



Summary of Selected Provisions of the Medicare Physician Fee Schedule Final Rule for Calendar Year 2012

On November 1, 2011, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (PFS) final rule for calendar year (CY) 2012 (“Final Rule”).¹ The Final Rule will be published in the Federal Register on November 28, 2011, and CMS will accept comments on it until January 3, 2012.

Highlights of the Final Rule:

The Final Rule will:

- Project a conversion factor of \$24.6712, reducing physician payment rates in 2012 by 27.4 percent.
- Implement the third year of a four-year transition to practice expense (PE) relative value units (RVUs) calculated using Physician Practice Information Survey (PPIS) survey data.
- Identify and revise potentially misvalued services under the PFS.
- Implement a new process for identifying misvalued codes.
- Expand the imaging multiple procedure payment reduction (MPPR) policy to the professional component of advanced imaging services.
- Implement provisions affecting the Physician Quality Reporting System (PQRS), Electronic Prescribing (eRx) Incentive Program, and Electronic Health Records (EHR) Incentive Program.
- Begin implementation of a value-based payment modifier.

The cumulative effect on total Medicare payments to physicians involved in cancer care when all of the changes except the cut to the conversion factor take effect are:

Specialty	Allowed Charges (millions)	Combined Impact (Transition)	Combined Impact (Full)
Hematology/Oncology	\$1,922	0%	-1%
Radiation Oncology	\$1,981	-6%	-10%
Radiology	\$4,716	-3%	-5%

Beginning with this rule, the addenda containing payment rates and other information no longer will be printed in the Federal Register. The addenda are available only on the CMS web site at: <http://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1249142>.

Conversion Factor

The Final Rule projects a 27.4 percent reduction to physician payment rates in 2012 under the sustainable growth rate (SGR) formula. The current estimate of the CY 2012 conversion factor is \$24.6712.

¹ CMS, Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012, http://www.ofr.gov/OFRUpload/OFRData/2011-28597_PI.pdf, (hereinafter “Final Rule”).

Potentially Misvalued Codes

CMS identifies misvalued codes annually, in addition to the five-year review process. In the Proposed Rule,² CMS was particularly interested in comments regarding data sources and studies that may be used to validate estimates of physician time and intensity that could be factored into the work RVUs, especially for services with rapid growth in Medicare expenditures, one of the categories that the Affordable Care Act (ACA) specifically directs it to examine. The agency also solicited comments regarding the Medicare Payment Advisory Commission's (MedPAC) suggestion of "collecting data on a recurring basis from a cohort of practices and other facilities where physicians and nonphysician clinical practitioners work."³ Although CMS received a "modest number of comments" specifically addressing the technical and methodological aspects of developing a validation system, the agency believes it would be beneficial to provide an additional opportunity for stakeholders to submit comments. CMS plans to discuss the validation process in more detail in a future rule once it has considered the matter further in conjunction with the public comments received on the CY 2011 and 2012 rulemaking. CMS notes that any proposals it would make on the formal validation process would be subject to public comment and that it would consider those comments before finalizing the policies.

CMS is required by statute to review RVUs no less often than every five years. For CY 2012 and future years, CMS finalized its proposal to consolidate the formal Five-Year Review of Work and PE with the annual review of misvalued codes. Thus, CMS will review work and PE RVUs for potentially misvalued codes at least every five years through an annual process, rather than once every five years. CMS will review the work and PE RVUs for each code together, rather than through separate processes. In this review, it will look to make sure that the relativity to other services is correct in terms of several key relationships:

- Appropriate ranking of work and PE RVUs within a family of codes;
- Work and PE RVUs are appropriately relative based on comparisons of physician time and/or intensity and/or direct inputs to services furnished by physicians in the same specialty; and
- Work and PE RVUs are appropriately relative across specialties.

CMS also finalized without modification its proposed process for public submission of codes for potential review, with supporting documentation, on an annual basis. Under this process, stakeholders may nominate potentially misvalued codes by submitting the code with supporting documentation during the 60-day public comment period following the release of the annual PFS final rule with comment period. CMS will evaluate the supporting documentation and decide whether the nominated code should be reviewed as potentially misvalued during the following year. The documentation would include:

- Documentation in the peer reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
 - Technique
 - Knowledge and technology
 - Patient population
 - Site-of-service
 - Length of hospital stay
 - Physician time

² 76 Fed. Reg. 42772 (July 19, 2011).

³ Id. at 42790.

- An anomalous relationship between the code being proposed for review and other codes. For example, a relationship is anomalous if code "A" describes a service that requires more work than codes "B," "C," and "D," but is nevertheless valued lower. The commenter would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.
- Evidence that technology has changed physician work, that is, diffusion of technology.
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.
- Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation;
- Prices for certain high cost supplies or other direct PE inputs that are used to determine PE RVUs are inaccurate and do not reflect current information.
- Analyses of physician time, work RVU, or direct PE inputs using other data sources (for example, Department of Veteran Affairs (VA) National Surgical Quality Improvement Program (NSQIP), the Society for Thoracic Surgeons (STS), and the Physician Quality Reporting Initiative (PQRI) databases).
- National surveys of physician time and intensity from professional and management societies and organizations, such as hospital associations.

CMS also would expect to receive a description and summary of the evidence required that shows how the service may have changed since the original valuation or may have been inappropriately valued due to an incorrect assumption.

In the following year's PFS proposed rule, CMS will publish a list of the codes received under the public nomination process, indicating whether the codes will be included in the annual review. In the event that CMS receives an overwhelming number of nominated codes that qualified as potentially misvalued in any given year, it will prioritize the codes for review and could decide to hold its review of some of the potentially misvalued codes for a future year. CMS also may identify additional potentially misvalued codes for review by the American Medical Association (AMA) RUC based on the seven statutory categories under section 1848(c)(2)(K)(ii) of the Social Security Act (SSA):

- Codes and families of codes for which there has been the fastest growth;
- Codes or families of codes that have experienced substantial changes in practice expenses;
- Codes that were recently established for new technologies or services;
- Multiple codes that are frequently billed in conjunction with furnishing a single service;
- Codes with low relative values, particularly those that are often billed multiple times for a single treatment;
- Codes which had not been subject to review since the implementation of the RBRVS ('Harvard valued'); and
- Codes potentially misvalued as determined by the Secretary.

The first opportunity to nominate codes for review was during the comment period on the Proposed Rule. CMS will publish the list of nominated codes and whether each code will be reviewed in the proposed rule for CY 2013.

As part of this process, CMS will ask the AMA RUC to review the codes identified by the public and by CMS and provide recommendations for appropriate physician times, work RVUs, and direct PE inputs. Notably, as articulated in the Proposed Rule, the AMA RUC would not be required to provide

CMS with these recommendations until July of each year.⁴ Therefore, the AMA RUC's recommendations would not be received by CMS until *after* that year's PFS proposed rule had been issued, meaning that stakeholders would not have the opportunity to review the AMA RUC's proposals until after the issuance of the final rule. In its comment letter, ACCC urged CMS to set an earlier deadline for the AMA RUC to make recommendations regarding these potentially misvalued codes so these recommendations may be included in each year's PFS proposed rule to allow for public comment. CMS did not accept this recommendation, however.

CMS will continue to review malpractice RVUs at five-year intervals because it is not possible to conduct the extensive physician surveys needed to collect the specialty level data on an annual basis.

CY 2012 Identification and Review of Potentially Misvalued Codes

In the Proposed Rule, CMS proposed to ask the AMA RUC to prioritize review of all evaluation and management (E/M) codes because CMS believes that the focus of primary care has evolved from an episodic treatment-based orientation to a focus on comprehensive patient-centered care management in order to meet the challenges of preventing and managing chronic disease. CMS did not finalize this proposal, however, in light of commenters' concern regarding "the possible inadequacies of the current E/M coding and documentation structure to address evolving chronic care management and support primary care and [the agency's] ongoing research on how to best provide payment for primary care and patient-centered management."⁵

On the other hand, CMS did finalize its proposal to ask the AMA RUC to review a select list of high PFS expenditure procedural codes that have not been reviewed since 2006 and have CY 2010 allowed charges greater than \$10 million at the specialty level. These codes include chemotherapy and non-chemotherapy infusions and several imaging services. CMS asks the AMA RUC to review half the list of high PFS expenditure codes by July 2012 so the revised valuations can be included in the CY 2013 final rule.

Review of Specific Codes

Abdomen and Pelvis Computed Tomography (CT): The AMA created a series of new Current Procedural Terminology (CPT®)⁶ codes for 2011 that describe combined CTs of the abdomen and pelvis. CMS accepted the AMA RUC-recommended direct PE inputs for the codes in the CY 2011 final rule, but stakeholders have told CMS that the PE RVUs for the new codes reflect an anomalous rank ordering compared to the stand-alone codes. The PE RVUs for the codes that describe CT scans without contrast for either body region are greater than the PE RVUs for CPT code 74176, describing a CT scan of both body regions. CMS thinks the anomaly may be due to outdated direct PE inputs for the stand-alone codes, and CMS finalized its proposal to request that the AMA RUC review the work and PE inputs for the stand-alone CPT codes, 72192-72194 and 74150, 74160, and 74170.

Ultrasound Equipment: A stakeholder raised concerns about potential inconsistencies with the inputs and prices related to ultrasound equipment in the PE database. There are 17 different pieces of ultrasound and ultrasound-related equipment in the database that are associated with 110 CPT codes, with price inputs for ranging from \$1,304.33 to \$466,492.00. CMS finalized its proposal to ask the AMA RUC to review the ultrasound equipment included in those codes as well as how the equipment is described and priced in the direct PE database.

⁴ Id. at 42793-94.

⁵ Final Rule at 121.

⁶ CPT is a registered trademark of the AMA.

Tissue Pathology: A stakeholder suggested that the AMA RUC relied upon an atypical clinical vignette in identifying the direct PE inputs for the service associated with CPT code 88305 (Level IV – Surgical pathology, gross and microscopic examination), causing the service to be overvalued. CMS asks the AMA RUC to review the work RVUs and direct PE inputs for this code.

Hospital Discharge Care Coordination

In the Proposed Rule, CMS sought comments on the hospital discharge care coordination services that are included in CPT codes 99238 (Hospital discharge day management; 30 minutes or less), 99239 (Hospital discharge day management; more than 30 minutes), 99203 (Level 3 new patient office or other outpatient visit), and 99213 (Level 3 established patient office or other outpatient visit) in order to ensure that these hospital discharge care coordination services are appropriately valued. Many commenters generally supported the use of care transition and transition measures, but cited the need for a robust risk-adjustment methodology together with these measures. On the other hand, several commenters opposed the use of the measures on the basis that the measures would require a level of coordination found only in highly integrated systems (e.g., accountable care organizations (ACOs)), because providers are not presently reimbursed for this type of care, or because data is often not available for the measures. As noted in the Proposed Rule, to the extent that CMS develops care coordination/transition measures, the agency will propose them in future rulemaking for inclusion in the value modifier.

Expanding the Multiple Procedure Payment Reduction (MPPR) Policy

CMS finalized its proposal to expand the MPPR to the professional component (PC) of advanced imaging services (CT, MRI, and ultrasound) (see Addendum F for list of the 119 codes affected). Note, however, that this MPPR will result in a 25 percent reduction in payment, rather than a 50 percent reduction, as had been proposed. The MPPR currently applies to the technical component (TC) of these codes. As finalized by CMS, the 25 percent payment reduction will apply to the second and subsequent advanced imaging service furnished in the same session by the same physician *or by multiple physicians in the same group practice*, without regard to whether the services are of the same modality or are furnished for contiguous body parts. The MPPR will be implemented in CY 2012 without a phase-in period, although CMS has committed to “monitor code combinations for possible future adjustments to the reduction percentage applied through this MPPR policy.”⁷

Although CMS’s initial proposal was developed with reference to the agency’s longstanding policy of applying a 50 percent MPPR to surgical services and the AMA’s recent valuation of new CPT codes for combined CT of the pelvis and abdomen, CMS performed an additional analysis for purposes of the Final Rule. Based on this analysis, CMS reportedly found that the typical multiple imaging case involves contiguous areas, and only a very small percentage involve more than one modality. The analysis also reportedly found significant duplication in pre- and post-service work and moderate efficiencies in intra-service work. CMS relied on data from this analysis to conclude that “a 25 percent reduction would more appropriately capture the range of physician work efficiencies for second and subsequent imaging services furnished by the same physician (including physicians in the same group practice) to the same patient in the same session on the same day.”⁸

The savings from the expansion of the MPPR to the professional component of these imaging services will be redistributed to other services under the PFS. CMS estimates that this change

⁷ Final Rule at 168.

⁸ Final Rule at 157.

would redistribute approximately \$50 million through a small increase in the conversion factor and a small adjustment to all PE RVUs.

CMS also solicits comments on further expansions of the MPPR that the agency is considering for CY 2013 and beyond. As in the Proposed Rule, CMS says it is “aggressively looking for efficiencies in other sets of codes.”⁹ Potential expansions of the MPPR include:

- Applying the MPPR to the TC of all imaging services, consistent with the statutory definition of imaging for purposes of the cap on payment at the Hospital Outpatient Prospective Payment System (OPPS) rate (x-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography);
- Applying the MPPR to the PC of all imaging services; and
- Applying the MPPR to the TC of all diagnostic tests.

The savings under these expansions of the MPPR would be redistributed to other services under the PFS. CMS received several comments regarding this proposed expansion of the MPPR, and the agency will take these into account as it develops further proposals. According to CMS, any such proposals would be presented in future rulemaking and subject to further public comment.

Substitution Threshold for Average Sales Price (ASP)

By statute, CMS is permitted to disregard the ASP for a drug or biological if the Office of Inspector General (OIG) finds that the ASP exceeds the widely available market price (WAMP) or average manufacturer price (AMP) by a certain percentage. If the threshold is exceeded, the payment for the drug or biological shall be the lesser of the WAMP or 103 percent of AMP. CMS has set this threshold for WAMP at five percent since 2006 but has not made any substitutions. CMS finalized its proposal to continue to use a five percent threshold for WAMP. For AMP, CMS finalized its proposal to apply price substitution of AMP for ASP will be made only when the ASP exceeds the AMP by five percent in two consecutive quarters immediately prior to the current pricing quarter, or three of the previous four quarters immediately prior to the current quarter. CMS also will apply the applicable AMP threshold percentage only for those situations where AMP and ASP comparisons are based on the same set of National Drug Codes (NDC) for a billing code (that is, “complete” AMP data).

Physician Quality Reporting System (PQRS)

For 2012, CMS proposed to retain all measures currently used in the 2011 PQRS. CMS finalized this proposal, with the exception that the agency will retire four measures that were retired by the measure owners and are therefore no longer available for quality reporting purposes.¹⁰ CMS also finalized its proposal to add 26 new individual measures for inclusion in the 2012 PQRS. These measures include:

- Cardiac rehabilitation referral from outpatient setting
- Two alcohol dependence measures
- Immunohistochemical (IHC) Evaluation of HER2 for Breast Cancer Patients
- Preoperative Diagnosis of Breast Cancer
- Sentinel Lymph Node Biopsy for Invasive Breast Cancer

⁹ 76 Fed. Reg. at 42812; Final Rule at 169.

¹⁰ These measures include: #135: Chronic Kidney Disease (CKD): Influenza Immunization; #79: End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD; #175: Pediatric Stage Renal Disease (ESRD): Influenza Immunization; and #199: Heart Failure: Patient Education.

- Biopsy Follow-up

For 2012, CMS finalized its proposal to again accept PQRS data from EHRs for a limited subset of 2012 PQRS quality measures.

CMS also finalized its proposal to retain the following 14 2011 PQRS measures groups for the 2012 Physician Quality Reporting System:

- (1) Diabetes Mellitus;
- (2) CKD;
- (3) Preventive Care;
- (4) CABG;
- (5) Rheumatoid Arthritis;
- (6) Perioperative Care;
- (7) Back Pain;
- (8) CAD;
- (9) Heart Failure;
- (10) IVD;
- (11) Hepatitis C;
- (12) HIV/AIDS;
- (13) CAP; and
- (14) Asthma.

For 2012, CMS finalized its proposal that the CABG, CAD, Heart Failure, and HIV/AIDS measures groups would continue to be reportable through the registry-based reporting mechanism only, while the remaining Diabetes Mellitus, CKD, Preventive Care, Rheumatoid Arthritis, Perioperative Care, Back Pain, IVD, Hepatitis C, CAP, and Asthma measures groups would continue to be reportable through either claims-based reporting or registry-based reporting for the 2012 PQRS. CMS also finalized eight of the ten proposed new measures groups for 2012 in order to provide eligible professionals with more measures groups on which to report:

1. Chronic Obstructive Pulmonary Disease (COPD);
2. Inflammatory Bowel Disease;
3. Sleep Apnea;
4. Dementia;
5. Parkinson's;
6. Elevated Blood Pressure;
7. Cardiovascular Prevention, which contains individual measures from the proposed PQRS core measure set previously discussed; and
8. Cataracts.

CMS did not, however, finalize the proposed groups for Epilepsy or Radiology. The Radiology group was not finalized because the measure owner withdrew the measure group from consideration as a 2012 PQRS measures group.

Generally speaking, the measures included in any proposed 2012 measures group are reportable either as individual measures or as part of a measures group. However, measures in the Back Pain measures group and the newly finalized measures groups continue to be reportable only as part of a measures group in 2012, with the exception of measures identified as individual measures elsewhere in the Final Rule. Each eligible professional electing to report a group of measures for 2012 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by the applicable reporting criteria.

Group Practice Reporting Option (GPRO)

For 2012, CMS proposed to require group practices selected to participate in the 2012 PQRS GPRO to report on 40 proposed measures. Specifically, CMS proposed to retain most of the measures available for reporting under the 2011 PQRS GPRO, retire three measures, and add 17 new measures. In the Final Rule, however, CMS finalized only 29 of the 40 measures. CMS eliminated the other measures because they had been excluded from the Medicare Shared Savings Program (MSSP) in an effort to align the MSSP and PQRS GPRO. The 29 selected measures appear in Table 71 of the Final Rule.

Physician Compare Website

The ACA requires CMS to implement a plan no later than January 1, 2013 for making information on physician performance publicly available. CMS finalized its proposal to share performance information based on 2012 data on the Physician Compare Website. Under this plan, CMS will initially share performance rates for group practices that submitted data under the PQRS GPRO reporting option for the 2012 reporting period. CMS will also report performance rates for ACOs participating in the MSSP on the Physician Compare Web Site in the same way as for group practices that report under the PQRS GPRO.

Medicare EHR Incentive Program

CMS finalized its proposal without modification that eligible professionals (EPs) will be required to electronically submit clinical quality measure (CQM) results using the following methods in order to demonstrate meaningful use of EHRs:

- Continue with attestation for reporting CQMs.
- Participate in a PQRS-Medicare EHR Incentive Pilot, established by the 2012 Proposed Rule that relies on the infrastructure of the PQRS. EPs could report CQMs through either of two methods:
 - o By using a PQRS qualified EHR data submission vendor to submit calculated results from the EP's certified EHR to CMS on the EP's behalf; or
 - o By submitting CQM data directly from his or her certified EHR to CMS via a secure portal. The EHR also must be a qualified PQRS EHR product.

eRx Incentive Program

As proposed, the Final Rule modifies the electronic prescribing measure to allow eligible professionals to use either a qualified electronic prescribing system (based on original criteria in measure) or certified EHR technology. For the 2013 and 2014 payment adjustments, CMS eliminated the requirement that the measure only be reported during specified instances. CMS will also provide significant hardship exemption categories for professionals who:

- Practice in a rural area with limited high speed internet access;
- Practice in an area with limited available pharmacies for electronic prescribing;
- Are unable to electronically prescribe due to local, state, or federal law; or
- Prescribe fewer than 100 prescriptions during a six-month, payment adjustment reporting period.

Value-Based Payment Modifier

Under the ACA, CMS is required to implement a value-based payment modifier that would adjust payment based on quality of care compared to cost, not later than January 1, 2015. The Act requires CMS to publish this year (a) the quality of care and cost measures established by the

Secretary for purposes of the modifier; (b) the dates for implementation of the value modifier; and (c) the initial performance period for application of value modifier in 2015.

CMS finalized its proposal to measure performance on: (1) the measures in the core set of the PQRS for 2012; (2) all measures in the GPRO of the PQRS for 2012; and (3) the core measures, alternate core, and 38 additional measures in the EHR Incentive Program measures for 2012. The one exception is that CMS will not include PQRS measure #200 (Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation) for the initial performance period because its specifications have not been updated. These measures are listed in Table 80 of the Final Rule.

CMS also finalized its proposal to use total per capita cost measures and per capita cost measures for beneficiaries with these four chronic conditions (chronic obstructive pulmonary disease; heart failure; coronary artery disease; and diabetes) in the value modifier. Prostate cancer was included in an earlier reporting phase but is not specifically listed for this phase in the Proposed Rule. CMS will test an “episode grouper” in the future.

CMS indicates that it may start by applying value modifier to certain physicians in 2015 and 2016, before expanding to all physicians in 2017. The initial performance period will be CY 2013.

Comparison of 2011 and Proposed 2012 Physician Fee Schedule Payment Rates for Drug Administration Services

		2011		2012		Difference 2012 vs. 2011	
CPT HCPCS	Description	Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
96360	Hydration iv infusion, init	\$57.08	NA	\$57.08	NA	0.00%	NA
96361	Hydrate iv infusion, add-on	\$15.29	NA	\$15.29	NA	0.00%	NA
96365	Ther/proph/diag iv inf, init	\$71.01	NA	\$72.37	NA	1.92%	NA
96366	Ther/proph/dg iv inf, add-on	\$21.74	NA	\$21.41	NA	-1.52%	NA
96367	Tx/proph/dg addl seq iv inf	\$32.96	NA	\$32.28	NA	-2.06%	NA
96368	Ther/diag concurrent inf	\$19.37	NA	\$19.03	NA	-1.76%	NA
96369	Sc ther infusion, up to 1 hr	\$170.90	NA	\$186.87	NA	9.34%	NA
96370	Sc ther infusion, addl hr	\$15.29	NA	\$15.63	NA	2.22%	NA
96371	Sc ther infusion, reset pump	\$80.18	NA	\$85.96	NA	7.21%	NA
96372	Ther/proph/diag inj, sc/im	\$23.10	NA	\$24.12	NA	4.42%	NA
96373	Ther/proph/diag inj, ia	\$19.03	NA	\$19.71	NA	3.57%	NA
96374	Ther/proph/diag inj, iv push	\$55.72	NA	\$55.72	NA	0.00%	NA
96375	Ther/proph/diag inj add-on	\$22.76	NA	\$22.42	NA	-1.49%	NA
96401	Chemo, anti-neopl, sq/im	\$72.71	NA	\$73.05	NA	0.47%	NA
96402	Chemo hormon antineopl sq/im	\$35.00	NA	\$33.64	NA	-3.89%	NA
96405	Chemo intralesional, up to 7	\$85.96	\$30.24	\$84.60	\$30.24	-1.58%	0.00%
96406	Chemo intralesional over 7	\$118.24	\$43.83	\$120.62	\$44.17	2.01%	0.78%
96409	Chemo, iv push, sngl drug	\$112.80	NA	\$110.76	NA	-1.81%	NA
96411	Chemo, iv push, addl drug	\$63.20	NA	\$62.18	NA	-1.61%	NA
96413	Chemo, iv infusion, 1 hr	\$146.44	NA	\$138.28	NA	-5.57%	NA
96415	Chemo, iv infusion, addl hr	\$31.26	NA	\$30.58	NA	-2.18%	NA
96416	Chemo prolong infuse w/pump	\$161.39	NA	\$137.94	NA	-14.53%	NA
96417	Chemo iv infus each addl seq	\$72.37	NA	\$71.01	NA	-1.88%	NA

96420	Chemo, ia, push technique	\$109.06	NA	\$107.03	NA	-1.86%	NA
96422	Chemo ia infusion up to 1 hr	\$175.32	NA	\$171.92	NA	-1.94%	NA
96423	Chemo ia infuse each addl hr	\$79.84	NA	\$78.83	NA	-1.27%	NA
96425	Chemotherapy,infusion method	\$179.74	NA	\$180.07	NA	0.18%	NA
96440	Chemotherapy, intracavitary	\$728.79	\$148.14	\$825.97	\$141.00	13.33%	-4.82%
96446	Chemotx admn prtl cavity	\$177.02	\$21.41	\$191.97	\$21.07	8.45%	-1.59%
96450	Chemotherapy, into CNS	\$198.76	\$85.62	\$186.87	\$81.54	-5.98%	-4.76%
96521	Refill/maint, portable pump	\$133.19	NA	\$136.59	NA	2.55%	NA
96522	Refill/maint pump/resvr syst	\$111.10	NA	\$110.76	NA	-0.31%	NA
96523	Irrig drug delivery device	\$25.48	NA	\$25.14	NA	-1.33%	NA
96542	Chemotherapy injection	\$127.07	\$43.83	\$122.65	\$41.79	-3.48%	-4.65%