82331	Calcium, infusion test	By Report
82340	Calcium, urine quantitative, timed spec	10
82355	Calculus (stone) qualitative analysis	40
82360	Calculus (stone) quant. Assay, chemical	40
82365	Calculus (stone) infrared spectroscopy	40
82370	Calculus (stone) x-ray diffraction	By Report
82373	Carbohydrate deficient transferrin	By Report

CPT Codes	Description	RVU
82374	Carbon dioxide (bicarbonate)	2
82375	Carbon monoxide (carboxyhemo) quantitative	20
82376	Carbon monoxide, qualitative	20
82378	Carcinoembryonic antigen (CEA)	25
82379	Carnitine (total and free), quantitative	150
82380	Carotene	25
82382	Catecholamines, total urine	30
82383	Catecholamines, blood	30
82384	Catecholamines, fractionated	90
82387	Cathepsin-D	80
82390	Ceruloplasmin	15
82397	Chemiluminescent assay	15
82415	Chloramphenicol	30
82435	Chloride, blood	2
82436	Chloride, urine	10
82438	Chloride, other source	10
82441	Chlorinated hydrocarbons, screen	17
82465	Cholesterol, serum or whole blood, total	4
82480	Cholinesterase, serum	15
82482	Cholinesterase, RBC	15
82485	Chondroitin B sulfate, quantitative	33
82486	Chromatography, qualitative; column, nos	20
82487	Chromatography, paper, 1 dimensional	By Report
82488	Chromatography, paper, 2 dimensional	By Report

CPT Codes	Description	RVU
82489	Chromatography, thin layer, nos	By Report
82491	Chromatography, quantitative; column, nos	30
82492	Chromatography, quant; column, multiple analytes	30
82495	Chromium	40
82507	Citrate	15
82520	Cocaine or metabolite	25
82523	Collagen crosslinks	25
82525	Copper	25
82528	Corticosterone	25
82530	Cortisol, free	30
82533	Cortisol, total	15
82540	Creatine	8
82541	Column chromatography/mass spec. qual, nos	20
82542	Column chrom/mass spec., quant, single phase	30
82543	Column chrom/mass spec., quant, isotope, single	100
82544	Column chrom/mass spec., quant, isotope, mult.	120
82550	Creatine kinas (CK), (CPK), total	6
82552	Creatine kinase isoenzymes	25
82553	Creatine kinase, MB fraction only	15
82554	Creatinine kinase, isoforms	25
82565	Creatinine, blood	2
82570	Creatinine, other source	10
82575	Creatinine, clearance	12
82585	Cyrofibrinogen	14

CPT Codes	Description	RVU
82595	Cyroglobulin, qualitative or semi-quant.	14
82600	Cyanide	29
82607	Cyanocobalamin (Vitamin B-12)	15
82608	Cyanocobalamin unsaturated binding capacity	23
82610	Cystatin C	50
82615	Cystine and homocystine, urine, qualitative	20
82626	Dehydroepiandrosterone (DHEA)	15
82627	Dehydroepiandrosterone - sulfate (DHEA-S)	15
82633	Desoxycorticostertone, 11-	25
82634	Deoxycortisol, 11-	25
82638	Dibucaine number	30
82646	Dihydrocodeinone	By Report
82649	Dihydromorphinone	By Report
82651	Dihydrotestosterone (DHT)	25
82652	Dihydroxyvitamin D, I, 25-	25
82654	Dimethadione	22
82656	Elastase, pancreatic, fecal qual or semiquant	By Report
82657	Enzyme activity in cells, nos, nonradioactive	40
82658	Enzyme activity in cells, radioactive substrate	100
82664	Electrophoretic technique, nos	25
82666	Epiandrosterone	25
82668	Erythropoietin	15
82670	Estradiol	15
82671	Estrogens; fractionated	25
82672	Estrogens; total	25

CPT Codes	Description	RVU
82677	Estriol	15
82679	Estrone	25
82690	Ethchlorvynol	24
82693	Ethylene glycol	15
82696	Etiocholanolone	25
82705	Fats/lipids, feces, qualitative	15
82710	Fats/lipids, feces, quantitative	40
82715	Fecal fat differential, quantitative	By Report
82725	Fatty acids, nonesterified	20
82726	Very long chain fatty acids	120
82728	Ferritin	15
82731	Fetal fibronectin, cervicoaginal, semi-quant.	175
82735	Fluoride	25
82742	Flurazepam	25
82746	Folic acid, serum	15
82747	Folic acid, RBC	15
82757	Fructose, semen	75
82759	Galactokinase, RBC	34
82760	Galactose	19
82775	Galactose-I-phosphate uridyl transferase, quant	107
82776	Galactose-I-phosphate uridyl transferase, screen	18
82777	Galectin-3	15
82784	Gammaglobulin, IgA, IgD, IgG, IgM, each	15
82785	Gammaglobulin IgE	15
82787	Immunoglobulin subclasses, (IgG 1, 2, 3, or 4) each	15

CPT Codes	Description	RVU
82800	Gases, blood, pH only	15
82803	Gases, blood, any of pH, pCO_2, PO_2, CO_2, HCO_3	31
82805	Blood gases with O_2 Saturation by direct meas.	31
82810	Blood gases, O_2 sat only, direct measurement	31
82820	Hemoglobin-oxygen affinity	31
82930	Gastric acid analysis, includes pH if performed, each specimen	By Report
82938	Gastrin, after secretin stimulation	15
82941	Gastrin assay	15
82943	Glucagon	25
82945	Glucose, body fluid, other than blood	4
82946	Glucagon tolerance test	By Report
82947	Glucose, quantitative, blood	4
82948	Glucose, blood, reagent strip	4
82950	Glucose, post glucose dose (includes glucose)	4
82951	Glucose tolerance test, 3 specimens	15
82952	GTT-additional specimens>3	4
82953	Glucose, tolbutamide tolerance test	8
82955	Glucose-6-phosphate dehydrogenase; quant.	15
82960	G6PD enzyme, screen	10
82962	Glucose blood test, monitoring device	8
82963	Glucosidase, beta	39
82965	Glutamate dehydrogenase	12
82975	Glutamine (glutamic acid amide)	30

CPT Code	Description	RVU
82977	Glutamyltransferase, gamma (GGT)	2
82978	Glutathione	15
82979	Glutathione reduatase, RBC	20
82980	Glutethimide	25
82985	Glycated protein	15
83001	Gonadotropin (FSH)	15
83002	Gonadotropin (LH)	25
83003	Growth hormone, human (HGH)	32
83008	Guanosine monophosphate (GMP) cyclic	34
83009	H. Pylori, blood test for urease activity, non-radioactive	By Report
83010	Haptoglobin, quantitative	15
83012	Haptoglobin, phenotypes	By Report
83013	Helicobacter pylori; unease activity, non-radioact	20
83014	Helicobacter, drug admin. and sample collection	By Report
83015	Heavy metal (arsenic, barium, mercury, etc.) screen	25
83018	Heavy metal, quantitative, each	30
83020	Hemoglobin fract. And quant., electrophoresis	25
83021	Hemoglobin fract. And quan.; chromatography	25
83026	Hemoglobin, copper sulfate method	By Report
83030	Hemoglobin, F (fetal), chemical	15
83033	Hemoglobin, F (fetal), qualitative	15
83036	Hemoglobin, glycosylated (A1C)	20
83037	Hemoglobin, glycosylated (A1C), device for home use	10
83045	Methemoglobin, qualitative	15

CPT Code	Description	RVU
83050	Methemoglobin, quantitative	20
83051	Hemoglobin, plasma	12
83055	Sulfhemoglobin, qualitative	5
83060	Sulfhemoglobin, quantitative	20
83065	Hemoglobin thermolabile	4
83068	Hemoglobin unstable, screen	13
83069	Hemoglobin urine	4
83070	Hemosiderin, qualitative	8
83071	Hemosiderin, quantitative	By Report
83080	b-Hexosaminidase	15
83088	Histamine	24
83090	Homocystine	30
83150	Homovanillic acid (HVA)	30
83491	Hydroxycorticosteroids, 17-(17-OHCS)	30
83497	Hydroxyindolactetic acid, 5-(HIAA)	30
83498	Hydroxyprogesterone, 17-d	35
83499	Hydroxyprogesterone, 20-	35
83500	Hydroxyproline, free	60
83505	Hydroxyproline, total	60
83516	Immunoassay, non-infec. Disease; multi. Step	25
83518	Immunoassay, non-infec. Disease; single step (reagent strip)	15
83519	Immunoassay, analyte, quant, RIA	25
83520	Immunoassay, not otherwise specified	By Report
83525	Insulin, total	15

CPT Code	Description	RVU
83527	Insulin, free	15
83528	Instrinsic factor	25
83540	Iron	6
83550	Iron binding capacity	12
83570	Isocitric dehydrogenase (IDH)	25
83582	Ketogenic steroids, fractionation	60
83586	Ketosteroids, 17-(17-KS) total	60
83593	Ketosteroids, fractionation	21
83605	Lactic acid	20
83615	Lactate dehydrogenase (LD, LDH)	4
83625	LD, LDH isoenzymes, separation and quant	25
83630	Lactoferrin, fecal; qualitative	By Report
83631	Lactoferrin, fecal; quant	By Report
83632	Lactogen, human placental (HPL)	60
83633	Lactose, urine; qualitative	15
83634	Lactose, urine; quantitative	15
83655	Lead	25
83661	Fetal lung maturity, lecithin-sphingomyelin (L/S) ratio	120
83662	Fetal lung maturity, foam stability	8
83663	Fetal lung maturity, fluorescence polarization	25
83664	Fetal lung maturity, lamellar body density	50
83670	Leucine aminopetidase (LAP)	25
83690	Lipase	8
83695	Lipoprotein (a)	25

CPT Codes	Description	RVU
83698	Lipoprotein-associated phospholipase A2	By Report
83700	Lipoprotein, blood; electrophoresis and quantitation	25
83701	Lipoprotein, blood; electrophor, high res fract. & quant.	50
83704	Lipoprotein, blood; electrophor, quant of particle	50
83718	Lipoprotein direct meas. HDL. Cholest.	15
83719	Lipoprotein, direct meas. VLDL cholest.	25
83721	Lipoprotein direct meas. LDL cholest.	15
83727	Leuteinizing releasing factor (LRH)	25
83735	Magnesium	6
83775	Malate dehydrogenase	25
83785	Manganese	25
83788	Mass spectrometry, tandem, nos, qualitative, ea spec	30
83789	Mass spectrometry, tandem, nos, quantitative, ea spec	40
83805	Meprobamate	30
83825	Mercury, quantitative	25
83835	Metanephrines	30
83840	Methadone	30
83857	Methemalbumin	10
83858	Methsuximide	15
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity	By Report
83864	Mucopolysaccharides, acid; quantitative	33
83866	Mucopolysaccharides screen	11
83872	Mucin, synovial fluid (Ropes test)	9
83873	Myelin basic protein, CSF	60

CPT Codes	Description	RVU
83874	Myoglobin	20
83876	Myeloperoxidase (MPO)	By Report
83880	Natriuretic peptide	30
83883	Nephelometry, not specified	15
83885	Nickel	40
83887	Nicotine	37
83915	Nucleotidase 5-	15
83916	Oligoclonal immunoglobulin (bands)	25
83918	Organic acids, total quantitative, each specimen	125
83919	Organic acids, qualitative, each specimen	40
83921	Organic acid, single quantitative	40
83925	Opitates	25
83930	Osmolality, blood	10
83935	Osmolality, urine	10
83937	Osteocalcin (bone gla protein)	15
83945	Oxalate	15
83950	Oncoprotein, HER-2/neu	33
83951	Oncoprotein; des-gamma-carboxy-prothrombin (DCP)	8
83970	Parathyroid hormone	15
83986	ph, body fluid, except blood	8
83987	pH; exhaled breath condensate	8
83992	Phencyclidine (PCP)	15
83993	Calprotectin, fecal	By Report
84022	Phenothiazine	30
84030	Phenylalanine (PKU), blood	20

CPT Code	Description	RVU
84035	Phenylketones, qualitative	8
84060	Phosphatase, acid; total	15
84061	Phosphatase, forensic exam	By Report
84066	Phosphatase, acid; prostatic	15
84075	Phosphatase, alkaline	2
84078	Phosphatase, alkaline, heat stable only	10
84080	Phosphatase, alkaline, isoenzymes	25
84081	Phosphatidylglycerol	120
84085	Phosphogluconate, 6-, dehydrogenase, RBC	39
84087	Phosphohexose isomerase	16
84100	Phosphorus inorganic (phosphate)	2
84105	Phosphorus inorganic (phosphate), urine	10
84106	Porphobilinogen urine; qualitative	12
84110	Porphobilinogen urine; quantitative	13
84112	Placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative	44
84119	Porphyrins, urine; qualitative	16
84120	Porphyrins, quantitation + fractionation	35
84126	Porphyrins, feces; quantitative	30
84127	Porphyrins, feces; qualitative	16
84132	Potassium, serum	4
84133	Potassium, urine	10
84134	Prealbumin	15
84135	Pregnanediol	25
84138	Pregnanetriol	25

CPT Codes	Description	RVU
84140	Pregnenolone	25
84143	17-hydroxypregnenolone	25
84144	Progesterone	15
84145	Procalcitonin (PCT)	150
84146	Prolactin	20
84150	Prostaglandin, each	39
84152	Prostate specific antigen (PSA); complexed	25
84153	Prostate specific antigen (PSA); total	20
84154	Prostate specific antigen (PSA); free	25
84155	Protein; total, except refractometry; serum	2
84156	Protein; total, except refractometry; Urine	10
84157	Protein; total, except refractometry; other source	10
84160	Protein; total, refractometric	4
84163	Pregnancy associated plasma protein-A (PAPP-A)	By Report
84165	Protein; electrophoretic fractionation + quant.	25
84166	Protein; electrophoretic fract + quan., other fluids with concentration	25
84181	Western blot, interpretation and report	60
84182	Western blot + Immunol. Probe for band ident.	75
84202	Protoporphyrin, RBC; quantitative	54
84203	Protoporphyrin, RBC; screen	14
84206	Proinsulin	120
84207	Pyridoxal phosphate (Vitamin B-6)	50
84210	Pyruvate	30
84220	Pyruvate kinase	15

CPT Codes	Description	RVU
84228	Quinine	31
84233	Receptor assay, estrogen	75
84234	Receptor assay, progesterone	75
84235	Receptor assay, endocrine, other	75
84238	Receptor assay, non-endocrine (eg, acetylcholine)	75
84244	Renin	15
84252	Riboflavin (Vitamin B-2)	25
84255	Selenium	40
84260	Serotonin	30
84270	Sex hormone binding globulin (SHBG)	25
84275	Sialic acid	24
84285	Silica	37
84295	Sodium; serum	2
84300	Sodium; urine	10
84302	Sodium, other source	10
84305	Somatomedin	15
84307	Somatostatin	25
84311	Spectrophotometry, analyte nos	25
84315	Specific gravity (except urine)	4
84375	Sugars, chromatographic (TLC/paper)	By Report
84376	Sugars (mono-, di-, oligo) single qual, each spec	8
84377	Sugars, multiple qualitative, each specimen	8
84378	Sugars, single quantitative, each specimen	4
84379	Sugars, multiple quantitative, each specimen	4

CPT Codes	Description	RVU
84392	Sulfate, urine	42
84402	Testosterone, free	15
84403	Testosterone, total	15
84425	Thiamine (Vitamin B-1)	49
84430	Thiocyanate	15
84431	Thromboxane metabolite(s), including thromboxane if performed, urine	25
84432	Thyroglobulin	25
84436	Thyroxine, total	15
84437	Thyroxine, requiring elution (neonatal)	By Report
84439	Thyroxine, free	15
84442	Thyroid binding globulin (TBG)	15
84443	Thyroid stimulating hormone (TSH)	15
84445	Thyroid stimulating immune globulins (TSI)	25
84446	Tocopherol alpha (vitamin E)	30
84449	Transcortiin (cortisol binding globulins)	25
84450	Transferase, aspartate amino (AST)(SGOT)	2
84460	Transferase, alanine amino (ALT)(SGPT)	2
84466	Transferrin	15
84478	Triglycerides	2
84479	Thyroid hormones (T3 or T4) uptake (THBR)	15
84480	Triiodothyronine T3, total (TT-3)	15
84481	Triiodothyronine, free (FT-3)	15
84482	Triiodothyronine, reverse	15
84484	Troponin, quantitative	25

CPT Codes	Description	RVU
84485	Trypsin, duodenal fluid	40
84488	Trypsin, feces qualitative	40
84490	Trypsin, feces, quantitative, 24 hr.	By Report
84510	Tyrosine	16
84512	Troponin, qualitative	8
84520	Urea nitrogen; quantitative	2
84525	Urea nitrogen; semi-quant (reagent strip)	4
84540	Urea nitrogen; urine	10
84545	Urea nitrogen; clearance	12
84550	Uric acid; blood	2
84560	Uric acid; other source	10
84577	Urobilinogen, feces, quantitative	22
84578	Urobilinogen, urine, qualitative	5
84580	Urobilinogen, qualitative, timed specimen	22
84583	Urobilinogen, urine, semiquantitative	By Report
84585	Vanillylmandelic acid (VMA), urine	30
84586	Vasoactive Intestinal Peptide (VIP)	25
84588	Vasopressin (antidiuretic hormone, ADH)	25
84590	Vitamin A	30
84591	Vitamin, not otherwise specified	50
84597	Vitamin K	25
84600	Volatiles (dichlor, alcohol, methanol, etc)	30
84620	Xylose absorption test	30
84630	Zinc	25

CPT Codes	Description	RVU
84681	C-peptide	15
84702	Gonadotropin, chorionic (hCG) quant.	24
84703	Gonadotropin, chorionic (hCG) qualitative	10
84704	Gonadotropin, chorionic (hCG) free beta chain	By Report
84830	Ovulation tests, visual method for LH	By Report
84999	Unlisted chemistry procedure	By Report

Hematology and Coagulation

85002	Bleeding time	15
85004	Blood count, automated differential	4
85007	Blood count, manual differential	10
85008	Blood count, manual exam w/o diff.	5
85009	Blood count, differential WBC, buffy coat	15

CPT Codes	Description	RVU
85013	Blood count, spun microhematocrit	5
85014	Blood count, other than spun hematocrit (Hct)	4
85018	Hemoglobin (Hgb)	4
85025	Hemogram + plt ct. + auto complete diff (CBC)	10
85027	Hemogram and platelet ct. automated	8
85032	Manual cell count, each	10
85041	Blood count, RBC only	4
85044	Reticulocyte count, manual	10
85045	Reticulocyte count, automated	10
85046	Blood count, reticulocytes, hemoglobin conc.	16
85048	Blood ct, automated WBC	4
85049	Platelet, automated	4
85055	Reticulated platelet assay	8
85060	Blood smear, physician interp and report	0
85097	Bone marrow, smear interpretation	0
85130	Chromogenic substrate assay	60
85170	Clot retraction	6
85175	Clot lysis time, whole blood dilution	6
85210	Clotting; factor II, prothrombin, specific	60
85220	Clotting; factor V, labile factor	60
85230	Clotting; factor VII (proconvertin stable factor)	60
85240	Clotting; factor VIII, (AHG), one stage	60
85244	Clotting; factor VIII related antigen	60
85245	Clotting; factor VIII, VW factor, ristocetin cofact	60

CPT Codes	Description	RVU
85246	Clotting; factor VIII, VW factor antigen	60
85247	Von Willebrand's factor, multimetric analysis	120
85250	Clotting; factor IX (PTC or Christmas)	60
85260	Clotting; factor X (Stuart-Prower)	60
85270	Clotting; factor XI (PTA)	60
85280	Clotting; factor XII (Hageman)	60
85290	Clotting; factor XIII (fibrin stabilizing)	60
85291	Clotting factor XIII, screen solubility	25
85292	Clotting prekallikrein assay (Fletcher factor)	50
85293	High MW kininogen (Fitzgerald factor)	50
85300	Clotting inhibitors; antithrombin III, activity	19
85301	Clotting inhibitors; antithrombin III, antigen assay	17
85302	Protein C, antigen	60
85303	Protein C, activity	60
85305	Protein S, total	60
85306	Protein S, free	50
85307	Activated Protein C (APC) resistance assay	60
85335	Factor inhibitor test	60
85337	Thrombomodulin	50
85345	Coagulation time, Lee and White	15
85347	Coagulation time activated	15
85348	Coagulation time, other methods	15
85360	Euglobulin lysis	8
85362	Fibrin degradation products, semiquantitative	15

CPT Codes	Description	RVU
85366	Fibrin degradation products, paracoagulation	15
85370	Fibrin degradation products, quantitative	15
85378	Fibrin degradation prod, D-dimer; qual or semiquant	15
85379	Fibrin degradation prod, D-dimer; quantitative	15
85380	Fibrin degradation prod, D-dimer; ultrasensitive	15
85384	Fibrinogen; activity	9
85385	Fibrinogen; antigen	16
85390	Fibrinolysins screen, interpretation and report	60
85396	Coagulation/fibrinolysis (viscoelastic clot)	60
85397	Coagulation and fibrinolysis, functional activity, not otherwise specified, each analyte	70
85400	Fibrinolytic factors & inhibitors, plasmin	20
85410	Fibrinolytic; alpha 2 antiplasmin	50
85415	Fibrinolytic; plasminogen activator	50
85420	Plasminogen, except antigenic assay	23
85421	Plasminogen, antigen assay	16
85441	Heinz bodies; direct	10
85445	Heinz bodies; induced	10
85460	Hemoglobin fetal, Kleihauer-Betke	23
85461	Hemoglobin, fetal, rosette	15
85475	Hemolysin, acid	8
85520	Heparin assay	23
85525	Heparin neutralization	50
85530	Heparin-protamine tolerance	50
85536	Iron stain, peripheral blood	10
85540	Leukocyte alkaline phospatase with count	20

CPT Codes	Description	RVU
85547	Mechanical fragility, RBC	20
85549	Muramidase	33
85555	Osmotic fragility, RBC; unincubated	21
85557	Osmotic fragility, RBC; incubated	21
85576	Platelet; aggregation (in vitro), each agent	60
85597	Phospholipid neutralization; platelet	50
85598	Phospholipid neutralization; hexagonal phospholipid	50
85610	Prothrombin time	8
85611	Prothrombin time, substitutions, each	24
85612	Russell viper venom time, undiluted	12
85613	Russell viper venom, diluted	15
85635	Reptilase test	20
85651	Sedimentation rate, RBC, non-automat	6
85652	Sedimentation rate, automated	5
85660	RBC sickle cell test	10
85670	Thrombin time, plasma	10
85675	Thrombin time titer	15
85705	Thromboplastin inhibition, tissue	15
85730	Thromboplastin time, partial (PTT)	8
85732	Thromboplastin time, substitutions, fract, each	24
85810	Viscosity	25
85999	Unlisted hematol and coag procedure	By Report

Immunology

86000	Agglutinins; febrile, each antigen	20
86001	Allergen specific lgG, each allergen	By Report

CPT Codes	Description	RVU
86003	Allergen specific lgE, quantitative or semi-quant, each	15
86005	Allergen specific lgE qualitative, multiallergen scr	25
86021	Antibody identification, leukocyte antibodies	40
86022	Antibody identification, platelet antibodies	50
86023	Platelet assoc. Immunoglobulin assay	40
86038	Antinuclear antibodies, (ANA)	15
86039	Antinuclear antibodies, titer	28
86060	Antistreptolysin O titer	25
86063	Antistreptolysin O screen	12
86077	Physician; diff crossmatch and/or eval AB, interp/report	0
86078	Physician; investigation transfusion reaction, interp/report	0
86079	Physician; auth for deviation from standard procedures	0
86140	C-reactive protein	15
86141	C-reactive protein; high sensitivity (hsCRP)	16
86146	Beta 2 Glycoprotein I antibody, each	20
86147	Cardiolipin (phospholipid) antibody, each Ig class	20
86148	Anti-phosphatidylserine antibody	20
86152	Cell enumeration using immunologic selection and identifcation in fluid specimen;	By Report
86153	Cell enumeration using immunologic selection and identifcation in fluid specimen; physician interpretation and report when required	By Report
86155	Chemotaxis assay, specific method	40
86156	Cold agglutinin screen	13
86157	Cold agglutinin titer	26
86160	Complement; antigen each component	25
86161	Complement; funct activ, each component	25
86162	Complement; total hemolytic (CH50)	25
86171	Complement fixation tests, each antigen	15

CPT Codes	Description	RVU
86185	Counterimmunoelectrophoresis, each antigen	20
86200	Cyclic citrullinated peptide (CCP), antibody	25
86215	Deoxyribonuclease, antibody	21
86225	DNA antibody, native or double stranded	31
86226	DNA antibody, single stranded	31
86235	Extractable nuclear antigen, antibody (RNP, JOI)	28
86243	Fc receptor	72
86255	Fluorescent antibody; screen, ea antibody	15
86256	Fluorescent antibody; titer, ea antibody	28
86277	Growth hormone, human (HGH), antibody	30
86280	Hemagglutination inhibition (HAI)	13
86294	Immunoassay, tumor ant, qual/semiquant (bladder tumor)	33
86300	Immunoassay, tumor antigen, quant CA 15-3	33
86301	Immunoassay, tumor antigen, quant CA 19-9	33
86304	Immunoassay, tumor antigen, quant CA 125	33
86305	Human epididymis protein 4	135
86308	Heterophile antibodies, screening	8
86309	Heterophile antibodies, titer	10
86310	Heterophile antibodies, titer after absorption	12
86316	Immunassay, tumor antigen; other, quant, each	33
86317	Immunassay, infect agent antibody, quant, NOS	25
86318	Immunassay, infect agent antibody, qual, single step	15
86320	Immunoelectrophoresis serum	35
86325	Immunoelectrophoresis, other fluid w conc	39
86327	Immunoelectrophoresis (two dimension)	50

CPT Codes	Description	RVU
86329	Immunodiffusion, nos	8
86331	Immunodiffusion gel. qual (Ouchterlony) each	19
86332	Immune complex assay	36
86334	Immunofixation electrophoresis	40
86335	Immunofixation electrophoresis, other fluids	44
86336	Inhibin A	24
86337	Insulin antibodies	37
86340	Instrinsic factor antibody	35
86341	Islet cell antibodies	20
86343	Leukocyte histamine release (LHR)	20
86344	Leukocyte phagocytosis	34
86352	Cellular function assay involving stimulation and detection of biomarker	77
86353	Lymphocyte transformation, induced blastogenesis	77
86355	B cells, total count	50
86356	Mononuclear cell antigen, quantitative, not otherwise specified, each antigen	50
86357	Natural killer cells, total count	50
86359	T cells, total count	50
86360	T cells, absolute CD4, CD8 and ratio	100
86361	T cell, absolute CD4 count	50
86367	Stem cells (CD34), total count	50
86376	Microsomal antibidies (thyroid, liver) each	22
86378	Migration inhibitory factor (MIF)	28
86382	Neutralization test, viral	50
86384	Nitrobllue tetrazolium dye (NTD)	50
86386	Nuclear Matrix Protein 22, qualitative	By Report
86403	Particle agglutination; screen, each antibody	15
86406	Particle aggluination titer, each antibody	30

CPT Codes	Description	RVU
86430	Rheumatoid factor, qualitative	8
86431	Rheumatoid factor, quantitative	10
86480	Tuberculosis test, cell mediated-gamma interferon antigen	35
86481	Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing t-cells in cell suspension	40
86485	Skin test; candida	By Report
86486	Skin test; unlisted antigen, each	By Report
86490	Skin test; coccidioidomycosis	By Report
86510	Skin test; histoplasmosis	By Report
86580	Skin test; tuberculosis, intradermal	By Report
86590	Streptokinase antibody	17
86592	Syphilis test; qualitative (eg, VDRL, RPR, ART)	8
86593	Syphilis test; quantitative	10
86602	Actinomyces antibody	33
86603	Adenovirus, antibody	33
86606	Aspergillus antibody	33
86609	Bacterium, not specified, antibody	33
86611	Bartonella, antibody	33
86612	Blastomyces, antibody	33
86615	Bordetella antibody	33
86617	Borrelia burgdorferi (Lyme) confirmatory (WB)	60
86618	Borrelia burgdorferi (Lyme) antibody	25
86619	Borrelia (relapsing fever) antibody	33
86622	Brucella, antibody	33
86625	Campylobacter; antibody	33

CPT Codes	Description	RVU
86628	Candida antibody	33
86631	Chlamydia, antibody	20
86632	Chlamydia, IgM antibody	20
86635	Coccidioides, antibody	33
86638	Coxiella Burnetii (Q fever) antibody	33
86641	Cryptococcus antibody	47
86644	CMV antibody	15
86645	CMV antibody, IgM	25
86648	Diphtheria antibody	33
86651	Encephalitis, California, antibody	47
86652	Encephalitis, Eastern equine, antibody	47
86653	Encephalitis, St. Louis, antibody	47
86654	Encephalitis, Western equine, antibody	47
86658	Enterovirus (cox, echo, polio) antibody	40
86663	Epstein-Barr (EB) virus; EA antibody	33
86664	Epstein-Barr (EB) virus; EBNA antibody	33
86665	Epstein-Barr (EB) VCA antibody	47
86666	Ehrlichia, antibody	33
86668	Francisella tularensis antibody	47
86671	Fungus, not specified, antibody	By Report
86674	Giardia lamblia antibody	25
86677	Helicobacter pylori antibody	25
86682	Helminth, not elsewhere spec. antibody	33
86684	Haemophilus influenza, antibody	47

CPT Codes	Description	RVU
86687	HTLV I, antibody	33
86688	HTLV II, antibody	33
86689	HTLV or HIV antibody confirmatory (WB), antibody	75
86692	Hepatitis, delta agent, antibody	33
86694	Herpes simplex, nonspec type, antibody	25
86695	Herpes simplex, type I, antibody	25
86696	Herpes simplex, type 2, antibody	25
86698	Histoplasma, antibody	20
86701	HIV-1, antibody	25
86702	HIV-2, antibody	33
86703	HIV-1/HIV-2, single assay, antibody	25
86704	Hep B core antibody (HBcAb); total	20
86705	Hep B core antibody; IgM	20
86706	Hepatitis B surface antibody (HbsAB)	20
86707	Hepatitis Be antibody (HbeAB)	20
86708	Hepatitis A antibody (HAAb); total	20
86709	Hepatitis A antibody; IgM	20
86710	Influenza virus antibody	30
86711	Antibody; JC Virus	20
86713	Legionella antibody	20
86717	Leishmania antibody	20
86720	Leptospira antibody	20
86723	Listeria monocytogenes antibody	20
86727	Lymphocytic choriomeningitis antibody	20
86729	Lymphogranuloma Venereum antibody	20

CPT Codes	Description	RVU
86732	Mucormycosis antibody	20
86735	Mumps antibody	20
86738	Mycoplasma antibody	20
86741	Nisseria meningitidis antibody	20
86744	Nocardia; antibody	20
86747	Parvovirus antibody	30
86750	Plasmodiium (malaria); antibody	25
86753	Protozoa, not elsewhere specified; antibody	By Report
86756	Respiratory syncytial virus; antibody	25
86757	Rickettsia antibody	20
86759	Rotavirus; antibody	25
86762	Rubella antibody	15
86765	Rubeola; antibody	20
86768	Salmonella antibody	60
86771	Shigella antibody	20
86774	Tetanus; antibody	25
86777	Toxoplasma; antibody	25
86778	Toxoplasma, IgM; antibody	25
86780	Antibody; Treponema pallidum	17
86784	Trichinella; antibody	20
86787	Varicella-zoster antibody	20
86788	Antibody; West Nile Virus IgM	20
86789	Antibody; West Nile Virus	20
86790	Virus, not specified; antibody	By Report
86793	Yersinia; antibody	20
86800	Thyroglobulin antibody	25

CPT Codes	Description	RVU
86803	Hepatitis C antibody	25
86804	Hepatitis C antibody; confirmatory test	100
86805	Lymphocytotoxicity assay, w titration	75
86806	Lymphocytotoxicity assay, without titration	50
86807	Cytotoxic percent reactive antibody (PRA), std method	100
86808	Cytotoxic precent reactive antibody (PRA), quick method	47
86812	HLA typing, A, B, or C, single antigen	45
86813	HLA typinig, A, B, or C, multiple antigens	125
86816	HLA typing DR/DQ, single antien	115
86817	HLA typing DR/DQ, multiple antigens	230
86821	Lymphocyte culture, mixed (MLC)	150
86822	Lymphocyte culture, primed (PLC)	150
86825	Human leukocyte antigen crossmatch, non-cytotoxic; first serum sample or dilution	442
86826	Human leukocyte antigen crossmatch, non-cytotoxic; each additional serum sample or dilution	By Report
86828	Antibody to human leukocyte antigens, solid phase assays; qualitative assessment of presence or absence of antibody to HLA Class I and Class II HLA antigens	By Report
86829	Antibody to human leukocyte antigens, solid phase assays; quantitative assessment of presence or absence of antibody to HLA Class I and Class II HLA antigens	By Report
86830	Antibody to human leukocyte antigens, solid phase assays; antibody identification by qualitative panel using complete HLA phenotypes HLA Class I	140

CPT Codes	Description	RVU
86831	Antibody to human leukocyte antigens, solid phase assays; antibody identification by qualitative panel using complete HLA phenotypes HLA Class II	140
86832	Antibody to human leukocyte antigens, solid phase assays; high-definition qualitative panel for identification of antibody specificities, HLA Class I	140
86833	Antibody to human leukocyte antigens, solid phase assays; high-definition qualitative panel for identification of antibody specificities, HLA Class II	140
86834	Antibody to human leukocyte antigens, solid phase assays; semi-quantitative panel, HLA class I	By Report
86835	Antibody to human leukocyte antigens, solid phase assays; semi-quantitative panel, HLA class II	By Report
86849	Unlisted immunology procedure	By Report

Transfusion Medicine

86850	Antibody screen, RBC ea technique	12
86860	Antibody elution, RBC, each elution	20
86870	Antibody ident, RBC antibodies, ea panel	30
86880	Coombs test, direct, ea antiserum	8
86885	Coombs test, indirect, qualitative, ea antiserum	12
86886	Coombs test, indirect titer, ea antiserum	32
86890	Autologous bld, collect, proc, store; predeposited	170
86891	Autologous intra or post operative salvage	525
86900	Blood typing, ABO	4
86901	Blood typing, Rh(D)	4
86902	Blood typing; antigen testing of donor blood using reagent serum, each antigen test	15
86904	Blood typing, antigen screen, using patient serum, per unit	12
86905	Blood typing, RBC antigens, other than ABO, Rh, each	15
86906	Blood typing, Rh phenotyping, complete	30
86910	Blood typing, paternity, per individual	64
86911	Blood typing, paternity, each additional antigen system	30
86920	Compatibility tests each unit, immediate spin	8
86921	Compatibility test, incubation technique	1
86922	Compatibility, antiglobulin technique	10
86923	Compatibility test, electronic	6
86927	Fresh frozen plasma, thaw, each unit	4
86930	Fresh blood, prepare/freeze, each unit	80
86931	Frozen blood, thaw, each unit	120
86932	Frozen blood, prepare/freeze/thaw, each unit	240
86940	Hemolysins/agglutinins; auto screen, each	13
86941	Hemolysins/agglutinins, incubated	18
86945	Irradiation of blood prod, each unit	80
86950	Leukocyte transfusion	600

CPT Codes	Description	RVU
86960	Volume reduction of blood/product, each unit	20
86965	Pooling of platelets or blood products	20
86970	Pretreatment of RBC's incubate with chem, each	31
86971	Pretreatment of RBC's incubate with enzymes, each	31
86972	Pretreatment by density gradient	31
86975	Pretreatment of serurm, inc with drugs, each	31
86976	Pretreatment of serum by dilution	31
86977	Pretreatment of serum, incub with inhititors, each	31
86978	Pretreatment of serum, by diff RBC absorption, each	100
86985	Splitting of blood or blood prod each unit	20
86999	Unlisted transfusion medicine procedure	By Report

Microbiology

CPT Codes	Description	RVU
87001	Small animal inoculation, w/observation	100
87003	Small animal inoculation and dissection, w/ observation	150
87015	Specimen concentration (any type), for infectious agents	20
87040	Blood culture-bact, isol, presumpt. ident, aero w/wo anaero	40
87045	Stool culture-Salmonella and Shigella, pres. Ident., aero	30
87046	Stool culture for additional pathogens, ea plate, aero	10
87070	Culture, bacteria, source exc. Blood, urine, stool, aero	40
87071	Culture, aerobic, quant, exc blood, urine, stool	40
87073	Culture, anaerobic, quant, exc blood urine, stool	40
87075	Culture, anaerobic, quant, any source	40
87076	Definitive identification, anaerobic	10
87077	Definitive identification, aerobic	10
87081	Culture, bacterial screen	20
87084	Culture w colony estimate, density chart	20
87086	Urine culture, colony count	20
87088	Urine culture, isol, presump. identification	10
87101	Fungus culture, presump. identification skin/hair/nail, isol	25
87102	Fungus culture, presump. Ident, other source exc blood	25
87103	Fungus culture, presump. Identification, blood	30

CPT Codes	Description	RVU
87106	Fungi, definitive identification, each yeast	10
87107	Fungi, definitive identification, each mold	10
87109	Culture, Mycoplasma, any source	31
87110	Culture, Chlamydia, any source	31
87116	Culture, Tubercule or other; isolation, 213ultipl. ident	60
87118	Mycobacteria, definitive ident, each isolate	76
87140	Culture typing, fluorescent method, each antiserum	20
87143	Culture typing, GLC or HPLC method	40
87147	Culture typing, immunologic, per antiserum	20
87149	Culture typing, ident by nucleic acid probe	25
87150	Culture typing: identification by nucleic acid (DNA or RNA) probe, amp probe tech, per culture or isolate, ea org probed	25
87152	Culture ident by pulse field gel typing	68
87153	Culture typing; identification by nucleic acid sequencing method, each isolate	By Report
87158	Culture typing, other methods	10
87164	Dark field exam any source, includes collection	25
87166	Dark field exam any source, w/o collection	25
87168	Macroscopic exam, arthropod	20
87169	Macroscopic exam, parasite	20
87172	Pinworm exam, cellophane tape prep	6
87176	Homogenization, tissue, for culture	150
87177	Ova and parasite, dir. smear, conc.and ident	40
87181	Susceptibility, agar dil. Each agent (grad. strip)	10
87184	Susceptibility, up to 12 disks, per plate	10
87185	Susceptibility, enzyme detection, per enzyme	5
87186	Susceptibility, MIC or breakpoint, multi, per plate	10
87187	Susceptibility, MLC, per plate (add to primary MIC)	10

CPT Codes	Description	RVU
87188	Susceptibility, macrobroth dilution, each agent	10
87190	Susceptibility (mycobacteria), proportion, each agent	15
87197	Serum bactericidal titer (Schlicter)	45
87205	Smear, primary source, bact, fung, cells	20
87206	Smear, fluor or acid fast, bact, fung, cells, etc.	20
87207	Smear, stain for inclusion bodies or parasites.	15
87209	Smear, complex special stain for ova & parasites	10
87210	Smear, wetmount, infect. Agents (eg: KOH, India Ink)	8
87220	Tissue exam (KOH) for fungi, ectoparasites, mites	15
87230	Toxin or antitoxin assay, tissue cult. (Eg: C, diff toxin)	30
87250	Virus isol, egg/animal inoculation, observ+dissection	100
87252	Virus tissue culture, inoculation, observ, CPE ident	100
87253	Virus tissue cult, addit. Studies or ID, each isolate	25
87254	Virus isolation, shell vial, incl ident, IF stain, each virus	30
87255	Virus isol, incl ID by non-immuno method non-cyto effect	60
87260	Adenovirus antigen, immunofluorescent technique	25
87265	Bordetella pertussis/parapertussis antigen, IFA	25
87267	Enterovirus, direct fluroscent antibody (DFA)	25
87269	Giardia, antigen, primary source, IFA	25
87270	Chlamydia trachomatis antigen, IFA	25
87271	Cytomegalovirus dir. fluorescent antibody (DFA)	25
87272	Cryptosporidium antigen, IFA	25
87273	Herpes simplex virus type 2, primary source, IFA	25
87274	Herpes simplex virus type 1, primary source, IFA	25

CPT Codes	Description	RVU
87275	Influenza B virus antigen, primary source, IFA	25
87276	Influenza A virus antigen, primary source, IFA	25
87277	Legionella micdadei antigen, primary source, IFA	25
87278	Legionella pneumophila antigen, IFA	25
87279	Parainfluenza virus, each type, antigen, IFA	25
87280	Respiratory syncytial virus antigen, IFA	25
87281	Peumocystis carinii antigen, IFA	25
87283	Rubeola antigens IFA	25
87285	Treponema pallidum antigen, IFA	25
87290	Varicella zoster virus antigen, IFA	25
87299	Infectious agent antigen, nos, IFA	25
87300	Infectious agent AG, IFA, each polyvalent antiserum	25
87301	Adenovirus 40/41 antigen, EIA, multi step	25
87305	Infectious agent antigen detection by enzyme immunoassay technique, qual or semiquant mult step meth; Aspergillus	25
87320	Chlamydia trachomatis antigen, EIA	25
87324	Clostridium difficile toxin(s) antigen, EIA	25
87327	Cryptococcus neoformans antigen, EIA	25
87328	Crytosporidum antigen, EIA	25
87329	Giardia antigen, EIA	25
87332	Cytomegalovirus antigen, EIA	25
87335	E. coli 0157 antigen, EIA	25
87336	Entamoeba histolytica dispar group, EIA	40
87337	Entoamoeba histolytica group, EIA	40
87338	Helicobacter pylori, stool	30
87339	Helicobacter pylori, EIA	25

CPT Codes	Description	RVU
87340	Hepatitis B surface antigen (HbsAg), EIA	25
87341	Hepatitis B surface antigen (HbsAG) neutralization	25
87350	Hepatitis Be antigen (HbsAg), EIA	20
87380	Hepatitis, Delta agent antigen EIA	25
87385	Histoplasma capsullatum antigen, EIA	40
87389	Infectious agent antien detection by enzyme immunoassay technique, qual or semiquant mult step meth; HIV-1 antigen w/HIV-1 & HIV-2 antibodies, single result	25
87390	HIV-1 ag, EIA	40
87391	HIV-2 ag, EIA	40
87400	Influenza, A or B, each	40
87420	Respiratory syncytial virus ag, EIA	25
87425	Rotavirus ag, EIA	25
87427	Shiga-like toxin ag, EIA	25
87430	Streptococcus Group A antigen, EIA	25
87449	Infectious agent ag nos, multiple steps, each organism	By Report
87450	Infectious agent ag nos, single step, each organism	By Report
87451	Infectious agent ag, multi step, each antiserum	By Report
87470	Bartonella, DNA, dir probe	120
87471	Bartonella DNA, amp probe	120
87472	Bartonella DNA, quantification	160
87475	Borrelia burgdorferi, dna, dir probe	120
87476	Borrelia burgdorferi, DNA, amp probe	120
87477	Borrelia burgdorferi, DNA, quantification	160
87480	Candida, DNA dir probe	120
87481	Candida, DNA, amp, probe	120
87482	Candida, DNA, quant	160

CPT Codes	Description	RVU
87485	Chlamydia pneumoniae, DNA, dir probe	120
87486	Chlamydia pneumoiuae, DNA, amp probe	120
87487	Chlamydia pneumoniae, DNA, quant	160
87490	Chlamydia trachomatis, DNA, dir probe	45
87491	Chlamydia trachomatis, DNA, amp probe	45
87492	Chlamydia trachomatis, DNA, quant	160
87493	Infectious agent detection by nucleic acid; Clostridium difficile, toxin genes, amp probe tech	120
87495	Cytomegalovirus, direct probe	120
87496	Cytomegalovirus, amp probe	120
87497	Cytomegalovirus, quantification	160
87948	Infectious agent detection by nucleic acid; enterovirus, reverse transcription and amp probe tech	120
87500	Vancomycin resistance, amp probe tech	120
87501	influenza virus, reverse trans and amp probe tech, ea type	160
87502	influenza virus for mult types, multiplex reverse trans and amp probe tech, first 2 types or sub-types	160
87503	influenza virus for mult types, 217ultiplex reverse trans and amp probe tech, ea addl influenza virus type beyond 2	By Report
87510	Gardnerella vaginalis, DNA, dir probe	120
87511	Gardnerella vaginalis, DNA, amp probe	120
87512	Gardnerella vaginalis, DNA, quantification	160
87515	Hepatitis B virus, DNA, dir probe	120
87516	Hepatitis B virus, DNA, amp probe	120
87517	Hepatitis B virus, DNA, quantification	160
87520	Hepatitis C, DNA, direct probe	140
87521	Hepatitis C, DNA, amp probe	140
87522	Hepatitis C, DNA, quantification	160
87525	Hepatitis G, DNA, direct probe	120
87526	Hepatitis G, DNA, amp probe	120
87527	Hepatitis G, DNA, quantification	160
87528	Herpes simplex virus, DNA, direct probe	120
87529	Herpes simplex virus, DNA, amp probe	120
87530	Herpes simplex virus, DNA, quantification	160

CPT Codes	Description	RVU
87531	Herpes virus-6, DNA, direct probe	120
87532	Herpes virus-6, DNA, amp probe	120
87533	Herpes virus-6, DNA, quantification	160
87534	HIV-1, DNA, direct probe	120
87535	HIV-1, DNA, amp probe	120
87536	HIV-1, DNA, quantification	160
87537	HIV-2, DNA, direct probe	120
87538	HIV-2, DNA, amp probe	120
87539	HIV-2, DNA, quantification	160
87540	Legion pneumo, DNA, direct probe	120
87541	Legion pneumo, DNA, amp probe	120
87542	Legion pneumo, DNA quantification	160
87550	Mycobacteria, DNA, direct probe	120
87551	Mycobacteria, DNA, amp probe	120
87552	Mycobacteria, DNA quantification	160
87555	M. tuberculosis, DNA direct probe	120
87556	M. tuberculosis, DNA, amp probe	120
87557	M. tuberculosis, DNA quantification	160
87560	M. avium-intracellulare, DNA, direct probe	120
87561	M. avium-intracellulare, DNA amp probe	120
87562	M. avium-intracellulare, DNA quantification	160
87580	Mycoplasma pneumoniae, DNA, direct probe	120
87581	Mycoplasma pneumoniae, DNA, amp probe	120
87582	Mycoplasma pneumoniae, DNA quantification	160

CPT Codes	Description	RVU
87590	N. gonorrhoeae, DNA direct probe	45
87591	N. gonorrhoeae, DNA, amp direct probe	45
87592	N. gonorrhoeae, DNA quantification	160
87620	Human papillomavirus, DNA, direct probe	120
87621	Human papillomavirus, DNA, amp probe	120
87622	Human papillomavirus, DNA quantification	160
87631	Respiratory virus, multiplex reverse transcription and amp probe tech, mult types or subtypes, 3-5 targets	60
87632	Respiratory virus, multiplex reverse transcription and amp probe tech, mult types or subtypes, 6-11 targets	120
87633	Respiratory virus, multiplex reverse transcription and amp probe tech, mult types or subtypes, 12-25 targets	180
87640	Staphylococcus aureus, amplified probe tech	120
87641	Staphylococcus aureus, methicillin resistant, amp probl tech	120
87650	Streptococcus Group A DNA, direct probe	120
87651	Streptococcus Group A DNA, amp probe	120
87652	Streptococcus Group A DNA, quantification	160
87653	Streptococcus, group B, amp probe tech	120
87660	Trichomonas vaginalis, DNA, direct probe	45
87661	Infectious agent detection by nucleic acid (DNA or RNA); trichomonas vaginalis, amplified probe technique	45
87797	Infectious agent, nucleic acid, nos, direct probe, eaorg.	120
87798	Infectious agent, nucleic acid, amp probe, nos, each org.	120
87799	Infectious agent nucleic acid, nos, quant	160
87800	Infectious agent, DNA, multiple orgs, direct probe	120
87801	Infectious agent, DNA, multiple orgs, amplified probe	120
87802	Immunoassay, direct optical, Strep Gr B	25
87803	Immunoassay, direct optical, C. Difficile toxin A	25
87804	Immunoassay, direct optical, Influenza	25
87807	Immunoassay, respiratory syncytial virus	25
87808	Infectious agent antigen detection by immunoassay w/direct optical obv; Trichomonas vaginalis	25
87809	Infectious agent antigen detection by immunoassay w/direct optical obv; adenovirus	25
87810	Immunoassay, direct optical Chalamydia trachomatis	25

CPT Codes	Description	RVU
87850	Immunoassay, direct optical, N-gonorrhoeae	25
87880	Immunoassay, direct optical, Strep Crr. A	25
87899	Immunoassay, direct optical, nos	25
87900	Infectious agent drug susceptibility phenotype prediction	By Report
87901	Genotype by nucleic acid, HIV, RT and Protease	340
87902	Genotype by nucleic acid, Hepatitis C	340
87903	Phenotype, HIV, DNA, drug resistance, up to 10 drugs	340
87904	Phenotype, HIV, DNA, each additional drug, 1–5 (add on)	340
87905	Infectious agent enzymatic activity other than virus	By Report
87906	Infectious agent genotype analysis by nucleic acid; HIV-1 another region	By Report
87910	Infectious agent genotype analysis by nucleic acid; cytomegalovirus	By Report
87912	Infectious agent genotype analysis by nucleic acid; Hepatitis B virus	By Reoprt
87999	Unlisted microbiology procedure	By report

Anatomic Pathology

88000	Necropsy, gross exam only, without CNS	0*unbillable Code
88005	Necropsy, gross exam only, with brain	0*unbillable Code
88007	Necropsy, gross exam only, with brain and spinal cord	0*unbillable Code
88012	Necropsy, gross exam only, infant with brain	0*unbillable Code
88014	Necropsy, gross exam only, stillborn or newborn with brain	0*unbillable Code
88016	Necropsy, gross exam only, macerated stillborn	0*unbillable Code
88020	Necropsy gross and microscopic; without CNS	0*unbillable Code
88025	Necropsy gross and microscopic; with brain	0*unbillable Code
88027	Necropsy gross and microscopic; with brain and spinal cord	0*unbillable Code
88028	Necropsy gross and microscopic; infant with brain	0*unbillable Code
88029	Necropsy gross and microscopic; stillborn or newborn with brain	0*unbillable Code
88036	Necropsy, limited, gross and/or microscopic; regional	0*unbillable Code
88037	Necropsy, limited, gross and/or microscopic; single organ	0*unbillable Code
88040	Necropsy; forensic exam	0*unbillable Code
88045	Necropsy, coroners call	0*unbillable Code
88099	Unlisted necropsy procedure	0*unbillable Code

Cytopathology

88104	Cytopath, Fluid/Wash/Brush, Sm + interp	30
88106	Cytopath, filter meth only, interpretation	70
88108	Cytopath, smear + conc, interpret	70
88112	Cytopath, selective cellular enhancement	100
88120	Cytopath, in situ hybridization, urinary tract specimen w/morophometric analysis, 3-5 molecture probes each specimen; manual	By Report
88121	Cytopath, in situ hybridization, urinary tract specimen w/morophometric analysis, 3-5 molecture probes each specimen; using computer assisted tech	By Report
88125	Cytopath, forensic (eg, sperm)	20
88130	Sex chromatin ident. (Barr bodies)	20
88140	Sex chromatin ident, peripheral blood	20
88141	Cytopath, cerv/vag interp by physician	20
88142	Cytopath, cerv/vag thin layer, cytotech	40
88143	Cytopath, man scr and re-screen, phys suprv	50
88147	Cytopath, cerv/vag, auto screen, phys suprv	20
88148	Cytopath, auto screen w manual re-screen	50
88150	Cytopath, slides, cerv/vag, man scr, phys suprv	20
88152	Cytopath cerv/vag, man scr, comput re-screen	40
88153	Cytopath, slides, man scr, rescr, phys suprv	30

CPT Codes	Description	RVU
88154	Cytopath, slides, man scr, comp rescr, review, phys sup	50
88155	Cytopath cerv/vag, hormonal evaluation (add on)	22
88160	Cyto smears, other, screen & interp	30
88161	Cyto, prep, screening & interpretation	70
88162	Cyto, Extended study > 5 slides, mult. Stains	75
88164	Cytopath, slides, cerv/vag, TBS, man scr, phys sup	20
88165	Cyto, slides, cervvag, TBS, man scr, rescr phys sup	30
88166	Cyto, slides, TBS, man scr, comp rescr, phys suprv	40
88167	Cyto, slides, TBS, man scr, comp rescr, cell select	55
88172	FNA, immediate adequacy of specimen	60
88173	FNA, interpretation and report	90
88174	Cyto, auto thin prep & scr, phys sup	By Report
88175	Cyto, auto thin prep & scr, man rescr	By Report
88177	immediate cytohisto study to determine adequacy for diagnosis, each add'l eval episode, same site	30
88182	Flow cytometry, cell cycle or DNA analysis	150
88184	Flow cytometry, cell surface, TC only	50
88185	Flow cytometry, cell surface, TC only, ea addl marker	50
88187	Flow cytometry, interpretation, 2–8 markers	0
88188	Flow cytometry, interpretation, 9–15 markers	0
88189	Flow cytometry, interpretation, 16 or more markers	0
88199	Unlisted cytopathology procedure	By Report

Cytogenetic Studies

88230	Tissue culture, lymphocyte	100
88233	Tissue culture, skin or solid tissue biopsy	200
88235	Tissue culture, amniotic fluid or chorionic villus	150
88237	Tissue culture, bone marrow, blood cells	150

CPT Codes	Description	RVU
88239	Tissue culture, solid tumor	250
88240	Cryopreservation, freeze, store, each cell line	50
88241	Thawing, expansion, frozen cells, each aliquot	100
88245	Chromosome anal, breakage, (SCE) 20–25 cells	320
88248	Chromosome anal, breakage, 50–100 cells, 2kary	400
88249	Chromosome anal, 100 cells, clastogen stress	465
88261	Chromosome anal, 5 cells, 1 kary, banding	125
88262	Chromosome count: 15–20 cells, 2 kary, banding	320
88263	Chromosome analysis: 45 cells, 2 kary, banding	400
88264	Chromosome analysis, 20–25 cells	400
88267	Chromosome anal, amn fl/chorion villus, 15 cells, 1 kary	300
88269	Chromosome anal, in situ for amn fluid, 6–12 colonies	300
88271	Cytogenetics, Molecular, DNA probe, each (FISH)	50
88272	Cytogenetics, Molecular, chrom in situ hyb, 3–5 cells	150
88273	Cytogenetics, Molecular; chrom in situ hyb, 10–30 cells	175
88274	Cytogenetics, Molec, interphase in situ hyb, 25–99 cells	200
88275	Cytogenetics, Molec, interphase in situ hyb, 100–300 cells	230
88280	Chromosome analysis, add karyotypes, each study	20
88283	Chromosome anal, additional banding technique	75
88285	Chromosome anal, additional cells counted, each study	20
88289	Chromosome anal, additional high-resolution study	100
88291	Cytogenetics and Mol. cytogenetics, interp and report	By Report
88299	Unlisted Cytogenetic Study	By Report

Surgical Pathology

CPT Codes	Description	RVU
88300	Surg path, level I gross exam only	20
88302	Surg path, level II gross & microscopic	25
88304	Surg path level III gross & microscopic	40
88305	Surg path level IV gross & microscopic	60
88307	Surg path, level V gross & microscopic	100
88309	Surg path, level VI gross & microscop	125
88311	Decalcification procedure (add on)	5
88312	Special stains, Grp I (eg, Gridley, AFB, Methenamine) ea	15
88313	Special stains, Group II (eg, iron, trichrome), ea	10
88314	Histochemical staining w frozen section(s)	30
88319	Determinative histochem. ID enzyme constituents	50
88321	Consultation report, referred slides	non-regulated
88323	Consultation report, referred material w slide preparation	non-regulated
88325	Consultation, comprehensive, referred materials	non-regulated
88329	Pathology consultation, during surgery	20
88331	Path consults with frozen section(s), single specimen	30
88332	Path consult, each additional block frozen sections	5
88333	Path consult, cyto exam, initial site	50
88334	Path consult, cyto exam, ea addl site	30
88342	Immunohistochemistry, each antibody	60
88343	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear, each additional separately idenfiable antibody per slide (list separately in addition to code for primary procedure)	60
88346	Immunofluorscent, direct method, ea antibody	60
88347	Immunofluorescent study, indirect method, ea antibody	80
88348	Electron microscopy, diagnostic	400

CPT Codes	Description	RVU
88349	Electron microscopy, scanning	400
88355	Morphometric analysis, skeletal muscle	By Report
88356	Morphometric analysis, nerve	By Report
88358	Morphometric analysis, tumor	By Report
88360	Tumor IHC quant or semi quant., ea antibody, manual	75
88361	Tumor IHC; quant or semi-quant, computer assist	90
88362	Nerve teasing preparations	By Report
88363	Exam and selection of retrieved archival tissue for mol analysis	By Report
88365	Tissue in situ hybridization, interpretation & report	By Report
88367	Morphometric analysis, in situ hybridization each probe; using computer-assisted tech	By Report
88368	Morphometric analysis, in situ hybridization each probe; manual	By Report
88371	Protein analysis of tissue by WB, interpret. & Report	60
88372	Protein analysis, WB, Immun probe for band ident, each	75
88375	Optical endomicroscopic image, interp & report, each endo session	Pro Fee/0
88380	Microdissection (mechanical, laser capture)	By Report
88381	Microdissection; manual	By Report
88387	Macroscopic exam, dissection and prep of tissue for non-micro analytical studies; each tissue prep	By Report
88388	Macroscopic exam, dissection and prep of tissue for non-micro analytical studies; in conjunction w/touch imprint, intraop consult, or frozen section, each tissue prep	By Report
88399	Unlisted surgical pathology procedure	By Report

Transcutaneous Procedures

CPT Codes	Description	RVU
88720	Bilirubin, total, transcutaneous	By Report
88738	Hemoglobin (Hcg), quantitative, transcutaneous	By Report
88740	Hemoglobin (Hcg), quantitative, transcutaneous, per day; carboxyhemoglobin	By Report
88741	Hemoglobin (Hcg), quantitative, transcutaneous, per day; methemoglobin	By Report
88749	Unlisted in vivo	By Report

Other Procedures

89049	Caffeine Halothane test for malignant hyperthermia...	By Report
89050	Cell count, body Fluids, except blood	20
89051	Cell count, body fluids, exc bld with differential count	25
89055	Leukocyte assessment, fecal, qual or semiquant	5
89060	Crystal identification by microscopy (except urine)	15
89125	Fat stain, feces, urine, or respiratory secretions	15
89160	Meat fibers, feces	8
89190	Nasal smear for eosinophils	8
89220	Sputum, obtain, aerosol induced technique	By Report
89230	Sweat collection by iontophoresis	30
89240	Unlisted misc. pathology test	By Report

Reproductive Medicine Procedures

CPT Codes	Description	RVU
89250	Culture of oocyte(s)/embryo(s), <4 days	By Report
89251	Culture of oocyte(s)/embryo(s) with co-culture of oocytes	By Report
89253	Assisted embryo hatching, microtechniques	By Report
89254	Oocyte identification from follicular fluid	By Report
89255	Preparation of embryo for transfer	By Report
89257	Sperm identification from aspiration	By Report
89258	Cryopreservation; embryo(s)	By Report
89259	Cryopreservation; Sperm	By Report
89260	Sperm isolation; simple prep for insemination	By Report
89261	Sperm isolation; complex prep	By Report
89264	Sperm identification from testis tissue	By Report
89268	Insemination of oocytes	By Report
89272	Extended culture of oocytes/embryos 4–7 days	By Report
89280	Assisted oocyte fertilization, </= 10 oocytes	By Report
89281	Assisted oocyte fertilization, greater than 10 oocytes	By Report
89290	Biopsy, oocyte, microtechnique, </= 5 embr.	By Report
89291	Biopsy, oocyte, microtechnique, > 5 embr.	By Report
89300	Semen analysis, presence + motility, incl Huhner	8
89310	Semen analysis, motility and count, not incl Huhner	14
89320	Semen anal, complete (vol. count, motility + differential)	29
89321	Semen anal, presence and/or motility of sperm	By Report
	[see also G0027]	
89322	Semen analysis; volume count, motility and differential using strict morphologic criteria	By Report
89325	Sperm antibody test	17
89329	Sperm evaluation, hamster penetration	50
89330	Sperm/cervical mucous penetration test	23
89331	Sperm evaluation, for retrograde ejaculation, urine	By Report
89335	Cryopreservation, reprod. Tissue, testicular	By Report
89342	Storage, (per year): embryo(s)	By Report
89343	Storage, (per year): sperm/semen	By Report

CPT Codes	Description	RVU
89344	Storage, reproductive tissue, testic/ovarian	By Report
89346	Storage, oocyte	By Report
89352	Thawing of cryopreserved; embryo(s)	By Report
89353	Thawing of cryopreserved; semen/sperm	By Report
89354	Thawing of cryopreserved; reprod tissue	By Report
89356	Thawing of cryopreserved; oocytes, ea aliquot	By Report
89358	Unlisted reproductive medicine lab procs	By Report

Therapeutic Phlebotomy

99195	Therapeutic Phlobotomy	50

New Technology

0023T	HIV Virtual Phenotype	By Report

HCPCS - Level II

CPT Codes	Description	RVU
G0027	Semen analysis: presence and/or motility [see 89321]	By Report
G0107	CA screen: fecal blood test [see 82270]	5
G0123	Screen cytopath, auto thin prep, phys superv [see 88142]	By Report
G0124	Screen cytopath, auto thin prep, phys interp [see 88141]	By Report
P2038	Mucoprotein, blood	By Report
P3000	Screening Pap, by technician	Based on method
P3001	Screening Pap, interp by physician [See 88141]	By Report
Q0111	Wet mounts, incl vaginal, cervical, and skin prep	10
Q0112	All potassium hydroxide preps	15
Q0113	Pinworm exam	6
Q0114	Fern test	10
Q0115	Post-coital direct, qual exam, vag or cerv mucous	14

Addendum I

Blood Products	RVU value
Whole Blood	135
Red Blood Cells	90
Fresh Frozen Plasma	40
Platelet, Concentrated	55
Platelet, Pheresed	460

Manipulations	RVU value
Washing*	70
Freezing (80 and deglycerolization (90)	170
Aliquot and splitting (RBCs)	20
Irradiation	80
Leukoreduction RBC	55
Leukoreduction platelet, pheresed	40
Leukoreduction platelet, concentrate, per unit	5
CMV tested	20
Plasma cyroprecipitate reduced	10
Irradiation per platelet concentrate	10
HLA-matching, A, B, C, multiple	125
Autologous/Directed	125

*Freezing and deglycerolization includes washing.

HCPCS Code	Description	RVU value
P9010	Whole Blood for transfusion, per unit (non-autologous)	135
P9010	Whole Blood for transfusion, per unit (autologous)	260
P9011	Blood (split unit), specify amount (for Pediatrics)	110
P9012	Cryoprecipitate, ea unit	35
P9016	RBC leukoreduced, ea unit (non-autologous)	145
P9016	RBC leukoreduced, ea unit (autologous)	270
P9017	Fresh frozen plasma (sgl donor), frozen 8 hrs of collect, ea (non-autologous)	40
P9017	Fresh frozen plasma (sgl donor), frozen 8 hrs of collect, ea (autologous)	165
P9019	Platelets, ea unit	55
P9020	Platelet rich plasma, ea unit	By Report
P9021	RBC, ea unit (non-autologous)	90
P9021	RBC, ea unit (autologous)	215
P9022	RBC, washed, ea unit (non-autologous)	160
P9022	RBC, washed, ea unit (autologous)	285

P9023	Plasma, multi-donor, solvent/detergent treated, froz, ea	120
P9031	Platelets, leukoreduced, ea unit	60
P9032	Platelets, irradiated, ea unit	65
P9033	Platelets, leukoreduced, irradiated, ea unit	70
P9034	Platelets, pheresis, ea unit	460
P9035	Platelets, pheresis, leukoreduced, ea unit	500
P9036	Platelets, pheresis, irradiated, ea unit	540
P9037	Platelets, pheresis, leukoreduced, irradiated, ea unit	580
P9038	RBC, irradiated, ea unit (non-autologous)	170
P9038	RBC, irradiated, ea unit (autologous)	295
P9039	RBC, deglycerolized, ea unit (non-autologous)	260
P9039	RBC, deglycerolized, ea unit (autologous)	385
P9040	RBC, leukoreduced, irradiated, ea unit (non-autologous)	225
P9040	RBC, leukoreduced, irradiated, ea unit (autologous)	350
P9044	Plasma, cryoprecipitate reduced, ea unit	50
P9050	Granulocytes, pheresis, ea unit	600
P9051	Whole blood or RBC, Leuko reduced, CMV-neg, ea unit	165
P9052	Plt, HLA-matched leukored, apheresis/pheresis, ea unit	625
P9053	Plt, pheresis, leukoreduced, CMV-neg, irradiated, ea unit	600
P9054	Whole bld or RBC, leukoreduced, froz, degly/washed, ea	315
P9055	Plt, leukoreduced, CMV-neg, apheresis/pheresis, ea unit	520
P9056	Whole Blood, leukoreduced, irradiated, ea unit (non-autologous)	270
P9056	Whole Blood, leukoreduced, irradiated, ea unit (autologous)	395
P9057	RBC, froz, degly/washed, leukored, irradiated, ea unit (non-autologous)	395
P9057	RBC, froz, degly/washed, leukored, irradiated, ea unit (autologous)	520
P9058	RBC, leukoreduced, CMV-neg, irradiated, ea unit	245
P9059	FFP, frozen w/in 8-24 hrs of collection, ea unit	40
P9060	FFP, donor retested, ea unit	By Report

Emergency Services

EMG

HSCRC abbreviation for Emergency Department

EMTALA

Emergency Medical Screening Examination mandated by the Emergency Medical Treatment & Labor Act (EMTALA) to be provided to every person who seeks emergency care.

Relative Value Units (RVUs)

A standard unit of measure. A unique value or weight assigned to a specific service, e.g., number of visits for a particular hospital unit.

The RVUs for this cost center are based on resource consumption. Each facility is expected to develop, retain, and maintain Internal Guidelines, which identify the resources consumed. These resources may include but are not limited to time, staff intervention, complexity, patient severity, etc. The facility's Internal Guidelines are to be used for the purpose of maintaining Service Level reporting consistency among patients receiving comparable or similar treatment/care/resource consumption; and for patients who receive greater (or lesser) treatment/care/resource consumption to be assigned an appropriately higher (or lesser) Service Level.

General Guidelines

1. There is a direct relationship between the amounts of EMG resources consumed by a patient and the Service Level assigned to the patient.
2. The facility will prepare, record, and maintain appropriate documentation to support and justify the Service Level assigned. If a service or task is not documented, then that service or task cannot be included in the determination of the Service Level assignment. Patients are not to be charged, nor RVUs reported for a service or task that is not documented. Physician services are not to be included in the determination of Service Levels.
3. The facility's Internal Guidelines may not be totally inclusive or explanatory. It is recognized that the circumstance of the visit and the Service Level selected will involve a degree of clinical judgment and patient acuity. It is recommended that each facility's Internal Guidelines include an analysis of resource use and the services provided by EMG staff. The format and content are at the facility’s discretion.
4. Charges for EMG services are a by-product of all expenses and RVUs assigned to the EMG department. Ancillary services can be provided within the EMG area (e.g., laboratory, radiology, respiratory, etc.). If the cost of providing an ancillary service in the

EMG is assigned to the ancillary center, regulated charges for that ancillary service must be included as a separate line item in the patient bill. However, if the cost associated with an ancillary service is assigned to the EMG department (e.g., an EMG registered nurse or other EMG personnel providing respiratory care or specimen collection), then the cost associated with the service is part of the EMG determination of Service Level. It is recommended that this distinction be part of the facility's Internal Guidelines.

5. EMG patients will be assigned a Service Level based on total resources consumed, from the EMTALA Medical Screening Examination to final patient disposition.

6. In addition to EMG Service Level charge, the hospital will charge separately for drugs, supplies, and ancillary services (as noted in 4 above). Professional fees are not regulated by the HSCRC and, therefore, are not included in the hospital's charges. Professional fees would be a separate charge.

CPT Services Levels		**RVU**
99281	Level I/ EMTALA (Medical Screening Examination)	1
99282	Level II	1
99283	Level III	2
99284	Level IV	4
99285	Level V	7
99291	Level V	7

Each patient receives an EMTALA Medical Screening Examination and almost all patients receive subsequent treatment. Some payers prefer that the EMTALA screening be billed as a separate line item and post-EMTALA treatment as a separate line item. Other payers prefer that the EMTALA screening be bundled with post-EMTALA treatment as one line item. Therefore, applying the above RVU table, when combining EMTALA screening and post-EMTALA treatment, patients would be billed the following RVUs:

Total RVUs to be billed by CPT Services Levels	**RVU**

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99281	Level I (Includes EMTALA)	1
99282	Level II (Includes EMTALA)	2
99283	Level III (Includes EMTALA)	3
99284	Level IV (Includes EMTALA)	5
99285	Level V (Includes EMTALA)	8
99291	Level V (Includes EMTALA)	8

ECS (Extended Care Services) - The RVUs assigned are based on clock time.

1 RVU per 2 hours for a period up to 48 hours (maximum of 24 RVUs).

Extended Care Service (ECS)

- This service is associated with outpatients who have received EMG services and are awaiting transfer/discharge to another facility. Some examples include tertiary care facility, nursing home, inpatient psychiatric facility, etc. The services being provided to the patient during ECS may or may not be resource intensive.
- This is an add-on RVU to Level V only (e.g., ECS RVUs may be added to the Treatment Level V RVUs) and is for services provided AFTER EMG Treatment.
- If services provided during ECS are resource intensive, the Service Level may be increased.
- Extended Care Services are based on "clock time." For each full two-hour period of clock time, one (1) RVU is assigned. Any partial hours are rounded down to the nearest full two-hour period. For example, two hours and five minutes is reported as two hours = one RVU. Two hours and fifty-five minutes is reported as a two-hour period = one RVU.
- To qualify for ECS reporting, the patient must be an outpatient and must be transferred to another facility. The transfer must be fully documented in the medical record.

■ Below are four examples of the proper reporting of Extended Care Service:

1. A patient begins his EMG visit at noon. The resources utilized resulted in a service Level V being assigned. The patient is stabilized and is to be transferred to another facility. The time is now 12:55 pm. Due to conditions beyond the control of the transferring hospital, the transfer is delayed for four and one half (4.5) hours. The reporting of RVUs would be as follows: EMTALA 1 RVU plus Service Level V 7 RVUs, plus ECS for 4 hours = 2 RVUs (rounded down to four hours from the actual of four- and one-half hours), the total RVUs reported would be 10.
2. A patient begins his EMG visit at noon. The resources utilized resulted in a service Level III being assigned. The patient is stabilized and is to be transferred to another facility. The time is now 12:45 pm. The patient is immediately transferred to another facility. The reporting of RVUs would be as follows: EMTALA 1 RVU, plus Service Level III 2 RVUs. There are no ECS RVUs reported, because the Service Level was not Level V.
3. A patient begins his EMG visit at noon. The patient is stabilized and is to be transferred to another facility. The resources utilized resulted in a Service Level IV being assigned. The time is now 1:00 pm. Due to conditions beyond the control of the transferring hospital, the transfer is delayed for four and one half (4.5) hours. The reporting of RVUs would be as follows: EMTALA 1 RVU plus service Level IV 4 RVUs. There are no ECS RVUs reported, because the Service Level was not Level V.
4. A patient begins his EMG visit at noon. The patient is stabilized and is to be transferred to another facility. The resources utilized resulted in a service Level III being assigned. Due to conditions beyond the control of the transferring hospital, the transfer is delayed for nine (9.0) hours. Significant resources beyond typical ECS services were

utilized during the first three hours of the delay causing the Service Level to be increased from Level III to Level V. The remaining six (6) hours of the delay are now considered ECS. The reporting of RVUs would be a follow, EMTALA 1 RVU plus services Level V 7 RVUs, plus ECS for 6 hours 3 RVUs. The total RVUs reported would be 11 RVUs.

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CT Scanner

Approach

CT Scanner Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the Non-Facility Practice Expense (PE) RVU. ("RVU Assignment Protocol")

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.

2. CPT codes that do not have RVUs listed in the MPFS (e.g., CMS Status Code "C")
    a. CPT 76497 did not have a published RVU in the MPFS. As this code is for an unlisted procedure, RVUs should be developed "By Report" following the protocol below in the section "CPT Codes without an Assigned RVU Value.".
    b. CPT 77013 did not have a published RVU in the MPFS. As these codes are reported with a surgical code, these procedures should be reported under Interventional Radiology/Cardiovascular.
    c. HCPCS 0042T did not have a published RVU in the MPS. Due to its similarity to CPT 70496, it was assigned 72 RVUs (58 RVUs plus 14 RVUs for double time post processing).
    d. HCPCS 0351T-0354T did not have published RVU in the MPS. These are new technology codes and RVUs should be developed "By Report".
3. CPT/HCPCS codes for which the published RVU did not make sense,
    a. Even though the resources are higher for lung cancer screening patients due to registry and other documentation requirements, HCPCS G0297 (low dose lung cancer screening) has been synchronized with CPT 71250 (Chest CT wo Contrast) as they often share charge codes within hospitals.

Services with Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 that accompany a surgical CPT have been labeled as Interventional Radiology/Cardiovascular (IRC) and should be reported via the IRC rate center . If a CT CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as Interventional Radiology/Cardiovascular (IRC), and the associated costs of the procedure are to be reclassified to the IRC cost center. Note: These IRC procedures may be charged based on actual start/stop times or based on the average case time (based on an annual time study) for the service.

Surgical Component and Non-Invasive Exam on Same Day

If a patient has a service with a surgical component (invasive) and non-invasive exam on same day – for example, an enhanced CT arthrogram and a CT of the joint- the patient will be charged based on IRC rules for the invasive exam and CT RVUs for the non-invasive exam.

Intrathecal Injections

If intrathecal injections are performed, the service should be reported under IRC. If the service does not include intrathecal injections, standard CT RVUs should be reported.

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are to be charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol

described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to

like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e., 1xxxx-6xxxx) and being performed in the imaging suite, these services are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any CT examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

CPT Code	Description	RVU
70450	CT Head or Brain w/o contrast	21
70460	CT Head or Brain w contrast	30
70470	CT Head or Brain w & w/o contrast	36
70480	CT Orbit, Sella, Posterior Fossa or outer, middle or inner ear w/o contrast	47
70481	CT Orbit, Sella, Posterior Fossa or outer, middle or inner ear w/ contrast	58
70482	CT Orbit, Sella, Posterior Fossa or outer, middle or inner ear w/ & w/o contrast	64
70486	CT Maxillofacial area w/o contrast	27
70487	CT Maxillofacial area w contrast	31
70488	CT Maxillofacial area w & w/o contrast	40
70490	CT Soft Tissue Neck w/o contrast	36
70491	CT Soft Tissue Neck w/ contrast	47
70492	CT Soft Tissue Neck w/ & w/o contrast	58
70496	CT Angiography, Head w/ contrast, including noncontrast images, if performed and image postprocessing	58
70498	CT Angiography, Neck w/ contrast, including noncontrast images, if performed and image postprocessing	57
71250	CT Thorax w/o contrast	36
71260	CT Thorax w/ contrast	47
71270	CT Thorax w/ & w/o contrast	58
71275	CT Angiography, chest (noncoronary) w/ contrast; including noncontrast images, if performed & image postprocessing	59
72125	CT Cervical Spine w/o contrast - Contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	37

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CPT Code	Description	RVU
72126	CT Cervical Spine w/ contrast - Contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47
72127	CT Cervical Spine w/ & w/o Contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	
72128	CT Thoracic Spine w/o contrast contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	36
72129	CT Thoracic Spine w/ contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47
72130	CT Thoracic Spine w/ & w/o contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	58
72131	CT Lumbar Spine w/o contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	36
72132	CT Lumbar Spine w/ contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	47
72133	CT Lumbar Spine w/ & w/o contrast material in CT of spine is either by intrathecal or IV injection. For intrathecal injection use also 61055 or 62284. IV injection of contrast material is part of the CT procedure	58
72191	CT Angiography: Pelvis w/ contrast, including noncontrast images, if performed, and image postprocessing	60
72192	CT Pelvis w/o contrast	26
72193	CT Pelvis w contrast	47
72194	CT Pelvis w/ & w/o contrast	56
73200	CT Upper Extremity w/o contrast	36
73201	CT Upper Extremity w/ contrast	46
73202	CT Upper Extremity w/ & w/o contrast	61
73206	CT Angiography, Upper Extremity w/ contrast; including noncontrast images, if performed and image postprocessing	67
73700	CT Lower Extremity w/o contrast	36
73701	CT Lower Extremity w contrast	47
73702	CT Lower Extremity w/ & w/o contrast	60
73706	CT Angiography, Lower Extremity w/ contrast, including noncontrast images, if performed, and image postprocessing	73
74150	CT Abdomen w/o contrast	25
74160	CT Abdomen w contrast	47
74170	CT Abdomen w/ & w/o contrast	54

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CPT Code	Description	RVU
74174	CT Angiography, Abdomen & Pelvis w/ contrast material, including noncontrast images, if performed and image postprocessing	78
74175	CT Angiography, Abdomen w/ contrast material, including noncontrast images, if performed and image postprocessing	61
74176	CT Abdomen & Pelvis w/o contrast material	32
74177	CT Abdomen & Pelvis w contrast	62
74178	CT Abdomen & Pelvis w/ & w/o contrast	71
74261	CT colonography diagnostic, including image postprocessing; w/o contrast	103
74262	CT colonography diagnostic, including image postprocessing; w/ contrast including non-contrast images, if performed	118
74263	CT colonography, screening, including image postprocessing	180
75571	CT Heart w/o contrast; w/ quantitative evaluation of coronary calcium	20
75572	CT Heart w/ contrast material, for evaluation of cardiac structure & morphology (includes 3D imaging postprocessing, assessment of cardiac function and evaluation of venous structures, if performed)	55
75573	CT Heart w/ contrast material, for evaluation of cardiac structure & morphology in the setting of congenital disease (includes 3D imaging postprocessing, assessment of LV cardiac function, RV structure and function & evaluation of venous structures, if performed)	74
75574	CT Angiography, heart, CABG (coronary arteries and bypass graft - when present), with contrast, includes 3D imaging postprocessing (including evaluation of cardiac structure & morphology, assessment of cardiac function & evaluation of venous structures, if performed)	85
75635	CT Angiography, Abdominal aorta and bilateral iliofemoral lower extremity runoff, w/ contrast, including noncontrast images, if performed, and image postprocessing	74
75989	Radiological Guidance (ie. Fluoroscopy, US, or CT), for percutaneous drainage (ie. Abscess, specimen collection), w/ placement of catheter, radiological supervision and interpretation	IRC
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; not requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	4
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	9
76380	CT limited or localized follow-up study	27
76497	Unlisted CT Procedure (diagnostic or interventional)	By Report
77011	CT Guidance for stereotactic localization (do not report in conjunction w/ 22586, 0195T, 0196T, 0309T)	IRC

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CPT Code	Description	RVU
77012	CT Guidance for needle placement (eg. Biopsy, aspiration, injection, localization device), radiological supervision and interpretation (do not report in conjunction w/ 10030, 22586, 27906, 32554-32557, 64479-64484,64490-64495, 64633-64636, 0195T, 0196T, 0232T, 0309T)	IRC
77013	CT Guidance for, and monitoring of, parenchymal tissue ablation (do not report in conjunction w/ 20982, 20983, 0340T)	IRC
77014	CT Guidance for placement of radiation therapy fields	21
77078	CT Bone mineral density study, 1 or more sites, axial skeleton (hips, pelvis, spine)	29
G0297	Low dose CT scan (LDCT) for lung cancer screening (Medicare reporting only)	36
0042T	Cerebral perfusion analysis using CT w/ contrast, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	72
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	By Report
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	By Report
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	By Report
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	By Report

MRI

Approach

Magnetic Resonance Imaging Relative Value Units were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of codes in this section of Appendix D were obtained from the 2017 edition of the Current Procedural Terminology (CPT) manual and the 2017 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2017 Medicare Physician Fee schedule (MPFS) released November 2, 2016. RVUs were assigned using the Non-Facility Expense (PE) RVU. ("RVU Assignment Protocol").

The RVUs reported in the 2017 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed.
        a. CPT codes that are considered technical only, the single RVU reported will be used.
        b. CPT codes considered professional only are not listed in Appendix D.

2. CPT codes that do not have RVUs listed in the MPFS (e.g., CMS Status Code "C").
    a. CPT 77022 did not have a published RVU in the MPFS. As these codes are reported with a surgical code , these procedures should be reported under Interventional Radiology/Cardiovascular.
    b. CPT 70557, 70558 and 70559 did not have a published RVU in the MPS. Even though these are performed intraoperatively, they will be charged using standard brain MRI RVUs. They will mirror 70551 (44 RVUs), 70552 (65 RVUs), and 70553 (74 RVUs).
    c. CPT 70555 did not have a published RVU in the MPFS. As this code is similar to 70554, it was set to mirror 70554. See #3 below.
    d. CPT 76498 did not have a published RVU in the MPFS. As this code is for an unlisted procedure, RVUs should be developed "By Report".
    e. CPT 0159T did not have a published RVU in the MPFS. As this procedure is always performed in conjunction with a primary procedure, one RVU will be assigned.

HCPCS 0398T did not have a published RVU in the MPFS. Intracranial procedures are typically performed in the operating room. However, this code is for the MRI piece. Hospital data to establish RVUs is limited as this is a new code and very few hospitals are performing this procedure. Therefore, RVUs should be developed "By Report"

a. Following the protocol below in the section "CPT Codes without an Assigned RVU Value."

3. CPT/HCPCS codes for which the published RVU did not make sense
    a. CPT 70554 has a published RVU in the MPFS that is too low for the number of resources involved. On the professional side, the physician charges this CPT and CPT 96020. Given the significant time and resources involved, the group felt there was a valid reason for deviating from the prescribed methodology. Therefore, an additional 54 RVUs will be added to the MPFS for a total of 150 (96 + 54 = 150).

Services with Both a HCPCS Code for Medicare and CPT Code for Non-Medicare

All known HCPCS codes have been addressed in a payer-neutral fashion with this update. In instances of where Medicare implements a new HCPCS code to be utilized in lieu of a CPT code for a service, the RVU developed by the hospital must mirror the established CPT RVUs. The RVU for the service must be the same for all payers.

CPT Codes with Bundled Procedures

CPT codes from 2017 that accompany a surgical CPT have been labeled as Interventional Radiology/Cardiovascular (IRC) and should be reported via the IRC rate center. If an MRI CPT becomes bundled with a surgical code or replaced with a surgical code, these procedures should be charged as IRC, and the associated costs of the procedure are to be reclassified to the IRC cost center. Note: These IRC procedures may be charged based on actual start/stop times or based on the average case time (based on an annual time study) for the service.

Surgical Component and Non-Invasive Exam on Same Day

If a patient has a service with a surgical component (invasive) and non-invasive exam on same day – for example, an enhanced MR arthrogram and an MRI of the joint- the patient will be charged based on IRC rules for the invasive exam and MRI RVUs for the non-invasive exam.

Reporting of Imaging Guidance for Invasive Cases

Standard imaging RVUs are to be used for non-invasive imaging services. For invasive imaging services, the imaging guidance is either separately reportable or bundled into the code for the invasive service. Invasive imaging services occurring in an imaging suite must be charged using IRC minutes based on case time. For separately reportable imaging guidance, hospitals are to report one (1) IRC minute per imaging code. Imaging expenses associated with the guidance are to be allocated from the diagnostic imaging rate center to the IRC rate center.

When an operating room or operating room-clinic case involves separately reportable intraoperative/intraprocedural imaging guidance or imaging services, standard imaging RVUs are to be used. These cases are charged based on OR or ORC minutes. When imaging guidance is bundled into the underlying procedure, hospitals should not report any additional RVUs for the imaging. If imaging staff is assisting during a case where the imaging is bundled into the underlying procedure, expenses should be allocated from the imaging department to the operating room or operating room-clinic rate center.

CPT Codes without an Assigned RVU Value

RVUs for new codes developed and reported by CMS after the 2017 reporting, must be developed "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible using the most current MPFS. For codes that are not listed in the MPFS, hospitals should assign RVUs based on time and resource intensity of the services provided compared to like services in the department. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

For any codes that are in the surgical series of CPT (i.e., 1xxxx-6xxxx) and being performed in the imaging suite, these services are to be reported via IRC.

General Guidelines

The AMA CPT Code will be used as the identifier throughout the system. Assigned RVU's will be strictly tied to the CPT Code.

All RVUs are per CPT unless otherwise stated.

Standard supplies and contrast material are included in the RVU assignment and should not be assigned separately.

No drug is considered a routine part of any MRI examination; however, sedation and pain reducing agents may be used to make procedures more easily tolerated. These drugs should NOT be included in the RVU of the exam but would be billed separately through the pharmacy on an "as needed" basis. Drugs should not be assigned an RVU.

CPT Code	Description	RVU
70336	MRI Temporomandibular joints	70
70540	MRI Orbit, Face, and/or Neck w/o contrast	66
70542	MRI Orbit, Face, and/or Neck w/ contrast	72
70543	MRI Orbit, Face, and/or Neck w/ & w/o contrast	87
70544	MRA Head w/o contrast	93
70545	MRA Head w contrast	92
70546	MRA Head w/ & w/o contrast	143
70547	MRA Neck w/o contrast	94
70548	MRA Neck w contrast	99
70549	MRA Neck w & w/o contrast	144
70551	MRI Brain (including brain stem), w/o contrast	44
70552	MRI Brain (including brain stem), w/ contrast	65
70553	MRI Brain (including brain stem), w/ & w/o contrast	74
70554	MRI Brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	150
70555	MRI Brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, requiring physician or psychologist administration of entire neurofunctional testing	150

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
MRI

CPT Code	Description	RVU
70557	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residual tumor or residual vascular malformation); w/o contrast	44
70558	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residual tumor or residual vascular malformation); w/ contrast	65
70559	MRI Brain (including brain stem & skull) during open intracranial procedure (to access for residual tumor or residual vascular malformation), w/ & w/o contrast	74
71550	MRI Chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); w/o contrast	96
71551	MRI Chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); w/ contrast	105
71552	MRI Chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); w/ & w/o contrast	131
71555	MRA Chest (excluding myocardium) w or w/o contrast	87
72141	MRI, C-spine, spinal canal and contents; w/o contrast	42
72142	MRI, C-spine, spinal canal and contents; w/ contrast	66
72146	MRI, T-spine, spinal canal and contents; w/o contrast	42
72147	MRI, T-spine, spinal canal and contents; w/ contrast	66
72148	MRI, L-spine, spinal canal and contents; w/o contrast	42
72149	MRI, L-spine, spinal canal and contents; w/ contrast	65
72156	MRI, C-spine, spinal canal and contents; w/ & w/o contrast	74
72157	MRI, T-spine, spinal canal and contents; w/ & w/o contrast	75
72158	MRI, L-spine, spinal canal and contents; w/ & w/o contrast	74
72159	MRA spinal canal and contents w or w/o contrast	92
72195	MRI Pelvis w/o contrast	85
72196	MRI Pelvis w/ contrast	91
72197	MRI Pelvis w/ & w/o contrast	110
72198	MRA Pelvis w/ or w/o contrast	88
73218	MRI Upper Extremity, other than joint; w/o contrast	84
73219	MRI Upper Extremity, other than joint; w/ contrast	90
73220	MRI Upper Extremity, other than joint; w/ & w/o contrast	110
73221	MRI any Joint of Upper Extremity w/o contrast	47
73222	MRI any Joint of Upper Extremity w/ contrast	83
73223	MRI any Joint of Upper Extremity w/ & w/o contrast	102
73225	MRA Upper Extremity w or w/o contrast	91
73718	MRI Lower Extremity, other than joint, w/o contrast	83
73719	MRI Lower Extremity, other than joint, w/ contrast	91
73720	MRI Lower Extremity, other than joint, w/ & w/o contrast	111
73721	MRI any Joint of Lower Extremity w/o contrast	47
73722	MRI any Joint of Lower Extremity w/ contrast	84
73723	MRI any Joint of Lower Extremity w/ & w/o contrast	102
73725	MRA Lower Extremity w/ or w/o contrast	87

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
MRI

CPT Code	Description	RVU
74181	MRI Abdomen w/o contrast	73
74182	MRI Abdomen w/ contrast	103
74183	MRI Abdomen w & w/o contrast	111
74185	MRA Abdomen, w/ or w/o contrast	88
74712	MRI Fetal; including placental and maternal pelvic imaging when performed; single or first gestation	93
74713	MRI Fetal; including placental and maternal pelvic imaging when performed; each additional gestation	39
75557	Cardiac MRI for morphology and function w/o contrast	57
75559	Cardiac MRI for morphology and function w/o contrast; w/ stress imaging	83
75561	Cardiac MRI for morphology and function w/ & w/o contrast	83
75563	Cardiac MRI for morphology and function w/ & w/o contrast; w/ stress imaging	101
75565	Cardiac MRI for velocity flow mapping (list separately in addition to code for primary procedure)	12
76376	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; not requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76377	3D Rendering w/ interpretation and reporting of CT, MRI, US, or other tomographic modality w/ image post processing under concurrent supervision; requiring image postprocessing on an independent workstation - use in conjunction w/ code(s) for base imaging procedure	By Report
76390	Magnetic Resonance Spectroscopy	106
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)	By Report
77021	Magnetic Resonance Guidance for needle placement (eg. Biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation (do not report in conjunction w/ 10030,19085, 19287, 32554 ,32555, 32556, 32557 or 0232T)	IRC
77022	Magnetic Resonance Guidance for monitoring of parenchymal tissue ablation	IRC
77058	MRI Breast w/ and/or w/o contrast; unilateral	129
77059	MRI Breast w/ and/or w/o contrast; bilateral	128
77084	MRI Bone Marrow blood supply	87
0159T	Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, w/ further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure)	1
0398T	MRI guided high intensity focused US (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed	By Report

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
MRI

GLOSSARY

1. Extremities, non-joint; Pertains to all extremity imaging where the joint is not the area of interest. However, the nearest joint must be included on at least one series for validation of scan placement. Most commonly used for bone or tissue diseases.
2. MRA; Pertains to all blood vessels imaging. Procedures require multiple images (frequently surpassing 300 source images), requires additional prep and supplies, and requires a minimum of 30 additional minutes of post-processing time.
3. Without contrast, no contrast is injected.
4. With contrast, IV contrast is injected followed by the scanning protocol.
5. Without and with Contrast, the scanning protocol is completed, the patient is brought out from the scanner, the technologist or nurse preps the patient. IV contrast is injected, the patient is returned to the proper scanning position, and the scanning protocol is repeated.

Appendix B
List of Maryland Hospitals

PREFACE:

This document contains the name of all **regulated** Maryland hospitals including their HSCRC Financial ID, full CMS ID, Fiscal Year End, and Facility Type (Acute, Freestanding Medical Facility (FMF), Specialty, and Psychiatric). This hospital list was last updated as of the date displayed in the header above.

GENERAL ACUTE CARE HOSPITALS

HOSPITAL NAME	Financial ID	CMS ID	Fiscal Year End	Type of Facility
Adventist HealthCare Fort Washington Medical Center	60	210060	June 30	Acute
Adventist HealthCare Shady Grove Medical Center	5050	210057*	December 31	Acute
Adventist HealthCare White Oak Medical Center	16	210016	December 31	Acute
Ascension St. Agnes Hospital	11	210011	June 30	Acute
Atlantic General Hospital	61	210061	June 30	Acute
Calvert Health Medical Center	39	210039	June 30	Acute
ChristianaCare, Union Hospital	32	210032	June 30	Acute
Frederick Health Hospital	5	210005	June 30	Acute
Greater Baltimore Medical Center	44	210044	June 30	Acute
Holy Cross Hospital	4	210004	June 30	Acute
Holy Cross Hospital Germantown	65	210065	June 30	Acute
Johns Hopkins Bayview Medical Center	29	210029	June 30	Acute
Johns Hopkins Hospital	9	210009	June 30	Acute
Johns Hopkins Howard County Medical Center	48	210048	June 30	Acute
Johns Hopkins Suburban Hospital	22	210022	June 30	Acute
LifeBridge Health Carroll Hospital Center	33	210033	June 30	Acute
LifeBridge Health Grace Medical Center	13	210013	June 30	FMF
LifeBridge Health Levindale	5033	210064	June 30	Acute
LifeBridge Health Northwest Hospital Center	40	210040	June 30	Acute
LifeBridge Health Sinai Hospital	12	210012	June 30	Acute

Appendix B
List of Maryland Hospitals

HOSPITAL NAME	Financial ID	CMS ID	Fiscal Year End	Type of Facility
Luminis Health Anne Arundel Medical Center	23	210023	June 30	Acute
Luminis Health Doctors Community Medical Center	51	210051	June 30	Acute
MedStar Franklin Square Hospital	15	210015	June 30	Acute
MedStar Good Samaritan Hospital	2004	210056	June 30	Acute
MedStar Harbor Hospital	34	210034	June 30	Acute
MedStar Montgomery Medical Center	18	210018	June 30	Acute
MedStar Southern Maryland Hospital Center	62	210062	June 30	Acute
MedStar St Mary's Hospital	28	210028	June 30	Acute
MedStar Union Memorial Hospital	24	210024	June 30	Acute
Mercy Medical Center	8	210008	June 30	Acute
Meritus Medical Center	1	210001	June 30	Acute
TidalHealth McCready Pavilion	45	210045	June 30	Acute
TidalHealth Peninsula Regional	19	210019	June 30	Acute
UM Baltimore Washington Medical Center	43	210043	June 30	Acute
UM Bowie Health Center	333	210333	June 30	FMF
UM Capital Region Medical Center	3	210003	June 30	Acute
UM Charles Regional Medical Center	35	210035	June 30	Acute
UM Laurel Medical Center	55	210055	June 30	FMF
UM Medical Center	2	210002	June 30	Acute
UM Queen Anne's Freestanding Emergency	88	210088	June 30	FMF
UM Rehabilitation & Orthopaedic Institute	2001	210058	June 30	Acute
UM Shock Trauma	8992	218992	June 30	Acute
UM Shore Regional Health at Cambridge	10	210010	June 30	FMF
UM Shore Regional Health at Chestertown	30	210030	June 30	Acute
UM Shore Regional Health at Easton	37	210037	June 30	Acute
UM St. Joseph Medical Center	63	210063	June 30	Acute

Appendix B
List of Maryland Hospitals

HOSPITAL NAME	Financial ID	CMS ID	Fiscal Year End	Type of Facility
UM Upper Chesapeake Medical Center – Bel Air	49	210049	June 30	Acute
UM Upper Chesapeake Medical Center – Aberdeen	6	210006	June 30	Acute
UMMC Midtown Campus	38	210038	June 30	Acute
UPMC Western Maryland	27	210027	December 31	Acute
WVU Medicine Garrett Regional Medical Center	17	210017	December 31	Acute

PSYCHIATRIC HOSPITALS

HOSPITAL NAME	Financial ID	CMS ID	Fiscal Year End	Type of Facility
Brook Lane	4003	214003	June 30	Psychiatric
Luminis Health J. Kent McNew Family Medical Center	4020	214020	June 30	Psychiatric
Sheppard & Enoch Pratt Hospital	4000	214000	June 30	Psychiatric
UM Behavioral Health Pavilion - Aberdeen	4022	214022	June 30	Psychiatric

SPECIALITY HOSPITALS

HOSPITAL NAME	Financial ID	CMS ID	Fiscal Year End	Type of Facility
Adventist HealthCare Rehabilitation - White Oak	89	210089*	December 31	Specialty
Encompass Health Rehabilitation Hospital of Salisbury	3028	213028	June 30	Specialty
Adventist HealthCare Rehabilitation - Rockville	3029	213029*	December 31	Specialty
Encompass Health Rehabilitation Hospital of Bowie	3030	213030	June 30	Specialty
UM Mt. Washington Pediatric Hospital	5034	213300	June 30	Specialty

*** These CMS ID numbers are for HSCRC reporting purposes only.**

Appendix C
Cost Center Codes and Descriptions

PREFACE:

Appendix C lists the cost center (direct, indirect, auxiliary enterprise, other institutional program, unassigned expense, and unregulated service) codes for hospitals in alphabetical order by code, grouped by service type

Direct Cost Centers

CODE	CENTER DESCRIPTION	STANDARD UNIT OF MEASURE	SERVICE TYPE
ADD	Adolescent Dual Diagnosed	Patient Days	Daily Hospital Services
BUR	Burn Care	Patient Days	Daily Hospital Services
CCU	Coronary Care	Patient Days	Daily Hospital Services
CRH	Chronic Care	Patient Days	Daily Hospital Services
DEF	Definitive Observation	Patient Days	Daily Hospital Services
MIS	Medical Surgical Intensive Care	Patient Days	Daily Hospital Services
MSG	Medical Surgical Acute	Patient Days	Daily Hospital Services
NEO	Neonatal Intensive Care	Patient Days	Daily Hospital Services
NUR	Newborn Nursery	Patient Days	Daily Hospital Services
OBS	Obstetric Acute	Patient Days	Daily Hospital Services
ONC	Oncology	Patient Days	Daily Hospital Services
PAD	Psychiatric – Adult	Patient Days	Daily Hospital Services
PCD	Psychiatric – Child/Adolescent	Patient Days	Daily Hospital Services
PED	Pediatric Acute	Patient Days	Daily Hospital Services
PIC	Pediatric Intensive Care	Patient Days	Daily Hospital Services
PRE	Premature Nursery	Patient Days	Daily Hospital Services
PSD	Pediatric Step Down	Patient Days	Daily Hospital Services
PSG	Psychiatric – Geriatric	Patient Days	Daily Hospital Services
PSP	Pediatrics Specialty	Patient Days	Daily Hospital Services
PSY	Psychiatrics Acute	Patient Days	Daily Hospital Services
RDS	Respiratory Dependent	Patient Days	Daily Hospital Services
RHB	Rehabilitation	Patient Days	Daily Hospital Services
TRM	Shock Trauma	Patient Days	Daily Hospital Services
CL	Clinic Services	RVUs	Ambulatory
CL-340	340B Clinic Services	RVUs	Ambulatory
EMG	Emergency Services	RVUs	Ambulatory
OBV	Observation	Hours	Ambulatory
OCL	Oncology Clinic	Visits	Ambulatory
ORC	Operating Room Clinic	Minutes	Ambulatory
PDC	Psych Day/Night Care	Visits	Ambulatory
SDS	Same Day Surgery	Visits	Ambulatory
TRU	Trauma Resuscitation	Visits	Ambulatory
ADM	Admission	Visits	Ancillary
AMR	Ambulance Services Rebundled	RVUs	Ancillary
ANS	Anesthesiology	Minutes	Ancillary
AUD	Audiology	RVUs	Ancillary

Appendix C
Cost Center Codes and Descriptions

CODE	CENTER DESCRIPTION	STANDARD UNIT OF MEASURE	SERVICE TYPE
CAT	Cat Scanner	RVUs	Ancillary
CDS	Cost of Drugs Sold	Either invoice cost or EIPA	Ancillary
CDS-340	340B Drugs	Either invoice cost or EIPA	Ancillary
DEL	Labor & Delivery	RVUs	Ancillary
EEG	Electroencephalography	RVUs	Ancillary
EKG	Electrocardiography	RVUs	Ancillary
ETH	Electro-convulsive Therapy	Hours	Ancillary
GTH	Group Therapies	Hours	Ancillary
HYP	Hyperbaric Chamber	Hours	Ancillary
IRC	Interventional Radiology/Cardiology	Minutes	Ancillary
ITH	Individual Therapies	Hours	Ancillary
LAB	Laboratory Services	RVUs	Ancillary
LAB-340	340B Laboratory Services	RVUs	Ancillary
LEU	Leukapheresis	RVUs	Ancillary
LIT	Lithotripsy	# of Procedures	Ancillary
MRI	MRI Scanner	RVUs	Ancillary
MSS	Medical Supplies Sold	Either invoice cost or EIPA	Ancillary
NUC	Nuclear Medicine	RVUs	Ancillary
OA	Organ Acquisition	# Acquired	Ancillary
OID-340	Oncology & Infusion Drugs	Invoice Cost	Ancillary
OPM	Other Physical Medicine	# of Treatments	Ancillary
OR	Operating Room	Minutes	Ancillary
OTH	Occupational Therapy	RVUs	Ancillary
PST	Psychological Testing	Hours	Ancillary
PUL	Pulmonary Function Testing	RVUs	Ancillary
PTH	Physical Therapy	RVUs	Ancillary
RAD	Radiology Diagnostic	RVUs	Ancillary
RAT	Radiology Therapeutic	RVUs	Ancillary
RAT-340	340B Radiology Therapeutic	RVUs	Ancillary
RDL	Renal Dialysis	# of Treatments	Ancillary
REC	Recreational Therapy	# of Treatments	Ancillary
RES	Respiratory Therapy	RVUs	Ancillary
STH	Speech Therapy	RVUs	Ancillary
TUMT	Transurethral Microwave Thermo Therapy	# of Procedures	Ancillary
TUNA	Transurethral Needle Ablation	# of Procedures	Ancillary

Appendix C
Cost Center Codes and Descriptions

Indirect Cost Centers

CODE	CENTER DESCRIPTION	STANDARD UNIT OF MEASURE	SERVICE TYPE
MGT	Hospital Administration	EIPD	Administrative Services
PUR	Purchasing and Stores	EIPD	Administrative Services
FIS	General Accounting	EIPD	Fiscal Services
PAC	Patient Accounts	# of Patient Days Plus Outpatient	Fiscal Services
CSS	Central Services and Supply	EIPD	General Services
DTY	Dietary Services	Patient Meals	General Services
HKP	Housekeeping	Hours Assigned	General Services
LL	Laundry and Linen	Pounds Processed	General Services
OAO	Organ Acquisition Overhead	Transplant Coordinator Staff Expense	General Services
PHM	Pharmacy	EIPA	General Services
POP	Plant Operations	Gross Square Feet	General Services
SSS	Social Services	Admissions	General Services
MRD	Medical Records	IP Discharges plus 1/8 of OP visits	Medical Care Administration
MSA	Medical Staff Administration	EIPD	Medical Care Administration
NAD	Nursing Administration	Hours of Nursing Service Personnel Supervised	Medical Care Administration

Auxiliary Enterprise Centers

CODE	CENTER DESCRIPTION	STANDARD UNIT OF MEASURE	SERVICE TYPE
AMB	E01: Ambulance	# of Occasions of Service	Auxiliary enterprise
PAR	E02: Parking	# of Parking Spaces	Auxiliary enterprise
DPO	E03: Doctor's Private Office Renal	Gross Square Feet	Auxiliary enterprise
OOR	E04: Office and Other Rentals	Gross Square Feet	Auxiliary enterprise
REO	E05: Retail Operations	Gross Square Feet	Auxiliary enterprise
PTE	E06: Patient Telephones	# of Patient Telephones	Auxiliary enterprise
CAF	E07: Cafeteria	Equivalent # of Meals Served	Auxiliary enterprise
DEB	E08: Day Care Center, Rec Areas, etc	Gross Square Feet	Auxiliary enterprise
HOU	E09: Housing	Avg # of Persons Housed	Auxiliary enterprise

Other Institutional Program Centers

CODE	CENTER DESCRIPTION	STANDARD UNIT OF MEASURE	SERVICE TYPE
REG	F01: Research	# of Research Projects	Research
RNS	F02: Nursing Education	Avg # of Nursing Students	Education
OHE	F03: Other Health Professional Education	Avg # of Students	Education
CHE	F04: Community Health Education	# of Participants	Education

Unassigned Expense Centers

Appendix C
Cost Center Codes and Descriptions

CODE	CENTER DESCRIPTION	STANDARD UNIT OF MEASURE	SERVICE TYPE
DEP	Depreciation and Interest	N/A	Unassigned Expense
ILT	Interest – Long Term	N/A	Unassigned Expense
IST	Interest – Short Term	N/A	Unassigned Expense
LEA	Leases and Rentals	N/A	Unassigned Expense
LIC	Licenses and Taxes	N/A	Unassigned Expense
MAL	Malpractice Expense	N/A	Unassigned Expense
MCR	Medical Care Review	N/A	Unassigned Expense
OIN	Other Insurance	N/A	Unassigned Expense

Unregulated Service Centers

CODE	CENTER DESCRIPTION	STANDARD UNIT OF MEASURE	SERVICE TYPE
FSC	UR01: Free Standing Clinic Services	# of Visits	Unregulated Activities
HHC	UR02: Home Health Services	# of Visits	Unregulated Activities
ORD	UR03: Outpatient Renal Dialysis	# of Treatments	Unregulated Activities
ECF	UR04: Skilled Nursing Care	# of Patient Days	Unregulated Activities
ULB	UR05: Laboratory – Non-Patient	RVUs	Unregulated Activities
UPB	UR06: Physicians Part B Services	# of FTEs	Unregulated Activities
CAN	UR07: Certified Nurse Anesthetist	# of CNA Minutes	Unregulated Activities
PSS	UR08: Physician Support Services – Part B Services	# of FTEs	Unregulated Activities
ADC	UR09: Adult Day Care	N/A	Unregulated Activities
CCC	UR10: Cancer Center	N/A	Unregulated Activities
CAR	UR11: Cardiac	N/A	Unregulated Activities
CCS	UR12: Community Services	N/A	Unregulated Activities
CS	UR13: Consolidation/Eliminations	N/A	Unregulated Activities
FDN	UR14: Foundation	N/A	Unregulated Activities
HSP	UR15: Hospice	N/A	Unregulated Activities
IMG	UR16: Imaging	RVUs	Unregulated Activities
OMC	UR17: Outpatient Medical Center	N/A	Unregulated Activities
OUR	UR18: Other Unregulated	N/A	Unregulated Activities
REH	UR19: Rehabilitation	N/A	Unregulated Activities
URRF1	UR20: Hospital Specific 1	N/A	Unregulated Activities
URRF2	UR21: Hospital Specific 2	N/A	Unregulated Activities
URRF3	UR22: Hospital Specific 3	N/A	Unregulated Activities
URRF4	UR23: Hospital Specific 4	N/A	Unregulated Activities
URRF5	UR24: Hospital Specific 5	N/A	Unregulated Activities
URRF6	UR25: Hospital Specific 6	N/A	Unregulated Activities

Summary of
Draft Revisions

- **Section 200 – Chart of Accounts**
  - Updated language in the Anesthesiology section (pg.54).
- **Section 400 – Reporting Requirements**
  - Updated the requirements for specific reports and reformatted the section.
- **Section 500 – Reporting Instructions**
  - Provided an overview of reports and removed detailed reporting instructions.
- **Section 700 / Appendix D – Standard Units of Measure**
  - Updated language in the Labor and Delivery section (pgs. 89, 91, 93).
- **Appendix B – Hospital List**
  - Updated list of hospital names; added Facility Type and Fiscal Year information.
- **Appendix C – Center Codes**
  - Added Standard Unit of Measure and Service Type for procedures.

maryland
health services
cost review commission

Final Recommendation for Global Budget Carve-outs Under AHEAD

July 22, 2026

Health Services Cost Review Commission
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Baltimore, Maryland 21215
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This document contains the final staff recommendations for Global Budget Carve-outs under AHEAD

Table of Contents

Executive Overview

This final policy presents a list of services determined by staff as highly specialized care, eligible for carve-out from population-based methodologies per Achieving Healthcare Efficiency through Accountable Design (AHEAD) specifications. This document outlines the staff methodology for determining the list of services based on a five-part criteria which prioritizes quaternary and tertiary care performed at the states' academic medical centers and tertiary services performed at other service specialty designated hospitals in the state. Carve-out volumes will be based on calendar year 2025 (CY 2025) performance inflated to fiscal year 2027 (FY 2027) and removed from the hospital's global budget. Going forward, carved-out volumes will be charged at 100 percent of the current applicable rates (i.e. 100 percent variable cost factor) with hospitals being held 100 percent liable for volume volatility.

This final policy recommendation does not significantly change from the draft but includes revisions to the list of carve-out DRGs from the version incorporated in the draft recommendation; includes a classification for small volume hospitals; and addresses/clarifies various operational and funding comments and concerns from stakeholders. The final carve-out DRG list for implementation July 1 of 2026 can be found in Appendix 2.

Introduction

In 2014, Maryland transitioned all its acute care hospitals to an All-Payer Global Budget Revenue (GBR) model. Under this model, hospitals operate under fixed revenue caps as opposed to traditional fee-for-service payments. The Maryland All-Payer model focused on improving quality, enhancing health outcomes, and controlling Medicare spending for hospital inpatient and outpatient services. Between 2014 and 2018, hospitals successfully reduced unnecessary readmissions and hospital-acquired conditions while slowing growth in hospital costs per capita. However, the All-Payer Model primarily targeted hospitals and did not fully support coordinated care across the broader health care system.

In 2019, Maryland transitioned to the Total Cost of Care (TCOC) Model. Under the TCOC Model, Maryland was expected to transform care delivery across the health system, improve health and quality of care, and maintain Medicare spending growth below the national rate. The TCOC Model gave Maryland the flexibility to tailor initiatives to the state's unique health care environment and encouraged innovation among providers. It supported investments in population health improvement, care redesign and provided new tools and resources for primary care providers to better manage complex and chronic conditions, helping Marylanders achieve better health. The State achieved significant savings, quality improvements, and care transformation progress under the TCOC Model.

As of January 1, 2026, Maryland transitioned from the Maryland TCOC Model to the national Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model; a voluntary, state-based total cost of care model that allows Maryland to manage healthcare costs and quality and improve the overall health of the state through expanding primary care and strengthening population health.

This policy recommendation will detail the work staff have done with the Volume Workgroup and the methods by which staff and stakeholders concluded on a carve-out list that prioritizes quaternary and tertiary cases performed at academic centers and tertiary services also performed at non-academic hospitals.

Background

Majority of Maryland hospitals have seen a growth in inpatient case-mix acuity despite declines or stable volumes between fiscal year 2023 (FY 2023) and 2025 (FY 2025). This is an indicator that Maryland has successfully shifted low acuity cases out of the inpatient setting and volumes that tend to remain are appropriate for that setting of care as the patients tend to be sicker and in certain instances

require care that is complex and highly specialized.

Given the focus on growth in high acuity and highly specialized care, staff recognize that shielding that care from global budget limitations may be appropriate. While the AHEAD Model includes a requirement that at least 85 percent of in-state, acute care hospital revenue remain under population-based methodologies that is down from 95 percent under the Total Cost of Care Model, leaving an opportunity to implement an alternative financing mechanism.

In addition to revising the amount available for exclusion under existing global budgets, Maryland can also propose additional exclusions under the Medicare Hospital Global Budgets that are effective January 1, 2028. As stipulated in section 12(a)(iii) of the State Agreement, "the State may propose additional services to be added to the list of exclusions in the financial specifications for the CMS-Designed Hospital Global Budget Methodology for Medicare FFS. This proposal must include:

1. A definition of additional services to be excluded from the CMS-Designed Hospital Global Budget Methodology for Medicare FFS, as described in this Section 12;
2. A policy explanation for each set of excluded services, which considers various factors such as:
    - Disproportionate cost growth for certain services driven by factors outside of the control of hospitals;
    - The innovative nature of certain areas of care, such as high-intensity quaternary and tertiary care;
    - The statistical reliability of the volume of services provided in a year"[1]

The HSCRC identified (1) revenue associated with high-cost drugs, (2) complex tertiary/quaternary care, and (3) certain low volume surgeries as volumes potentially appropriate for carve-out under AHEAD, given that these services are often unpredictable and often characterized by high volume variability and high-cost. While this recommendation is focused on Maryland's global budget, the State plans to use the approach developed as a starting point for discussions with CMS.

High-cost outpatient physician-administered drugs were prioritized under the TCOC Model 5 percent carve-out allotment given the volume volatility and high-cost nature of these therapies. The Commission approved use of a quantitative evaluation to identify eligible drugs which are funded at 100 percent of drug costs through the CDS-A policy.[2] Based on this approach, 2.1 percent of total hospital in-state revenue is carved out of hospital GBRs. Not using the entire 5 percent in one year provided enough cushion in the model for growth and future additions of new emerging innovative therapies.

Staff and stakeholders generally support the continuation of high-cost outpatient drug carve-outs identified in the CDS-A Policy under AHEAD albeit with refinements to align with Center for Medicare and Medicaid Innovation's (CMMI) drug carve-out list. As there is already a carve-out for these drugs that was revised relatively recently, Staff felt that revisions to this policy could wait to be implemented co-incident with the shift to separate Medicare Hospital Global Budgets. However, complex tertiary/quaternary care, some of which was handled under the Complexity and Innovation Policy as well as certain low volume surgeries were flagged by staff and stakeholders as potential areas of opportunity which necessitate new policy development and/or refinements.

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[1] Amended and Restated AHEAD Model Maryland State Agreement
https://hscrc.maryland.gov/Documents/AHEAD/Amended%20and%20Restated%20AHEAD%20Model%20Maryland%20State%20Agreement_vFinal_State%20signed_CMMI%20Signed_vPublic.pdf

[2] Proposed Revisions to Outpatient High-Cost Drug Funding Policy
https://docs.google.com/document/d/1VZOCwRnIaaPVrQsjJ39rGEpwTFfh9wqX/edit

Low volume Surgical Service Lines

Through various statistical analyses done in 2025 to assess the reliability of service lines included in the State's Market Shift Adjustment policy, staff identified and recommended seven surgical service lines for possible exclusion due to their low volumes.[3] These service lines make up approximately 2.5 percent of all in-state revenue and include Endocrinology Surgery, Ear Nose and Throat (ENT) Surgery, Gynecological Surgery, Ophthalmologic Surgery, Thoracic Surgery, Urological Surgery, and Ventilator Support.

While stakeholders generally acknowledged that excluding low-volume surgical service lines could improve market shift reliability, concerns regarding impact on reimbursement, TCOC savings target and access implications led to further evaluations by staff on whether or not to completely carve-out these service lines. Analyses conducted by staff revealed that while these service lines were characterized by low or declining volumes, they also experienced the most growth in acuity levels, hence, fewer but sicker patients seeking care in the most appropriate setting. Hospital-specific evaluations on volume variability for these service lines between FY 2023 and FY 2025 also showed relative stability and as such staff ruled out the decision to carve out these service lines entirely. However, some cases contained within these service lines could be eligible for carve-outs under AHEAD should they meet the expanded quaternary and tertiary care definitions/criteria.[4]

Figure 1. FY 2023 – 2025 Top Service line Volume and Acuity Growth

Site	Product Line	FY 23 CMI	FY24 CMI	FY25 CMI	FY23-FY25 CMI Growth	FY23-FY25 ECMAD Growth
IP	Transplant Surgery	7.33	7.97	8.14	11%	11%
	Ophthalmologic Surg	1.48	1.34	1.54	5%	38%
	Urological Surgery	1.57	1.61	1.64	5%	-3%
	Endocrinology Surgery	1.22	1.23	1.27	4%	-53%
	Gynecological Surg	1.14	1.16	1.18	4%	-11%
	Spinal Surgery	2.31	2.40	2.38	3%	1%
	Vascular Surgery	2.70	2.76	2.78	3%	0%
	Infectious Disease	1.14	1.16	1.17	3%	16%

Restricted to product lines with Case Mix Growth (CMI) growth rates >= the average growth rate of 3 percent and CMI >= 1.00 between FY23 and FY24

Complex Tertiary and Quaternary Care Services

In CY 2020, Staff developed and the Commission approved the Complexity and Innovation Policy, which determined prospectively through a case-mix acuity and cell dominance approach, highly specialized care. Highly specialized care as defined by the policy includes unique and costly tertiary and/or quaternary services, such as organ transplants, that are typically performed at academic medical centers. To qualify for the policy, hospitals must exhibit a 95 percent cell dominance for procedures related to that service and the case must have a case-mix index of 1.5 or greater.[5] Currently, about 2.7 percent of

[3] Final Recommendation for Market Shift Refinement https://docs.google.com/document/d/1k8PbDWNoE594AGLeBfvbLAIMtMXnB6ch/edit

[4] See figure 3 on definitions and criteria for identifying tertiary and quaternary care and Appendix 6 with the details

[5] Final Recommendation for a Complexity and Innovation Policy https://hscrc.maryland.gov/Documents/global-budgets/2023%20Website%20Update%20Files/Final%20Innovation%20Policy%20v3%20%28002%29.pdf

Maryland in-state, all-payer revenue is funded through the Complexity and Innovation Policy but funding is limited to the States Academic Medical Centers (AMCs).

Staff and Stakeholders believe that with the expanded maximum GBR carve-outs from 5 percent under TCOC to 15 percent under AHEAD, there is opportunity to revise the definitions of "highly specialized care" to capture more services previously defined as population-based though not well suited to fixed global budgets given their high cost, innovation-driven and volume variable nature. The Carve-out Policy will replace the current Complexity and Innovation policy and staff intention is to develop an approach that prioritizes highly complex, innovative quaternary and tertiary care typically occurring at academic medical centers while recognizing that other complex care non-academic hospitals may provide services that are unique and costly and therefore expand the highly specialized care definition to include those hospitals.

Procedure Code Based Approach

Staff initially sought to leverage the Current Complexity and Innovation Policy framework to define highly specialized care meriting carve-out from population-based methodologies albeit without the nuances associated with the methodology such as cell dominance scenarios, and cost to charge conversions for supplies and drugs. Using the International Classification of Disease (ICD) procedure codes identified under the Current Complexity and Innovation Policy at 95 percent cell dominance and 1.5 CMI thresholds at AMCs, staff isolated procedure codes that meet this criteria statewide to identify eligible cases and carve-out magnitude. Then the cell dominance thresholds were lowered in decrements of 5 percent, stopping at 70 percent while CMI was increased by 0.1 stopping at 2.0 in each scenario, with the goal of increasing carve-out eligible volume statewide to a level that was reasonable while still prioritizing tertiary and quaternary care at the AMCs.[6]

Figure 2. FY 2025 Statewide Total Charges based on Adjusted Procedure Cell Dominance and CMI Thresholds

Total charges (in millions $) (AMC & Non-AMC)	CMI	1.4	1.5	1.6	1.7	1.8	1.9	2.0
Cell Dominance Threshold	95%	$677	$670	$667	$662	$656	$648	$638
	90%	828	819	815	810	802	793	778
	85%	917	906	903	896	887	874	858
	80%	1,141	1,128	1,123	1,113	1,097	1,078	1,054
	75%	1,308	1,293	1,287	1,274	1,252	1,226	1,199
	70%	1,513	1,495	1,488	1,470	1,443	1,411	1,382

Charges as a % of total in-state revenue (AMC & Non-AMC)	CMI	1.4	1.5	1.6	1.7	1.8	1.9	2.0
Cell Dominance Threshold	95%	3.2%	3.2%	3.1%	3.1%	3.1%	3.1%	3.0%
	90%	3.9%	3.9%	3.8%	3.8%	3.8%	3.7%	3.7%
	85%	4.3%	4.3%	4.2%	4.2%	4.2%	4.1%	4.0%
	80%	5.4%	5.3%	5.3%	5.2%	5.2%	5.1%	5.0%
	75%	6.2%	6.1%	6.1%	6.0%	5.9%	5.8%	5.6%
	70%	7.1%	7.0%	7.0%	6.9%	6.8%	6.6%	6.5%

Staff believes that procedure codes are generally objective and do a better job at isolating specific, highly intensive services; however, they are more frequently subjected to changes making them unstable. Stakeholders argued that the ever-changing nature of procedure codes further complicated the current Complexity and Innovation policy subjecting it to more frequent updates and making it hard for hospitals to predict volumes and therefore they generally expressed a desire to move away from a procedure-based approach in favor of one using Diagnosis Related Groups (DRGs).

[6] See appendix 1: Complex cases at AMC versus Non-AMCs using high end and low-end Procedure-based dominance thresholds

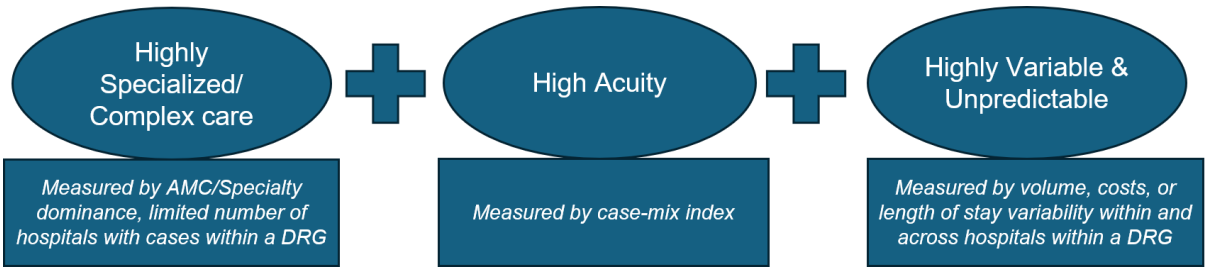
Medicare Severity Diagnosis Related Group (MS-DRG) Based Approach

Stakeholders expressed support for a simpler carve-out approach that has stable, clear definitions and enables modeling. Several recommended using a DRG based approach such as the Sg2's tertiary and quaternary DRG list to define eligible services. CMMI, while indicating a strong preference for using a transparent, non-proprietary approach, also indicated a strong preference towards an MS-DRG based approach for defining carve-out eligible services for reasons of payment simplicity.[7] CMMI also stated that alignment on a list of carve-out services and not a methodology to arrive at an annual carve-out list was preferable. While staff believe that using DRGs erodes procedure specificity, for purposes of alignment, simplification and transparency, staff have pivoted to an MS-DRG based approach for defining eligible carve-out services.

Establishing a Definition of Highly specialized care for carve-out consideration

Highly specialized and complex care refers to advanced tertiary and quaternary services for rare or life-threatening conditions delivered at the highest levels of care, for this purpose, Staff have defined that specifically as tertiary and quaternary care at AMCs[8] and tertiary care at Maryland Institute for Emergency Medical Services Systems (MIEMSS) and National Cancer Institute (NCI)-designated specialty centers.[9]

Cases considered for carve-out under this policy must meet all three of the following criteria:



It is important to note that high acuity does not necessarily always equate to highly specialized care. Highly acute and specialized care includes services often delivered at a limited number of specialty designated hospitals such as burn care, NICU and Trauma services. These services will be eligible for carveouts. On the other hand, highly acute but not specialized care includes cases with a high CMI but for which services have greater volume dispersion, such as cardiac services. While cardiac services are also highly acute there are 24 cardiac centers in the state and volumes are broadly distributed across all hospitals, indicating that they are relatively accessible rather than highly specialized. As such some of these services are less obviously suitable for carve-outs. Services prioritized for the carve-out should also be unpredictable or inconsistent in terms of cost, volume, length of stay, or care pathway. These types of cases are not ideal for a population-based methodology due to their variable nature and therefore would be identified as carve-out eligible.

Staff developed a formulaic approach, which is described in Figure 3, to identify potential carveouts and modeled two scenarios. Appendix 6 of this draft recommendation outlines the methodology in detail.

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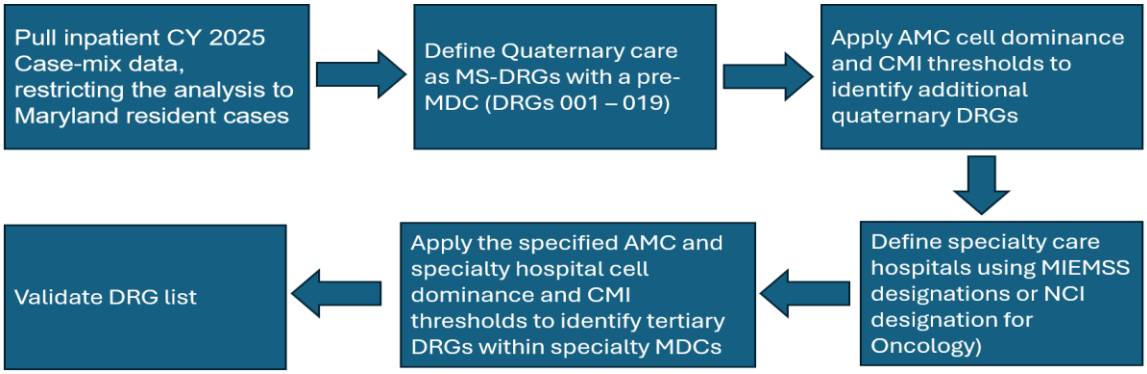
[7] Due to the desire to align with CMMI this policy uses MS-DRGs and not APR-DRGs, that are used in most HSCRC policies. All references to DRGs should be assumed to reference MS-DRGs

[8] A limited number of hospitals with advanced resources for treating highly complex cases

[9] A limited number of hospitals with specialized programs and resources for treating highly complex cases within a given specialty such as trauma, NICU, cardiac specialty designations

Figure 3. Formulaic DRG-Based Approach to Identify Highly Specialized Care[10]



Scenario 1 - More restrictive

Included all "pre-MDC" categories (DRGs 1-19), quaternary and tertiary services at AMCs with a cell dominance of 50 percent and CMI of 2.5, Burn cases at a 90 percent cell dominance threshold and 1.5 CMI, Trauma at 50 percent cell dominance and a 2.5 CMI and NICU cases with a 60 percent cell dominance and 1.5 CMI. The pre-MDC DRGs were included because, by definition, they represent a set of highly specialized services. For the remaining categories thresholds were set based on the observed distribution of cases in that category in order to balance inclusion of high acuity services with the relative level of dispersion in that service area. In this model only the Burn, Neonatal Intensive Care Unit (NICU) and Trauma specialties were included as they are the only categories with MIEMSS designation which represent services delivered by only a few select hospitals. Using FY 2025 case-mix data this scenario rendered 48 DRGs amounting to 1.4 billion in total charges, the equivalent of 6.8 percent of in-state revenue of which 63 percent was delivered at AMCs (See Figure 4).

Figure 4. More Restrictive Scenario Results

Total carve out charges	% of In-state revenue*	Number of DRGs
$ 1.4B	6.8%	48

% AMC Contribution to Carve out charges	% Specialty Hosp Contribution to Carve out charges	% Other Hosp Contribution to Carve out charges
63%	17%	20%

Categories	Quaternary		Tertiary					
	Pre-MDC (DRGs 1-19)	AMC Dominance	Cardiac	Stroke	Burn	Trauma	NICU	Oncology
Cell Dominance	-	50%	-	90%	90%	50%	60%	-
CMI	-	2.5	-	1.5	1.5	2.5	1.5	-
Charges in $M	$654.5	$190.2	-	-	$15.4	$ 331.1	$240.5	-

[10] Process relies on DRG and Major Diagnostic Categories (MDC) for analysis

Scenario 2 - Less Restrictive with Clinical Edits and Refinements

Realizing that there are some areas of highly specialized care that are not captured by the more restrictive scenario, staff revised scenario 1 to incorporate cardiology cases at 90 percent cell dominance and 2.5 CMI and oncology cases at 60 percent cell dominance with 1.5 CMI. Using FY 2025 case-mix data, this scenario renders an additional 18 DRGs bringing the total DRGs eligible for carve-outs to 78. Staff used this list of 78 as the starting point for further clinical review and refinement.

Initial clinical evaluations flagged DRGs related to cardiac valves for removal from the carve-out lists given the high level of dispersion across hospitals. However, hospital stakeholders argued for their re-statement given their high clinical acuity and specialization. Staff have re-instated the DRGs related to cardiac valves identified by the methodology to the carve-out list but will monitor them on an annual basis as potential advances in technology and dispersion could warrant removal in the future.

Spinal fusion DRGs, cardiac defibrillator DRGs, AICD and certain cardiac device implant DRGs that made the list based on the algorithm were later determined based on clinical review as not carve-out eligible. These DRGs were deemed as "standard of care" and not highly specialized given the level of dispersion across hospitals despite their high levels of acuity.[11] These DRGs were subsequently manually removed from the staff proposed carve-out list, reducing the list to 66 DRGs. These 66 DRGs constituted the proposed carve-out list included in the staff draft recommendation.

DRGs flagged for further Investigation and additional DRGs

Staff noted in the draft recommendation, specific DRGs that were included on the carve-out lists strictly based on the algorithm but which warranted further investigation into eligibility per the carve-out criteria. These included the two NICU DRGs (789 & 790), and DRGs 04, 492, 515, and 653.

1. **NICU DRGs (789 - Neonates, Died or Transferred to Another Acute Care Facility & 790 - Extreme Immaturity or Respiratory Distress Syndrome, Neonate):** After further review and stakeholder feedback, Staff agree that MS DRGs lack the specificity needed to identify neonatal complexity. DRGs 789 and 790 also have a high level of dispersion across hospitals statewide. Furthermore, carving out these DRGs coupled with declining NICU volumes statewide could create access to care or financial risks for hospitals. Therefore, staff are proposing to remove this DRGs from the carve-outs list and maintain them in hospital global budgets at this time.

2. **Trauma DRGs (492 - Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC & 515 - Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC):** Staff evaluation shows that these DRGs have a high dispersion statewide with cases reported at 35 of the state's acute care hospitals. Staff also noted that the algorithm influenced their inclusion on the carve-outs list, as the quantifying statistics supporting inclusion for both DRGs are quite marginal. Trauma quantifies DRGs for inclusion at 50 percent cell dominance and a case-mix threshold of 2.5 or higher. DRGs 492 and 515 have case-mix thresholds of 2.6 and 2.5, respectively. These DRGs also do not exist on the CMMI list and for alignment purposes, staff proposes removing them from the HSCRC Carve-outs list.

3. **DRG 04 - Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures:** DRG 04 is highly dispersed statewide; however, because it is classified as a pre-MDC DRG, typically denoting a highly intensive procedure, staff proposes maintaining it on the list. Doing so is consistent with the CMMI list which also includes all DRGs with a pre-MDC classification.

[11] See Appendix 4: DRGs that Made Carve-out List but were Removed Upon Clinical Review

4. **DRG 653 - Major Bladder Procedures with MCC:** This DRG tends to be characterized by low and variable volumes, the majority of which are reported at the academic medical centers (50 percent). Non-academic hospitals report an average of fewer than 2 cases annually. Therefore, staff have resorted to keeping this DRG on the list. Maintaining this DRG on HSCRC's Carve-out list will align with the CMMI list which includes it.

As advocated for by hospitals, two craniotomy DRGs (024 & 026) have been manually added to the carve-outs list. While these DRGs did not meet the staff algorithm to qualify on the margins, they are part of DRG severity families for which the higher severity DRG exists on the carve-out list. Adding these DRGs could potentially prevent any potential unintended consequences of this policy specifically related to upcoding. Both DRGs also exist on the CMMI list and thus adding them to the HSCRC list improves alignment.

Post clinical edits and refinement, Staff is recommending 64 DRGs for carve-outs, this list can be found in Appendix 2. Statewide these DRGs amount to $1.7 billion in total charges, equivalent to 8.4 percent of total in-state revenue. This list prioritizes highly specialized care performed at AMCs (61 percent of total charges), tertiary services performed at specialty hospitals (23 percent of total charges) and tertiary services at other community hospitals (16 percent of total charges) (See Figure 5).

Figure 5. Less Restrictive Scenario Results with Clinical Edits

Total In-state Carve-out Charges	% of Total In-State Revenue	Number of DRGs
$ 1.7B	8.4%	64

% AMC Contribution to Carve-out Charges	% Specialty Hosp Contribution to Carve-out Charges	% Other Hosp Contribution to Carve-out Charges
61%	23%	16%

Categories	Quaternary		Tertiary					
	Pre-MDC (DRGs 1-19)	AMC Dominance	Cardiac	Stroke	Burn	Trauma	NICU	Oncology
Cell Dominance	-	50%	90%	90%	90%	50%	60%	60%
CMI	-	2.5	2.5	1.5	1.5	2.5	1.5	1.5
Charges in $M	$654.5	$96.5	$568.1	-	$15.4	$344.9	-	$66.5

The staff methodology did not include specific specialty designations for other service lines such as orthopedics or neurology, as Maryland does not issue standalone specialty hospital licenses for those services. Hospitals specialty status for these programs is typically designated through hospital accreditation, clinical ratings and the presence of a state-sanctioned Trauma Center. The staff methodology includes MIEMSS designated Trauma Centers which captures DRGs that are highly specialized pertaining to these service lines.

Funding and Implementation

Effective July 1, 2026, the Commission will begin using the service Carve-out DRG list to identify carve-out volumes at Maryland hospitals. Carve-out DRGs are mapped to rate centers and associated rate center revenue and volumes will be deducted from hospital GBRs and funded on a unit rate basis. From FY 2027 all payers, including Medicare, will charge at the approved unit rate. In CY 2028 when the State

transitions to non-Medicare global budgets, hospitals will charge at the unit rates for all payers while Medicare will pay at the DRG level.

Staff recommend that all in-state cases with DRG assignments on the Carve-out list, regardless of whether they are seen at an AMC, specialty or community hospital, be removed from all eligible volume methodologies and instead be funded at a 100 percent variable cost factor (VCF) to prevent any duplicate funding.[12] As such, hospitals will be held 100 percent liable for changing volumes associated with these cases. Funding for all other cases, not eligible for carve-outs, will maintain the respective inpatient medical and surgical service line VCFs. The Carve-out Policy will replace the current Complexity and Innovation Policy therefore, any prospective adjustments relevant to that policy will be reversed once the carve-out policy is approved and in effect; retrospective adjustments for FY 2025 and 2026 will be made. Staff will continue to include carve-out eligible volumes in the Integrated Efficiency Policy and the various quality pay for performance programs and PAU Redistribution Policy.

Baseline Volumes

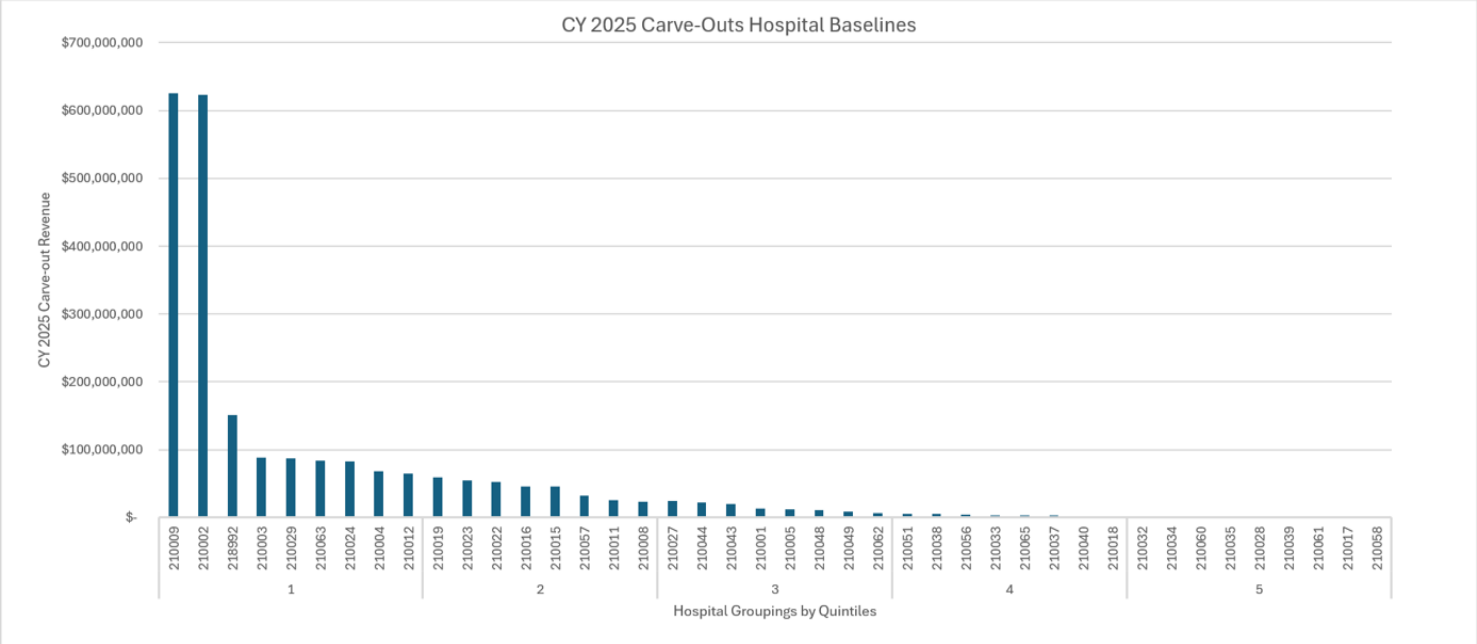
Staff are aware that volumes eligible for carve-out will vary across hospital types, so it is important to set base line volumes at the hospital specific level that are appropriate and reflect true hospital activity. Year over year hospital performance will be measured against the baseline to determine hospital carve-out growth or decline. Hospital baselines will be set using Calendar Year (CY) 2025 performance inflated to FY 2027. However, due to the volatile nature of these services, hospitals with small volumes will have their baselines established using an inflated three-year average.[13] Staff have assessed the magnitude of hospital-specific carve-out volumes over the last three years and although there were slight fluctuations in percentile distributions, hospitals in the bottom two quintiles (quintiles 4 & 5) were consistent across all three years.[14] As shown on the graph below, small volume hospitals will include those hospitals in quintiles 4 and 5.

[12] Volume methodologies including but not limited to Market Shift Adjustment, Demographic Adjustment, Surge Funding, Out-of-State and Repatriation/Expatriation

[13] The carve-out baselines for small volume hospitals will average their CY 2023 to CY 2025 performance inflated to FY2027

[14] Three years evaluated include CY 2023 – CY 2025

Figure 6. Hospital-Specific Carve-outs Baseline



Additional Considerations

Outpatient Cosmetic Surgery Exemption

HSCRC has long permitted hospitals, who meet the requirements of the program, to provide discounts below approved rates for some cosmetic surgeries. For the most recently reported four quarters statewide charges under this program were $1.3 million or approximately 0.01 percent of statewide regulated revenue across 5 hospitals (payments were significantly less since discounts are provided). In response to stakeholder advocacy and to allow greater flexibility, Staff recommend revenues charged in compliance with this program also be carved out of the global budget. Given the minimal revenue involved, no global budget adjustments will be made for this carve out, however, staff agree that these revenues will no longer impact year end GBR compliance.

Monitoring and Updating of Carved Out Services

The list proposed in this recommendation will be used for carve-outs in FY 2027 and may be modified for future periods as follows:

1. **CMMI List:** Staff will work with CMMI on the carve out list under their Hospital Global Budgets and where possible update the Maryland list to match the final CMMI list in CY 2028. CMMI has also indicated flexibility in refining their lists for purposes of alignment and are open to further discussions around collectively updating the carve-out lists annually.

2. **Adding DRGs:** Staff will annually review DRG updates to consider if new DRGs should be added to the carve out list

3. **Removing DRGs:** Staff will annually review utilization of DRGs on the carve-out lists and consider removing DRGs which have diffused across a majority of hospitals and that may no

longer qualify as specialized. At the time the changes are made, charges will be added back to the global budget for dropped DRGs based on recent utilization levels. Such adjustment will only be made once diffusion is believed to be complete to avoid locking into the global budget utilization patterns that do not reflect the end state of diffusion.

4. **Program Monitoring:** Staff will monitor utilization across carved out DRGs to ensure there are not unintended consequences opposed to the goals of the carve out, the HSCRCs regulatory mandate or the AHEAD model and make changes should unintended consequences be noted.

5. **AHEAD Carve-out Limit:** Staff will monitor overall utilization to ensure compliance with the carve-out limit under the AHEAD model and consider changes to ensure the most appropriate use of the carve out should the State be close to the 15 percent cap.

Any changes contemplated under the bullets above will be shared with the relevant HSCRC workgroups. Material changes under any of these provisions will be subject to Commission approval.

Stakeholder Feedback

Staff received comment letters from 13 stakeholders which have been broadly categorized into eight areas of concern as depicted in the table below.

Figure 7. Summary of Public Comments

Key Topics	UMMS	JHHS	Adventist	UPMC	Luminis	MedStar	LifeBridge	MWPH	MHA	CareFirst	Autolus Therap.	Gilead Sciences	Cancer Support Community
Implementation Timing & Readiness	X	X	X	X	X	X	X		X	X			
NICU/ Newborn DRGS	X	X	X		X	X		X	X				
Out-of-State Patients	X	X	X	X		X							
Funding Mechanics & Payment Methodology	X	X			X	X	X			X			
Operational Mechanics, Compliance, and C&I Transition	X	X			X	X	X		X				
Scope of Eligible Services & Applicability Beyond AMCs	X		X	X		X	X		X			X	
Alignment with CMMI & AHEAD Transition	X	X	X			X	X		X			X	
CAR-T and Innovative Therapies											X	X	X

Staff will address each stakeholder comment below

1. **NICU / Newborn DRGs 789 & 790:** Multiple stakeholders recommend removing the proposed NICU/newborn DRGs from the carve-out list or evaluating them separately, often noting that MS-DRGs are not sufficiently refined for neonatal complexity and that carve-out treatment could create access, transfer, or financial risks

Figure 8. Summary of NICU/Newborn DRGs Comments

Organization	Summary of Comments
Adventist	Adventist recommends removing the two NICU MS-DRGs from the carve-out list and evaluating NICU separately. They note that MS-DRGs are not well suited to identifying highly specialized neonatal care and that moving NICU services fully to volume-based reimbursement could jeopardize access.
MHA	MHA supports further consideration of the two NICU DRGs and notes that the MS-DRG system lacks the specificity and clinical precision needed to assess whether neonatal cases meet the criteria for highly specialized care.
JHHS	JHHS says NICU MS-DRGs should not be included in the carve-out list because MS-DRGs do not adequately differentiate more complex from less complex neonates and APR-DRGs are more appropriate.
Luminis	Luminis supports further study of the two NICU DRGs rather than including them in the carve-out list now, stating that the current MS-DRG structure may not be sufficiently refined to account for complexity and intensity of care.
UMMS	UMMS recommends removing newborn cases from the carve-out methodology. They note that inclusion would increase the carve-out percentage by over 1% and that the newborn MS-DRG definitions capture more standard-of-care cases than the carve-out is intended to include.
MedStar	MedStar says NICU services need further evaluation; the letter supports staff's intent to include NICU services conceptually but says MS-DRGs are not designed for this patient population and recommends considering an alternative methodology.
MWPH	MWPH asks that DRGs 790 and 789 not be carved out and instead remain in hospital global revenue budgets, noting that approximately 24% of its annual net revenue comes from neonates and 200–250 of these cases transfer from acute care hospitals each year, making the carve-out a financial threat to its broader services.

Staff Response: *After further review and stakeholder feedback*, *Staff agree that MS DRGs lack the specificity needed to identify neonatal complexity. DRGs 789 and 790 also have a high level of dispersion across hospitals statewide. Furthermore, carving out these DRGs coupled with declining NICU volumes statewide could create access to care or financial risks for hospitals. The staff priority on carve-outs is to maintain access to neonatal services in a way that is manageable for all hospitals and in agreement with Stakeholder comments, Staff believe that NICU DRGs should not be carved out at this time. Removing these DRGs from the carve-outs list should promote continued access.*

2. **Out-of-State Patients:** Several stakeholders recommend applying the carve-out methodology consistently regardless of patient residency. These commenters argue that once a service meets the carve-out criteria, reimbursement should follow the characteristics of the service rather than whether the patient is in-state or out-of-state, both to reduce administrative complexity and to support consistent payment for specialized referral care.

Figure 9. Summary of Out-of-State Patients Comments

Organization	Summary of Comments
Adventist	Adventist recommends applying the carve-out policy uniformly regardless of patient residency, arguing that different reimbursement rules for in-state and out-of-state patients create unnecessary administrative complexity and payment variation.
JHHS	JHHS recommends applying the carve-out methodology to all volumes regardless of state of origin, arguing that the AHEAD 15% limit is measured on in-state revenue only and that a bifurcated approach would create unnecessary operational and compliance complexity.
UMMS	UMMS says the carve-out policy should include both in-state and out-of-state patients because identification of excluded GBR cases should occur before separating revenue into carve-out volume and hospital global budget volume.
UPMC	UPMC advocates including out-of-state volumes in carve out methodology because about 20% of its specialized service volumes come from Pennsylvania and West Virginia.
MedStar	MedStar says the draft's in-state limitation is inconsistent with the intent of carving out high-cost and unpredictable services from hospital global budgets and recommends expanding the policy methodology to out-of-state patients.

Staff Response: *Staff agree that carve-outs should also apply to out-of-state volumes, however, AHEAD Model Savings Tests as stipulated in the State Agreement will be assessed on in-state volumes only. The carve-out DRG list will be determined using in-state volumes only but reimbursements for DRGs identified as carve-out eligible will be applied consistently across in-state and out-of-state volumes. Out of state-of-state carve-outs amounts to about $226.6 million statewide in FY 2027.*

3. **Implementation Timing and Readiness:** Stakeholders are divided on implementation timing. Some supported a July 1, 2026, start or a phased or opt-in opt-out approach, and others recommended delaying implementation to January 1, 2027, or July 1, 2027, to allow more time for technical review, operationalization preparation, and the resolution of outstanding policy questions. A subset of commenters specifically tied this timing concern to hospital compliance, revenue monitoring, or financial volatility.

Figure 10. Summary of Implementation Timing and Readiness Comments

Organization	Summary of Comments
Adventist	Adventist HealthCare (Adventist) supports implementation effective July 1, 2026 and, if statewide implementation is not feasible, suggests an optional pilot approach.
MHA	Maryland Hospital Association (MHA) requests that HSCRC consider allowing hospitals to opt into the policy beginning January 1, 2027 instead of July 1, 2026 if operationally feasible.
JHHS	Johns Hopkins Health System (JHHS) supports the July 1, 2026 effective date but suggests voluntary implementation on July 1, 2026 for systems that are ready and statewide implementation on January 1, 2027 for systems needing additional time.
Luminis	Luminis Health (Luminis) recommends delaying implementation until January 1, 2027 at the earliest because the review and implementation timeline is too compressed.
CareFirst	CareFirst says implementation should be delayed by at least six months so stakeholders can assess the financial and operational implications of the policy.
UMMS	University of Maryland Medical System (UMMS) supports implementation on July 1, 2026 and argues the policy should be implemented now to ensure hospitals are adequately reimbursed for high-acuity care.
UPMC	UPMC Western Maryland (UPMC) supports July 1, 2026 implementation for AMCs already familiar with carved-out services, but requests the option of January 1, 2027 implementation for other hospitals newly subject to carve-outs.
LifeBridge	LifeBridge Health (LifeBridge) recommends delaying the effective date until January 1, 2027 to allow communication with clinical stakeholders and a transition period for monitoring and financial recording changes.
MedStar	MedStar Health (Medstar) recommends delaying implementation until July 1, 2027 and says more time and due diligence are required to avoid unintended consequences.

Staff Response: *Staff acknowledge the quickness of the carve-outs list generation and implementation and are sympathetic to the industry concerns on readiness and timing however, the State committed to a July 1, 2026, carve-out start date. Staff also perceive that an opt-in opt-out approach to implementation could present challenges related to other volume policy calculations, for example the market shift calculation given the variations in associated variable cost factors for GBR versus Carve-out volumes. An opt-in opt-out approach could also inadvertently create an unfair market advantage for early adopters which could affect the AHEAD Savings test Funding Mechanics and Payment Methodology.*

4. **Funding Mechanics and Payment Methodology:** Stakeholders raise a range of comments on how carved-out services should be funded. Comments include support for using MS-DRGs as a stable basis for identifying cases, as well as objections to paying at 10 percent of hospital charge per case. They also include recommendations for service-line-specific variable cost factors or rate-center baselines. There are competing views on whether carved-out services should be paid at HSCRC-approved rates or on a DRG basis. Stakeholders also raise concerns about how funding design could affect incentives, predictability, and revenue adequacy.

Figure 11. Summary of Funding Mechanics and Payment Methodology Comments

Organization	Summary of Comments
CareFirst	CareFirst recommends using DRG payments for carve-out services rather than the older HSCRC rate-setting approach, arguing that DRG payments better align incentives and would help avoid creating a third payment system under AHEAD.
Luminis	Luminis opposes funding 100% of hospital charge per case, recommending service-line-specific variable cost factors and standardized charge-per-case caps. Luminis also recommends retrospectively adjusting revenue for CON-approved carve-out projects, citing its 50% VCF open-heart program as underfunded, and emphasizes that methodology is as critical as the carve-out list itself.
JHHS	JHHS proposes establishing baselines at the rate-center level using CY 2025 experience and FY 2027 approved rates rather than embedding CY 2025 rates with a uniform inflation assumption.
UMMS	UMMS supports using MS-DRGs in the carve-out policy and sunsetting the current Complexity & Innovation policy because a DRG approach provides greater stability and operational consistency.
LifeBridge	LifeBridge recommends developing a process to monitor real-time growth in carve-out / excluded cases and any associated unintended lower-complexity volume movement, allowing for a more responsive market-shift adjustment funded at a 100% variable cost factor.
MedStar	MedStar says carved-out services should continue to be paid at HSCRC-approved rates, not on a DRG basis. The letter opposes creating a new all-payer DRG case-rate system during the AHEAD transition.

Staff Response: *Staff are not proposing to change the draft recommendation but will like to provide further clarity that the Staff approach is to identify carve-out volumes using DRGs and fund on a unit rate basis as under the current system. Carve-out DRGs map to rate centers and associated rate center revenues and volumes will be deducted from hospital GBRs.*

Moving to a DRG-based reimbursement would require significant changes to current rate setting practices and places additional burden on the system during the AHEAD transition. From FY 2027, all payers, including Medicare, will be charged at the approved unit rate. In CY 2028 when the State transitions to non-Medicare global budgets, hospitals will charge at the unit rates for all payers while Medicare will pay at the DRG level. Payment at 100 percent of hospital charges is consistent with CMS's approach to carve-outs. Staff do not expect this to impact the cost shift approved by the Commission in January 2026 as that amount is stated in fixed dollar terms.

5. **Operational Mechanics, Compliance, and C&I Transition:** Many commenters emphasize that important technical and operational questions remain unresolved. Stakeholders raise concerns about compliance monitoring, reconciliation, interaction with other HSCRC policies, transition from the Complexity & Innovation policy, revenue monitoring, and how the policy would function in practice once implemented. Several recommend further technical evaluation or workgroup discussion before or during rollout.

Figure 12. Summary of Operational Mechanics, Compliance, and C&I Transition Comments

Organization	Summary of Comments
MHA	MHA says operational and process questions remain, including how the carve-out policy will interact with market shift and how HSCRC would evaluate changes to the carve-out list if excluded revenue approaches the AHEAD 15% cap.
JHHS	JHHS requests clarification on the transition from the Complexity & Innovation policy, including how current C&I revenue will be assigned to carve-out cases, how retrospective FY 2025 and FY 2026 C&I adjustments will be calculated, and how year-end global budget compliance will be determined in the transition year.
Luminis	Luminis says technical and operational questions remain related to implementation, compliance monitoring, and reconciliation, and argues these issues should be addressed before implementation to avoid financial volatility and administrative burden.
UMMS	UMMS recommends convening a workgroup to address rate mechanics and other policy impacts so staff and hospitals can develop an agreed-upon implementation and management approach.
LifeBridge	LifeBridge cites the need for a transition period to change revenue monitoring and financial recording practices.
MedStar	MedStar says numerous implementation questions remain, including effects on Market Shift, Repatriation/Expatriation, Out-of-State, Deregulation, and Efficiency, supply and drug compliance, unit rate pricing, coding delays, and possible reporting requirements.

Staff Response: *The table below shows the impact of the Carve-out Policy on various HSCRC policies and how those policies will be amended to avoid duplicate funding. Staff anticipate revisiting all of these policies in the fall of 2026 as part of the planning process for the transition to Medicare Hospital Global*

Budgets in 2028 and specific details regarding the treatment of the carve-outs will be incorporated in that process.

Figure 14. Carve-out Impact on HSCRC Policies

HSCRC Policy	Proposed Action
Market Shift Adjustment	FY 2027 Marketshift assesses CY 2025 performance over CY 2024. Baseline volumes for carve-outs will be set using CY 2025 performance and the volume excluded in both Market shift base and performance years when CY 2025 becomes the market shift base
Repatriation/Expatriation Adjustment	FY 2027 Repatriation/Expatriation assess CY 2025 performance over CY 2024. Baseline carve-out volumes will be set using CY 2025 performance and the volumes excluded from the assessment periods
Complexity and Innovation Policy	The carve-outs will replace the current complexity and innovation policy. All propective FY 2027 Complexity and Innovation adjustments will be reversed
Out of State (OOS) Policy	FY 2027 Out-of-State assesses FY 2025 performance. Baseline volumes will be st using CY 2025 performance and the volumes excluded from the assessment periods
Deregulation Adjustment	Carve-outs will not apply. The current Deregulation Policy is an outpatient only assessment
Surge Funding Policy	FY 2027 Surge funding will assess FY 2025 performance over a FY 2019 base. Depending on the magnitude 1). If small, deduct out the hospital-specific carve-out volume proportion from the final surge allottment 2). If large, create a 2 month lag in experience data reporting to allow hospitals to distinguish between carve-out and GBR volumes
Demographic Adjustment	Inflate the CY 2025 carve-out baseline by the FY 2027 demographic adjustment. Exclude out actual carve-out volumes from the FY 2027 demographic assessment
Integrated Efficiency Policy	Carve-out volumes will be included in assessment periods
Quality Pay for performance programs	No distinction will be made to hospital volumes in quality assessments. Carve-out volumes will still be subject to all quality programs

Carve-outs will not be subjected to compliance corridors, but actual rates and unit rates charged on the carve-out volumes will still need to be reconciled at year end. In order words, GBR volumes and carve-out volumes will be charged at the same rates. So, if a hospital undercharges its rates, it also undercharges its carved-out rates. At year end, a reconciliation must be done to calculate the amount of revenue that would have been charged had the carved-out rates been charged at actual and the resulting value applied as settlements to the GBR as shown on Figure 14 below. Reconciliations will only apply to non-Medicare volumes in CY 2028. HSCRC staff are committed to working with hospitals in the first year of operation to review and determine charging appropriateness and any additional considerations.

Figure 14. Compliance Example

				Global Budgets			Carve-outs			Settlements		
				A	*B*	*C=A*B*	*D*	*E*	*F=D*E*	*G=C+F*	*H=C+(E*D1)*	*I=G-H*
Row	Compliance Scenarios	Revenue center	Service Unit	Unit Rate	Budgeted Volume	Budgeted Annual Revenues	Unit Rate	Baseline Volume	Standard Revenues	Total Revenue	Expected	Settlement
1	Expected	Med.Surg ICU	Patient Days	$ 2,500	2,800	$ 7,000,000	$ 2,500	100	$ 250,000	$ 7,250,000	$ 7,250,000	$ -
				Unit Rate	Actual Volume	Standard Revenues	Unit Rate	Actual Volume	Standard Revenues	Total Revenue	Expected	Settlement
2	Scenario 1	Med.Surg ICU	Patient Days	$ 2,600	2,600	$ 6,760,000	$ 2,600	95	$ 247,000	$ 7,007,000	$ 6,997,500	$ 9,500
3	Scenario 2	Med.Surg ICU	Patient Days	$ 2,300	3,100	$ 7,130,000	$ 2,300	110	$ 253,000	$ 7,383,000	$ 7,405,000	$ (22,000)
4	Scenario 3	Med.Surg ICU	Patient Days	$ 2,600	2,600	$ 6,760,000	$ 2,600	100	$ 260,000	$ 7,020,000	$ 7,010,000	$ 10,000

6. **Scope of Eligible Services & Applicability Beyond AMCs:** Stakeholders commented extensively on which services and providers should fall within the carve-out framework. Several support expanding carve-outs beyond academic medical centers to include qualifying services delivered at specialty and community hospitals, while others request inclusion of specific service lines such as structural heart, complex brain cases, limb-lengthening, psychiatric, and rehabilitation services. Some also sought clarification that listed DRGs

should apply consistently across hospital types. The common theme is that eligibility should be driven by the characteristics of the service rather than solely by provider type.

Figure 15. Summary of Scope of Eligible Services & Applicability Beyond AMCs Comments

Organization	Summary of Comments
Adventist	Adventist strongly supports inclusion of structural heart procedures, explaining that these programs require specialized teams, major infrastructure investment, and high-cost implantable devices.
MHA	MHA supports not categorically excluding the seven low-volume service lines identified in the market shift policy, stating those services generally fail to meet the specified carve-out criteria and should not automatically be treated as carve-outs. MHA also supports applying carve-outs based on defined DRGs regardless of which hospital provides the service.
UMMS	UMMS says the carve-out policy should apply to all hospitals, noting that over $800 million (42%) of this highly complex care is provided outside AMCs. UMMS also recommends adding all complex brain cases—specifically MS-DRGs 024, 026, and 027—because those DRGs are highly concentrated at trauma-designated centers and are highly variable.
UPMC	UPMC Western Maryland supports continued inclusion of cardiac / structural heart MS-DRGs because those services are highly acute, highly specialized, and difficult to control.
LifeBridge	LifeBridge Health says the revision to include cardiac valve procedures appropriately recognizes highly specialized, technology-intensive procedures with costs driven by patient acuity, implant expenses, and continuous innovation. LifeBridge Health also requests inclusion of non-cosmetic limb-lengthening procedures at Sinai Hospital, arguing that they meet the criteria for highly specialized services and are performed almost exclusively at Sinai Hospital.
MedStar	MedStar argues that if hospital volumes are complex, expensive, and unpredictable, they should be carve-out candidates regardless of where the service is provided and says DRG selection should be held to the same site-neutral standard as the ultimate funding rather than relying on AMC cell dominance or special designations.
Gilead	Gilead asks HSCRC to clarify that all DRG carve-out list cases, including Pre-MDC MS-DRG 018, will be removed from the global budget regardless of whether care is delivered at an AMC, specialty hospital, or community hospital, and flags language in the draft recommendation as potentially narrowing the policy more than intended.

Staff Response: *Staff would like to further emphasize that it is the list of carve-out services that counts versus the methodology used to generate the list. Also, the staff methodology defines specialty by DRG MDC as the dominant criteria prior to assessing dominance within specialty state resource providers. Staff would also like to emphasize that the final list of carve-out eligible services is applied consistently across all hospitals in the State so all hospitals will carve-out DRGs identified on the carve-outs list that occur at their hospitals.*

7. **Alignment with CMMI & AHEAD Transition:** Many stakeholders recommend aligning Maryland's carve-out policy as closely as possible with CMMI under AHEAD. Commenters emphasize that consistency across State and Federal methodologies would reduce administrative burden, improve predictability, and help hospitals prepare for the CY 2028 transition. Some specifically recommend reconciling to a CMMI-aligned list before implementation or preserving the FY 2027 framework as the basis for the future AHEAD exclusion list Transition

Figure 16. Summary of Alignment with CMMI & AHEAD Transition Comments

Organization	Summary of Comments
Adventist	Adventist supports alignment with CMMI's final carve-out methodology and recommends that Maryland seek alignment where practical while preserving flexibility to refine policy before Medicare Hospital Global Budgets begin in 2028.
MHA	MHA supports aligning the carve-out list with CMMI's carve-out list as much as possible to reduce administrative complexity and align incentives across payers.
JHHS	JHHS says the policy should prioritize alignment between State and Federal methodologies and supports maintaining a single, reconciled carve-out list across HSCRC-administered and CMS-administered global budgets in CY 2028 and beyond.
UMMS	UMMS says the carve-out methodology should align with CMMI's planned definition under AHEAD to reduce administrative burden and maintain consistency across multiple regulatory frameworks.
LifeBridge	LifeBridge recommends that, at the appropriate time, HSCRC align its exclusion list with the services ultimately finalized and included on the CMMI exclusion list.
MedStar	MedStar recommends aligning with CMMI under AHEAD everywhere possible and adopting a CMMI-aligned list from the start to avoid two rounds of rebasing and sustained unpredictability and also recommends aligning HSCRC's approach for inpatient psychiatric and rehabilitation services with CMMI for consistency under AHEAD.
Gilead	Gilead asks HSCRC to preserve an access-protective, setting-neutral carve-out framework through the AHEAD transition and use the FY 2027 framework as the basis for a targeted CY 2028 exclusion list.

Staff Response: *Staff acknowledge stakeholder concerns on alignment with a CMMI list for simplicity and consistency and can confirm that there is currently an 87 percent match in charges across 59 DRGs identified by the Staff and CMMI lists combined. The HSCRC list includes 5 DRGs (amount to ~$92.6 M)*

not on CMMI's list, while 20 DRGs (~148.7M) on CMMI's list do not exist on the HSCRC list. CMMI have noted that their list is algorithm driven but indicate flexibility in refining their list for purposes of alignment including the removal of spinal fusion DRGs.

8. **CAR-T and Innovative Therapies:** A subset of commenters focuses specifically on preserving or expanding carve-outs for CAR-T and other innovative therapies to support access. These stakeholders emphasize that financial barriers under global budgets can delay treatment, reinforce AMC concentration, and limit access for patients who live farther from major academic centers. The common recommendation is a setting-neutral framework that maintains carve-out treatment for CAR-T as Maryland transitions under AHEAD.

Figure 17. Summary of CAR-T and Innovative Therapies Comments

Organization	Summary of Comments
Autolus	Autolus Therapeutics (Autolus) supports extending the global budget carve-out for CAR-T to all hospitals, arguing that it reduces financial pressure, supports site-of-care flexibility, and helps avoid delays in treatment.
CSC	Cancer Support Community (CSC) requests a carve-out for CAR-T therapies regardless of treatment setting, arguing that patients outside the Baltimore–Washington corridor face significant travel, logistical, and caregiver burdens when CAR-T remains concentrated at AMCs.
Gilead	Gilead supports finalizing a setting-neutral carve-out for CAR-T, including Pre-MDC MS-DRG 018, and says access to innovative therapies should not depend on whether a patient can travel to or be treated at an AMC.

Staff Response: *Staff agree with stakeholders and would like to re-iterate that the staff priority on carve-outs is to protect access to care for rare life-threatening conditions in a way that is manageable for all hospitals while considering affordability for the system. CAR-T is an innovative therapy which Marylanders should have access to and hospitals providing this care regardless of type should equally be reimbursed accordingly.*

Recommendations

Based upon the analyses and validations performed by staff, staff is putting forth the following recommendations

1. Staff recommend the adoption of the less restrictive list with clinical edits and refinements effective July 1, 2026, which carves out approximately 8.4 percent of statewide revenue associated with highly specialized care from population-based methodologies
    - Proposed carve-out list prioritizes highly specialized tertiary and quaternary care performed at AMCs (61 percent), with expansions to include certain tertiary services also performed at non-AMCs (39 percent)
    - The list could be updated effective January 1, 2028, based on desired alignment with a final CMMI list
2. Staff recommends the use of CY 2025 charges, inflated to FY 2027, as the baseline for carve-out eligible volume which would be removed from global budgets. The baseline for lower volume hospitals would be based on a three-year average
3. Staff recommend that all volumes eligible for carve-outs under this policy be funded at 100 percent variable costs and hospitals are held 100 percent liable for volatility
4. Staff recommend that the carve-out list be determined using in-state volumes, but reimbursements also apply consistently to out-of-state patients
5. All prospective adjustments in FY 2027 rates relevant to the current Complexity and Innovation Policy will be reversed upon a Carve-out Policy approval, retrospective adjustments for FY 2025 and FY 2026 will be made

6. Staff recommend the removal of all carve-out volumes from all other volume methodologies including the Market Shift, Demographic Adjustment, Surge Funding, Deregulation, and Repatriation/Expatriation.

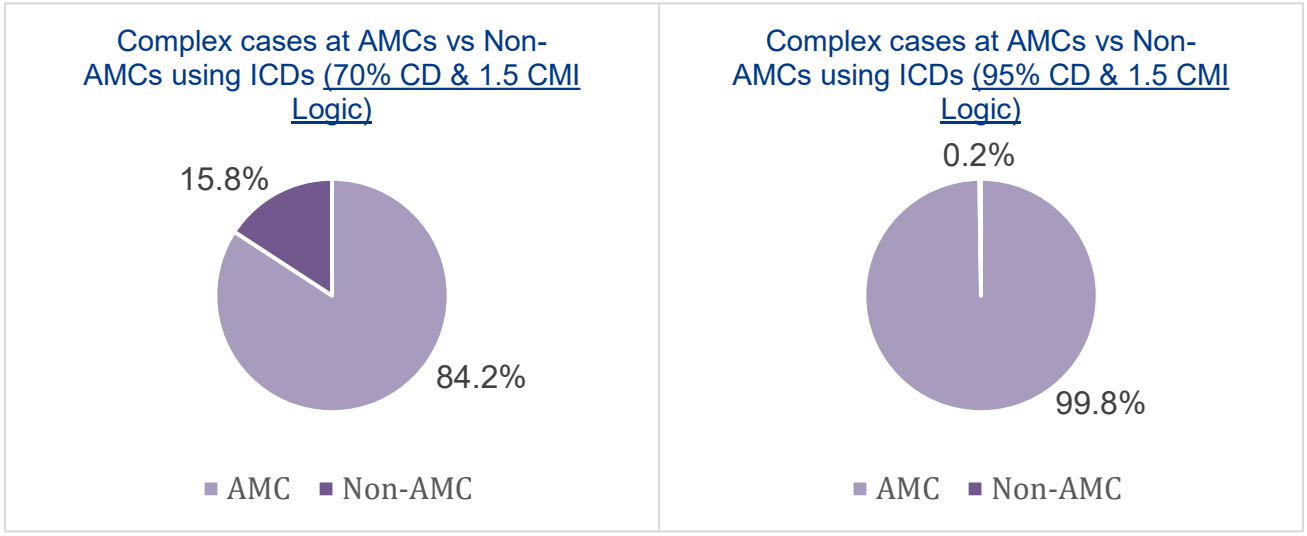
    a. Continue to include carve-out eligible volumes in the Integrated Efficiency assessment, quality pay-for-performance and PAU Redistribution assessments

7. Staff recommend reviewing the list annually (1) for potential additions and subtractions and (2) to understand the impact of the policy. Material changes will be brought to the Commission for approval

8. Volumes eligible under the existing Outpatient Cosmetic Surgery program will also be carved out effective July 1, 2027

Appendices

Appendix 1: Complex Cases at AMC versus Non-AMCs Using High End and Low-End Procedure-Based Dominance Thresholds



Appendix 2: HSCRC DRG Carve-outs List

DRG	Description
1	Heart Transplant or Implant of Heart Assist System with MCC
2	Heart Transplant or Implant of Heart Assist System without MCC
3	ECMO or Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures
4	Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures
5	Liver Transplant with MCC or Intestinal Transplant
6	Liver Transplant without MCC
7	Lung Transplant
8	Simultaneous Pancreas and Kidney Transplant
10	Pancreas Transplant
11	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with MCC
12	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with CC
13	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy without CC/MCC
14	Allogeneic Bone Marrow Transplant
16	Autologous Bone Marrow Transplant with CC/MCC
17	Autologous Bone Marrow Transplant without CC/MCC
18	Chimeric Antigen Receptor (CAR) T-Cell and Other Immunotherapies
19	Simultaneous Pancreas and Kidney Transplant with Hemodialysis
20	Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage with MCC
23	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator
24	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis without MCC
25	Craniotomy and Endovascular Intracranial Procedures with MCC
26	Craniotomy and Endovascular Intracranial Procedures with CC
28	Spinal Procedures with MCC
29	Spinal Procedures with CC or Spinal Neurostimulators
31	Ventricular Shunt Procedures with MCC
140	Major Head and Neck Procedures with MCC
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC
212	Concomitant Aortic and Mitral Valve Procedures
215	Other Heart Assist System Implant
216	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC
217	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with CC
218	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization without CC/MCC
219	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC

220	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with CC
221	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization without CC/MCC
228	Other Cardiothoracic Procedures with MCC
231	Coronary Bypass with PTCA with MCC
232	Coronary Bypass with PTCA without MCC
233	Coronary Bypass with Cardiac Catheterization or Open Ablation with MCC
234	Coronary Bypass with Cardiac Catheterization or Open Ablation without MCC
235	Coronary Bypass without Cardiac Catheterization with MCC
236	Coronary Bypass without Cardiac Catheterization without MCC
266	Endovascular Cardiac Valve Replacement and Supplement Procedures with MCC
267	Endovascular Cardiac Valve Replacement and Supplement Procedures without MCC
268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
270	Other Major Cardiovascular Procedures with MCC
319	Other Endovascular Cardiac Valve Procedures with MCC
405	Pancreas, Liver and Shunt Procedures with MCC
650	Kidney Transplant with Hemodialysis with MCC
651	Kidney Transplant with Hemodialysis without MCC
652	Kidney Transplant
653	Major Bladder Procedures with MCC
829	Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedures with CC/MCC
834	Acute Leukemia with MCC
837	Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapy Agent with MCC
838	Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or High Dose Chemotherapy Agent
846	Chemotherapy without Acute Leukemia as Secondary Diagnosis with MCC
927	Extensive Burns or Full Thickness Burns with MV >96 Hours with Skin Graft
928	Full Thickness Burn with Skin Graft or Inhalation Injury with CC/MCC
929	Full Thickness Burn with Skin Graft or Inhalation Injury without CC/MCC
955	Craniotomy for Multiple Significant Trauma
956	Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma
957	Other O.R. Procedures for Multiple Significant Trauma with MCC
958	Other O.R. Procedures for Multiple Significant Trauma with CC

Appendix 3: Specialty Hospital Designations

HOSPID	Hospital Name	Cardiac	Stroke	NICU	Burns	Trauma
210029	Bayview Medical Center (JHM)	Y	Y	Y	Y	Y
210003	Capital Region Medical Center (UM)	Y		Y		Y
210012	Sinai Hospital of Baltimore (LifeBridge)	Y	Y	Y		Y
210022	Suburban Hospital (JHM)	Y	Y			Y
210001	Meritus Medical Center	Y				Y
210019	Peninsula Regional Medical Center (TidalHealth)	Y				Y
210027	Western Maryland (UPMC)	Y				Y
210024	Union Memorial Hospital (MedStar)	Y				
210023	Anne Arundel Medical Center (Luminis)	Y		Y		
210005	Frederick Health Hospital	Y		Y		
210044	Greater Baltimore Medical Center			Y		
210004	Holy Cross Hospital - Silver Spring	Y		Y		
210048	Howard County Medical Center (JHM)	Y		Y		
210008	Mercy Medical Center			Y		
210011	Saint Agnes Health (Ascension)	Y		Y		
210063	Saint Joseph Medical Center (UM)	Y		Y		
210057	Shady Grove Medical Center (Adventist HealthCare)	Y	Y	Y		
210015	Franklin Square Medical Center (MedStar)	Y	Y	Y		
210043	Baltimore Washington Medical Center (UM)	Y				
210033	Carroll Hospital (LifeBridge)	Y				
210037	Shore Medical Center at Easton (UM)	Y				
210062	Southern Maryland Medical Center (MedStar)	Y				
210049	Upper Chesapeake Medical Center (UM)	Y				
210016	White Oak Medical Center (Adventist HealthCare)	Y				

Note: Stroke only considered Thrombectomy and Comprehensive stroke centers

Appendix 4: DRGs that Made Carve-out List Based on the Algorithm but were Removed Upon Clinical Review

MS-DRG	Description
226	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC
227	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC
245	AICD Generator Procedures
258	Cardiac Pacemaker Device Replacement with MCC
275	Cardiac Defibrillator Implant with Cardiac Catheterization and MCC
276	Cardiac Defibrillator Implant with MCC or Carotid Sinus Neurostimulator
277	Cardiac Defibrillator Implant without MCC
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with MCC
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with CC
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC
459	Spinal Fusion Except Cervical with MCC
471	Cervical Spinal Fusion with MCC

Appendix 5: Methodology

Using FY 2025 Case-mix data, staff methodology to quantify highly specialized care eligible for carve-outs include a 5-step process

1. Define Quaternary care as MS-DRGs with a pre-Major Diagnostic Category (MDC) (DRGs 1 – 19)

Pre-MDC DRGs are specialized procedure-driven hospital cases that are categorized strictly by high-cost, high-resource surgical procedures regardless of the principal diagnosis, such as organ transplants or tracheostomies. The pre-MDC category typically includes DRGs 001 through 019 and because they require the highest level of specialization, are typically handled by major academic medical centers.

2. Apply AMC cell dominance and CMI thresholds to identify additional quaternary DRGs

After scoring DRGs 1-19 as quaternary, staff further quantifies quaternary services at AMCs by isolating cases where AMC volumes combined make up the larger share of statewide activity, greater than 50 percent of statewide volumes, and with a case-mix index of 2.5 or greater.

3. Define specialty care using Maryland Institute for Emergency Management Services Systems (MIEMSS) designations (National Cancer Institute (NCI) designation for Oncology)

To define tertiary services eligible for carve-outs, staff used MIEMSS trauma and specialty center designations to identify Maryland hospitals that are officially verified and equipped to handle specific, life-threatening medical emergencies. The MIEMSS specialty and referral center designations used in the staff approach include adult and pediatric trauma centers, comprehensive stroke and thrombectomy centers only, cardiac interventional centers, adult and pediatric burn centers and Level III and IV perinatal and neonatal intensive care units.[1516] Staff used NCI designations to identify tertiary oncology services.[17]

4. Apply AMC and specialty hospital cell dominance and CMI thresholds to identify tertiary DRGs within specialty MDCs

After defining tertiary hospitals, staff determined specialty DRGs by way of MDCs assigned to the specific service. Staff quantified tertiary services at AMCs and specialty hospitals by isolating cases where AMC and specialty volumes combined made up a larger share of statewide activity within the MDC's DRG listing. Recognizing that DRG distributions and associated costs and technology vary within services, staff varied the cell dominance and CMI thresholds for the various specialty services.[18]

5. Validate DRG list

The final step involved performing various validations to further refine the staff list. These include:

a) **Threshold calibration:** Staff recognized that the cell dominance and CMI thresholds will need to vary across specialty services based on DRG volume distributions and level of specialty service dispersion. For example, in Maryland, cardiology has 24 specialty designated hospitals while oncology only has two. Also, DRGs assigned to the cardiology

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[15] Maryland Institute for Emergency Medical Services Systems (MIEMSS) https://www.miemss.org/home/hospitals/specialty-referral-centers

[16] See appendix 3: Specialty Hospital Designations

[17] National Cancer Institute (NCI) https://www.cancer.gov/research/infrastructure/cancer-centers/find

[18] See Figure 6: Less Restrictive scenario results with Clinical edits. For the various cell dominance and CMI thresholds per specialty

MDC in FY 2025 make up about 58,000 statewide volumes while oncology equates to about 3,700.

b) **Severity hierarchy validations:** Staff reviewed "With Complication or Comorbidity" DRGs (CC) and "With Major Complication or Comorbidity" (MCC) DRG hierarchies to ensure consistent application within DRG families. When a CC DRG met the carve-out thresholds for highly specialized and complex services while the corresponding MCC DRG did not, the corresponding MCC variants were manually included in the carve-out list to maintain alignment across the DRG family. However, in instances where the MCC made the carve-out list while the CC did not, no change was made. We assume in such an instance that the methodology appropriately isolates the more highly specialized and acute service for carve-out. This is a change from the previous approach to remove from the list DRG families in instances where a lesser complication DRG made the list while a more complicated one did not.

c) **Exclusion review:** Staff also reviewed and excluded from its list, few select medical DRGs pertaining to rehabilitation and psychiatry that met the various cell dominance and CMI threshold criteria to classify as highly specialized care.

d) **Clinical Validation:** Staff had the list of identified DRGs reviewed by clinical experts who found the Staff approach to be directionally sound and analytically rigorous. Various DRGs were flagged for removal from the carve-out lists, while a few others were flagged for further review.[19]

e) **Year over Year validation:** Staff performed longitudinal analyses to validate consistency of the DRG list over time. The majority of DRGs identified as highly specialized remained relatively consistent between FY 2023 and FY 2025 with fewer than 10 DRGs newly classified as highly specialized under the same criteria.

f) **Comparisons to other stakeholder developed carve-out lists:** The staff list was compared against other stakeholder-developed lists including Sg2 and another developed by a hospital system to which there was significant overlap. The staff list also includes NICU DRGs which the other lists do not include.

[19] See DRGs flagged for further investigation section on page 9 and Appendix 4

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Final Recommendation Individual Market Stabilization & Uncompensated Care: RY 2027 Update Factor Amendment

This represents the Final Amendment to the RY2027 Update Factor

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Table of Contents

Overview

As part of the formal amendment to the RY 2027 Update Factor, the Health Services Cost Review Commission (HSCRC) Staff are proposing several considerations to stabilize the individual insurance market and mitigate future uncompensated care (UCC) costs. This would be achieved through an increase in hospital rates among all payers - including Medicare, Medicaid, and self-insured employers.

The proposal includes increasing hospital rates beginning in July of 2026. These rate increases would then be assessed back from hospitals to provide for the following:

1. $100 million to the Maryland Health Benefit Exchange (MHBE) special fund to ensure adequate funds for reinsurance and Maryland premium subsidies. This will allow MHBE to maintain the current 2026 subsidy structure into 2027, and avert coverage loss for approximately 29,000 Marylanders (*i.e.,* maintaining coverage to avoid future UCC);
2. $50 million for advance funding to the UCC Fund for coverage losses that Maryland cannot mitigate such as loss of coverage due to immigration status. This would be divided into 2 buckets:
    a. $25 million for Federally Qualified Health Center (FQHCs) and local health departments (LHDs) to provide primary care to avoid hospital utilization
    b. $25 million to increase the reserves in the UCC Fund
3. The Commission will consider continuing this funding as part of the RY 2028 update factor.

Using the majority of the increase to fund market stabilization in the individual market and safety-net non-hospital providers avoids hospital UCC costs in a way that most benefits Maryland residents. It addresses affordability and coverage challenges that will result in the individual market on January 1, 2027 protecting those consumers while mitigating hospital cost exposures.

This recommendation includes funding for RY 2027. The Commission will consider continuing this funding as part of the RY 2028 update factor, as stated above.

Introduction & Background

Annual Update Factor

HSCRC updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. The components of and considerations related to the Update Factor are presented and discussed in HSCRC Payment Models Workgroup between January

and June of each year, and are informed by significant stakeholder input, including providers, payers, consumer advocates, and representatives of the business community.

As in all HSCRC policies, the aim of the update factor is equity and fairness for all hospitals and payers, balancing the need to provide sufficient resources for operational expenses and necessary investments while ensuring affordability for consumers and purchasers of hospital services.

UCC Adjustment

The annual UCC adjustment is one component of the Update Factor process. UCC is hospital care provided for which no compensation is received, inclusive of both charity care and bad debt.

In general, hospital UCC is accounted for in hospital rates set by HSCRC. Through the UCC adjustment to hospital rates, Maryland provides funding support to hospitals for related costs, distributes the burden of funding UCC across payers, and assures equitable access to all hospitals for those patients who cannot afford hospital services.

The UCC adjustment is calculated prospectively for each year based on data from the most recent year for which data is available, which is two years before the period for which the UCC is being set.[1] Due to this data lag, there is typically a delay between when UCC is incurred by hospitals and when it is paid in rates. Thus, when actual UCC decreases significantly, as it did after the Affordable Care Act (ACA) in 2014 and earlier Medicaid expansions, the amount of UCC built into rates may be higher than the actual UCC experience in following years. On the other hand, the UCC amount built into hospital rates may be lower than the actual UCC experienced after periods of increasing UCC. Recognizing this pattern, historically HSCRC Staff have evaluated anticipated changes in UCC and, when appropriate, implemented adjustments to the UCC methodology to smooth the impact on hospitals and payers.

Maryland Reinsurance Program and State Subsidies

In 2018, the Maryland General Assembly passed House Bill (HB) 1795,[2] directing MHBE to establish a State Reinsurance Program. State reinsurance programs serve to mitigate the risk carriers may incur when offering coverage to enrollees with significant or high cost health care needs.

In essence, reinsurance programs provide coverage to carriers when individual health care costs exceed a set cap, and in doing so preserve the opportunity to offer coverage to a broader population while maintaining lower premiums than would otherwise be required. The ability to

[1] The calculation process also includes applying a blend of actual and predicted UCC to determine how much each hospital will either withdraw from or pay into the statewide UCC Fund.

[2] 2018 Maryland General Assembly Legislative Session, HB1795; Accessed June 15, 2026

offer lower premiums also helps to ensure that younger and healthier individuals remain enrolled. Additionally, decreased premiums may encourage individuals to purchase higher levels of coverage ("metal levels"), thereby lowering out-of-pocket costs and decreasing bad debt. The reinsurance program reduces premiums by approximately one-third.[3] Preserving coverage should also increase access to preventive care and other lower cost care thereby reducing total cost.

In 2026, Maryland also implemented a state subsidy program to help mitigate the loss of enhanced federal tax credits. The state subsidy had the benefit of keeping individuals in coverage who were under 400 percent of the Federal Poverty Level (FPL). The state subsidy is currently authorized through calendar year (CY) 2027.

Potential Impact of Recent Federal Actions On UCC and Healthcare Coverage

During the FY 2026 Update Factor development process, HSCRC Staff and stakeholders discussed the potential impacts of recent federal actions, including House Resolution 1 (H.R. 1) and federal rulemaking, on access to healthcare coverage and, in turn, UCC.

Potential impacts on Medicaid Coverage

Working with Medicaid, HSCRC estimates FY 2027 Medicaid losses to translate into approximately $11 million of hospital UCC. This number will rise in subsequent fiscal years as the new eligibility requirements come into effect (*e.g.*, six-month redeterminations and work requirements, effective January 1, 2027 and largely manifesting in July 2027 and after).

Potential Impacts on Marketplace Coverage

MHBE initially projected coverage losses in the individual market of 48,000 in 2026. As of April 2026, the individual market had seen an 8 percent decline in year-over-year enrollment, numbering approximately 18,000 individuals. Much of the drop in coverage was for individuals who lost federal tax credits due to immigration status - otherwise, the market was stable due to reinsurance and state subsidy. If further market stability is not provided in advance of CY 2027, further drops in coverage will be seen - having a greater impact on UCC and leading to higher costs across all payers.

A 48,000-beneficiary decline in the marketplace (as originally projected publicly by the end of the 2026 plan year) would correlate to approximately $117 million in hospital UCC, assuming these enrollees use hospital services similarly to existing uninsured individuals.

Total Potential Exposure

Based on the above estimates, which contain considerable uncertainty, the anticipated FY 2027 UCC exposure is $128 million or approximately 0.50 percent of total hospital global budgets. If

[3] MHBE. Joint Chairmen's Report: Reinsurance Program Costs and Forecast. Sept. 30, 2025

this occurs under the current system, the cost of UCC will ultimately be borne by all payers starting in FY 2028; however, due to the data lags, hospitals would bear the cost in the interim. As noted above, one important consideration is that increases to hospital rates in CY 2026 will be included in the base global budgets for Medicare Fee for Service when the Center for Medicare and Medicaid Innovation (CMMI) takes control of Medicare global budgets January 1, 2028 per the AHEAD State Agreement.

Opportunities to Address Coverage Losses

Increase support for the individual market through the Maryland Reinsurance Program and state subsidies.

MHBE is currently modeling scenarios to help determine the right mix of reinsurance support and state subsidy in order to minimize coverage loss for 2027. MHBE is waiting for the Centers for Medicare and Medicaid Services (CMS) to provide 2026 federal passthrough funding, which we normally receive around March; if the actual 2026 federal funding varies significantly from our assumption, the following projections could change.

At this time, MHBE anticipates that absent additional funding, for CY 2027 MHBE will have to discontinue the state subsidy program and reduce the generosity of the reinsurance program. Internal estimates from MHBE project that these changes will drive approximately 29,000 individuals to drop coverage in 2027.

The $100 million in proposed funding, coupled with federal reinsurance passthrough funding, would allow MHBE to maintain the current 2026 subsidy structure into 2027preserving the 29,000 enrollment otherwise expected to lapse, MHBE projects federal passthrough funding to remain steady from 2026 to 2027. In practice, the $100 million investment yields an additional $140 million in federal reinsurance funding that Maryland will otherwise lose.

To administer this funding, HSCRC would increase hospital rates by $100 million, this amount will be directed to MHBE Fund to be used for reinsurance and premium subsidies

Utilize a Special Fund to Facilitate Access to Primary and Preventative Care

Maryland's 16 FQHCs and 24 LHDs are vital hubs that support community access to health care services including primary care, immunizations and vaccines, preventative screening, dental services and behavioral health services, regardless of the ability to pay. Expanded access to health care services within local communities serves to increase consumer use of primary and preventative care, and in turn to reduce the use of hospital services for these needs - particularly

for those individuals who can no longer access Medicaid or individual market coverage due to changes in H.R. 1.[4]

Staff recommends $25 million to support this access. Prior studies have estimated that this would translate to 15,000 people obtaining primary care services for a year. To administer this funding, HSCRC would increase hospital rates by $25 million, this amount will be directed to a fund established for this specific purpose by the Maryland Healthcare Commission (MHCC) which will execute a plan approved by the Secretary of the Maryland Department of Health to provide funding to individual community health centers and local health departments.

Utilize the UCC Fund to support hospitals with increases in bad debt due to treatment of uninsured patients

Even with the preventative tactics described above, there will still be an increase in UCC for hospitals which the Maryland model is required to incorporate into hospital rates. Given the goals discussed above to proactively provide hospital financial support, Staff recommends $25 million for this effort. Initially this fund would be directed to build reserves in the UCC Fund and would be released as additional hospital UCC emerges. Staff will monitor hospital UCC throughout the year using unaudited data and base reserve releases on this monitoring. Final reconciliations will be reviewed and determined based on audited data. Any release of these reserves will not occur before January 2027 to allow time for data to develop and a reserve adjustment plan to be identified. Staff will communicate with industry on plans for future distribution calculations and the basis for such distributions.

Monitoring and Management of Proposed Funds

In order to manage administration of the funds for market stabilization and distribution to FQHCs and LHDs, Staff will develop a Memorandum of Understanding (MOU) among the other state agencies involved to delineate the functions, responsibilities, time frames, etc., consistent with the recommendation as approved by the Commission.

Staff will also work with MHBE and MHCC to produce a report on the funding as part of evaluating continued funding for FY 2028. Unused funds will be carried over to future periods and considered in the evaluation of future funding needs.

Impact on FY2027 Update Factor

The impact on the fiscal year Update Factor with the recommendations outlined in this review updates the fiscal year revenue growth to 4.41 percent. This is outlined in the table below. The Individual Market Stabilization adjustment on line M reflects $125 million, which is inclusive of

[4] Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures; Accessed June 15, 2026

$100 million to MHBE and $25 million dollars directed to FQHCs. Both of these will be included as one-time adjustments. Guidance on payments related to these adjustments will come in a subsequent communication. Line U on the below chart reflects a $25M increase to UCC Fund reserves as outlined in this recommendation

Balanced Update Model for RY 2027					
Components of Revenue Change Link to Hospital Cost Drivers /Performance					
			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 3.10% for Wages and Salaries)			3.11%	$746.5	$246.3
- Additional Inflation Support			0.20%	$48.1	$15.9
- Outpatient Oncology Drugs			0.06%	$15.2	$5.0
Gross Inflation Allowance	**A**		**3.37%**	**$809.8**	**$267.2**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$36.9	-$12.2
- Grant Funding RY27			0.02%	$3.7	$1.2
- HOPE			0.21%	$50.0	$16.5
- CTI Transition			0.20%	$48.7	$16.1
Total Care Coordination/Population Health	**B**		**0.27%**	**$65.5**	**$21.6**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.12%	$28.8	$9.5
- Demographic Policy Refinement - RY2026 Incremental Change			0.03%	$7.9	$2.6
Total Adjustment for Volume	**C**		**0.15%**	**$36.7**	**$12.1**
Financial Methodologies & Other Adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.40%	$96.1	$31.7
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.16%	$37.5	$12.4
- Full Rate Application & Capital Funding	G		0.07%	$16.2	$5.3
- Reversal of one-time adjustments for drugs	H		-0.06%	-$14.7	-$4.9
- Reversal of Surge Funding (RY24-RY25 in RY26 rates)	I		-0.81%	-$194.3	-$64.1
- RY26 Respiratory Surge Funding Estimate (9 month)	J		0.19%	$44.7	$14.7
- RY25 New Volume Policies	K		0.06%	$14.7	$4.8
- AHEAD ReadinessFunding (Commissioner Amendment)	L		0.21%	$50.0	$16.5
- Individual Market Stabilization	M		0.52%	$125.0	$41.3
Net Other Adjustments	**N =**	**Sum of D thru M**	**0.73%**	**$175.1**	**$57.8**
Quality and PAU Savings					
- PAU Redistribution	O		-0.02%	-$5.5	-$1.8
- Reversal of prior year quality incentives	P		0.04%	$9.7	$3.2
- Current Year Quality Incentives	Q		-0.06%	-$15.0	-$5.0
Net Quality and PAU Savings	**R =**	**Sum of O thru Q**	**-0.04%**	**-$10.7**	**-$3.5**
Total Update First Half of Rate Year					
	S =	Sum of A + B + C + N+ R	**4.48%**	**$1,076.4**	**$355.2**
	T =	(1+S/(1+0.12%)	**4.35%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	U		0.12%	$29.8	$9.8
- Deficit Assessment	V		-0.20%	-$47.6	-$15.7
	W =	**Sum of S thru T**	**-0.07%**	**-$17.8**	**-$5.9**
Total Update First Half of Rate Year 27					
Revenue growth, net of offsets	**X =**	S + W	**4.41%**	**$1,058.6**	**$349.3**
Per Capita Revenue Growth	**Y =**	(1+X)/(1+0.12%)	**4.28%**		
Adjustments in Second Half of Rate Year					
- Medicare Advantage Stabilization*			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**Z =**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
	AA =	X + Z	**4.41%**	**$1,058.6**	**$349.3**
	AB =	(1+AA)/(1+0.12%)	**4.28%**		

*MA Stabilization has a revenue neutral impact on proposed increase to revenues, staff are adding this for awareness due to the adjustment being new in CY27.

The 4.41 percent revenue growth has a minimal impact on any tests under our waiver. Staff is not concerned with significant deviations from previously reported savings positions as a result of these recommendations related to Individual Market Stabilization and UCC.

Stakeholder Comments

HSCRC Staff opened a public comment period regarding the draft proposal for how to mitigate individual market coverage losses and received comments from 19 stakeholders. These comment letters generally focused on seven areas. These comment focus areas are noted below and include Staff's responses in italics.

1. Adequacy of the Proposed 0.10% UCC Fund Reserve Increase

   MHA, UMMS, Medstar Health, Luminis Health, and Adventist HealthCare stated that the proposed 0.10% increase to the UCC Fund Reserve is insufficient to address anticipated increases in UCC associated with Marketplace and Medicaid coverage losses. JHHS supported the proposed 0.10 percent increase and recommended that reserve releases or reconciliations be based on audited hospital financial statements. Adventist HealthCare also requested clarification regarding the methodology for allocating reserve funding among hospitals and the timing of distributions.

   HSCRC Response: Staff believe that the 0.10 percent is an appropriate increase to the reserves. Staff will monitor UCC throughout the year using unaudited data, and will base reserve releases on unaudited data. This decision is based on the timeliness of data. Reconciliations will be reviewed and determined based on audited data. Any release of these reserves will not occur before January 2027 to allow time for data to develop and a reserve adjustment plan to be identified. Staff will communicate with industry on future distribution calculations. As noted in the Update Factor Recommendation, Staff believe most Medicaid coverage reductions will occur in FY 2028.

2. Support MHBE funding to preserve Marketplace coverage

   MHBE/MIA, MCHI, UULM-MD, the Lutheran Office of Public Policy in Maryland, Maryland Episcopal Public Network, 1199SEIU, Robert Laughlin, and Kaiser Permanente supported directing funding to MHBE to strengthen the State Reinsurance Program and State Subsidy Program. Commenters stated that preserving Marketplace coverage would maintain affordability, reduce coverage losses, improve access to preventive and primary care, stabilize premiums, and reduce UCC. Kaiser Permanente stated that reinsurance and other marketplace subsidies are valuable tools to lower premiums, increase enrollment, and stabilize the market by mitigating the impact of high-risk claims. Hospital stakeholders generally supported the goal of preserving Marketplace coverage but stated that additional prospective hospital UCC funding would likely remain necessary while requesting clarification regarding implementation of the proposed MHBE funding strategy.

HSCRC Response: Staff appreciate the support of the recommendation to fund reinsurance and subsidies through MHBE. This will be input as one-time funding for RY 2027, and will be evaluated for continued funding as part of the RY 2028 Update Factor.

3. Allocation of the Proposed 0.50% UCC Adjustment

   CareFirst recommended directing the full 0.50 percent adjustment to MHBE to support reinsurance and Marketplace subsidies rather than reserving funding for prospective hospital UCC. CareFirst stated that investing upstream in maintaining insurance coverage would benefit both patients and hospitals by reducing future UCC, whereas prospectively funding hospital UCC primarily addresses downstream financial impacts. Similarly, Kaiser Permanente stated that directing funding to reinsurance represents an upstream intervention that keeps more individuals covered and reduces coverage losses, rather than relying solely on UCC funding. In contrast, hospital commenters generally supported maintaining additional prospective hospital funding to address anticipated UCC associated with federal coverage losses.

   HSCRC Response: Staff appreciate the comments made by payers supporting the entire allocation being directed to MHBE. However, at this time, Staff believe it is appropriate to direct some level of funding to the UCC Fund to help mitigate any future coverage concerns that may not be addressed through support to the marketplace plans.

4. Directing UCC Funding to FQHCs

   MACHC, MCHS, Health Care for the Homeless (HCH), and 1199 SEIU supported directing a recurring portion of UCC funding to FQHCs. Commenters argued that FQHCs provide primary and preventive care regardless of insurance status and that additional investment would expand capacity, reduce avoidable emergency department visits and hospitalizations, improve health outcomes, and reduce overall UCC. Several commenters emphasized that anticipated Marketplace and Medicaid coverage losses would substantially increase UCC delivered by FQHCs and recommended dedicating a recurring funding source to support these providers. MCHI also emphasized ensuring that FQHCs have sufficient resources to provide essential care and reduce unnecessary emergency department visits for individuals who remain uninsured.

   HSCRC Response: Staff value the comments we received relating to FQHCs. The final recommendation reflects $25 million (approx. 0.10 percent) directed to funding for FQHCs. Staff acknowledge that these centers play an important role in ensuring that individuals receive primary and preventative care regardless of insurance status. This funding will be input as one-time funding in RY 2027, and will be evaluated for continued funding as part of the RY 2028 Update Factor.

5. MHBE Pass-Through Funding

   MHA, JHHS, Luminis Health, and Adventist HealthCare supported preserving Marketplace coverage through MHBE but requested additional clarification regarding implementation of the proposed funding strategy. Commenters requested additional information regarding the allocation of funding between reinsurance and state subsidies, funding methodology, implementation timelines, expected impacts on Marketplace enrollment and premiums, and evaluation of program effectiveness. JHHS also requested clarification regarding the legal authority for the proposal, governance and accountability for MHBE pass-through funding, reconciliation and reporting of funds, and the treatment of funds collected but not ultimately expended. Luminis Health recommended using hospital-specific collection rates rather than mark-up rates for any MHBE pass-through funding.

   HSCRC Response: Staff will allocate MHBE funding by proportioning the funding relative to revenue or another decided upon criteria. This funding will be marked up and placed in rates as a one-time assessment. Clarification on how payments should be made to MHBE will follow, pending the Commission decision on the recommendation. Staff will work with MHBE on a report evaluating program effectiveness as part of continued funding in FY 2028. Unused funds will be carried over to future periods and considered in the evaluation of future funding needs.

   HSCRC has statutory authority to establish reasonable rates, implement alternative payment methodologies, promote hospital financial stability, and address hospital UCC within the scope of its responsibilities. Under this authority, HSCRC may establish hospital revenue adjustments that support the state funding component of Maryland's 1332 waiver.

   MHBE is responsible for governance, financial accountability, and the disposition of unexpended funds. A forthcoming MOU amongst the participating state agencies will delineate each agency's role and responsibilities, promoting accountability while formalizing a clear governance framework for implementation and administration of the 1332 waiver.

6. Prospective Hospital UCC Funding

   MHA, UMMS, MedStar Health, Luminis Health, and Adventist HealthCare requested that HSCRC prospectively recognize anticipated increases in hospital UCC associated with H.R.1 by providing an approximately 0.66% adjustment to the UCC provision in rates for RY 2027. UMMS reiterated its previously submitted 0.69% request while expressing support for MHA's recommendation. MedStar Health cited the Commission's prospective UCC adjustment following implementation of the ACA as a precedent and reported approximately $23 million in additional UCC year-over-year. Commenters stated that hospitals are already experiencing increased self-pay patients, bad debt, collection costs,

and UCC, while the current UCC methodology would not recognize these impacts until future rate years. MHA, UMMS, and Luminis Health also recommended reconciling prospective funding to actual experience once data becomes available.

HSCRC Response: At this time, Staff believe the approach described in the RY2027 Update Factor recommendation is the appropriate path forward.

7. Monitor UCC Trends

   MHA, UMMS, and CareFirst recommended that HSCRC continue monitoring UCC throughout the rate year and incorporate emerging experience into Maryland's existing UCC policy. Commenters recommended monitoring Marketplace enrollment, Medicaid enrollment, payer mix, emergency department utilization, and UCC levels to determine whether additional policy action becomes necessary as federal coverage changes are implemented.

   HSCRC Response: Staff agree and are committed to continued monitoring of UCC throughout the year.

Recommendations

Staff are recommending the following one-time funding for RY 2027:

1. $100 million to the Maryland Health Benefit Exchange (MHBE) special fund to ensure adequate funds for reinsurance and Maryland premium subsidies. This will allow MHBE to maintain the current 2026 subsidy structure into 2027, and avert coverage loss for approximately 29,000 Marylanders (*i.e.,* maintaining coverage to avoid future UCC);

2. $50 million for advance funding to the UCC Fund for coverage losses that Maryland cannot mitigate such as loss of coverage due to immigration status. This would be divided into 2 buckets:
   a. $25 million for FQHCs and LHDs to provide primary care to avoid hospital utilization
   b. $25 million to increase the reserves in the UCC Fund

3. The Commission will consider continuing this funding as part of the RY 2028 update factor.

Appendix I: Comment Letters

1. Maryland Hospital Association (MHA)
2. Robert Laughlin
3. Maryland Citizens' Health Initiative (MCHI)/Maryland Episcopal Public Network
4. Lutheran Office of Public Policy in Maryland
5. CareFirst BlueCross BlueShield
6. Mid-Atlantic Association of Community Health Centers (MACHC)
7. Johns Hopkins Health System (JHHS)
8. Unitarian Universalist Legislative Ministry of Maryland (UULM-MD)
9. Luminis Health
10. 1199 SEIU
11. Maryland Health Benefit Exchange (MHBE)
12. Maryland Insurance Administration (MIA)
13. University of Maryland Medical System (UMMS)
14. Health Care for the Homeless (HCH)
15. Maryland Community Health System (MCHS)
16. Adventist HealthCare
17. Kaiser Permanente
18. Maryland Association of County Health Officers (MACHO)
19. Medstar Health

Maryland
Hospital Association

June 23, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, thank you for the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation related to uncompensated care (UCC) included in the final recommendation for the Rate Year 2027 update factor.

We appreciate HSCRC's recognition of the need to explore strategies to mitigate the expected rise in UCC. However, we are concerned that the proposed policies may not adequately address the higher burden of UCC hospitals are likely to face in the upcoming year as the coverage landscape changes. **While the proposal to direct funding to the Maryland Health Benefit Exchange (MHBE) Fund could help stabilize the Marketplace, the impact on premiums and enrollment is uncertain. We respectfully urge HSCRC to provide a 0.66% ($158 million) prospective adjustment to the UCC provision in rates for RY 2027 and offer the following comments as justification for this request.**

Loss of health coverage has real consequences for Maryland families and communities. As more people become uninsured, hospitals and health systems will continue to care for everyone who comes through their doors, regardless of their ability to pay. The resulting increase in UCC will further strain the resources hospitals need to preserve access to essential services.

Prospective UCC Adjustment
RY 2027 uncompensated care funding levels must reflect contemporary conditions and the changing coverage landscape. It is especially important that HSCRC act now because CY 2026 revenue will serve as the baseline for Medicare hospital global budgets starting in 2028. As noted in our comment letter on the update factor, any increase in UCC in the upcoming year due to federal policy changes and resulting coverage losses would not be reflected in rates until RY 2029 under the current UCC policy, placing further financial strain on hospitals and threatening their ability to preserve access to essential acute care services for Marylanders in the interim.

The draft recommendation includes a 0.10% (~ $25 million) increase to the reserves held in HSCRC's UCC Fund, which would be released as additional UCC emerges. The proposed UCC provision in rates for RY 2027 (4.05%), even after accounting for the release of these additional

funds, will likely not be sufficient to address the UCC burden hospitals will face in the upcoming year. Therefore, we urge HSCRC to prospectively adjust the UCC provision in rates by 0.66% for RY 2027 and reconcile this amount to actuals once the necessary data are available.

In our May 20 comment letter, MHA requested a 0.69% prospective adjustment to the UCC provision in rates based on a total state-estimated coverage loss of 65,000 due to policy changes that take effect in CY 2026. This request has been updated to 0.66% to reflect the UCC per uninsured estimate ($2,438) in HSCRC's analysis of UCC included in the recommendation. The actual increase in UCC could be higher due to additional coverage losses resulting from policy changes taking effect in CY 2027 that are not reflected in MHA's analysis.[1]

A comparison of MHA's UCC estimates with HSCRC's, as shown in Table 1, reveals that the primary difference is HSCRC's and the Maryland Department of Health's (MDH) assumptions about the extent to which Medicaid enrollment losses and associated increases in UCC will be mitigated by Emergency Medicaid Services, procedural re-enrollments, and work requirement exemptions. However, questions remain about the effectiveness of these mitigation strategies due to the limited scope of Emergency Medicaid Services, greater churn due to more frequent redeterminations, and recent federal guidance that restricts the medical frailty exemption from work requirements. Given these limitations, it is reasonable to assume higher levels of UCC associated with the reduction in Medicaid enrollment to ensure hospitals are adequately resourced to manage higher UCC in the upcoming year.

Table 1. Comparison of HSCRC and MHA Uncompensated Care Analyses

	HSCRC Analysis	MHA Analysis
Projected *Marketplace* Enrollment Loss	48,000	50,000
Estimated UCC Impact of Projected *Marketplace* Enrollment Losses	$117 million	$122 million
Projected *Medicaid* Enrollment Loss	27,000	15,000
Estimated UCC Impact of Projected *Medicaid* Enrollment Losses	$11 million	$37 million
Total Projected Enrollment Loss	75,000	65,000
Total Estimated UCC Impact	**$128 million**	**$158 million***

* $158 million represents approximately 0.66% of the $24.029 billion Final Approved RY 2026 GBR.

Notes: MHA's analysis is based on MDH and MHBE projections of coverage losses due to policies that have already taken effect, or will take effect, in CY 2026; these include changes to immigrant eligibility for Marketplace premium tax credits, the loss of federal enhanced premium tax credits (ePTCs), and changes to immigrant eligibility for Medicaid coverage.[2] More information on these policy changes and coverage losses is available in the Appendix.

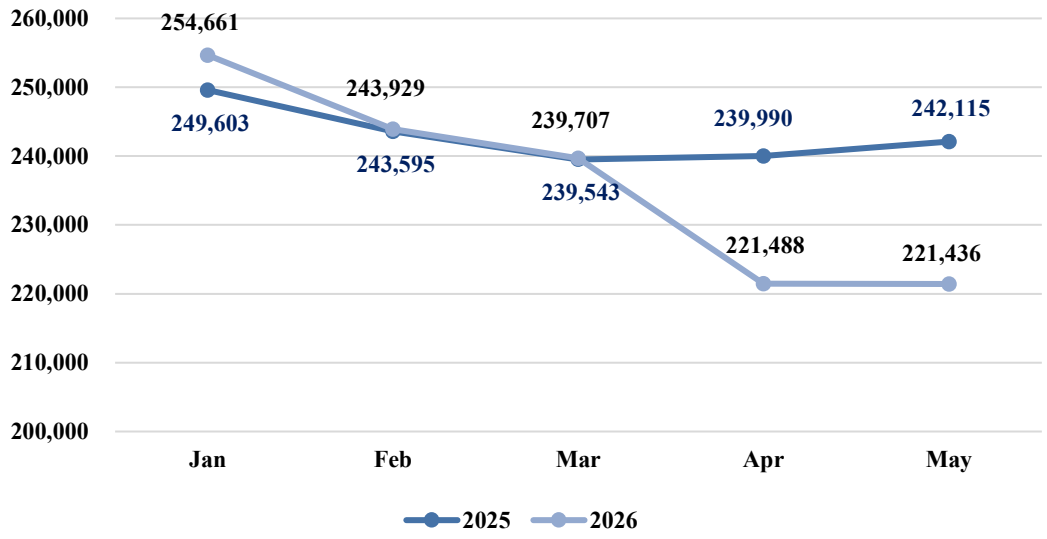
MHA estimated the increase in UCC by multiplying the total coverage loss associated with these policy changes (65,000) by the UCC per uninsured ($2,438) derived from HSCRC's UCC estimate in the draft recommendation.

[1] A summary of all policy changes that take effect in CY 2026 and CY 2027 is available in the Appendix.
[2] Maryland Department of Health and Maryland Health Benefit Exchange January 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available here. MHBE presentation starts on slide 42; MDH on slide 69.

The impacts of Marketplace policies that went into effect at the beginning of the year are already emerging. As noted in the draft recommendation, the number of individuals enrolled in coverage through Maryland Health Connection (MHC) has declined significantly year-over-year. As shown in Figure 1, enrollment as of May 2026 was 20,679 (8.5%) lower than it was in May 2025.[3] This loss in coverage could lead to an approximately $50 million (0.21%) increase in UCC: more than twice as much as the proposed 0.10% increase in UCC reserves, before accounting for anticipated increases in bad debt due to higher patient cost exposure as enrollees shift to less comprehensive coverage. Hospitals are seeing the effects of these coverage trends as they are observing an increase in self-pay patients and bad debt, with one member hospital reporting that they saw twice as many self-pay patients from January to May of 2026 as the same time period last year.

We encourage staff to routinely monitor trends in enrollment, hospital payer mix, increased use of emergency departments, and other predictors of UCC throughout the year to determine if subsequent policy action is needed to align funding with contemporary UCC levels.

Figure 1. MHC Private Health Plan Enrollment (as of May 31, 2026)



Maryland Health Benefit Exchange Fund Proposal

MHA supports efforts to stabilize the ACA Marketplace through the state's reinsurance and subsidy programs and hopes these strategies will mitigate coverage losses and associated increases in UCC. To assess the potential impact of these policy interventions, key questions must be answered, including the portion of the proposed 0.40% allocation that is intended to support the reinsurance and subsidy programs, respectively, and the anticipated implementation timeline for any changes to these programs. It will also be important for stakeholders to understand the specific changes under consideration, whether it be modifications to the attachment point or coinsurance rate for the reinsurance program or the level of state subsidies

[3] Maryland Health Benefit Exchange. Maryland Health Connection Enrollment Data Dashboard. Available here.

available to enrollees in the individual market, as well as the expected impact of these changes on premiums and enrollment.

UCC Funding for Federally Qualified Health Centers

MHA recognizes the important role of Federally Qualified Health Centers (FQHCs) in providing primary and preventive care to uninsured individuals. At the same time, any efforts to strengthen the safety net through FQHCs should complement—not replace—the allocation of needed UCC funding to hospitals. Hospitals must have adequate UCC funding to meet the acute care needs of patients as coverage losses increase uncompensated care. HSCRC has a responsibility to set hospital rates in alignment with the reasonable costs hospitals are confronting; to carry out this mandate, HSCRC must prioritize adequate UCC funding for hospitals.

****

Thank you for the opportunity to comment on this critical policy issue. MHA is ready to assist HSCRC, MDH, and other state partners in identifying an uncompensated care policy solution that helps preserve access to essential acute care for all Marylanders. Please do not hesitate to contact me if you have any questions.

Sincerely,

Patrick D. Carlson
Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi

Appendix. Key Policy Changes and Estimated Coverage Losses

Policy Provision, Description	Effective Date	State Estimated Coverage Loss
Marketplace Policy Changes		
Immigrant Eligibility for Tax Credits (1st change) Ends eligibility for Marketplace premium tax credits for lawfully present immigrants under 100% FPL who are ineligible for Medicaid due to their immigration status.	January 1, 2026	20,000
Enhanced Premium Tax Credits (ePTCs) Ends federal Affordable Care Act enhanced premium tax credits made available via the American Rescue Plan Act.	January 1, 2026	30,000
Immigrant Eligibility for Tax Credits (2nd change) Ends eligibility for Marketplace premium tax credits for all lawfully present immigrants under 100% FPL except for lawfully present residents (LPRs), Cuban-Haitian entrants, and COFA (Compacts of Free Association) migrants.	January 1, 2027	20,000
Total Estimated Marketplace Coverage Loss		70,000
Medicaid Policy Changes		
Immigrant Eligibility Changes Limits Medicaid and CHIP eligibility to lawful permanent residents, certain Cuban and Haitian entrants, and individuals from the Compacts of Free Association nations. Excludes refugees, asylees, and other humanitarian groups.	October 1, 2026	15,000
Work Requirements Requires certain expansion adults to complete 80 hrs. per month of work, education, or community service as a condition of eligibility. Applies to individuals ages 19-64, with limited exemptions and must be verified through ex-parte processes.	January 1, 2027*	115,000
Six-Month Redeterminations Requires Medicaid eligibility redeterminations every six months for adult expansion enrollees or those receiving Minimum Essential Coverage (MEC) through a waiver.	January 1, 2027	--
Retroactive Coverage Reduces retroactive coverage from three months to one month for expansion adults and two months for all other groups.	January 1, 2027	--
Total Estimated Medicaid Coverage Loss		130,000
Total Estimated Coverage Loss – Marketplace and Medicaid		200,000

* States can request good faith effort extensions through December 31, 2028

Source: Maryland Department of Health and Maryland Health Benefit Exchange Jan. 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available here. MHBE presentation starts on slide 42, MDH on slide 69.

June 22, 2026

Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: hscrc.payments@maryland.gov

Dear HSCRC Payment Models Workgroup,

Thank you for this opportunity provide written comments in support of the draft proposal to increase the Rate Year 2027 Uncompensated care adjustment by 0.50 percent, with 0.40 percent in funding allocated to the Maryland Health Benefit Exchange Fund directed to the state reinsurance fund and state subsidies for marketplace enrollees.

In 2021 Maryland passed legislation to create the Young Adult Subsidy Program which since 2022 has helped lower-income young adults ages 18-34 purchase health coverage. This premium assistance program has been a lifeline to thousands of young adults, including myself, who struggle to afford quality health insurance. Though I have two jobs working in a restaurant and doing HVAC installation, neither job offers health insurance and I buy my health insurance from Maryland Health Connection. The state program has lowered my monthly premiums significantly, reduced my deductible by thousands of dollars, and improved my access to healthcare greatly. Before this program I was paying for an expensive plan that did not give me much coverage. I had a high deductible and was paying hundreds of dollars for visits to specialists. I recently suffered a fall that resulted in a fractured vertebra. Without my current health insurance plan, I would have faced thousands of dollars in medical expenses to receive the care and treatment necessary for my recovery. Additionally, the premium assistance provided me with preventative care for elevated cholesterol which would have otherwise gone unnoticed.

Now, my health insurance coverage and that of millions of other Americans and tens of thousands of other Marylanders is under attack by the failure of the US Congress to extend the federal enhanced premium assistance program which expired at the end of 2025. Luckily, I live in Maryland where the State Subsidy Program, which includes the young adult subsidy, makes up for this gap in my premium assistance. Unfortunately, this Maryland back-up plan is temporary. If Congress does not act this year to extend the enhanced premium assistance, which is very unlikely, and if you don't provide additional resources for the State Subsidy Program, my premiums will skyrocket and I will likely have to drop my health insurance coverage.

This draft proposal could raise ~$120 million for the state subsidy and reinsurance programs. This would help ensure that myself and many others keep the benefits that we have enjoyed for the past four and a half years. Easy access to affordable health care has made it possible for Marylanders to stay healthy and productive without fear of financial ruin from expensive medical bills. This law is not only important for the health and wellbeing of enrollees, but it has significant economic benefits for Maryland. By providing affordable health care to young and low-income adults, we can make the risk pool healthier while reducing uncompensated care, helping to reduce the overall cost of health care in the state. This will lead to a healthier workforce, reduced absenteeism, and increased productivity.

Thank you for your consideration and I urge the HSCRC to approve this draft proposal.

Sincerely,

Robert Laughlin

THE EPISCOPAL DIOCESE OF MARYLAND

June 23, 2026

Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: hscrc.payments@maryland.gov

Dear HSCRC Payment Models Workgroup,

We appreciate the opportunity to provide comments on the draft proposal to increase the Rate Year 2027 Uncompensated Care adjustment by 0.50 percent. The strategic allocation of 0.40 percent to the Maryland Health Benefit Exchange (MHBE) Fund for state reinsurance and marketplace subsidies represents a vital investment to help Marylanders keep their health coverage and reduce uncompensated care. **Maryland Citizens' Health Initiative (MCHI) strongly supports this proposal.** MCHI is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders.

We have made great progress in Maryland over the past twenty years by expanding health care coverage to over 400,000 people. A study commissioned by MCHI found that health coverage expansion saved the Maryland health care system over $460 million, which helped stabilize premiums for all Marylanders. But, this progress is now under attack by the federal government through the passage of HR 1, federal rules for Medicaid and qualified health plan (QHPs), and the failure of Congress to extend enhanced Premium Tax Credits (ePTCs). Tens of thousands of Marylanders have already lost health care coverage and hundreds of thousands more could potentially lose coverage in the coming years. When Marylanders lose health coverage, they are often forced to get their care in the emergency room. This drives up uncompensated care, which then increases health insurance premiums for everybody.

We commend the HSCRC for this draft proposal which offers a proactive solution to safeguard access to health coverage and reduce uncompensated care. This draft proposal could help raise ~$120 million/year for the MHBE fund to sustain the essential reinsurance and subsidy programs described below.

Reinsurance Program

Maryland's reinsurance program has helped make Maryland's health insurance premiums some of the lowest in the nation. Protecting the program is critical to prevent approximately 17,000 Marylanders from losing coverage, and to help keep coverage affordable for tens of thousands more. Maintaining this program requires approximately **$150 million per year** from the state.

THE EPISCOPAL DIOCESE OF MARYLAND

State Subsidy Program

The state subsidy program is a critical tool for enabling young adults and low-income residents to maintain their health coverage.

Since its inception in 2022, the young adult subsidy has driven unprecedented enrollment growth in this demographic, stabilizing the insurance pool and lowering premiums for all age groups. Furthermore, the program has made significant strides in reducing racial and ethnic disparities in healthcare access. Recognizing its impact, Governor Moore and the Maryland General Assembly made this subsidy permanent in 2025, contingent upon available funding.

In 2025, state leadership further empowered the MHBE to establish a new subsidy program designed to mitigate the potential expiration of federal ePTCs. That program went into effect for PY 2026 and provides critical assistance to Marylanders below 400% of the Federal Poverty Level (FPL)—with targeted support for those under 250% FPL—while fully integrating the young adult subsidy. This program is currently helping an estimated 30,000 Marylanders keep their health coverage, and is helping many more with affordability and accessing higher-tier plans. Due to exceptional demand, the MHBE temporarily paused subsidies for new Special Enrollment Period enrollees in April, with plans to modify and reinstate the program for PY 2027 as funding allows.

Maintaining the State Subsidy Program at PY 2026 levels would help prevent ~30,000 people from losing coverage and would cost **~$190 million per year.** Expanding the state subsidy program to fully cover the loss of ePTCs would help restore coverage for an additional ~30,000 people and cost an additional **~$60 million per year** more. If Maryland were to take a step further to restore and protect coverage for ~40,000 people under 400% FPL fully losing eligibility for APTCs, that would require an additional **~$250 million**.

Conclusion

The approximately $120 million for the MHBE Fund generated by this draft proposal would provide a critical foundation for maintaining Maryland's historic enrollment gains as federal decisions continue to threaten access to coverage. Separately, our organization is also advocating for five revenue sources which we presented at the HSCRC meeting on June 10. Combined with enacting this draft proposal, Maryland could lead the nation in protecting our residents' access to quality, affordable health care.

Even with the investments from the draft proposal, we anticipate that there will still be people who lose coverage. For this population we must ensure that Federally Qualified Health Centers (FQHCs) have the resources necessary to provide essential care and reduce unnecessary emergency department visits.

THE EPISCOPAL DIOCESE OF MARYLAND

We urge the Commission to finalize this proposal and continue exploring every avenue to protect access to quality, affordable health care for all Marylanders. We appreciate all that you do and thank you for this opportunity to provide comments.

Sincerely,

Rev. Ken Phelps, Jr.
Maryland Episcopal Public Network
The Episcopal Diocese of Maryland

Delaware-Maryland Synod
Evangelical Lutheran Church in America

Comment Prepared for the
Maryland Health Services Cost Review Commission
Payment Models Workgroup
4160 Patterson Avenue
Baltimore, MD 21215
June 23rd, 2026

HSCRC Payment Models Workgroup, thank you for the opportunity to provide comments on the draft proposal to increase the Rate Year 2027 Uncompensated Care adjustment by 0.50 percent. I am Reverend Melody Hession-Sigmon, director of the Lutheran Office of Public Policy in Maryland for the Delaware-Maryland Synod of the Evangelical Lutheran Church in America, a faith community with congregations in every part of the state.

Our church body has a history of advocating for expanded access to health care for all people in Maryland, particularly under the leadership of Rev. Lee Hudson. We write today continuing that legacy, in support of the draft proposal by the HSCRC, which offers a proactive solution to safeguard access to health coverage and reduce uncompensated care in the wake of federal cuts. We support the strategy to allocate .40 percent of the Maryland Health Benefit Exchange (MHBE) fund for state reinsurance and marketplace subsidies. In the past, we have supported the subsidy project on the MHBE directed towards medically uninsured young adults, and today this state subsidy continues to be an essential tool for protecting coverage for both young adults and low-income residents.

We are grateful that Maryland is a leader in our country for protecting access to quality, affordable health care. When people get left behind and must resort to emergency room visits without insurance, this drives up premiums for insured Marylanders, so we all suffer. As Christians, we understand this concept without the economic framework, because we believe that when even just one person in the community suffers, we all bear with them.

"'Being well' for Christians does not mean we are untouched by pain and suffering. Human beings are finite and vulnerable, and so we recognize limits on what we expect of health and health care for our families and ourselves. 'Being well' means that we participate in Christ's own 'greater love' (John 15:13) by

giving ourselves for others and sharing their suffering in response to Christ who bore the suffering of all.

"Regardless of the means used to provide health care and ensure access to it, we must diligently preserve the nature of health care as a shared endeavor. This means that we recognize our mutual responsibilities and guard against the ways in which motivation to maximize profit and to market health care like a commodity jeopardizes health and the quality of health care for all." (*Caring for Health: Our Shared Endeavor*, ELCA, 2003)

We would also like to see the state subsidies for health care coverage expanded to protect immigrants in Maryland, who stand to lose coverage due to the policies of HR1. We believe that protecting health care access for immigrants and refugees in Maryland is part of taking proper share of international responsibility for the resettlement of refugees and other persons urgently in need of the compassionate haven of a new home land.

Please finalize the proposal, and please continue to both look for and take every opportunity afforded to you to both protect and expand healthcare access for all residents of Maryland. Thank you so much for all that you do.

Rev. Melody Hession-Sigmon

June 23, 2026

Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: hscrc.payment@maryland.gov

Dear HSCRC Payment Models Workgroup,

We appreciate the opportunity to provide comments on the draft proposal to increase the Rate Year 2027 Uncompensated Care adjustment by 0.50 percent. The strategic allocation of 0.40 percent to the Maryland Health Benefit Exchange (MHBE) Fund for state reinsurance and marketplace subsidies represents a vital investment to help Marylanders keep their health coverage and reduce uncompensated care. **Maryland Citizens' Health Initiative (MCHI) strongly supports this proposal.** MCHI is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders.

We have made great progress in Maryland over the past twenty years by expanding health care coverage to over 400,000 people. A study commissioned by MCHI found that health coverage expansion saved the Maryland health care system over $460 million, which helped stabilize premiums for all Marylanders. But, this progress is now under attack by the federal government through the passage of HR 1, federal rules for Medicaid and qualified health plan (QHPs), and the failure of Congress to extend enhanced Premium Tax Credits (ePTCs). Tens of thousands of Marylanders have already lost health care coverage and hundreds of thousands more could potentially lose coverage in the coming years. When Marylanders lose health coverage, they are often forced to get their care in the emergency room. This drives up uncompensated care, which then increases health insurance premiums for everybody.

We commend the HSCRC for this draft proposal which offers a proactive solution to safeguard access to health coverage and reduce uncompensated care. This draft proposal could help raise ~$120 million/year for the MHBE fund to sustain the essential reinsurance and subsidy programs described below.

Reinsurance Program

Maryland's reinsurance program has helped make Maryland's health insurance premiums some of the lowest in the nation. Protecting the program is critical to prevent approximately 17,000 Marylanders from losing coverage, and to help keep coverage affordable for tens of thousands more. Maintaining this program requires approximately **$150 million per year** from the state.

2600 St. Paul Street Baltimore, MD 21218
www.healthcareforall.com
Phone (410)235-9000 Fax (410)235-9000

State Subsidy Program

The state subsidy program is a critical tool for enabling young adults and low-income residents to maintain their health coverage.

Since its inception in 2022, the young adult subsidy has driven unprecedented enrollment growth in this demographic, stabilizing the insurance pool and lowering premiums for all age groups. Furthermore, the program has made significant strides in reducing racial and ethnic disparities in healthcare access. Recognizing its impact, Governor Moore and the Maryland General Assembly made this subsidy permanent in 2025, contingent upon available funding.

In 2025, state leadership further empowered the MHBE to establish a new subsidy program designed to mitigate the potential expiration of federal ePTCs. That program went into effect for PY 2026 and provides critical assistance to Marylanders below 400% of the Federal Poverty Level (FPL)—with targeted support for those under 250% FPL—while fully integrating the young adult subsidy. This program is currently preventing an estimated 30,000 Marylanders from losing their health coverage, and is helping many more afford higher-tier plans. Due to exceptional demand, the MHBE temporarily paused subsidies for new Special Enrollment Period enrollees in April, with plans to modify and reinstate the program for PY 2027 as funding allows.

Maintaining the State Subsidy Program at PY 2026 levels would help prevent ~30,000 people from losing coverage and would cost **~$190 million per year.** Expanding the state subsidy program to fully cover the loss of ePTCs would help restore coverage for an additional ~30,000 people and cost an additional **~$60 million per year** more. If Maryland were to take a step further to expand the state subsidy program to cover ~40,000 immigrants under 400% FPL who became – or will soon become –ineligible for APTCs due to HR 1, that would require an additional **~$250 million**.

Conclusion

The approximately $120 million for the MHBE Fund generated by this draft proposal would provide a critical foundation for maintaining Maryland's historic enrollment gains as federal decisions continue to threaten access to coverage. Separately, our organization is also advocating for five revenue sources which we presented at the HSCRC meeting on June 10. Combined with enacting this draft proposal, Maryland could lead the nation in protecting our residents' access to quality, affordable health care.

Even with the investments from the draft proposal, we anticipate that there will still be people who lose coverage. For this population we must ensure that Federally Qualified Health Centers

(FQHCs) have the resources necessary to provide essential care and reduce unnecessary emergency department visits.

We urge the Commission to finalize this proposal and continue exploring every avenue to protect access to quality, affordable health care for all Marylanders. We appreciate all that you do and thank you for this opportunity to provide comments.

Best regards,

Stephanie Klapper, MSW
Deputy Director, Maryland Citizens' Health Initiative
stephanie@healthcareforall.com

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
carefirst.com

June 23, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm,

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on the draft recommendation embedded in item (c) of the Final Recommendation for the Update Factors for Rate Year 2027.

We find it problematic that the Health Services Cost Review Commission (HSCRC) acted on three items that were new to the public at its June public meeting, totaling roughly $213 million in incremental cost:

- $48 million in funding related to Care Transformation Initiatives that had been voted to be canceled by Commissioners at the prior meeting;
- $115 million in funding related to uncompensated care and reinsurance; and
- $50 million in funding related to AHEAD Model preparation for which no data or explanation in writing was presented.

HSCRC has a process intended to include the public, welcome their input, and act transparently. Adherence to this process helps build trust; conversely, actions that evade this process erode trust.

CareFirst remains concerned about the affordability of healthcare services. Rate year 2026 and 2027's approved update factors have been historically high. Maryland has a unique ability to deliver predictable, reasonable all-payer hospital rate increases that support the delivery system while also placing value on the dollars earned by local businesses and residents. Annual increases of approximately 5% do not strike the balance Marylanders deserve.

We understand the funding on this item has been approved and the question for the public regards how it should be allocated. Fundamentally, HSCRC is asking whether they should (1) focus dollars upstream on the root cause of uncompensated hospital care by increasing the likelihood individuals can remain covered by an insurance carrier; or (2) accept that prices will drive more individuals to opt out of coverage, resulting in higher uncompensated care costs at hospitals. This is a false choice. Using the approved 0.5% for reinsurance subsidies on the Maryland Health Benefit Exchange would help people and hospitals; using the funding to prefund uncompensated care only helps hospitals.

HSCRC should direct the full 0.5% to the Maryland Health Benefit Exchange to provide additional reinsurance and state subsidies for marketplace enrollees. HSCRC should also evaluate changes in uncompensated care as they occur and incorporate those findings into their existing uncompensated care policy, which builds the cost of uncompensated care into hospital rates.

Thank you for the opportunity to comment on this recommendation. We look forward to continued work

with HSCRC, staff, and the industry during this dynamic period in healthcare.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224

MID-ATLANTIC ASSOCIATION OF
COMMUNITY HEALTH CENTERS

June 24, 2026

Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Comment on the Proposed Hospital Rate Adjustment for the State Reinsurance and Individual Market Subsidy Programs — Dedicating a Portion to FQHCs

Dear Commissioners,

The Mid-Atlantic Association of Community Health Centers (MACHC) supports the HSCRC's proposal of using Maryland's all-payer system to stabilize coverage and reduce the number of uninsured residents. The association strongly encourages the Commission to allocate a significant portion of the proposed funding to Federally Qualified Health Centers (FQHCs). A dedicated state investment in FQHC uncompensated care is essential to controlling overall health spending and offers a cost-effective means of directing funding upstream, before expensive hospital care is required.

Summary

The financial situation of Maryland's sixteen FQHCs is daunting even before the implementation of policy changes set forth by H.R. 1. Centers already absorb roughly $81.4 million in unreimbursed care each year. In 2024, Federal Section 330 Health Center Program funding to Maryland health centers totaled $60.5 million, while the gross cost of care for uninsured patients was $135 million. This difference, after accounting for self-pay collections, still amounts to a $57.9 million shortfall, in addition to the $23.4 million gap between commercial reimbursements and the cost of caring for commercially insured patients.

Three additional pressures threaten to further destabilize health center finances. Projected Medicaid coverage loss estimates indicate that 13,900 to 24,600 FQHC patients will move from Medicaid to uncompensated care, shifting $24.5 to $43.3 million in annual costs from reimbursed to unreimbursed care. The 2026 expiration of enhanced federal premium tax credits, while partially offset by the state, is also expected to result in losses. In late 2025, Capital Link estimated $32 million in lost revenue for Maryland FQHCs beginning in 2026, with the figure increasing each year. Finally, the 340B Drug Pricing Program — long a critical means of stretching scarce FQHC funding beyond what federal grant dollars can cover — is losing flexibility as Medicare drug price negotiations shrink the savings health centers depend on.

FQHCs have been working from behind for years to close budget gaps due to insufficient funding. Dedicating a defined, recurring portion of the HSCRC's proposed revenue to FQHCs would close part of that gap while advancing total cost of care priorities to invest in upstream primary care to contain avoidable and expensive hospital use. The remainder of this report further illustrates these points, describing the unique needs of Maryland FQHCs and the populations they serve.

About Maryland Federally Qualified Health Centers

Maryland's sixteen FQHCs serve more than 374,000 patients annually, regardless of insurance status or ability to pay. Eighty-six percent of Marylanders seeking care at FQHCs live at or below 200 percent of the Federal Poverty Level. Additionally, health centers serve a disproportionate share of uninsured Marylanders, acting as a critical primary care safety net. In 2024, FQHCs cared for one in five uninsured Marylanders despite serving only 6 percent of the state's population.

Current Funding Does Not Cover the Full Cost of Care

Two key funding streams for Maryland FQHCs do not adequately support care for patients: federal funding and reimbursement from commercial payers. Federal Section 330 Health Center Program grants are capped, have not kept pace with inflation or rising demand, and are allocated nationally rather than in proportion to Maryland's specific needs.

While 330 funding is intended to cover services for both under- and uninsured patients, it does not cover the cost of care for uninsured patients. Between 2019 and 2024, 330 funding payment adequacy, or the ability to cover the cost of care for uninsured patients at FQHCs, fell from 65 percent to 45 percent. In 2024, the gross cost of care for uninsured patients at Maryland health centers was $135 million, while 330 funding totaled only $60.5 million. During 2024, FQHCs also collected roughly $16.7 million in self-pay collections from patients. As defined by the Uniform Data System, FQHCs' annual centralized data submission tool, self-pay collections include full charges for services for uninsured patients, as well as copays, deductibles, charges to insured individuals for non-covered services, and cost-sharing for Medicaid patients.

This leaves an annual shortfall in the cost of care for uninsured patients of $57.9 million, as illustrated in Table 1. Across this and all subsequent tables, MACHC applies a single average cost per patient ($1,762), calculated from 2024 Maryland FQHC data and applied to all FQHC patients, regardless of insurance type or status.

Table 1. Baseline Uninsured Annual Loss (UDS, 2024)	
Uninsured FQHC Patients	76,644
Average Cost Per Patient	$1,762
Gross Uninsured Cost of Care	$135,046,728
Section 330 Funding	($60,464,191)
Self-Pay Collections	($16,675,384)
Net Baseline Uninsured Loss	**$57,907,153**

Reimbursement from commercial payers is the second largest income stream for Maryland FQHCs, totaling approximately $124.6 million per year. Similar to 330 grant funding, commercial insurers covered an average of 84% of the cost of care for commercially insured patients, resulting in an annual loss of $23.4 million for health centers. Table 2 provides more detailed annual loss estimates.

Table 2. Baseline Commercial Annual Loss (UDS, 2024)	
Commercially Insured FQHC Patients	84,001
Average Cost Per Patient	$1,762
Gross Commercial Cost of Care	$148,009,762
Commercial Reimbursements	($124,563,232)
Net Baseline Commercial Reimbursement Loss	**$23,446,530**

Collectively, these losses mean that Maryland FQHCs must backfill at least $98 million each year to remain solvent. Many centers have found ways to stay afloat with other federal, state, local, and private grants, but relief is time-limited and inconsistent, as seen with American Rescue Plan Act investments from the federal government during the COVID-19 pandemic.

Existing Funding Streams, Like the 340B Program, Are Losing Impact

For years, the 340B Drug Pricing Program has been a vital source of program income for FQHCs, funding point-of-sale drug discounts for uninsured patients, pharmacy services, and wraparound care through the spread between the discounted 340B price and payer reimbursement. The Inflation Reduction Act, while important for many Americans, now narrows that spread: as Medicare negotiates a Maximum Fair Price on a growing list of high-cost drugs, acquisition cost and reimbursement converge, collapsing the margin health centers once captured — and FQHC revenue from the program will keep declining as more drugs enter negotiation.

Changes to the Marketplace and Medicaid Will Further Destabilize Funding

In addition, health centers are bracing for the possibility that patients will lose insurance coverage from both Medicaid and the Maryland Health Benefit Exchange. Based on the HSCRC's proposal, the number of residents estimated to lose Medicaid coverage ranges from 130,000 to 230,000. As shown in Table 3 below, this will have an outsized impact on FQHCs. Given that Maryland centers care for more than 1 in 10 adults on Medicaid, estimated coverage losses could reach nearly 25,000 FQHC patients, totaling $43.3 million in annual lost revenue.

Table 3. Projected Medicaid Losses Based on State Projections	
FQHC Adult Medicaid Patients	97,968
Maryland Adult Medicaid Patients	916,397
MDH Estimated Medicaid Enrollment Loss	130,000
RAND Estimated Medicaid Enrollment Loss	230,000
Estimated Medicaid Patient Coverage Loss	13,898 – 24,588 Patients
Average Cost Per Patient	$1,762
Estimated Medicaid Reimbursement Shift to Uncompensated Care	**$24.5 – $43.3 Million**

Beyond Medicaid, the Health Benefit Exchange is also expected to see lower utilization due to the federal premium tax credits, which expired at the end of 2025. While Maryland has partially offset the credit to mitigate the loss, FQHCs still expect impacts on the rate of uncompensated

care. Attached to this letter are estimates prepared by Capital Link in late 2025 for Maryland FQHCs to determine long-term losses due to the expired tax credits. The analysis shows that, beginning in 2026, FQHCs could incur an annual loss of $32 million, which would grow each year. While it does not capture Maryland's premium tax credit subsidies, it is a helpful proxy for understanding the potential impact should premium tax credits become unavailable for patients covered through marketplace plans.

Supporting Primary Care Through the HSCRC Strengthens the TCOC Model

Under Maryland's Total Cost of Care model, avoidable utilization is a direct system cost. Every uninsured patient whose diabetes, hypertension, asthma, or behavioral health condition is managed in an FQHC is less likely to experience an avoidable emergency department visit or hospital admission. This is the same underlying rationale that supports funding reinsurance through hospital rates: a more stable, appropriately served population reduces uncompensated care and downstream hospital costs.

Conclusion

MACHC strongly supports the Commission's proposal and urges it to dedicate a defined, recurring portion of new revenue to FQHCs.

Doing so would ensure that Maryland continues to strengthen its all-payer, global budget system by directly addressing uncompensated care. Investment in safety-net primary care reduces avoidable high-cost utilization and helps contain overall system expenditures. Failing to fund care for uninsured patients in FQHCs does not eliminate the cost—it only shifts it to emergency departments and hospital budgets.

MACHC would welcome the opportunity to provide additional data or testify in support of this proposal. Thank you for your consideration.

Respectfully,

Nora E. Hoban

Nora E. Hoban
Chief Executive Officer
Mid-Atlantic Association of Community Health Centers

Maryland

September 26, 2025

Scenario Planning for Health Centers

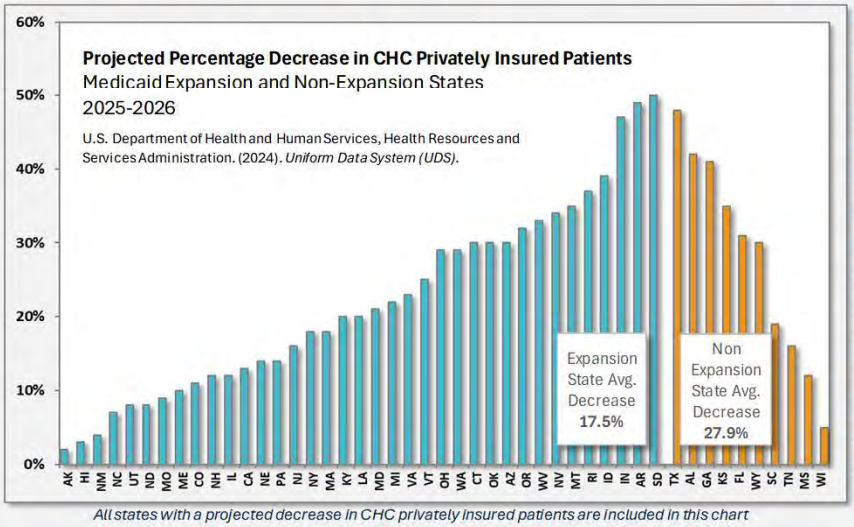
Analyzing the Impact of Potential Policy Changes on Patient Volume and Health Center Revenues

Projected CHC Patients With Private Insurance at Risk of Losing Coverage

Background: Beginning in 2014, the Affordable Care Act (ACA) health insurance exchanges ("Marketplaces") offered affordable coverage for millions of people. Bolstered by 2021 enhancements to premium tax credits (also known as subsidies) and simplified enrollment processes, Marketplace reforms expanded private insurance coverage for low-income people, dramatically reduced the number of uninsured community health center (CHC) patients, and, in turn, supported expansion of CHC capacity.

Last year CHCs served more than 32 million people nationwide in urban, rural and frontier communities across America. Subsidized Marketplace plans are an important source of coverage for low-income CHC patients, who typically work at jobs without affordable employer-based insurance. Federal data show that in 2024, in excess of 7 million CHC patients (22%) had private insurance, more than double the 3 million (14%) who had private coverage in 2013 before Marketplace plans became available. This growth in private insurance among CHC patients can be attributed to Marketplace coverage. There is no evidence that access to employer-based insurance has increased for low-income people since the implementation of the ACA. The Bureau of Labor Statistics reports that in 2022, just 26% of private industry workers in the lowest wage category were offered coverage and only 12% actually enrolled. Furthermore, the increase in private insurance coverage among health center patients parallels the surge in Marketplace enrollment among states following the adoption of enhanced tax credits and simplified enrollment policies enacted in 2021, particularly among people with incomes below 150%.

The Congressional Budget Office (CBO) estimates that, with the passage of the One Big Beautiful Bill Act (OBBBA) and the decision not to extend enhanced premium subsidies, Marketplace enrollment will fall by more than 8 million people by 2034. Losses in coverage will be especially high in states that have not adopted the ACA Medicaid expansion, since in these states eligibility for premium subsidies begins at 100% of the federal poverty level, rather than the higher 138% level used in Medicaid expansion states. CHC patients, 90% of whom have incomes at or below twice the federal poverty level, are likely to be disproportionately affected.

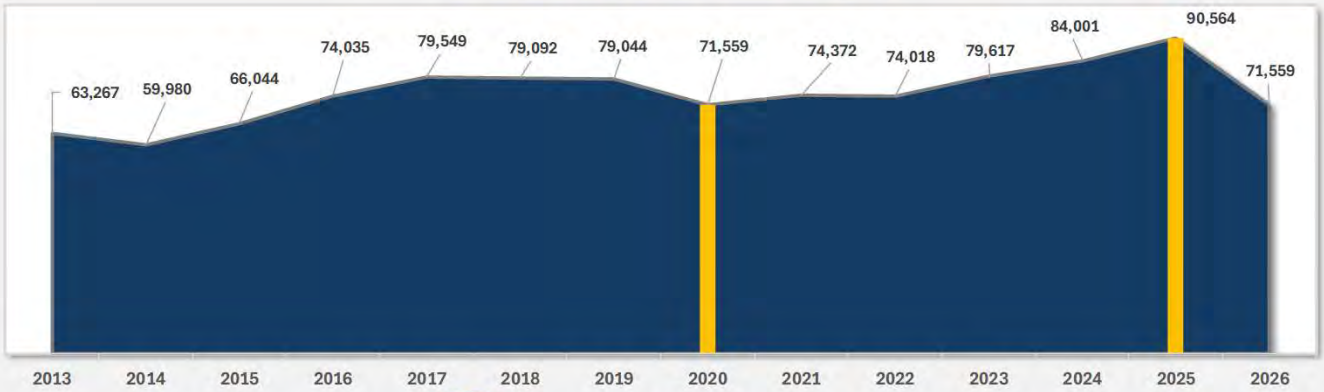


All states with a projected decrease in CHC privately insured patients are included in this chart

Analysis and Methods: This analytic tool estimates reductions in private insurance coverage among CHC patients when Marketplace policy changes go into effect in 2026, and the impact of these losses. Our analysis uses data on CHC grantee patient private coverage for 2013-2024 from HRSA's Uniform Data System (UDS), to which all health centers report annually. The analysis assumes, based on findings cited above, that the increase in private coverage among CHC patients through 2025 is attributable to the Marketplace. According to UDS, CHC grantees (excluding those in U.S. territories) served over 7 million patients with private insurance coverage in 2024 - which includes adults and children who would likely be covered under Marketplace plans as a family. Using Marketplace enrollment trends from 2021 to 2024 and growth estimates from KFF, we project 7.75 million CHC patients have private coverage in 2025. Subsequent coverage losses are projected from the 2025 estimate.

Number of CHC Patients with Private Insurance

Actual 2013-2024 and Estimated 2025-2026



Estimated Percentage of Privately Insured CHC Patients Losing Coverage

Estimated Number of Privately Insured CHC Patients Losing Coverage

19,005

We assume a coverage cliff will occur in January 2026, coincident with the implementation of Marketplace policy changes. The projected reduction in private coverage in 2026 is calculated as the difference between the projected number of CHC patients with private coverage in 2025 and the actual number in 2020; the 2020 figure reflects the premium tax credit support available prior to the enhancement reforms under the ACA, as enacted. While some who lose Marketplace coverage may be able to secure other insurance (e.g., workplace, Medicaid), the CBO estimates almost two-thirds of those losing Marketplace coverage will become uninsured nationwide. We estimate that among CHC patients who lose private coverage, 90% of those in non-expansion states and 85% of those in expansion states will become uninsured.

Health Center Private Insurance Revenue Loss

Projected total cumulative loss from annual shortfalls from 2026 to 2029

$153,212,295

The dark blue segment of this chart illustrates the projected unrealized revenue resulting from the expiration of enhanced premium tax credits.

Average Annual Collections Per Patient

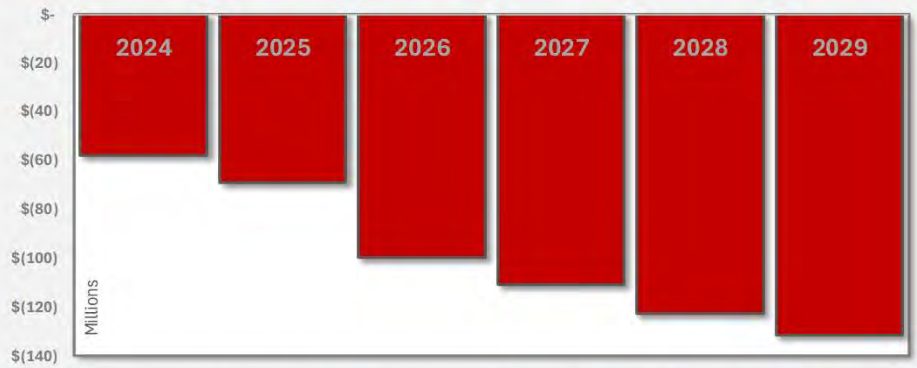
Private Insurance	**$1,483**
Self-Pay	**$218**

Payer Mix Variables

Estimated conversion rate from Private Insurance to Self Pay in 2026 **85%**

Estimated number of Private Insurance patients who become Self-Pay/Uninsured starting in 2026 **16,154**

Impacts on Total CHC Net Income



Year	Net Income
2024	$58,142,835
2025	$69,329,610
2026	$99,744,322
2027	$111,002,381
2028	$122,761,960
2029	$131,502,895

Total Number of FQHCs **17**

Total net income includes expected collections by payer (Medicaid, Medicare, Private Insurance, and Self-Pay), expected Section 330 grant funding, normalized patient increases, and corresponding revenue/expense changes. Net income declines are calculated as lost patients multiplied by historical collections per capita from the respective payer category. 2024 figures are UDS actuals and 2025-2029 are projections.

Health Center Patient Characteristics

CHC privately insured patients likely differ from the general population with Marketplace coverage. National survey data show that, compared to other low-income adults, CHC patients are more likely to: 1) have lower incomes; 2) be older; 3) be in poorer health, with serious chronic physical and mental health conditions; 4) live in isolated rural communities; and 5) include large numbers of highly vulnerable populations such as homeless individuals. This suggests that low-income CHC patients who do not qualify for Medicaid are more likely to need and seek affordable private coverage through the Marketplace, and to rely on premium tax credits benefiting the lowest income people.

Notes

These estimates are based on the One Big Beautiful Bill Act (PL 119-21) signed into law on July 4, 2025, pending regulations, and Office of Management and Budget estimates.

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Unitarian Universalist Legislative Ministry of Maryland

June 23, 2026

Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear HSCRC Payment Models Workgroup:

The Unitarian Universalist Legislative Ministry of Maryland (UULM-MD) appreciates this opportunity to enthusiastically support your draft proposal to increase the 2027 Uncompensated Care adjustment by 0.50% allocating 0.40% to the Maryland Health Benefit Exchange Fund for state reinsurance and marketplace subsidies. This approximately $120 million a year could help many Marylanders including low-income residents and young adults keep health insurance coverage.

The UULM-MD has been working for 20 years to improve health care in Maryland and we have seen great progress with a decrease of uninsured from 13% to 6%. The reinsurance program has helped Maryland have some of the lowest health insurance premiums in the U.S. State subsidies have helped low-income residents with affordability. Because of the Federal reductions tens of thousands of Marylanders have lost coverage, hundreds of thousands more are at risk of losing coverage, and many will see major increases in the costs for their insurance. A Maryland Citizens' Health Initiative study estimated over $460 million was saved by the Maryland health care system because of the health care expansion and reducing uncompensated care. The Federal actions will substantially increase uncompensated care.

Maryland has created innovative ways for young adults and low-income residents to obtain health insurance coverage. The young adult (18-37) subsidy program improved health equity by increasing insurance coverage for Black young adults by 46% and Hispanic young adults by more than 50% year over year compared to an overall enrollment increase for all young adults of 27%. Having 36% of the current total enrollment be young adults helps keep rates more affordable for all participants. Young adults have the lowest rate of access to employer-based insurance and Federal data indicates almost three out of every ten young adults do not have health insurance. The young adult subsidy program has been wrapped into the new state subsidy program which now also provides premium assistance to low-income Marylanders from other age groups to mitigate the loss of federal enhanced premium tax credits. This program and others in Maryland greatly need efforts such as your wonderful proposal to cope with the unexpected losses of Federal support.

The UULM-MD is composed of 23 congregations in Maryland and recognizes the need for affordable and quality health care. Thank you for sharing your draft. We urge you to finalize it and help continue to explore ways to protect the advances made in providing health care for the most underserved.

Sincerely,

Betty McGarvie Crowley
Lead Advocate for Health Care
UULM-MD
info@uulmmd.org

June 24, 2026

Dr. Jonathan Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Kromm:

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide feedback on staff's recommendation to address the impending impact of uncompensated care (UCC) increases. JHHS appreciates staff's recognition that anticipated Medicaid coverage losses under H.R.1 and related federal policy changes will place growing UCC pressure on hospitals, and shares the goal of mitigating those losses and protecting access to care for Marylanders. JHHS offers the following comments on the two components of the draft proposal, as well as on the operational realities hospitals face in serving a growing uninsured and underinsured population.

Increase to the HSCRC Uncompensated Care Fund Reserve (0.1%)

JHHS supports the proposed 0.1% increase to the reserves held in the HSCRC's UCC Fund. Building reserve capacity is appropriate given the impending magnitude of coverage losses. Due to concerns that the magnitude of UCC increases will not be known until realized, JHHS recommends that any release or reconciliation of these reserves be implemented effective January 1, 2027, based on hospitals' audited financial statements. Tying adjustments to audited data will ensure that reserve releases are grounded in verified UCC experience, and would align the mechanism with the Commission's existing reliance on annual filing submissions.

Pass-Through Funding to the Maryland Health Benefit Exchange (MHBE) (0.4%)

While JHHS appreciates the intent behind directing funding to the MHBE to support reinsurance and state subsidies for Marketplace enrollees, significant additional clarification is needed regarding the legality, mechanics, and implementation of this proposal.

JHHS is concerned that this rate increase exceeds the HSCRC's statutory authority to generate funds through increasing hospital rates for the sole purpose of financing delivery of hospital uncompensated care and the disproportionate share hospital payment., per Md. Health Gen Section 19-214(c). Part of funds being raised under this rate increase will be required to be passed from the hospitals to the MHBE, which does not finance the delivery of hospital uncompensated care. Maryland has consistently held that if the purpose of a measure is to raise revenue, it is a tax.[1] Under the Maryland Constitution,

[1]See Maryland Theatrical Corp. v. Brennan, 180 Md. 377 (1942); Eastern Diversified Properties, Inc. v. Montgomery County, 319 Md. 45 (1990)

Article 14, no tax may be levied without the consent of the Legislature.[2] We are not aware that the General Assembly has approved this tax for the purpose of raising funds for the MHBE; therefore, raising funds through a rate increase for the benefit of the MHBE is likely an unlawful tax that has not been approved by the General Assembly.

Beyond this legal question, there are additional technical considerations that require further clarification, including: 1) how funds collected by hospitals and remitted to the MHBE Fund would be tracked, governed, and reconciled, 2) how the MHBE's use of these funds would be accounted for and reported back to hospitals and the Commission; and 3) how funds collected but not ultimately expended to support UCC are utilized.

Hospitals Must Retain the Resources and Capabilities to Serve Patients Directly

As the State weighs how to effectively deploy funding in response to coverage losses, JHHS urges the Commission to consider that the work of identifying coverage, enrolling eligible patients, and providing financial assistance takes place at the hospital and at the point of care. Hospitals are a critical touchpoint for screening patients for Medicaid eligibility, assisting with applications and increasingly frequent re-enrollments, working denied claims arising from coverage lapses, and connecting uninsured patients to financial assistance and charity care. Therefore, the technical resources needed to support patients through this period of coverage disruption must also remain with hospitals.

These efforts require significant and growing cost. In anticipation of rising need, JHHS has scaled up its financial counseling teams by 50% to ensure continued access for patients as coverage losses materialize. It is critical that hospitals remain adequately resourced to perform the patient-facing work of connecting Marylanders to coverage and care.

JHHS shares the Commission's commitment to protecting coverage and access during a period of significant federal policy change. Further funding of the HSCRC's UCC fund reserves ensures preparedness and hospital support for the significant impending impact, and protects continued access for Marylanders in a time of great need.

Sincerely,

Ed Beranek

Ed Beranek, MBA
Vice President, Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chair
Dr. Ben Stallings
Ricardo Johnson
Dr. David Maine
Jonathan Blum
Nicki McCann
Dr. Farzaneh Sabi

[2] "That no aid, charge, tax, burthen or fees ought to be rated or levied, under any pretense, without the consent of the Legislature." Maryland Constitution, Article 14.

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

June 24, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

I am writing on behalf of Luminis Health regarding the Health Services Cost Review Commission's ("HSCRC's") draft recommendation on uncompensated care (UCC) included in the final FY 2027 update factor. While we appreciate the HSCRC's efforts to recognize the potential increase in UCC, we believe the proposed adjustment may not fully capture emerging UCC pressures and that additional considerations are warranted to ensure the recommendation accurately reflects hospitals experience.

The impacts of recent federal policy changes are already emerging and are expected to increase uncompensated care levels and increase the costs to collect for services. We continue to support the Maryland Hospital Association recommendation to provide a prospective UCC adjustment of 0.66%. As noted in our Annual Payment update comment letter, Luminis Health projects $1.3M in additional annual costs beginning in FY2027 related to coverage retention effort. The prospective funding is not only essential to maintaining stability in the short term, but is critical to ensure the CY2026 revenue base accurately reflects the expected future cost to provide care as it serves as the baseline for Medicare hospital global budgets. We agree with MHA that a reconciliation should occur once actual data is available.

We need to ensure that any pass-through funding to the Maryland Health Benefit Exchange (MHBE) to stabilize and mitigate Marketplace coverage losses are based on hospital specific collection rate and rather than a mark-up rate. This approach accounts for increased uncollectible revenue driven by high-deductible health plans and payer denials, while avoiding any hospital financial impact.

Thank you for the opportunity to comment.

Kathy Talbot

Kathy Talbot

VP of Revenue Strategy & Optimization

CC: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chair
Jon Blum, Commissioner
Ricardo Johnson, Commissioner
Dr. David Maine, Commissioner
Nicki McCann, Commissioner
Dr. Farzineh Sabi, Commissioner

1199SEIU
United Healthcare Workers East

June 24, 2026

Maryland Health Services Cost Review Commission
410 Patterson Avenue
Baltimore, MD 21215

Dear HSCRC Payment Models Workgroup,

We appreciate the opportunity to provide comments on the draft proposal to increase the Rate Year 2027 Uncompensated Care adjustment by 0.5 percent. The strategic allocation of 0.40 percent to the Maryland Health Benefit Exchange Fund for state reinsurance and marketplace subsidies represents a vital investment to help Marylanders keep their health coverage and reduce uncompensated care. **1199 SEIU strongly supports this proposal.** 1199 SEIU is the largest healthcare workers union in the nation with over 5,000 healthcare workers in Maryland in hospitals, nursing homes, and federally qualified health centers.

1199 SEIU members, who are the backbone of our health systems, know that when Marylanders lose health coverage, they are often forced to get their care in understaffed emergency rooms. This drives uncompensated care for the hospital, overburdens our health care workers, and creates unsafe staffing conditions affecting patients and workers alike. We want to direct our comments to the need for funding for FQHCs. Because FQHCs' patients are heavily represented among Medicaid expansion enrollees, many clinics can expect more uninsured patients and enrollment churn. Maryland's FQHCs serve over 350,000 patients, with approximately 19% uninsured and 48% covered by Medicaid.

Over the past twenty years, Maryland has made great progress by expanding health care coverage to over 400,000 people. But, this progress is under attack by the federal government's passage of HR 1 and federal rules for Medicaid. Governor Moore and the Maryland General Assembly recognize the impact of the state subsidy program on young adults and low-income residents to maintain health coverage. Maintaining the state subsidy program would help prevent ~30,000 from losing coverage and would require significant funding.

The approximately $120 million for the MHBE Fund generated by this draft proposal would provide a critical foundation for maintaining Maryland's historic enrollment gains as federal decisions continue to threaten access to coverage.

Sincerely,

Loraine Arikat
Senior Policy Analyst
1199 SEIU United Healthcare Workers East
Loraine.arikat@1199.org

To: Health Services Cost Review Commission (HSCRC)

From: Maryland Health Benefit Exchange (MHBE) and Maryland Insurance Administration (MIA)

Re: Support for DRAFT Recommendation for the Update Factors for Rate Year 2027 - Additional Funding Related to Uncompensated Care to Support Reinsurance and Subsidies for Marketplace Enrollees

Date: 6/24/2026

The Maryland Health Benefit Exchange (MHBE) and the Maryland Insurance Administration (MIA) share a commitment to maintaining market stability and enrollment in the midst of significant federal changes, and support the HSCRC proposal to direct additional funding towards reinsurance and state subsidies in 2027. Our agencies have worked closely together to implement and expand affordability programs in 2026, including the State Reinsurance and the State-Based Subsidies Programs which continue to keep individual market health insurance premium rates among the lowest in the nation and Marylanders enrolled in health insurance.

The State of Maryland has provided critical support for these programs over the years. Without state action to expand the generosity of the state subsidy in response to recent federal action and impending affordability challenges in the individual market, Maryland would have seen significant enrollment declines and an increase in the number of uninsured this year. Instead, thanks to the support the state has invested, Maryland's individual market remains stable, even for consumers over 400% FPL and ineligible for financial assistance, which is a significant achievement as we continue to face federal affordability challenges.

To illustrate the impact of the state subsidy, a Maryland family of four with an income of $64,000 would have seen the premium for a benchmark silver plan rise 225% in 2026, an increase of nearly $3,000 annually, due to the decline in federal premium assistance. With the state subsidy, Maryland was able to fully protect a family at this income level from this dramatic increase.[1] The generosity of the state subsidy phases out at higher income levels due to funding constraints; nevertheless, due to the combination of state subsidy and reinsurance Maryland was able to hold enrollment steady year-over-year for enrollees above 100% FPL.[2]

However, the State cannot sustain this level of generosity under current funding mechanisms beyond 2026. The 2026 state subsidy was established as a temporary measure and was never sustainable in the long-term under current revenue sources. The

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[1] 9/19/25 MIA press release: 2026 ACA Press Release - Approved Rates Exhibit 2a.

[2] MHBE Enrollment Dashboard, enrollment as of May 31, 2025 and May 31, 2026. Legally present immigrants below 100% FPL lost eligibility for federal premium assistance as of January 1, 2026 due to the federal legislation H.R.1 of 2025.

state subsidy shares a funding source with the State Reinsurance Program (SRP) - the 1% reinsurance assessment on most state-regulated health insurance premiums. In developing proposed 2027 subsidy parameters, MHBE, in close partnership with MIA, continues to consider market impacts, subsidy program costs, and available funds. Expanding the state subsidy in 2026 has required drawing down from the reinsurance fund significantly more than originally anticipated prior to 2026. Absent any additional funding, to maintain the reinsurance fund's solvency MHBE will have to significantly reduce the generosity of the state subsidy in 2027 and concurrently reduce the generosity of the reinsurance program.

In the face of a reduction in federal premium assistance in 2026, MHBE and MIA worked with the General Assembly and Governor to keep people enrolled and had hoped for future Congressional action to keep plans affordable. At this point our agencies do not expect federal action to improve affordability in 2026 or 2027. The 2026 State Subsidy Program has successfully delayed affordability challenges for many consumers this year, but scaling back the program in 2027 will result in more significant premium increases for consumers, greater enrollment losses, and an increase in the uninsured rate in the State.

Ensuring Marylanders remain insured and covered promotes continued access to preventive care, chronic disease management, and other necessary health services, leading to improved overall health outcomes. In contrast, increases in the uninsured population will drive up uncompensated care costs and impose additional financial burdens on the state. The HSCRC has an important opportunity to mitigate uncompensated care through maintaining and increasing coverage, which has wide benefits across our state.

For these reasons MHBE and MIA support the HSCRC proposal to direct additional funding from the state's uncompensated care fund to be used for reinsurance and state subsidies in 2027. Additional funds amounting to approximately $100 million in FY2027 would allow MHBE to continue Maryland's successful efforts to stabilize the individual market through reinsurance and the state subsidy program.

MHBE and MIA are working to update modeling of potential 2027 state subsidy and reinsurance parameters, with and without the potential funding through this proposal, to project impacts on enrollment in the individual market. We expect to be able to share updated modeling within the next few weeks.

Sincerely,

Marie Grant
Commissioner
Maryland Insurance Administration

Johanna Fabian-Marks
Deputy Executive Director
Maryland Health Benefit Exchange

Appendix: Highlighting the Success of Maryland's Market Affordability Programs

State Reinsurance Program

Maryland's State Reinsurance Program (SRP) has stabilized Maryland's individual health insurance market, significantly reducing premiums and increasing enrollment since its establishment in 2019. The SRP continues to keep premiums well below the national average.

The SRP stabilizes rates and reduces the cost of premiums in the individual market by reimbursing insurers for a percentage of enrollees' high-cost claims. It is funded with a combination of federal pass-through payments through the state's federal 1332 waiver, and a 1% state-based health insurance provider assessment. In 2024, the program cost $639M, of which 82% was funded by federal funds.[3]

Impact on Premiums and Enrollment

- The SRP **reduced individual market premiums by more than 30%** over its first four years. Average rates have since increased below claim trends, with the exception of 2026 which saw a double digit rate increase because of the increased morbidity associated with expected enrollment losses from those who lost enhanced federal premium assistance. Even with the 2026 rate increase, average 2026 rates are still down more than 6% compared to pre-reinsurance 2018 rates.
- The MIA estimates rates would be 30-35% higher without the SRP.[4]
- Maryland's premiums remain 34-38%% lower than those of similar plans across the U.S.[5]
- Total individual market **enrollment is up over 48%** since the program's launch.

2026 State Premium Assistance Program

Additional federal marketplace premium assistance, known as enhanced premium tax credits (ePTC) provided savings to Marylanders between 2021 and Dec. 31, 2025. The expiration of ePTC presented significant affordability challenges for Maryland consumers. Without ePTC, MHBE projected that Maryland would face enrollment losses as high as 90,000 individuals. To counter this tidal wave, the Maryland legislature passed HB 1082 in 2025, which authorized the MHBE to establish a state based individual subsidy program to mitigate enrollment losses and stabilize the market in 2026 and 2027.

Pursuant to HB 1082 MHBE is operating a State Premium Assistance program in 2026 to provide financial help to Marylanders and help stabilize the individual market. Maryland residents of any age who are eligible for federal premium tax credits are eligible to receive

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[3] Reinsurance Program Costs and Forecast, Pursuant to 2025 Joint Chairmen's Report p. 58:

[4] 9/19/25 MIA press release: 2026 ACA Press Release - Approved Rates.

[5] Kaiser Family Foundation: Average Marketplace Premiums by Metal Tier.

state premium subsidies, which pair with the federal premium tax credits to further lower monthly health insurance costs.

MHBE, in close consultation with MIA, structured 2026 state subsidies to fully replace the value of lost ePTC for enrollees with household incomes below 200% FPL (approximately $31,000 for an individual or $64,000 for a family of four). These lower income enrollees are the most price sensitive and retaining their enrollment benefits the market in a number of ways. For enrollees between 250%-400% FPL, the state subsidy replaces 50% of lost ePTC; between 200%-250% FPL the state subsidy phases out from the full to partial replacement. At all eligibility levels, enrollees must be eligible for federal premium assistance to receive the state assistance. In sum, state subsidies pair with federal premium assistance to provide the most assistance to the lowest income enrollees and phase out as enrollees approach 400% FPL, with no state or federal premium assistance available for those above 400% FPL. Enrollees above 400% FPL, however, continue to benefit from the reinsurance program, which reduces their premiums by approximately one-third. Enrollment data indicates the success of these paired programs, with Exchange enrollment between 100-200% FPL (the bracket eligible for full ePTC replacement) up year-over-year, and overall enrollment above 100% FPL steady year-over-year.[6]

Currently around **154,000 Marketplace enrollees are receiving an average additional $94 per member per month in state subsidies,** and the program has successfully helped keep rates down and moderated premium increases despite federal challenges. Marketplace consumers (inclusive of subsidized and unsubsidized enrollees) saw an average 19% increase in net monthly premiums year over year as of May,[7] compared to a national average net premium increase of 58% for the federal Marketplace[8]. Additionally Marketplace enrollment has declined by around 8.5% year over year with the subsidy in place (an enrollment loss of approximately 21,000 individuals)[9] compared to a reported minimum 17% decrease for the federal Marketplace. As noted previously, MHBE estimated that without the state subsidy in place in 2026, Maryland would face enrollment losses as high as 90,000 consumers.

[6] See footnote 2.

[7] Some subsidy-eligible income brackets saw average net premium increases as high as 39% (250-300%FPL bracket - MHBE May 2026 Executive Report)

[8] Kaiser Family Foundation: What we know so far about 2026 ACA Marketplace enrollment, premiums and deductibles

[9] MHBE May 2026 Executive Report

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829

CORPORATE OFFICE

June 24, 2026

Jon Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter re: FY 2027 .50% Uncompensated Care Funding Recommendation

Dear Jon:

On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, thank you for the opportunity to submit comments in response to the Health Services Cost Review Commission's ("HSCRC" or "the Commission") proposal to provide funding for the Maryland Health Benefit Exchange (MHBE) as part of the Draft Recommendation for FY 2027 Update Factor.

UMMS supports MHA's comment letter dated June 23 and, consistent with our Update Factor comment letter dated May 22, we emphasize the need to fund an additional 0.69% in Uncompensated Care (UCC) to account for the anticipated increase in bad debt and charity care associated with HR-1. We appreciate Commission's consideration of exploring mitigation strategies for the impending UCC increase, however, the outcome of providing funding to the Maryland Health Benefit Exchange (MHBE), is uncertain and direct UCC funding to hospitals will likely remain necessary.

The 0.1% increase in the UCC pool for growth in uncompensated care is likely not enough to support the expected impact of HR1 as shown in MHA's estimates. To ensure this important policy matter is considered throughout the year, we suggest Commission staff include a provision in the final staff recommendation that uncompensated care key indicators be monitored closely throughout the year, and new policy action will be available if needed.

Thank you for the opportunity to provide comments on this important issue.

Sincerely,

Alicia Cunningham
Senior Vice President, Corporate Finance & Revenue Advisory Services
University of Maryland Medical System

cc:
Chairman
Vice Chairman
Ricardo Johnson
Nicki McCann, JD
Farzaneh Sabi, MD
David N. Maine, MD
Jonathon Blum, MPP

Maryland Community Health System

To: **Health Services Cost Review Commission**

From: **Salliann Alborn, CEO**

Subject: **Comments on HSCRC Update Factor Recommendations – Supporting Federally Qualified Health Centers**

Date: **June 24, 2026**

The Maryland Community Health System (MCHS) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) Update Factor Recommendations that were presented during the commission meeting on June 10, 2026. MCHS is a network of federally qualified health centers (FQHCs) providing somatic, behavioral health, and dental care to underserved communities across Maryland.

During the June 10th meeting HSCRC presented on the changes from the draft recommendations to the final recommendations of the Update Factor by including the following (slide 3):

- 0.50% included in UCC to help mitigate marketplace declines and Medicaid losses.
- .40% in funding to the Maryland Health Benefit Exchange Fund to provide additional reinsurance and state subsidies for marketplace enrollees
    - 0.10% to increase the reserves held in the UCC Fund
    - Staff also are considering options for providing funding to FQHCs to expand services to reduce the unnecessary use of hospital services. This is not included in this recommendation due to the complexity required but Staff are interested in comments on whether and how to direct uncompensated care funding to FQHCs, so that uninsured individuals can receive care in the most appropriate setting.

MCHS strongly supports HSCRC's interest in directing a portion of Maryland's uncompensated care funding to FQHCs, as a reflection of the critical role that FQHCs play in their communities. As required under long-standing federal rules, FQHCs must serve every person who seeks their services, regardless of their insurance status or ability to pay, using a sliding fee scale. FQHCs must offer comprehensive primary care services, care coordination, and behavioral health services. Many FQHCs also offer dental services which are essential to improving overall health outcomes, including chronic disease management.

The HSCRC's recommendation recognizes that strengthening community-based care can reduce avoidable hospital utilization. By expanding access to primary care, chronic disease management, behavioral health services, same-day appointments, and care coordination, FQHCs can help prevent unnecessary emergency department visits, hospital admissions, and readmissions. Investing in these services upstream can reduce uncompensated care costs by addressing patients' needs before they require hospital-based care.

The recommendation also acknowledges that FQHCs are experiencing an increase in the number of uninsured clients, as recent federal policy changes have begun to impact the number of people who qualify for Medicaid or can afford commercial coverage. As more individuals become uninsured or underinsured, many will turn to FQHCs for affordable primary care rather than delaying treatment until conditions worsen. Currently the Maryland Department of Health expect 130,000 individuals to lose Medicaid coverage.[1] Providing uncompensated care funding to FQHCs would help expand capacity and continue serving vulnerable populations, while supporting the state's efforts to maintain equitable access to care despite anticipated increases in the uninsured.

From a policy perspective, directing a portion of uncompensated care funding to FQHCs aligns with Maryland's broader healthcare transformation goals, which emphasize improving population health and reducing unnecessary hospital utilization. Rather than using uncompensated care funds solely to offset hospital losses after care is delivered, MCHS supports investing more resources in FQHCs as the providers who are most able to prevent hospital admissions. MCHS supports strategically investing in communities that FQHCs serve which would improve health outcomes and reduce overall uncompensated care costs over time.

MCHS strongly encourages HSCRC to direct a portion of uncompensated care funding to FQHCs because of the critical role FQHCs play in delivering primary and preventive care to Maryland's uninsured and underserved populations. As the HSCRC solicits feedback on this proposal, MCHS would request that the HSCRC convene a meeting with FQHCs across the state to better understand the most appropriate way to support FQHCs through the use of uncompensated care funding.

Thank you again for the opportunity to submit these comments. If we can provide any additional information, please contact me at salborn@mchsmd.com or our policy consultants, Robyn Elliott and Michael Paddy at relliott@policypartners.net and mpaddy@policypartners.net.

[1] "H.R. 1 (2025) Impact on Maryland SNAP and Medicaid"
https://dhs.maryland.gov/documents/SNAP/H.R.%201%20MDH_%20DHS%20One%20Pager.pdf

Adventist HealthCare

June 25, 2026
Dr. Jon Kromm
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Draft Recommendation – Uncompensated Care Policy for Rate Year 2027

Dear Dr. Kromm:

Adventist HealthCare appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Rate Year (RY) 2027 Uncompensated Care (UCC) Policy.

We appreciate staff's thoughtful and innovative efforts to address the anticipated impacts of changes in the individual insurance marketplace. The proposed partnership with the Maryland Health Benefit Exchange (MHBE) reflects a creative approach to preserving coverage and reducing future uncompensated care.

At the same time, we remain concerned that the proposal does not sufficiently address the uncompensated care hospitals are already beginning to experience as marketplace enrollment declines and patients migrate to plans with higher deductibles and cost-sharing obligations as well as emerging deterioration of Medicaid coverage. **We believe the final policy should prospectively recognize the increase in uncompensated care emerging today which represents care for our most disadvantaged patients.**

Executive Summary
Adventist HealthCare respectfully recommends that the Commission:

1. **Prospectively recognize the anticipated increase in hospital uncompensated care associated with Calendar Year (CY) 2026 marketplace changes through the RY 2027 update factor**, consistent with HSCRC's longstanding practice of using prospective estimates when establishing hospital rates.

2. **Pilot the proposed MHBE funding strategy at a lower investment before relying on it as the primary policy solution**, allowing the Commission to evaluate its effectiveness and implementation.

3. **Clarify how the proposed 0.10 percent reserve funding would be allocated and distributed** to hospitals as additional uncompensated care emerges.

4. **Continue evaluating community-based strategies that improve access to care while ensuring hospitals receive appropriate reimbursement** for uncompensated care already being incurred.

Marketplace Changes Are Already Increasing Hospital Uncompensated Care
Within Adventist HealthCare, we are already observing these trends:

- **Medicaid volume during the first five months of CY 2026 has declined while self-pay volume has approximately doubled, despite continued use of Medicaid presumptive eligibility processes**.

- **Actual uncompensated care write-offs for Medicaid and Medicaid-pending accounts during the twelve months ending May 2026 have approximately doubled**.

While these data are preliminary, they provide early evidence that hospitals are already experiencing the anticipated financial impacts from anticipated changes in the market.

Waiting for these trends to fully mature within the retrospective UCC methodology delays recognition of costs hospitals are already absorbing while continuing to care for Maryland's most vulnerable patients.

RY 2027 Represents a Unique Opportunity for Prospective Action
RY 2027 presents a unique and time-sensitive policy opportunity. Hospital uncompensated care associated with CY 2026 marketplace changes is already emerging. However, because uncompensated care reporting necessarily lags actual experience due to claims runout, billing cycles, and payment resolution timelines, these impacts will not be fully reflected in official data for many months.

This timing is particularly important because RY 2027 represents the final year Maryland will establish hospital rates before Medicare hospital payment authority transitions to CMMI under the AHEAD Model beginning in Calendar Year 2028. **Delaying recognition of increased CY 2026 uncompensated care until future policy years would unnecessarily complicate reimbursement under split rate-setting authority and further exacerbate cost shifting across payers as Maryland transitions to the AHEAD Model.**

Prospective rate setting has long been a hallmark of Maryland's payment system. HSCRC routinely relies on projected experience when establishing hospital rates, including demographic

adjustments, respiratory surge funding, and other update factor components. The same prospective approach should apply here.

Moreover, the Commission has previously adjusted the uncompensated care methodology prospectively in response to significant changes in insurance coverage. During Medicaid expansion, UCC funding was prospectively reduced to reflect anticipated declines in uncompensated care. Today's marketplace changes represent the opposite circumstance. As coverage declines and patient financial responsibility increases, prospectively recognizing increased uncompensated care is both appropriate and consistent with established Commission practice.

Accordingly, Adventist believes RY 2027 rates should prospectively recognize the anticipated impacts of CY 2026 marketplace changes rather than relying exclusively on future retrospective adjustments.

Support for Innovation, but Concerns with the Proposed MHBE Strategy
Adventist appreciates staff's innovative proposal to strengthen marketplace coverage through targeted investments in the Maryland Health Benefit Exchange. Preserving insurance coverage is an important policy objective and may reduce uncompensated care over the long term.

However, we believe several aspects of the proposal would benefit from additional consideration. First, Adventist would appreciate additional clarity regarding how funding would be deployed, how investments would support reinsurance and state subsidies including number of impacted lives, and how program success would be evaluated.

Second, because marketplace enrollment occurs during the fall for the following calendar year, the proposal is largely directed toward CY 2027 coverage and does little to address uncompensated care already emerging during CY 2026. Under the current methodology, these costs would not be recognized until RY 2029, creating a multi-year gap during which hospitals would absorb higher uncompensated care without corresponding reimbursement while Maryland transitions to the AHEAD Model.

Third, the proposal places significant reliance on a single intervention to prevent projected increases in uncompensated care. **If marketplace stabilization is only partially successful, hospitals will continue experiencing higher uncompensated care that will ultimately still require reimbursement on top of the proposed investment through future UCC adjustments that come due after the transition to Medicare rate setting.**

Finally, Adventist respectfully requests additional clarity regarding the legal and operational framework supporting the proposed MHBE funding mechanism. Given Maryland's transition to the AHEAD Model and the importance of maintaining alignment with CMMI, additional explanation regarding the federal authority supporting the use of hospital rate-supported funding, including

federally matched dollars, for marketplace subsidies and reinsurance activities would strengthen confidence in the proposal and minimize implementation risk.

Rather than relying exclusively on one strategy, Adventist recommends a balanced approach that prospectively recognizes anticipated hospital uncompensated care while simultaneously piloting the proposed MHBE investment at a smaller investment and evaluating its effectiveness before broader implementation.

Adventist also respectfully requests clarification regarding the proposed 0.10 percent increase to the uncompensated care reserve, including the methodology for allocating reserve funding among hospitals and the timing of distributions as additional uncompensated care emerges.

Community-Based Care Models
Adventist supports continued exploration of community-based interventions that improve access to care while reducing unnecessary hospital utilization.

For example, Adventist HealthCare and Montgomery County are currently piloting direct payments to urgent care centers for uninsured individuals using funds associated with the Germantown Emergency Center transition. This initiative may provide valuable insight into targeted investments that improve access for uninsured patients while preserving hospital capacity for higher-acuity care.

Adventist would welcome the opportunity to collaborate with HSCRC staff and share insights from this pilot as the Commission continues to evaluate community-based strategies to improve access to care.

Stakeholder Engagement
Adventist appreciates staff's willingness to pursue innovative policy solutions. Given the significance of this issue and its implications for Maryland's hospitals and the patients they serve, we believe additional stakeholder engagement through a dedicated workgroup would have strengthened the proposal by providing an opportunity to evaluate alternative policy approaches prior to implementation.

We offer this observation in the spirit of continuous improvement and hope it will help inform future policy development processes involving issues of similar complexity.

Conclusion
Adventist appreciates HSCRC staff's thoughtful efforts to preserve insurance coverage and proactively address anticipated marketplace changes.

However, while the proposed MHBE strategy may help reduce future uncompensated care, hospitals are already experiencing increased uncompensated care associated with these

marketplace changes. We respectfully recommend that the final policy both prospectively recognize anticipated CY 2026 uncompensated care increases through the RY 2027 update factor and pilot the proposed MHBE funding strategy for CY 2027 impact. This balanced approach would reduce financial risk, improve policy evaluation, preserve access to care, and better position Maryland for a successful transition to the AHEAD Model.

Thank you for the opportunity to comment on this important proposal. Adventist HealthCare appreciates the Commission's continued partnership and looks forward to working collaboratively with HSCRC staff to develop a sustainable uncompensated care policy that protects access to care for Maryland's most vulnerable patients.

Sincerely,

Katie Eckert

Katie Eckert, CPA
Senior Vice President, Strategic Operations
Adventist HealthCare

cc: Jonathan Kromm, PhD, Executive Director, HSCRC
Joshua Sharfstein, MD, HSCRC Chairman
James N. Elliott, MD, HSCRC Vice-Chairman
Jonathan Blum, MPP
Ricardo R. Johnson, JD
David N. Maine, MD
Nicki McCann, JD
Farzaneh Sabi, MD

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
4000 Garden City Drive
Hyattsville, Maryland 20785

June 26, 2026

Jon Kromm, Ph.D.
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Funding Allocation for Reinsurance and Uncompensated Care

Dear Dr. Kromm:

Kaiser Permanente appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation to increase hospital rates an additional 0.5 percent in advance of anticipated uncompensated care, due to coverage losses, consisting of 0.4 percent to the Maryland Health Benefit Exchange Fund for reinsurance and marketplace subsidies, and 0.1 percent to the HSCRC's Uncompensated Care Fund reserve. We understand the care and coverage challenges the state is facing and want to be a strong partner in identifying solutions.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to 12.9 million members in nine states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States (Virginia, Maryland, and Washington, DC) provides and coordinates complete health care services for over 775,000 members. In Maryland, we deliver care to approximately 425,000 members.

We support efforts to make coverage more affordable and accessible and to mitigate the impact of coverage changes on providers. Reinsurance and other marketplace subsidies are valuable tools to lower premiums, increase enrollment, and stabilize the market by mitigating the impact of high-risk claims. Directing additional funding into the reinsurance program allows for an upstream intervention, keeping more individuals covered and reducing coverage losses. This approach is preferable to a proposal that directs additional funding solely to the uncompensated care fund without a balanced investment in maintaining coverage.

Kaiser Permanente is concerned that the recent decisions to divert funds from reinsurance to other health related priorities threaten premium stability for Maryland enrollees. Over the past five years, at least $190 million from the fund has been diverted to other state health priorities—resources that could have helped stabilize coverage costs. Without a stable, long-term funding

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

strategy, proposals that increase plan costs will ultimately be passed on to enrollees. Before advancing any measure that would ultimately result in higher premiums for Marylanders, the State should develop a comprehensive plan to fully fund the Reinsurance Program and premium subsidies and ensure affordability throughout the AHEAD model term.

Thank you for the opportunity to comment. Please feel free to contact me at (804) 525-8105 with questions.

Sincerely,

Christopher E. West

Christopher E. West
Head of Government Relations
Kaiser Permanente Mid-Atlantic States Region

cc: Jon Blum, Commissioner
Ricardo Johnson, Commissioner
Dr. David Maine, Commissioner
Nicki McCann, Commissioner
Dr. Fazi Sabi, Commissioner
Marie Grant, Maryland Insurance Commissioner
Michele Eberle, Executive Director, MHBE

June 24, 2026

Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Comment on the Proposed Hospital Rate Adjustment in Response to Federal Changes — Dedicating a Portion to FQHCs

Submitted electronically to hscrc.payments@maryland.gov

Dear Commissioners,

Health Care for the Homeless (HCH) respectfully submits the following comments in strong support of the Health Services Cost Review Commission (HSCRC) allocating a portion of the proposed funding to Federally Qualified Health Centers (FQHCs). Increasing numbers of uninsured Marylanders facing residential insecurity and homelessness are already challenging our ability to sustain annual operations. The new threats posed by H.R.1 and related Medicaid work requirements, address verifications and more frequent eligibility determination will only further harm vulnerable people, drive increases in unnecessary emergency department visits and hospitalizations, and threaten our ability to sustain our services and advance our mission.

Health Care for the Homeless is Maryland's leading provider of integrated health services and supportive housing for people experiencing homelessness, serving more than 12,000 people annually in Baltimore City and Baltimore County and sustaining 550 of the most vulnerable households (800+ people) in permanent supportive housing. We deliver care at clinic sites in West Baltimore, Downtown Baltimore, East Baltimore County, through shelter-based "mini-clinics," through a Mobile Clinic and a Street Medicine team. The clients we serve face significant barriers to care and disproportionately high rates of chronic conditions. Access to community-based primary and specialty care is often the difference between managed illness and avoidable crisis, emergency department visits and hospitalization for the population we serve.

We are also members of the Mid-Atlantic Association of Community Health Centers, and we support their recent comment letter that demonstrates the large amount of uncompensated care already faced by Community Health Centers and estimates projected losses in 2027 following implementation of H.R.1. At Health Care for the Homeless, approximately 40% off our patients are uninsured (among the highest uninsured rates in the state) and most of those we serve are among the "expansion population" and subject to new Medicaid regulations. Existing UDS data from the

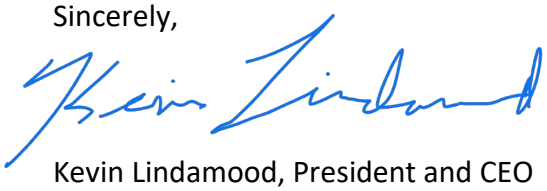
Health Resources and Services Administration (HRSA) documents the annual rate of uninsured Marylanders served by FQHCs. Every health center in Maryland and those they serve will be harmed by the loss of Medicaid coverage.

The population served by Health Care for the Homeless greatly benefitted from access to care through Medicaid expansion in 2014. Driven by Medicaid expansion, we doubled the size of our organization and the population served within a five-year period and have sustained modest growth ever since, even as we saw growth in the rate of uninsured clients and a reduction in Medicaid coverage. Now, major federal policy changes are threatening access to this essential coverage even further. About 130,000 people across the state are expected to lose their health coverage through Medicaid once provisions of H.R. 1 are implemented, not because they are no longer eligible, but because of new administrative barriers designed which will disproportionately harm populations experiencing homelessness and the providers that serve them.

As people inevitably lose their health insurance, they will seek primary care at FQHCs or rely on hospitals. As the HSCRC rightly observes, providing funding to FQHCs will reduce the unnecessary use of emergency rooms and additional costs of hospital services. As such, dedicated health system investment in FQHC uncompensated care is essential to controlling overall health spending, particularly in hospitals, and ensure that uninsured individuals receive care in the most appropriate setting.

Thank you for your consideration. And we welcome the opportunity for further dialogue to address the health challenges facing vulnerable Marylanders.

Sincerely,



Kevin Lindamood, President and CEO
Health Care for the Homeless
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MedStar Health

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P 410-772-6500
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Susan K. Nelson
Executive Vice President and
Chief Financial Officer

June 24, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm,

On behalf of MedStar Health and our seven Maryland hospitals, we appreciate the opportunity to comment on the proposed increase for Uncompensated Care (UCC) Funding included as part of the final RY2027 Annual Payment Update. MedStar Health appreciates the recognition that changes to federal payment policy, namely Medicaid enrollment eligibility and subsidies on the affordable care act insurance exchanges are increasing uncompensated care for hospitals in Maryland. Our request is for the HSCRC to make a prospective adjustment to fund these increases under the global budget revenue model. This approach follows the precedent set when the ACA was enacted at which time the HSCRC prospectively adjusted uncompensated care in anticipation of the reduction in uninsured patients. **Therefore, MedStar Health supports the Maryland Hospital Association's request for additional funding in FY27 to be provided directly to Hospitals.**

MedStar Health's seven Maryland hospitals are already experiencing an increase in UCC in FY26 that is expected to worsen in FY27. For the 11 months ended May 2026, MedStar Health's UCC was 5.5% of gross charges. This compares unfavorably to the same 11 month period in FY25, where UCC was only 4.7% of gross charges. Further, MedStar Health's average UCC for the 5 months ended May 2026 is 15% higher than the average for the 6 months ended December 2025. Overall, the year-over-year increase of 0.8% represents an additional **$23 million** in UCC that is currently unfunded and under current policy, will remain unfunded until FY28 without commission action. While MedStar Health agrees with the concept of trying to maintain insurance coverage for Marylanders, unfortunately, the Staff's recommendation is an unproven approach and its effectiveness is therefore unknown. At best, due to the time required to implement such a program, any interventions in this area will not result in additional coverage for residents in the next year. Maryland's hospitals are already feeling the financial burden of increases in UCC, and FY26 is just the beginning as further coverage reductions are expected over the next year. We cannot afford to wait. Maryland's hospitals need financial support now. Adequately funding UCC is a critical component of global budgets for hospitals in

Maryland, and therefore, MedStar Health strongly urges the HSCRC to consider the MHA proposal.

MedStar Health appreciates the Commission's consideration of this suggestion and welcomes continued engagement with staff as the policy is finalized.

Sincerely,

Susan K. Nelson
Executive Vice President and Chief Financial Officer
MedStar Health

cc:
Joshua Sharfstein, MD
James Elliott, MD
Jonathon Blum, MPP
Ricardo R. Johnson
David N. Maine, MD
Nicki McCann, JD
Farzaneh Sabi, MD

maryland
health services
cost review commission

TO:	HSCRC Commissioners
FROM:	HSCRC Staff
DATE:	July 22, 2026
RE:	Hearing and Meeting Schedule

August 2026 **NO MEETING**

September 9, 2026

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.