THE ISSUES

Congress Keeps 2008 Radioimmunotherapy Reimbursement Payment at 2007 Levels

New Medicare legislation passed by the House and Senate in December extends the 2007 reimbursement methodology for radiopharmaceuticals to June 2008. CMS had called for new hospital outpatient reimbursement rates for 2008 for radiopharmaceuticals such as Zevalin (ibritumomab tiuxetan) and Bexxar (tositumomab, iodine I-131) below their acquisition costs. The new Medicare legislation will maintain the current methodology for reimbursement of therapeutic radiopharmaceuticals for the first six months of 2008, giving the drugs' manufacturers and CMS time to seek a permanent reimbursement procedure that more accurately reflects hospital costs associated with the therapy.

ACCC joined other advocacy groups, including the Lymphoma Research Foundation and the Leukemia and Lymphoma Society, in calling on Congress to roll back these payment changes to radiopharmaceuticals. ACCC had urged its members to contact the Senate Finance Committee and other members of Congress to urge them to include a one-year freeze on Medicare payments for radioimmunotherapies that were changed in the final 2008 HOPPS Rule.

President Bush Cancels 10 Percent Medicare Physician Cut, Approves SCHIP Legislation

By a 411-3 vote, the House Dec. 19 approved legislation (S. 2499) providing a six-month Medicare pay increase for physicians and extending funding for the State Children's Health Insurance Program (SCHIP) through March 2009. The Senate approved the measure by unanimous consent Dec. 18. President Bush signed the legislation on Dec. 29.

The legislation provides physicians a 0.5 percent payment increase through June 30, 2008, cancelling a 10.1 percent cut scheduled to take effect Jan. 1, 2008. Congress will have to address the issue again in mid-2008 to avoid yet another payment cut for physicians from taking effect July 1, 2008.

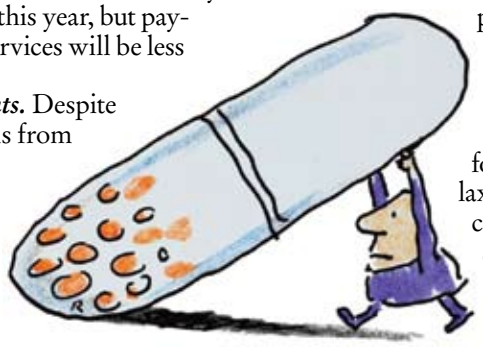
On Nov. 1, 2007, the Centers for Medicare & Medicaid Services (CMS) released the 2008 Physician Fee Schedule (PFS) final rule, which became effective Jan. 1, 2008. The conversion factor was set at $34.0682, a 10.1 percent reduction from the 2007 level of $37.8975. Congress has now reversed this reimbursement cut through legislation, as it has done in the past. For more on the 2008 PFS turn to page 9.

ACCC Analyzes 2008 HOPPS Rule

Below is a brief summary on how the 2008 final Hospital Outpatient Prospective Payment System (HOPPS) rule will impact ACCC members. Overall, estimated total payments to hospitals will increase by about 10 percent this year, but payment for many services will be less than in 2007.

Drug Payments. Despite recommendations from the Ambulatory Payment Classification (APC) Panel, ACCC, and other key stakeholders, CMS lowered payment for separately paid drugs without pass-through status to ASP+5 percent. Further, the agency states that it believes that adequate payment for drugs is ASP+3 percent; however, in 2008, CMS will provide a "transition" year with payment at ASP+5 percent. Drugs with pass-through status will continue to be reimbursed at ASP+6 percent. For all drugs and biologicals with average per day costs less than $60, CMS will package payment for the drug in with its administration payment. CMS will continue to make separate payment for anti-emetics, however.

Administration Payments. Payment for most drug administration services increased slightly (from 3.6 percent to 8.2 percent) from 2007 levels. CPT code 90768 (intravenous infusion, for therapy, prophylaxis, or diagnosis, concurrent infusion) will remain a packaged service—despite the APC Panel's recommendation to pay for this service separately.



Pharmacy Costs and Overhead. CMS did not accept the three-phase plan for reporting pharmacy overhead costs that was put forward by ACCC, the APC Panel, and other key stakeholders. The agency states that ASP+5 percent is sufficient reimbursement for *both* acquisition and service costs. CMS did not finalize its proposal to require hospitals to remove pharmacy overhead costs from drug acquisition costs and report overhead costs on an uncoded revenue code line.

Quality Measures. Similar to this year, hospitals must report on 7 quality measures in order to receive the full market basket increase of 3.3 percent in 2008. Hospitals that do not report quality data will have their annual update reduced by 2 percentage points. None of these quality measures are oncology-related.

Increased Packaging or "Bundling." As proposed, CMS

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increased the number of services to be packaged in 2008.

For more detailed coding and regulatory information, turn to the Coding Column, pages 10–14.

ACCC Analyzes 2008 Physician Fee Schedule

Below is a brief summary on how the 2008 PFS will impact ACCC members.

Drug Compendia. CMS did not revise the list of compendia used to determine covered off-label uses of anti-cancer drugs, but does create a new process for considering requests for changes to the list. The final process has a shorter time frame than the proposed process. Instead of publishing an annual notice for formal requests, CMS will receive requests annually during a 30-day window beginning on January 15. CMS will post on its website a request for comments on the requests by March 15. Comments will be accepted for 30 days, and the agency will announce its decision no later than 90 days after the close of the comment period.

IVIG. CMS will continue to make payment for pre-administration services for IVIG furnished in physicians' offices in 2008 at rates based on the practice expense RVUs established in 2007.

ESAs. CMS will issue a transmittal to provide implementing instructions for the new requirement to report hemoglobin or hematocrit levels for cancer patients receiving anti-anemia drugs.

PQRI. The oncology-related Physician Quality Reporting Initiative measures for 2008 include:

- Review of treatment options in patients with clinically localized prostate cancer.
- Adjuvant hormonal therapy for high-risk prostate cancer patients.
- 3D radiotherapy for patients with prostate cancer.
- Breast cancer patients who have a pT and pN category and histologic grade for their cancer.
- Colorectal cancer patients who have a pT and pN category and histologic grade for their cancer.
- Appropriate initial evaluation of patients with prostate cancer.
- Inappropriate use of bone scan for staging low-risk prostate cancer patients.
- MDS and acute leukemias: baseline cytogenetic testing performed on bone marrow.
- MDS: documentation of iron stores in patients receiving erythropoietin therapy.
- Multiple myeloma: treatment with bisphosphonates.
- CLL: baseline flow cytometry.
- Hormonal therapy for stage IC-III ER/PR positive breast cancer.
- Chemotherapy for Stage III colon cancer patients.
- Plan for chemotherapy documented before chemotherapy administered.
- Radiation therapy recommended for invasive breast cancer patients who have undergone breast conserving surgery.

Detailed specifications for all of the measures are available at: *www.cms.hhs.gov/pqri.*

Oncology Update 2008

by Cindy C. Parman, CPC, CPC-H, RCC

It's that time of year again when procedure codes and Medicare payment policies change, requiring updates to Charge Description Masters, superbills, software, and other charge capture tools. And, while some information remains the same, this year brings important changes for both hospital-based cancer programs and oncology practices.

New Codes, New Descriptors!

Table 1 is a list of the new CPT procedure codes and Table 2 is a list of the new HCPCS Level II codes that are of interest to oncology physicians and cancer programs for calendar year (CY) 2008. In addition to the new HCPCS Level II codes added, three codes for stem cell transplant procedures were deleted: G0265, G0266, and G0267. Hospitals will now report existing CPT codes for these services (38204-38215). Keep in mind, however, that the existence of a code does not guarantee reimbursement. Payment for a service depends on the patient's insurance policy, medical necessity, and other determining factors.

For 2008, the following radiation oncology code descriptors have eliminated the word "cerebral" and replaced it with the word "cranial."

- **77371:** Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based.
- **77372:** Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based.
- **77432:** Stereotactic radiation treatment management of cranial lesion(s) complete course of treatment consisting of one session.

Also for 2008 the following hydration administration code descriptor has been altered significantly: **90760,** intravenous infusion, hydration; initial, 31 minutes to 1 hour.

Regulatory Update for Hospitals

Here is a brief overview of the regulatory changes that will affect hospital-based cancer programs in 2008.

Packaging. For 2008 the Centers for Medicare & Medicaid Services (CMS) is implementing a number of important changes to its packaging policies under its hospital outpatient prospective payment system (OPPS). "Packaging" refers to the practice of making a single payment that includes payment for a significant procedure as well as the "minor, ancillary services" associated with the procedure. Although many of these "minor, ancillary services" will no longer be separately payable in 2008, hospitals should still report the codes for these services on their claim form unless contraindicated by CPT® coding guidelines or Correct Coding Initiative edits. This practice will allow CMS to continue collecting accurate data about the hospital's true costs.

In 2008 CMS will be packaging the following items and services:

- Image guidance services (Table 3)
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Diagnostic radiopharmaceuticals
- Contrast media
- Observation services.

Some of these items and services will be *unconditionally* packaged and never separately reimbursed (status indicator "N"). Other services are *conditionally* packaged, meaning that separate payment may be made depending on what other services are provided on the same date (status indicator "Q").

Clinic Visits. For 2008 hospitals are still required to distinguish between new patient and established patient clinic visits. New patient visits are reported with codes 99201-99205, while established patient visits are reported with codes 99211-99215. While CMS had considered eliminating the distinction between new and established patients, claims data showed consistently higher costs for services billed with the new patient codes, so the agency felt that it would not be appropriate to set a single payment level for both. The definitions of new and established patients have not changed for 2008. Specifically, an established patient is one for whom the hospital has created a medical record within the past three years. The agency is requesting comments as to whether this definition should be revised. For 2008 the consultation codes (99241-99245) will no longer be recognized for payment under the OPPS.

The APC assignments are unchanged from 2007, although the payment levels have been adjusted (see Table 4). Hospitals will continue to use their own internal guidelines for defining visit levels. CMS indicated that "creating national guidelines has proven more difficult than initially anticipated." Furthermore, analysis of claims data shows a relatively normal and stable distribution of visit levels over time, which the agency calls "a reassuring finding." CMS indicated that it will continue to work on national guidelines and encourages public comments, but it does not anticipate publication of such guidelines until 2009 at the earliest. The Final Rule lists 11 principles with which hospitals' internal guidelines must comply (see Table 5). CMS clarified that a hospital is not required to use the same visit guidelines for each of its specialty clinics. However, a Level 3 visit in one specialty clinic must be equivalent in the degree of resource utilization to a

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Table 1. New CPT Procedure Codes for 2008

90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s).
+90770	Each additional hour. (List separately in addition to code for primary procedure.)
+90771	Additional pump set-up with establishment of new subcutaneous infusion site(s). (List separately in addition to code for primary procedure.)
+90776	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility. (List separately in addition to code for primary procedure.)
99366	Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family, 30 minutes or more; participation by non-physician qualified healthcare professional.
99367	Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more; participation by a physician.
99368	Participation by non-physician qualified healthcare professional.
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention. (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening greater than 30 minutes.
99441, 99442, 99443	Telephone evaluation and management service provided by a physician 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. For 5-10 minutes of medical discussion use code 99441. For 11-20 minutes of medical discussion use code 99442. For 21-30 minutes of medical discussion use code 99443.
99444	Online evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days, using the Internet or similar electronic communications network.
98966, 98967, 98968	Telephone assessment and management service provided by a qualified non-physician healthcare 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. For 5-10 minutes of medical discussion use 98966. For 11-20 minutes of medical discussion use 98967. For 21-30 minutes of medical discussion use 98968.
98969	Online assessment and management service provided by a qualified non-physician healthcare professional to an established patient, guardian, or healthcare provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network.
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient.
99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient.
+99607	Each additional 15 minutes. (List separately in addition to code for primary service).
0182T	High-dose rate electronic brachytherapy, per fraction.
20555	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure).
36591	Collection of blood specimen from a completely implantable venous access device. Replaces code 36540.
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified.
36593	Declotting by thrombolytic agent of implanted vascular access device or catheter. Replaces code 36550.
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application.
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application.

Level 3 visit in another clinic.

Brachytherapy Services and Sources. CMS has established a "composite APC" for low-dose-rate (LDR) prostate brachytherapy. Composite APCs reflect an evolution in Medicare's approach to payment under the OPPS. Because claims for LDR prostate brachytherapy report at least two major separately payable procedure codes most of the time (CPT codes 77778 and 55875), CMS has established an encounter-based composite APC that provides a single payment when both codes are reported with the same date of service. Note: these services will be paid separately in cases where only one of the two procedures is provided in a hospital encounter. Beginning Jan. 1, 2008, composite APC 8001, LDR Prostate Brachytherapy Composite, will provide one bundled payment for LDR prostate brachytherapy when the hospital bills both CPT codes 55875 and 77778 as component services provided during the same hospital encounter. All services and supplies associated with prostate seed brachytherapy should continue to be captured and charged to ensure that the total cost of the procedure is accurately reported.

The AMA's CPT Editorial Panel created a new Category III code, 0182T [High-dose rate (HDR) electronic brachytherapy, per fraction], as of July 1, 2007. CMS has assigned this procedure to a New Technology APC 1519 [New Technology—Level IXX ($1,700-$1,800)], with a payment rate of $1,750, as of July 1, 2007. In addition, CMS has reassigned CPT code 19298 [Placement of radiotherapy afterloading brachytherapy catheters, multiple tube and button type, into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance] from New Technology APC 1524 [(New Technology - Level XXIV ($3,000-$3,500)] to APC 0648

Table 2. New HCPCS Level II Codes for 2008

A4648 Tissue marker, implantable, each.
A4650 Implantable radiation dosimeter, each.
C9728 Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple.
G0396 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes.
G0397 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes.
J1561 Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g., liquid), 500 mg.
J1568 Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg.
J1569 Injection, immune globulin, (Gammagard Liquid), intravenous, non-lyophilized (e.g., liquid), 500 mg.
J1571 Injection, hepatits B immune globulin, (HepaGam B), intramuscular, 0.5 ml.
J1572 Injection, immune globulin, (Flebogamma) intravenous, non-lyophilized (e.g., liquid), 500 mg.
J1573 Injection, hepatits B immune globulin, (HepaGam B), intravenous, 0.5 ml.
J2791 Injection, RHO(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 iu.

Table 3. Image Guidance Services Packaged in 2008*

Code	Short Descriptor	SI	APC
76000	Fluoroscope examination	Q	0272
76001	Fluoroscope exam, extensive	N	n/a
76950	Echo guidance, radiotherapy	N	n/a
76965	Echo guidance, radiotherapy	N	n/a
77014	CT scan for therapy guide	N	n/a
77417	Radiology port film(s)	N	n/a
77421	Stereoscopic X-ray guidance	N	n/a

*All but one of these codes will be unconditionally packaged—that is, separate payment will never be made for the imaging guidance. Instead, payment for the guidance will be included in the procedure with which the guidance is associated. For example, payment for an IMRT treatment delivery service (77418) will include payment for the stereoscopic imaging localization (77421). Note that code 77421 should still be reported on the claim even though it is not separately paid. Code 76000 (fluoroscopy) is conditionally packaged. Separate payment will not be made for 76000 when it is reported on the same day as a procedure that is status S, T, V, or X.

Table 4. 2008 Clinic Visit APC Assignments

APC	CPT® Codes	2007 Average Payment	2008 Average Payment
0604	99201, 99211	$51	$53
0605	99202, 99212, 99213	$60	$63
0606	99203, 99214	$84	$84
0607	99204, 99215	$105	$106
0608	99205	$134	$138

Table 5. Principles to Follow When Developing Internal Guidelines to Define Visit Levels

1. The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.

2. The coding guidelines should be based on hospital facility resources. The guidelines should *not* be based on physician resources.

3. The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.

4. The coding guidelines should meet HIPAA requirements.

5. The coding guidelines should only require documentation that is clinically necessary for patient care.

6. The coding guidelines should not facilitate upcoding or gaming.

7. The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.

8. The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.

9. The coding guidelines should not change with great frequency. (CMS indicated that annual revisions would be appropriate, but that guidelines should not be revised more often than "every few months.")

10. The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review. (CMS indicated it would encourage Medicare contractors to review the hospital's guidelines when an audit occurs.)

11. The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

(Level IV Breast Surgery), with a proposed median cost of approximately $3,560.

Effective Jan. 1, 2008, CMS will reimburse brachytherapy sources prospectively based on median costs from CY 2006 claims data. For stranded sources the median cost is set at the 60th percentile of the aggregate claims data for the predecessor code for this source; for non-stranded sources the median cost is set at the 40th percentile of the aggregate claims data for the predecessor code for this source. The final brachytherapy source HCPCS codes, APC assignments, status indicators, and median costs are provided in the Table 6.

Drug Administration Services. CMS will recognize all active calendar year 2008 CPT procedure codes for drug administration services under the OPPS. In addition, status indicator "N" will continue to be assigned to CPT code 90768 (concurrent therapeutic, diagnostic, or prophylactic infusion).

CMS created the temporary HCPCS code G0332 [Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin)] in CY 2006. For CY 2008, this HCPCS code will be assigned to APC 0430, with a median cost of approximately $37. In addition, CMS will consider packaging payment for HCPCS code G0332 in future years if it is determined that separate payment is no longer warranted.

Regulatory Update for Oncology Practices

Here is a brief overview of the regulatory changes that will affect oncology practices and freestanding cancer centers in 2008.

Imaging. Imaging services performed in physician offices and freestanding imaging centers are paid under the Medicare Physician Fee Schedule, not OPPS. However, under the Deficit Reduction Act (DRA), payments to physicians and imaging centers for the technical component of imaging services is limited to no more than the OPPS payment amount. CMS clarified in the OPPS Final Rule that when an imaging service is packaged under OPPS, the DRA technical component payment cap does not apply. As a result, these imaging services will be paid on the basis of the Physician Fee Schedule alone, which may result in payment increases.

Quality Reporting. CMS will continue the Physician Quality Reporting Initiative (PQRI) for CY 2008. Eligible providers who meet the reporting requirements will be eligible for bonus payments, which CMS anticipates will be approximately 1.5 percent of allowed charges. Complete PQRI information will be available on the CMS website at: *http://www.cms.hhs.gov/pqri* .

IVIG Payments. HCPCS Level II code G0332 (pre-administration services for IVIG therapy) will be separately paid under the Physician Fee Schedule in CY 2008. As indicated in the hospital regulatory update, CMS will consider bundling this service during future regulatory revisions.

Technical and Professional Components. For 2008 CMS imposed an anti-markup provision on purchased technical components (TCs) and/or purchased professional components (PCs) of diagnostic tests. For example, a physician in a group practice orders a diagnostic test and a technician who is a part-time employee of the group performs the test in the group's office. A physician who is an independent contractor of the group performs the PC in his or her home and reassigns his or her right to payment to the group. The group's billing of the TC is not subject to the anti-markup provision, but the group's billing of the PC is subject to the anti-markup provision because the work was not performed in the office of the billing supplier. In this scenario, the

professional component can only be billed at the amount paid for the service; the test cannot be billed "globally" and the professional component charge cannot be "marked up."

ESAs. Medicare Part B provides payment for certain drugs used to treat anemia. While the final rule did not establish new or additional standards related to anemia or the administration of erythropoietin stimulating agents (ESAs), it mandated the reporting of the most recent hemoglobin or hematocrit level on claims for payment of the administration of ESAs to treat anemia. CMS will use the information reported to help determine the prevalence and severity of anemia associated with cancer therapy, the clinical and hematologic responses to the use of anti-anemia therapy, and the outcomes associated with various doses of anti-anemia therapy. Final instructions regarding the reporting of the hemoglobin and hematocrit levels will be issued in CMS Transmittals at a later date.

A provider seeking payment for ESAs may report either the patient's most recent hematocrit or hemoglobin level on the claim. There are no instructions regarding when the hematocrit or hemoglobin level should be drawn that would affect a provider's decision to administer ESA therapy. The requirement is that "the most recent" hemoglobin or hematocrit level be reported on the claim. Thus, the provider should report the most recent level preceding the ESA administration. In some instances the same hemoglobin or hematocrit value might be reported on more than one claim.

While this article provides an overview of the coding and regulatory issues affecting healthcare entities providing oncology services, CMS will issues additional instructions and clarifications during the coming months that will clarify existing information and provide specific billing guidance. The best way to stay abreast of this information and receive timely updates is to join the email list(s) available from CMS and/or your local Medicare contractors. To sign up for any of the CMS email lists, enroll at: *http://www.cms.hhs.gov/apps/mailinglists/.* The 2008 Medicare OPPS Final Rule is available online at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/cms1392fc.pdf.* The 2008 Medicare Physician Fee Schedule Final Rule is available online at: *http://www.cms.hhs.gov/physicianfeesched/downloads/CMS-1385-FC.pdf.*

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Table 6. 2008 Brachytherapy Source HCPCS Codes, APCs, Status Indicators, and Median Costs

HCPCS Code	Long Descriptor	APC	CY 2008 Median Cost	CY 2008 Status Indicator
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	2632	$27	K
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	$33	K
C1717	Brachytherapy source, non-stranded, high-dose rate Iridium-192, per source	1717	$173	K
C1719	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	1719	$64	K
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	$11,621	K
C2634	Brachytherapy source, non-stranded, high activity, Iodine-125, greater than 1.01 mCi (NIST), per source	2634	$31	K
C2635	Brachytherapy source, non-stranded, high activity, Palladium-103, greater than 2.2 mCi (NIST), per source	2635	$46	K
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	$42	K
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	2637	N/A	B
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	*$45	K
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	**$32	K
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	*$65	K
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	**$51	K
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	*$97	K
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	**$63	K
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	$45	K
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	$31	K

*Estimated median cost for stranded version is based on the 60th percentile of the aggregate (stranded and non-stranded) claims data for this source.

**Estimated median cost for non-stranded version is based on the 40th percentile of the aggregate (stranded and non-stranded) claims data for this source.