



STATE OF NEW JERSEY
 Department of Human Services
 Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-311

September 1, 1981

TO: PHYSICIANS, PODIATRISTS
SUBJECT: PROCEDURE CODE MANUAL UPDATE
 WITH CERTAIN REVISIONS
EFFECTIVE: October 1, 1981

BACKGROUND: Enclosed is your new Procedure Code Manual which has been updated and revised.

In response to the request of the Medicaid Committee of the New Jersey Medical Society, the GEOGRAPHICAL factor has been eliminated as a parameter for reimbursement. In addition, the TIME factor has been deleted from the non-surgical codes except for vision training codes, the psychiatric and psychological codes, and Code 9071 (Prolonged detention with a patient) where time is the basis for the code, and Code 9030 (Comprehensive Consultation) where time is an optional alternative.

Please note any additions and/or deletions in the procedure codes or narrative descriptions relative to your practice.

SUMMARIZATION OF CHANGES:

- A. Revisions to certain non-surgical codes. The revisions represent the elimination of some codes, the consolidation of others, the alteration of certain fees both upward and downward, and the establishment of parity fee schedule for office, hospital, nursing home, sheltered boarding home and home visit services.
 A list reflecting these changes is attached to this Newsletter.
- B. Radiology: The fee schedule is now divided into an office and a hospital setting in order to accommodate the hospital based radiologist whose contract is based on fee-for-service.

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The procedure codes and their narratives are for the most part similar to Medicare codes.

ACTION:

- A. Both a procedure code and brief corroborative narrative description of the services rendered must be used when submitting claims, for example,

Code 3261 - Appendectomy
Code 0001 - Office Visit
- B. On and after October 1, 1981, claims will be reimbursed based on the date of processing at Prudential, and not the date of service, except for the deleted non-surgical codes which will be paid based on date of service.
- C. PROMPTLY SUBMIT ALL CLAIMS IN SEPTEMBER. CLAIMS PROCESSED THROUGH SEPTEMBER 30, 1981, WILL BE REIMBURSED UNDER THE EXISTING CODE DESCRIPTIONS AND FEE SCHEDULE; CLAIMS PROCESSED ON AND AFTER OCTOBER 1, 1981, WILL BE REIMBURSED UNDER THE NEW DESCRIPTIONS AND FEE SCHEDULE.

Please discard your old Procedure Code Manual.

Questions concerning this Newsletter may be referred to S. Eugene Yuliano, M.D. Medical Director, at CN 712, Trenton, New Jersey 08625.

- Attachments:
1. "Non-Surgical Codes - Listing of Changes to Procedure Code Manual," dated September 1, 1981.
 2. Procedure Code Manual, Ed. 9-81.

NON-SURGICAL CODES

LISTING OF CHANGES TO PROCEDURE CODE MANUAL

THE FOLLOWING LIST IS SEPARATED INTO FOUR CATEGORIES; I - GENERAL MEDICINE; II - CHILD HEALTH; III - EYE EXAMINATIONS; AND IV - PSYCHIATRIC SERVICES. UNDER EACH CATEGORY, "DELETED", "REVISED", AND "NEW" CODES ARE LISTED WHEN APPLICABLE.

PLEASE BE SURE TO READ THE FULL CODE DESCRIPTION IN THE PROCEDURE CODE MANUAL FOR EXCEPTIONS, LIMITATIONS, ETC., AS EACH CODE LISTED HAS BEEN CHANGED IN SOME FASHION.

I - GENERAL MEDICINE (SEE SECTION II FOR CHILD HEALTH CARE CODES)

A. DELETED CODES

- 1. OFFICE VISITS:
 - 9001 - INITIAL OFFICE VISIT, COMPREHENSIVE
 - 0005 - ROUTINE OR FOLLOW-UP OFFICE VISIT, BRIEF
 - 9007 - ROUTINE OR FOLLOW-UP OFFICE VISIT, PROLONGED

- 2. HOME/NURSING HOME) 9011 - INITIAL HOME VISIT, COMPREHENSIVE
 VISITS, INCLUDING) 9014 - FOLLOW-UP NURSING HOME VISIT, BRIEF
 SHELTERED BOARDING) 9016 - FOLLOW-UP NURSING HOME VISIT, PROLONGED
HOMES:)

- 3. HOSPITAL VISITS:
 - 9026 - INITIAL HOSPITAL DAY, COMPREHENSIVE
 - 9021 - 1ST DAY OF INTENSIVE CARE
 - 9022 - FOLLOW-UP HOSPITAL VISIT PROLONGED OR
2ND DAY OF INTENSIVE CARE

FEE SCHEDULE

B. REVISED CODES

		<u>SPECIALIST</u>	<u>NON-SPECIALIST</u>
1. <u>OFFICE VISITS:</u>	9000 - OFFICE VISIT, INITIAL	22	17
	0001 - OFFICE VISIT	9	7
	9008 - ANNUAL HEALTH MAINTENANCE RE-EXAMINATION	22	17
2. HOME-SHELTERED)	9010 - HOME - SHELTERED BOARDING HOME	22	17
BOARDING HOME OR)	OR NURSING HOME VISIT - INITIAL		
<u>NURSING HOME VISITS:</u>)	0002 - HOME OR SHELTERED BOARDING HOME VISIT	9	7
	0004 - NURSING HOME VISIT	9	7

GENERAL MEDICINE CONT'D
 B. REVISED CODES CONT'D

FEE SCHEDULE

		<u>SPECIALIST</u>	<u>NON-SPECIALIST</u>
3. <u>HOSPITAL VISITS:</u>	9020 - HOSPITAL DAY, INITIAL	22	17
	0003 - HOSPITAL DAY	9	7
4. <u>CONSULTATIONS:</u>	9029 - CONSULTATIONS - LIMITED	22	N/A
	9030 - CONSULTATION - COMPREHENSIVE	37	N/A
5. <u>OTHER SERVICES:</u>	9071 - DETENTION - PROLONGED	37	32

II - CHILD HEALTH CARE

A. DELETED CODES

9001 - INITIAL OFFICE VISIT, COMPREHENSIVE
 0005 - ROUTINE OR FOLLOW-UP OFFICE VISIT, BRIEF
 9007 - ROUTINE OR FOLLOW-UP OFFICE VISIT, PROLONGED

B. REVISED CODES

9580 - EARLY PERIODIC SCREENING DIAGNOSIS & TREATMENT (EPSDT) 23 18
 (CLAIMS MUST BE SUBMITTED WITHIN 30 DAYS WITH MC-19 ATTACHED. FAILURE TO SUBMIT AN MC-19 WILL RESULT IN REIMBURSEMENT UNDER PREVENTIVE HEALTH CARE CODES; I.E. CODE 9006 OR CODE 0011.)
 0001 - OFFICE VISIT - (PROBLEM ORIENTED) 9 7
 9000 - OFFICE VISIT, INITIAL 22 17
 9035 - ROUTINE NEWBORN CARE - WELL BABY 22 17
 9037 - ATTENDANCE DURING AND PEDIATRIC CARE TO NEWBORN(S) AT CESAREAN SECTION 22 17

C. NEW CODES

9006 - ANNUAL HEALTH MAINTENANCE EXAMINATION AGES 3 YEARS THROUGH 20 YEARS 22 17
 0011 - OFFICE VISIT - PEDIATRIC PREVENTIVE HEALTH CARE 9 7

EYE EXAMINATION

FEE SCHEDULE

SPECIALIST NON-SPECIALIST

III - EYE EXAMINATION

A. DELETED CODES

5407 - EYE EXAM, PROLONGED

B. REVISED CODES

5400 - COMPREHENSIVE EYE EXAMINATION	22	N/A
5401 - COMPREHENSIVE EYE EXAMINATION	26	N/A
5406 - SCREENING EXAMINATIONS	9	N/A

IV - PSYCHIATRIC SERVICES

A. REVISED CODES

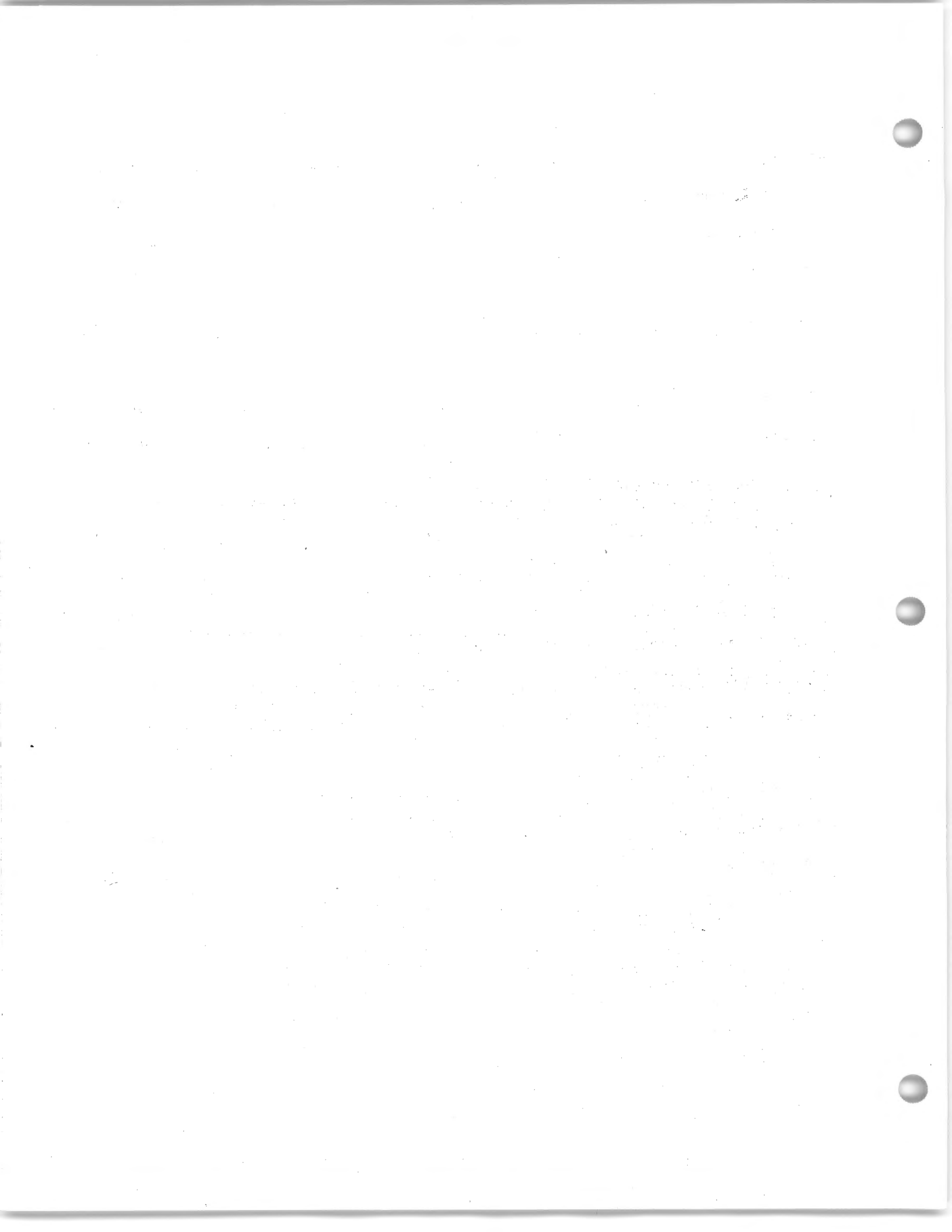
9050 - PSYCHOTHERAPY, INDIVIDUAL, ONE HOUR	NO CHANGE	
9051 - PSYCHOTHERAPY, INDIVIDUAL, ONE-HALF HOUR	NO CHANGE	
9053 - PSYCHOTHERAPY, GROUP	NO CHANGE	
9056 - INITIAL COMPREHENSIVE PSYCHIATRIC EVALUATION	NO CHANGE	26
9062 - FAMILY THERAPY - ONE AND ONE-HALF HOURS	NO CHANGE	
9064 - FAMILY THERAPY/FAMILY CONFERENCE, ONE HOUR	NO CHANGE	
9065 - FAMILY THERAPY/FAMILY CONFERENCE, ONE-HALF HOUR	NO CHANGE	

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PHYSICIAN'S PROCEDURE CODES

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FOREWORD

GENERAL POLICY

The coding and procedures in this manual have been developed to aid the practitioner in the preparation of claims. For purposes of reimbursement, as narrated in this manual, a physician, other practitioner, or group are to be considered one and the same.

The physician, other practitioner, or group must use a procedure code and a brief corroborative narrative description of services rendered.

It should be emphasized that the use of a code number and narrative infers that the service was delivered as specified. Written records in substantiation of the use of a given procedural code must be available for review and/or inspection if requested by the New Jersey Health Services Program.

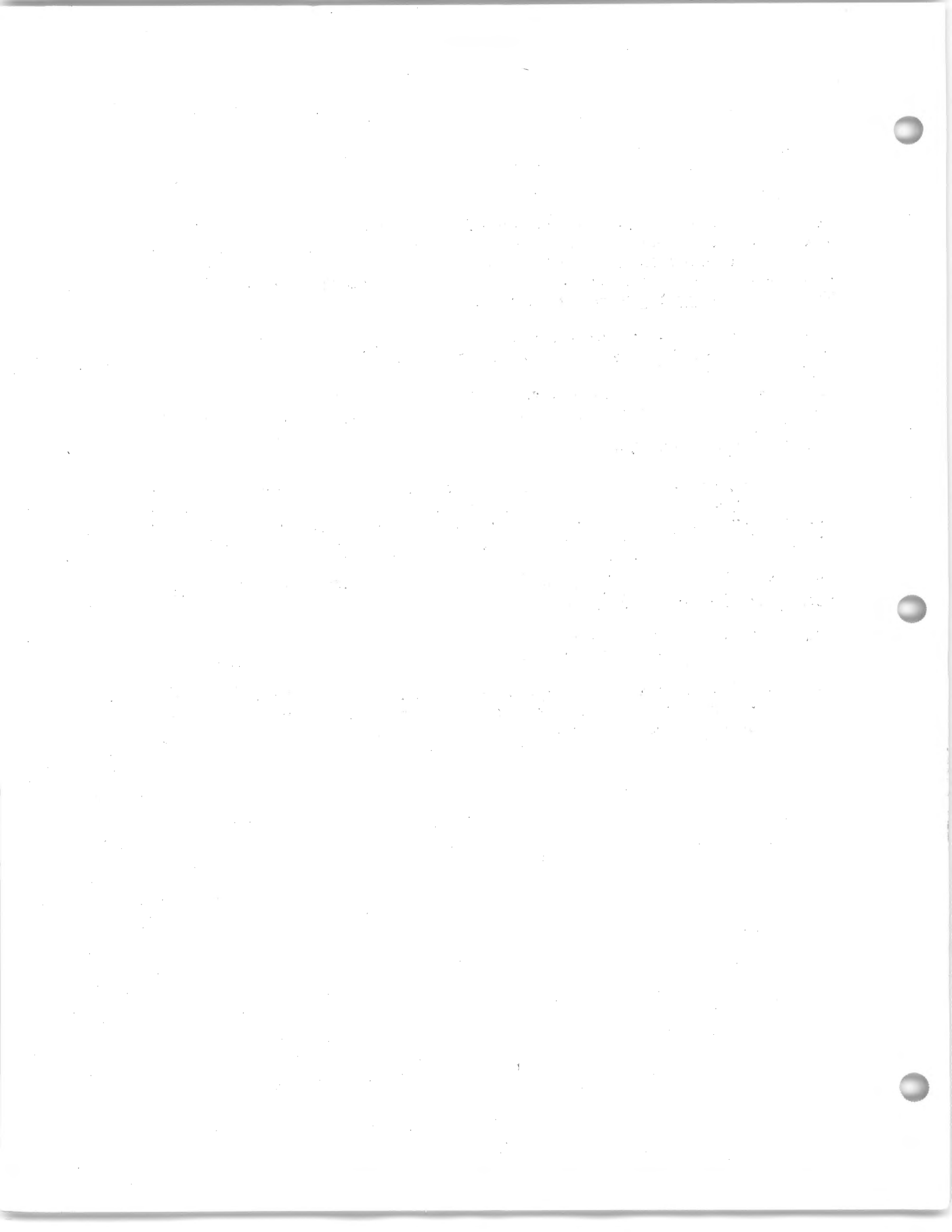
It is not the intent of the Program to reimburse a physician, or other practitioner, for history and/or physical examinations performed by Interns, Residents, other House Staff Members or Physicians' Assistants. (Exception: Procedure Code 9580 EPSDT, which may permit the use of a Nurse Practitioner under direct supervision of the physician.)

All references to performance of any or all parts of a history or physical examination shall mean that for reimbursement purposes these services were personally performed by the physician, or other practitioner, submitting the claim.

If documented that a covered service was rendered by the physician, or other practitioner, in a hospital or long term care facility, the medical record must contain notes by him/her which show that the physician, or other practitioner, personally did the following:

- (1) Reviewed the patient's medical history with the patient and/or his family, depending upon the medical situation.
- (2) Performed a physical examination.
- (3) Confirmed or revised the diagnosis.
- (4) Visited and examined the patient on the days for which a claim for reimbursement is made.
- (5) Personally discharged the patient.

NOTE: In hospital, long term care facility or group practice settings, such medical records as noted above must be signed by the physician, or other practitioner, providing the services.



FOREWORD (cont.)

For all other individual occasions of service billed, documentation of the billing physician's or other practitioner's involvement must be clearly demonstrated in notes reflecting his/her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by Interns, Residents, other House Staff Members, or Nurses. A countersignature alone is not sufficient.

Date(s) of service(s) for each procedure code in this manual must be indicated on both the claim form as well as the physician's or other practitioner's own record.

The fees as noted with these procedure codes represent the maximum payment for the given procedure. When submitting a claim, you must always use your usual and customary fee.

USE OF PROCEDURE CODES

The use of a procedure code and its brief corroborative description on a claim form will be interpreted by this Program as evidence that the physician, or other practitioner, personally furnished, as a minimum, the stated services. All references to time parameters in this manual means physician's or other practitioner's personal time.

The practitioner must list on the Health Insurance Claim Form (1500-N.J.) both procedure code and brief narrative description.

EXAMPLES: 0001 - Office Visit
 3515 - Cholecystectomy

NOTE: If the service rendered does not conform with any given code, the provider should enter an adequate narrative description of the services rendered in item 24d of the Health Insurance Claim Form (1500-N.J.).

SUBCHAPTER 4. HEALTH CARE FINANCING ADMINISTRATION
COMMON PROCEDURE CODING SYSTEM (HCPCS)

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Appendix I Medical Necessity Program

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:54-4.1 INTRODUCTION

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology - 4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. LEVEL I CODES (Narratives found in CPT-4)

These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4.

2. LEVEL II CODES (Narratives found in APPENDIX A)

These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4. Level II codes are listed in APPENDIX A of each section.

3. LEVEL III CODES (Narratives found in APPENDIX A)

These codes are assigned by the Division and the Prudential Insurance Co. to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey. These codes are listed in Appendix A of each section.

(b) The HCPCS codes listed in this Subchapter 4. are divided into four sections: Section 4.2 - Medicine; Section 4.3 - Surgery; Section 4.4 - Radiology (including Nuclear Medicine and Diagnostic Ultrasound); and Section 4.5 - Pathology and Laboratory.

(c) SPECIFIC ELEMENTS OF HCPCS CODING SYSTEM WHICH REQUIRE ATTENTION OF PROVIDER

The lists of HCPCS code numbers in the four separate sections of this Subchapter 4. are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODES", "MOD", "DESCRIPTION", "FOLLOW-UP DAYS", "MEDICAID DOLLAR VALUE" AND "ANES BASIC UNITS". The information given under each column is summarized below:

COLUMN
TITLE

IND

(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or services code is used.

Explanation of indicators and qualifiers used in this column are given below and in paragraph 1. (Alphabetic and Numeric Symbols) which follows:

"A" preceding any procedure code means that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.

"C" preceding any procedure code indicates that this service is primarily done for cosmetic purposes and is normally not a covered service unless prior authorized. Obtain authorization from the appropriate Medicaid District Office and attach the authorization to the 1500-N.J. claim form. (See Subchapter 1. 10:54-1.3 - Prior Authorization.)

"L" preceding any procedure code indicates that the complete narrative for the code is located in the Appendix A of the appropriate section. (Medicine, 4.2; Surgery, 4.3; Radiology, 4.4; or Pathology and Laboratory, 4.5)

"M" preceding any procedure code means that this service is a medical necessity procedure. (Refer to Appendix I at the end of the Pathology and Laboratory Section (4.5).

"N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B of the appropriate section. (Medicine, 4.2; Surgery, 4.3; Radiology, 4.4; or Pathology and Laboratory, 4.5)

"S" preceding any procedure code means that this service requires a second opinion consultation. (See Appendix D at the end of the Surgery Section (4.3).

HCPCS
CODES

Lists the HCPCS procedure code numbers.

MOD

Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are listed in Appendix C at the end of each section (Medicine, 4.2; Surgery, 4.3; Radiology, 4.4; and Pathology and Laboratory, 4.5)

- DESCRIPTION Lists the code narrative. (Narratives for Level I Codes are found in CPT-4, Narratives for Levels II and III Codes are found in Appendix A of each section.)
- FOLLOW-UP DAYS Lists the number of days for follow-up care.
- MEDICAID DOLLAR VALUE Lists New Jersey Medicaid Program's maximum reimbursement schedule for specialist and non-specialist. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the 1500-N.J. claim form.
- ANES BASIC UNITS B.U.V. (Basic Unit Value) + A.T. (Anesthesia Time) (units) x \$6.30 (specialist) or \$5.50 (non-specialist) equals reimbursement. For more information about anesthesia service, see Policies and Procedures Regarding Use of HCPCS ((d) 3. v.) which follows:

1. ALPHABETIC AND NUMERIC SYMBOLS UNDER "IND" & "MOD"

These symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS code as written in the CPT-4. THE PROVIDER WILL THEN BE LIABLE FOR THE ADDITIONAL REQUIREMENTS AND NOT JUST THE CPT/HCPCS CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.

ii. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

(d) POLICIES AND PROCEDURES REGARDING USE OF HCPCS

Listed below are both some general and specific policies of the New Jersey Medicaid Program relevant to HCPCS. (Additional requirements of the provider when rendering specific services and requesting reimbursement are listed in both Subchapter 1. (1.3 - Prior Authorization; 1.4 Record Keeping; and 1.5 - Basis of Payment) and Subchapter 2. under the specific procedure or service being provided.)

1. General Requirements

i. When filing a claim, the HCPCS Codes, including the referenced qualifiers and modifiers, must be used in conjunction with the narratives in the CPT-4 or Appendix A, whichever is applicable.

ii. The use of a procedure code will be interpreted by the New Jersey Medicaid Program as evidence that the physician personally furnished, as a minimum, the service for which it stands.

iii. For purposes of reimbursement, a physician, physicians' group, shared health care facility or physicians sharing a common record are considered a single provider.

iv. When billing, the provider must enter into the procedure code column of space 24-D of claim form 1500-N.J. a CPT/HCPCS code as listed in CPT-4 or this Subchapter 4. Claims filed for Preventive Health Care Services to patients through age 20 must use preventive health care codes. Preventive Health Care visits for patients through age 20 must include as a minimum the content of the code 90764. If an appropriate code is not listed, place an "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert into space 24-D a CPT code closest to the narrative description you have written.

v. Date(s) of service(s) must be indicated on the claim form and in the physician's own record for each service billed.

vi. When submitting a claim, the physician must always use his/her usual and customary fee. The fees designated for the HCPCS procedure codes represent the New Jersey Medicaid Program's maximum payment for the given procedure.

vii. All references to time parameters shall mean the physician's personal time in reference to the service rendered unless it is otherwise indicated.

2. Medicine (Specific Requirements)

i. It is not the intent of the program to reimburse for histories and/or physical examinations performed by physician assistants, interns, residents or other house staff. (Exception: Procedure Code W9820, EPSDT, permits the services of a pediatric nurse practitioner under the direct supervision of a physician.)

For reimbursement purposes, when reference is made to any of the following services it is understood that they were performed by the physician submitting the claim:

(1) Office, Hospital, Nursing Home, or Sheltered Boarding Home Visits.

(2) Any part of a history or physical examination.

ii. To qualify as documentation that the service was rendered by the physician during an inpatient stay, the medical record must contain the physician's notes indicating that he/she personally:

(1) Reviewed the patient's medical history with the patient and/or his family, depending upon the medical situation.

(2) Performed a physical examination.

(3) Confirmed or revised the diagnosis.

(4) Visited and examined the patient on the days for which a claim for reimbursement is made.

(5) Was personally responsible for discharge of the patient.

iii. The billing physician's involvement must be clearly demonstrated in notes reflecting his/her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A countersignature alone is not sufficient.

3. Surgery (Specific Requirements)

i. SEPARATE PROCEDURE: Certain of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "Separate Procedure" is applicable.

ii. COMPLICATIONS or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional charges on a fee-for-service basis.

iii. MULTIPLE SURGICAL PROCEDURES:

(1) When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total reimbursement shall be the allowance of the major procedure plus 50% of the allowance of the lesser procedure to a total maximum of 200% unless otherwise specified in this section.

(2) When an incidental procedure, (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the allowance will be that of the major procedure only.

iv. Listed allowances for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column titled "Follow-Up Days".

v. ANESTHESIA:

(1) Anesthesia services rendered to his/her patient by the operating surgeon are considered part of the surgical procedure and will not receive any additional reimbursement.

(2) A fully licensed physician may personally provide anesthesia under his licensure and be reimbursed.

(3) Anesthesia services provided by a CRNA are eligible for reimbursement provided he/she is employed by a physician who is a specialist in anesthesia and is a provider to the New Jersey Medicaid Program and will be the person who submits a claim for the services rendered. In addition, the CRNA's services must be performed under the direct supervision of the employer anesthesiologist throughout the period of anesthesia.

(4) Direct supervision of a CRNA requires that the anesthesiologist be free from other professional duties, that he/she be in the operating suite and within visual and/or auditory range throughout the period of supervision and that he/she not be involved in the care of more than two cases under anesthesia at the same time.

(5) The Division will not recognize direct reimbursement to a CRNA nor will it recognize direct charges submitted by an anesthesiologist for services rendered by a CRNA who is not in his employ, but is in the employ of a health care facility.

vi. Anesthesia Reimbursement is determined by the following formula unless otherwise noted:

(1) B.U.V. + A.T. (units) x \$6.30 (specialist) or \$5.50 (non-specialist) equals reimbursement.

(2) B.U.V. - Basic Unit Value - as appears on attached allowance listing.

(3) A.T. - Anesthesia Time which includes:

(A) Those professional activities of the anesthesiologist directly related to the pre-operative preparation of the patient in the operating room or pre-induction room preceding the proposed surgery;

(B) Introduction of the anesthetic agent;

(C) Continuous supervision during the surgery;

(D) Continuous supervision during the immediate post-operative period until release of the patient in a satisfactory physiological state to a competent recovery room staff.

(E) Anesthesia time is reported in the time element of 15 minutes (1 unit). Should the time element of 15 minutes (1 unit) in No. 1 or No. 4 above be exceeded, the reason(s) must be documented on the anesthesia record and the practitioner's claim form.

vii. ANESTHESIA: MULTIPLE SURGICAL PROCEDURES RENDERED DURING THE SAME OPERATIVE SESSION:

(1) The procedure with the highest basic unit value should be used when calculating anesthesia allowance.

(2) When billing for anesthesia services, affix to the appropriate procedure code the applicable anesthesia modifier. (See Appendix C of Surgery Section for definitions of modifiers.)

viii. ASSISTANT SURGEON: Reimbursement will be made for an assistant surgeon when the service is medically necessary and when a duly qualified surgical resident or house physician is unavailable, and when the primary procedure performed has a procedure code specialist fee of at least \$142. The allowance permitted is a maximum of 15 percent of the listed specialist fee. The minimum payment is \$27.

When billing for assistant surgical services, affix to the appropriate procedure code the modifier "80" which identifies surgical assistant services.

4. Radiology (Specific Requirements)

i. Values include usual contrast media, equipment and materials.

ii. Values include consultation and written report to the referring physician.

iii. S & I - Supervision and Interpretation only for the procedure given. This code is used only when a procedure is performed by more than one physician. Values include consultation and written report.

iv. Complete Procedure-Includes the Supervision and Interpretation (S & I) plus the injection services when performed by the same physician (e.g., necessary local anesthesia, placement of needle or catheter, injection of contrast media, supervision of the study and interpretation of the results). Values include usual contrast media, equipment and materials.

v. All films taken of an area which is to be subject to a contrast study will, for reimbursement purposes, be considered part of the contrast study unless stated otherwise in the section 4.4 (Radiology/Ultrasound).

vi. The fee listed under "Office" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

vii. The fee schedule for all radiology services performed in a hospital setting is indicated in the "Hospital Based" column and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

viii. Radiology services performed in Out-Patient Hospital setting require a referring physician.

ix. Ultrasound diagnostic procedures are for reimbursement purposes limited to physician specialists in the specific specialty they reflect or to a radiologist expert in that field. These procedures must include the mounted tracings with interpretations.

Codes: 93950, 93890, 93910, and R6144 - apply only to services rendered in a hospital or equivalent ultrasound or x-ray laboratory on fixed equipment under specialist supervision and include detailed interpretation of the graphic record, plus report. Do not use these codes for screening Doppler Flow studies. (See the Medicine Section to report Doppler Peripheral Flow Studies (93890-R6144)).

10:54—4.2 HCPCS CODES FOR MEDICINE

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE			IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE		
			S	\$	NS				S	\$	NS
N	90015		22.00		17.00	N	90620			37.00	
N	90017		22.00		17.00	N	90653	YY		50.00	
N	90020		22.00		17.00	N	90653	ZZ		50.00	
N	90050		9.00		7.00	N	90701			5.86	5.86
	90050	WM			6.30	N	90702			4.65	4.65
N	90060		9.00		7.00	N	90703			3.90	3.90
	90060	WM			6.30	N	90704			11.55	11.55
N	90070		9.00		7.00	N	90705			10.25	10.25
N	90150		9.00		7.00	N	90706			10.65	10.65
N	90160		25.00		25.00	N	90707			22.15	22.15
N	90170		25.00		25.00	N	90708			15.35	15.35
N	90215		22.00		17.00	N	90709			16.50	16.50
N	90220		22.00		17.00	N	90712			7.10	7.10
N	90250		9.00		7.00	N	90719			4.90	4.90
N	90260		9.00		7.00	N	90724			4.70	4.70
N	90270		9.00		7.00	N	90732			9.25	9.25
N	90285		22.00		17.00	N	90751			22.00	17.00
N	90315		22.00		17.00	N	90752			22.00	17.00
N	90320		22.00		17.00	N	90753			22.00	17.00
N	90350		9.00		7.00	N	90754			22.00	17.00
N	90360		9.00		7.00	N	90760			22.00	17.00
N	90370		9.00		7.00	N	90761			22.00	17.00
N	90415		22.00		17.00	N	90762			22.00	17.00
N	90420		22.00		17.00	N	90763			22.00	17.00
N	90450		9.00		7.00	N	90764			9.00	7.00
N	90460		9.00		7.00	N	90799			2.50	2.50
N	90470		9.00		7.00	N	90801			37.00	26.00
N	90510		9.00		7.00	N	90843			19.00	13.00
N	90515		9.00		7.00	N	90844			37.00	26.00
N	90517		9.00		7.00	N	90847			37.00	26.00
N	90550		9.00		7.00	N	90847	22		46.00	32.00
N	90560		9.00		7.00		90862			9.00	7.00
N	90570		9.00		7.00		90870			32.00	26.00
N	90600		22.00			N	90887			19.00	13.00
N	90605		22.00				90951			30.00	
N	90610		22.00				90966			61.00	61.00

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			S	NS
	90982		24.00	24.00
	90990		400.00	400.00
	90991		160.00	
	90992		400.00	400.00
	91010		54.00	
	91011		58.00	
	91012		58.00	
N	92002		22.00	
N	92002	AP	9.00	
N	92004		26.00	
N	92004	AP	9.00	
N	92012		22.00	
N	92012	AP	9.00	
N	92014		26.00	
N	92014	AP	9.00	
N	92018		15.00	
N	92019		15.00	
N	92020		15.00	
N	92065		10.00	
N	92081		8.00	
N	92082		8.00	
N	92083		8.00	
N	92100		8.00	
	92120		15.00	
	92130		15.00	
	92225		25.00	
	92226		21.00	
	92235		53.00	
	92250		10.00	
N	92260		15.00	
N	92280		45.00	
	92286		12.00	
	92541		5.00	
	92542		8.00	
	92543		8.00	
			EACH	
	92544		5.00	

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			S	NS
	92545		5.00	
	92552		11.00	11.00
	92553		14.00	14.00
	92557		19.00	19.00
	92561		12.00	
	92562		3.00	
	92563		3.00	
	92564		4.00	
	92566		10.00	
	92567		5.00	
	92572		20.00	
	92576		30.00	
	92582		14.00	14.00
N	92585		45.00	
N	92589		10.00	
	92590		40.00	
	92591		40.00	
	92950		37.00	32.00
	92960		30.00	26.00
	93000		16.00	16.00
	93015		40.00	
M	93201		21.00	
M	93205		26.00	
	93208		21.00	
	93220		26.00	
M	93240		BR	BR
	93255		21.00	
	93274		85.00	
	93501		180.00	
	93503		121.00	
	93510		153.00	
	93511		153.00	
	93514		153.00	
	93515		153.00	
	93524		153.00	
	93526		225.00	
	93527		225.00	

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE			IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE		
			S	\$	NS				S	\$	NS
	93528		225.00			N	95000		5.00	5.00	
	93542		225.00						PER 10 TESTS		
	93543		270.00			N	95001		5.00	5.00	
	93544		270.00						PER 10 TESTS		
	93545		153.00			N	95002		5.00	5.00	
	93549		314.00						PER 20 TESTS		
	93561		26.00			N	95003		5.00	5.00	
	93562		14.00						PER 20 TESTS		
	93762		15.00			N	95005		21.00		
	93770		5.00	5.00			95020		8.00	8.00	
M	93780		5.00	5.00			95021		8.00	8.00	
	93850		42.00				95022		8.00	8.00	
	93870		40.00			N	95023		8.00	8.00	
	93870	26	20.00			N	95040		1.00	1.00	
	93890		45.00						PER TEST		
	93890	26	21.60			N	95041		1.00	1.00	
	93910		45.00						PER TEST		
	93910	26	21.60			N	95042		1.00	1.00	
	93950		45.00						PER TEST		
	93950	26	21.60			N	95043		1.00	1.00	
	94010		18.00						PER TEST		
	94060		44.00				95060		2.00	2.00	
	94200		9.00				95065		2.00	2.00	
	94240		15.00				95080		16.00	16.00	
	94250		24.00				95081		16.00	16.00	
	94260		9.00				95082		16.00	16.00	
	94350		BR	BR			95819		32.00		
	94360		9.00				95821		32.00		
	94370		9.00				95828		155.00		
	94375		15.00				95831		10.00		
	94400		18.00				95832		13.00		
	94680		24.00				95833		32.00		
	94681		59.00				95834		37.00		
M	94690		9.00				95842		25.00		
	94710		140.00				95851		10.00		
	94720		18.00				95852		10.00		
	94750		9.00				95857		16.00		

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE			IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE		
			S	\$	NS				S	\$	NS
	95858			BR		L	R6114		42.00		
	95860		37.00			L	R6141		55.00		
	95861		57.00			L	R6141	26	25.20		
	95863		70.00			L	R6144		55.00		
	95864		83.00			L	R6144	26	25.20		
	95900		16.00								
	95904		16.00								
N	95925		55.00			L	W9050		22.00		
	95933		32.00			L	W9055		22.00	17.00	
	96540		61.00			L N	W9090		9.90	9.90	
N	96912		13.50			L N	W9095		5.45	5.45	
N	97799		7.00	7.00		L	W9105		37.00	26.00	
	99052		5.00	5.00		L	W9106		75.00		
N	99082		4.00	4.00		L	W9113		19.00	13.00	
N	99150		37.00	32.00		L	W9114		37.00	26.00	
			PER HOUR								
N	99151		37.00	32.00		L	W9115		8.00	6.00	
			PER HOUR								
N	99160		37.00	32.00		L	W9116		19.00	13.00	
			PER HOUR								
	99170		18.00	16.00		L	W9117		37.00	26.00	
	99190		35.00			L	W9118		46.00	32.00	
N	99195		28.00	28.00		L	W9119		48.00	34.00	
			PER HOUR								
L N	H5025		8.00	6.00		L	W9120		48.00	34.00	
			PER HOUR								
L N	J2790		42.40	42.40		L	W9121		30.00	21.00	
			PER HOUR								
L	R6012		42.00			L	W9122		15.00	10.00	
L	R6075		125.00			L	W9123		22.00	15.00	
L	R6076		125.00			L	W9124		18.00	13.00	
L	R6081		35.00			L	W9125		15.00	10.00	
L	R6081	50	56.00			L	W9126		30.00	21.00	
L	R6084		14.00			L	W9127		18.00	13.00	
L	R6111		21.00			L	W9128		55.00	39.00	
			PER HOUR								

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>			<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>			
			<u>S</u>	<u>\$</u>	<u>NS</u>				<u>S</u>	<u>\$</u>	<u>NS</u>	
L	W9148		15.00		10.00	L N	W9215			9.00		
L	W9149		30.00		21.00	L N	W9220			8.00		
L	W9150		18.00		13.00	L	W9225			25.00		
L	W9151		55.00		39.00	L N	W9230			8.00		
L	W9152		30.00		21.00	L	W9300			21.00		
L	W9153		30.00		21.00	L	W9310			51.00		
L	W9154		37.00		26.00	L	W9355			25.00		
L	W9155		55.00		39.00	L	W9375			16.00		
L	W9156		55.00		39.00	L	W9376			16.00		
L	W9157		55.00		39.00	L	W9377			16.00		
L	W9158		55.00		39.00	L	W9378			16.00		
L	W9159		26.00		18.00	L	W9379			16.00		
L	W9160		18.00		13.00	L	W9380			16.00		
L	W9161			BR	BR	L	W9400			15.00		
L	W9170		13.00		13.00	L N	W9500			8.00		
L	W9200		10.00			L N	W9760			7.00		7.00
L	W9205		60.00			L N	W9820			23.00		18.00
L	W9210		25.00									

APPENDIX A (CODES AND NARRATIVES NOT FOUND IN CPT-4)

MEDICINE

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MEDICAID DOLLAR VALUE		
				S	\$	NS
N	H5025		PSYCHOTHERAPY, GROUP (MAXIMUM 8 PERSONS PER GROUP; 90 MINUTES, PER PERSON, PER SESSION)	8.00		6.00
N	J2790		RHOGAM, RHO D IMMUNE GLOBULIN, HUMAN, ONE DOSE PACKAGE	42.40		42.40
	R6012		PHONOANGIOGRAPHY MULTIPLE SITES, INCLUDING LOCALIZATION, DURATION AND INTENSITY	42.00		
	R6075		ARTERIAL EVALUATION, COMPREHENSIVE, UNILATERAL, INCLUDES ANY COMBINATION OF STUDIES	125.00		
	R6076		ARTERIAL EVALUATION, COMPREHENSIVE, BILATERAL, INCLUDES ANY COMBINATION OF STUDIES	125.00		
	R6081		PRESSURE MEASUREMENT, POSTERIOR TIBIAL AND/OR DORSALIS PEDIS ARTERIES, UNILATERAL OR BILATERAL INCLUDING BRACHIAL PRESSURE CORRELATION AND ANKLE-ARM INDEX (AAI) CALCULATION, *SEE COMMENTS BELOW*	35.00		
			COMMENTS: (DOPPLER, STRAIN GAUGE PLETHYSMOGRAPHY, PULSE VOLUME RECORDER, PHOTO PLETHYSMOGRAPHY) SEPARATED PROCEDURE			
	R6081	50	PRESSURE MEASUREMENT, POSTERIOR TIBIAL AND/OR DORSALIS PEDIS ARTERIES, UNILATERAL OR BILATERAL INCLUDING BRACHIAL PRESSURE CORRELATION AND ANKLE-ARM INDEX (AAI) CALCULATION, *SEE COMMENTS BELOW*	56.00		
			COMMENTS: (DOPPLER, STRAIN GAUGE PLETHYSMOGRAPHY, PULSE VOLUME RECORDER, PHOTOPLETHYSMOGRAPHY) SEPARATED PROCEDURE			
			(50-BILATERAL)			
	R6084		PRESSURE MEASUREMENT, SEGMENTAL, MULTIPLE SITES, UNILATERAL OR BILATERAL INCLUDING GRADIENT EVALUATION BETWEEN LEVELS (DOPPLER, PULSE VOLUME RECORDER, STRAIN GAUGE OR PHOTO PLETHYSMOGRAPHY)	14.00		
	R6111		PLETHYSMOGRAPHY OR PULSE VOLUME DIGIT WAVE FORM ANALYSIS, MULTIPLE DIGITS, UNILATERAL	21.00		
	R6114		PLETHYSMOGRAPHY OR PULSE VOLUME DIGIT WAVE FORM ANALYSIS, MULTIPLE DIGITS, BILATERAL	42.00		
	R6141		DOPPLER EVALUATION OF ARTERIO-VEINUS FISTULA OR MALFORMATION, CONGENITAL OR ACQUIRED, SINGLE OR MULTIPLE INCLUDING SYSTOLIC PRESSURE MEASUREMENTS AND ANALOG VELOCITY *SEE COMMENTS BELOW*	55.00		
			COMMENTS: WAVE FORM ANALYSIS IN VESSELS PROXIMAL AND DISTAL TO SITE (S) OF FISTULA (E)			
	R6141	26	DOPPLER EVALUATION OF ARTERIO-VEINUS FISTULA OR MALFORMATION, CONGENITAL OR ACQUIRED, SINGLE OR MULTIPLE INCLUDING SYSTOLIC PRESSURE MEASUREMENTS AND ANALOG VELOCITY *SEE COMMENTS BELOW*	25.20		
			(26-PROFESSIONAL COMPONENT)			
			COMMENTS: WAVE FORM ANALYSIS IN VESSELS PROXIMAL AND DISTAL TO SITE(S) OF FISTULA(E)			
	R6144		DOPPLER EVALUATION, ARTERIOVENOUS SHUNT, INCLUDING PRESSURE MEASUREMENTS AND ANALOG VELOCITY WAVE FORM ANALYSIS	55.00		

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MEDICAID DOLLAR VALUE		
				S	\$	NS
	R6144	26	DOPPLER EVALUATION, ARTERIOVENOUS SHUNT, INCLUDING PRESSURE MEASUREMENTS AND ANALOG VELOCITY WAVE FORM ANALYSIS (26-PROFESSIONAL COMPONENT)	25.20		
	W9050		ATTENDANCE DURING AND PEDIATRIC CARE TO NEWBORNS AT AT-RISK VAGINAL DELIVERIES BY A PHYSICIAN OTHER THAN THE PHYSICIAN(S) RENDERING MATERNITY CARE. MEDICAL NECESSITY FOR REQUIRED ATTENDANCE MUST BE FULLY DOCUMENTED ON THE HOSPITAL RECORD AS WELL AS A BRIEF EXPLANATION WRITTEN IN ITEM 34 ON THE 1500 NEW JERSEY CLAIM FORM (EXAMPLE: FETAL DISTRESS). IF DIFFICULTIES OCCUR SO THAT CRITERIA OF PROLONGED SERVICES - CODE 99150 OR CRITICAL CARE- CODE 99160 CAN BE MET, THEN CODE 99150 OR 99160 CAN BE SUBSTITUTED IN LIEU OF CODE W9050. TIME BEGINS WITH ONSET OF ATTENDANCE. PAYMENT IS IN ADDITION TO OTHER ELIGIBLE PAYMENT FOR NEWBORN CARE. USE OF THIS CODE PRECLUDES THE USE OF 90600,90605,90610,OR 90620 DURING THE SAME HOSPITALIZATION.	22.00		
	W9055		ATTENDANCE DURING AND PEDIATRIC CARE TO NEWBORN(S) AT CAESAREAN SECTION BY A PHYSICIAN OTHER THAN THE PHYSICIAN(S) RENDERING MATERNITY CARE. IF DIFFICULTIES OCCUR SO THAT CRITERIA OF PROLONGED SERVICES-CODE 99150 OR CRITICAL CARE- CODE 99160 CAN BE MET, THEN CODE 99150 OR 99160 CAN BE SUBSTITUTED IN LIEU OF CODE W9055. TIME BEGINS WITH ONSET OF ATTENDANCE. PAYMENT IS IN ADDITION TO OTHER ELIGIBLE PAYMENT FOR NEWBORN CARE.	22.00		17.00
N	W9090		IMMUNIZATION-HAEMOPHILUS-B POLYSACCHARIDE VACCINE	9.90		9.90
N	W9095		IMMUNIZATION-TETANUS ANTITOXIN	5.45		5.45
	W9105		PSYCHOLOGICAL DIAGNOSTIC INTERVIEW EXAMINATION BY A PSYCHOLOGIST, INCLUDING HISTORY, MENTAL STATUS, OR DISPOSITION (MAY INCLUDE COMMUNICATION WITH FAMILY OR OTHER SOURCES, ORDERING AND INTERPRETATION OF OTHER PSYCHODIAGNOSTIC STUDIES). IN CERTAIN CIRCUMSTANCES OTHER INFORMANTS WILL BE SEEN IN LIEU OF THE PATIENT. CONSULTATIONS FOR PSYCHOLOGICAL EVALUATION OF A PATIENT, INCLUDES EXAMINATION OF A PATIENT AND EXCHANGE OF INFORMATION WITH REFERRING PERSON OR AGENCY. NOTE: WILL REQUIRE FOR REIMBURSEMENT PURPOSES A MINIMUM OF 50 MINUTES OF DIRECT PERSONAL CLINICAL INVOLVEMENT WITH THE PATIENT OR FAMILY MEMBER. NOTE: NO MORE THAN ONE DIAGNOSTIC INTERVIEW EXAMINATION IS REIMBURSABLE PER YEAR FOR THE SAME RECIPIENT BY THE SAME PSYCHOLOGIST.	37.00		26.00
	W9106		CRISIS INTERVENTION-AN EMERGENCY PROCEDURE PROVIDED IN A NURSING HOME BY A PSYCHIATRIC PHYSICIAN TO A RESIDENT OF THAT HOME TO MEET THE IMMEDIATE NEED OF THE RESIDENT IN PSYCHIATRIC CRISIS AND THE NEED OF THE FACILITY. REQUEST FOR THIS SERVICE SHALL BE INITIATED BY THE ATTENDING PHYSICIAN, OR BY THE NURSING SERVICE DIRECTOR, SUPERVISOR OR DESIGNEE. PROCEDURE INCLUDES WRITTEN EVALUATION, DRUG PRESCRIPTION, CONFERENCE WITH STAFF AND RECOMMENDATION OF TREATMENT PLAN. USE OF PROCEDURE IS LIMITED TO ONCE IN SIX MONTHS.	75.00		
	W9113		INDIVIDUAL PSYCHOTHERAPY, BY A PSYCHOLOGIST, WITH CONTINUING PSYCHOLOGICAL DIAGNOSTIC EVALUATION INCLUDING PSYCHOANALYSIS, INSIGHT ORIENTED, BEHAVIOR MODIFYING OR SUPPORATIVE PSYCHOTHERAPY. TIME 25 MINUTES.	19.00		13.00
	W9114		INDIVIDUAL PSYCHOTHERAPY, BY A PSYCHOLOGIST, WITH CONTINUING PSYCHOLOGICAL DIAGNOSTIC EVALUATION INCLUDING PSYCHOANALYSIS, INSIGHT ORIENTED, BEHAVIOR MODIFYING OR SUPPORATIVE PSYCHOTHERAPY. TIME 50 MINUTES.	37.00		26.00
	W9115		GROUP PSYCHOTHERAPY, BY A PSYCHOLOGIST, REQUIRES A MINIMUM OF 90 MINUTES OF DIRECT CLINICAL INVOLVEMENT WITH THE PATIENT AS A MEMBER OF A GROUP, OF WHICH 10 MINUTES CAN BE USED FOR DOCUMENTATION. THE MAXIMUM NUMBER OF THE GROUP IS 8 AND THE REIMBURSEMENT IS PER PERSON PER GROUP SESSION.	8.00		6.00
	W9116		INTERPRETATION OR EXPLANATION, BY A PSYCHOLOGIST, OR RESULTS OF PSYCHOLOGICAL EXAMINATION AND PROCEDURES, OR OTHER ACCUMULATED DATA TO FAMILY OR OTHER RESPONSIBLE PERSONS, OR ADVISING THEM HOW TO ASSIST PATIENT. TIME 25 MINUTES. (FORMERLY FAMILY CONFERENCE)	19.00		13.00

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MEDICAID DOLLAR VALUE		
				S	\$	NS
			NOTE: THIS PROCEDURE MUST BE USED AS AN ADJUNCT TO TREATMENT OF PATIENT OR CLIENT AND IS SUBJECT TO PRIOR AUTHORIZATION AND BILLING AS PART OF PATIENT'S TREATMENT.			
	W9117		FAMILY PSYCHOTHERAPY, BY A PSYCHOLOGIST, (CONJOINT PSYCHOTHERAPY) WITH CONTINUING PSYCHOLOGICAL EVALUATION. TIME 50 MINUTES.	37.00		26.00
	W9118		FAMILY PSYCHOTHERAPY BY A PSYCHOLOGIST, (CONJOINT PSYCHOTHERAPY) WITH CONTINUING PSYCHOLOGICAL EVALUATION. TIME 80 MINUTES.	46.00		32.00
	W9130		BAYLEY SCALE OF INFANT DEVELOPMENT	48.00		34.00
	W9131		BENDER VISUAL - MOTOR GESTALT TEST	15.00		10.00
	W9132		BENTON VISUAL RETENTION TEST	15.00		10.00
	W9133		BLACKY PICTURES	30.00		21.00
	W9134		CATTEL INFANT INTELLIGENCE SCALE	48.00		34.00
	W9135		CHILDREN'S APPERCEPTION TEST	30.00		21.00
	W9136		HOUSE-TREE-PERSON	22.00		15.00
	W9137		HUMAN FIGURE DRAWING (DRAW-A-PERSON)	15.00		10.00
	W9138		KINETIC DRAWINGS	15.00		10.00
	W9139		MERRILL-PALMER SCALE	37.00		26.00
	W9140		MICHIGAN PICTURE TEST	30.00		21.00
	W9141		MINNESOTA DEVELOPMENT	48.00		34.00
	W9142		MMPI (MACHINE SCORED)	22.00		15.00
	W9143		PEABODY PICTURE VOCABULARY TEST	18.00		13.00
	W9144		PROJECTIVE DRAWINGS	15.00		10.00
	W9145		RAVEN'S PROGRESSIVE MATRICES (1938)	30.00		21.00
	W9146		RAVEN'S PROGRESSIVE MATRICES (1947)	18.00		13.00
	W9147		RORSCHACH (OR HOLTZMAN) INKBLOTS	55.00		39.00
	W9148		SENTENCE COMPLETION (ANY FORM)	15.00		10.00
	W9149		SCHOOL APPERCEPTION METHOD	30.00		21.00
	W9150		SLOSSON INTELLIGENCE SCALE	18.00		13.00
	W9151		STANFORD - BINET	55.00		39.00
	W9152		SYMONDS PICTURE STORY TEST	30.00		21.00
	W9153		THEMATIC APPERCEPTION TEST	30.00		21.00
	W9154		VINELAND SOCIAL MATURITY SCALE	37.00		26.00
	W9155		WECHSLER ADULT INTELLIGENCE SCALE	55.00		39.00
	W9156		WECHSLER INTELLIGENCE SCALE FOR CHILDREN	55.00		39.00
	W9157		WECHSLER INTELLIGENCE SCALE FOR CHILDREN-REVISED	55.00		39.00
	W9158		WECHSLER PRIMARY & PRESCHOOL INTELLIGENCE SCALE (WPPSI)	55.00		39.00
	W9159		WECHSLER MEMORY SCALE	26.00		18.00
	W9160		WIDE RANGE ACHIEVEMENT TEST	18.00		13.00
	W9161		OTHER (BY REPORT)		BR	BR
	W9170		PERITONEAL DIALYSIS, 3RD TO 14TH DAY	13.00		13.00
	W9200		SUBNORMAL VISION EXAM, A CONTINUATION AFTER A COMPREHENSIVE EYE EXAM, WITH LIMITED ADDITIONAL TESTS TO DETERMINE IF SUBNORMAL VISION DEVICES WOULD BENEFIT VISION PROBLEMS THAT CANNOT BE NORMALIZED BY CONVENTIONAL SPECTACLES.	10.00		

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MEDICAID DOLLAR VALUE		
				\$	\$	NS
			NOTE: THIS SUBNORMAL VISION EXAMINATION IS USED AS AN ADDITIONAL PROCEDURE AT THE TIME OF THE ORIGINAL EXAMINATION			
	W9205		SUBNORMAL VISION WORK-UP WITH WRITTEN REPORT. PRIOR AUTHORIZATION REQUIRED. THIS IS A BATTERY OF EXTENSIVE TESTS AND INDEPENDENT PROCEDURES TO DETERMINE A DEVICE OR A COMBINATION OF DEVICES THAT WOULD PERMIT AN INDIVIDUAL TO ENHANCE VISUAL FUNCTIONS.	60.00		
	W9210		VISION TRAINING WORKUP AND WRITTEN REPORT (PRIOR AUTHORIZATION REQUIRED)	25.00		
N	W9215		VISION TRAINING WORKUP AND WRITTEN REPORT (PRIOR AUTHORIZATION REQUIRED)	9.00		
			SCREENING EXAMINATIONS—THIS SHALL CONSTITUTE PROCEDURES PERFORMED TO DETERMINE WHETHER A COMPREHENSIVE EXAMINATION IS NECESSARY. AS A MINIMUM, THE SCREENING EXAMINATION SHALL CONSIST OF THE FOLLOWING: 1. EXTERNAL EXAMINATION 2. VISUAL ACUITY IN EACH EYE 3. GROSS MUSCLE BALANCE			
			NOTE: IT IS THE INTENT OF THE PROGRAM TO REIMBURSE THE OPHTHALMOLOGIST OR THE OPTOMETRIST FOR EITHER A SCREENING EXAMINATION OR A COMPREHENSIVE EYE EXAMINATION RENDERED A PATIENT, NOT BOTH. IF, AS A RESULT OF THE SCREENING EXAMINATION, IT IS FELT THAT A COMPREHENSIVE EXAMINATION IS NECESSARY, IT SHOULD BE COMPLETED AT THAT TIME OR AT THE EARLIEST MUTUAL CONVENIENCE OF THE PROVIDER AND PATIENT. THE SCREENING EXAMINATION, IN THIS INSTANCE, BECOMES AN INTEGRAL PART OF THE COMPREHENSIVE EXAMINATION AND THE CLAIM SUBMITTED TO THE PROGRAM SHOULD BE FOR A COMPREHENSIVE EYE EXAMINATION. IF HOWEVER, THE SCREENING EXAMINATION REVEALS THAT NO FURTHER EXAMINATION IS NECESSARY, A CLAIM SHOULD BE SUBMITTED FOR A VISUAL SCREENING EXAMINATION.			
			MEDICAID ONLY			
N	W9220		SLIT LAMP EXAMINATION	8.00		
	W9225		LASER INTERFEROMETRY, UNILATERAL	25.00		
N	W9230		OPHTHALMOSCOPY (FUNDOSCOPY) WITH MYDRIASIS, DIRECT AND/OR INDIRECT METHODS (INDEPENDENT PROCEDURE)	8.00		
	W9300		EXERCISE TOLERANCE TEST - MASTERS OR EQUIVALENT INCLUDING APPROPRIATE ELECTROCARDIOGRAMS INTERPRETATION AND REPORT PERFORMED IN THE OFFICE, OUTPATIENT HOSPITAL OR NURSING HOME.	21.00		
			NOTE: THE REPORT MUST BE RECORDED ON THE MOUNTED TRACINGS.			
	W9310		PATIENT-ACTIVATED ECG RECORDERS OFFICE OR NURSING HOME, WITH OR WITHOUT TRANSTELEPHONIC TRANSMISSIONS OF THE RECORDING WITH OR WITHOUT VOICE RECORDING. INCLUDES ALL SERVICE (USE OF EQUIPMENT DECODER, PROFESSIONAL INTERPRETATION, REPORT, ETC.). NO ADDITIONAL ALLOWANCES FOR EITHER TIME OR NUMBER OF EVENTS RECORDED.	51.00		
	W9355		ELECTRONIC PACEMAKER ANALYSIS WITH SUPPRESSION	25.00		

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MEDICAID DOLLAR VALUE		
				S	\$	NS
	W9375		TRANSTELEPHONIC CARDIAC PACEMAKER MONITORING - ONCE PER WEEK LIMITATION: 1. MERCURY-ZINC BATTERY POWERED PACEMAKERS 1ST MONTH 19TH THROUGH TO FAILURE 2. LITHIUM BATTERY POWERED PACEMAKERS 1ST MONTH 3. ARCOLITH 3(LITHIUM PACEMAKERS) 20TH MONTH THROUGH TO FAILURE 4. ARCOLITH 4 (LITHIUM PACEMAKER) 28TH MONTH THROUGH TO FAILURE 5. ARCOLITH 6 (LITHIUM PACEMAKER) 50TH MONTH THROUGH TO FAILURE 6. AMERICAN TECHNOLOGY - MODEL DU15 (LITHIUM) 24TH MONTH THROUGH TO FAILURE 7. CORATOMIC-MODEL L500 (LITHIUM) 24TH MONTH THROUGH TO FAILURE INCLUDES: 1. PROFESSIONAL EVALUATION BY PHYSICIAN 2. PROVISION OF TRANSMITTER BY THE PROVIDER 3. TWENTY-FOUR HOUR - 7 DAY AVAILABILITY 4. COST OF PHONE CALL, TRANSMITTER, ETC. 5. MAINTENANCE OF RECORDS BY PROVIDER 6. SUBMISSION OF REPORTS TO ONE OR MORE PHYSICIANS INVOLVED IN THE PATIENT'S CARE.		16.00	
	W9376		TRANSTELEPHONIC CARDIAC PACEMAKER MONITORING - ONCE EVERY TWO WEEKS LIMITATION. 1. MERCURY-ZINC BATTERY POWERED PACEMAKERS 16TH MONTH THROUGH 18TH MONTH 2. AMERICAN TECHNOLOGY - ALL MODELS - EXCEPT MODEL DU15 24TH MONTH THROUGH TO FAILURE 3. CORDIS-190 MODEL ONLY 1ST MONTH THROUGH TO FAILURE INCLUDES: 1. PROFESSIONAL EVALUATION BY A PHYSICIAN 2. PROVISION OF TRANSMITTER BY THE PROVIDER 3. TWENTY-FOUR HOUR - 7 DAY AVAILABILITY 4. COST OF PHONE CALL, TRANSMITTER, ETC. 5. MAINTENANCE OF RECORDS BY PROVIDER 6. SUBMISSION OF REPORTS TO ONE OR MORE PHYSICIANS INVOLVED IN THE PATIENT'S CARE.		16.00	
	W9377		TRANSTELEPHONIC CARDIAC PACEMAKER MONITORING - ONCE EVERY FOUR WEEK LIMITATION. 1. MERCURY-ZINC BATTERY POWERED PACEMAKERS 2ND MONTH THROUGH TO 15TH MONTH 2. LITHIUM BATTERY POWERED PACEMAKERS 2ND MONTH THROUGH TO FAILURE 3. ARCOLITH 3 (LITHIUM PACEMAKERS) 2ND MONTH THROUGH 19TH MONTH 4. ARCOLITH 4 (LITHIUM PACEMAKERS) 2ND MONTH THROUGH 27TH MONTH 5. ARCOLITH 6 (LITHIUM PACEMAKERS) 2ND MONTH THROUGH 49TH MONTH 6. AMERICAN TECHNOLOGY - ALL MODELS 1ST MONTH THROUGH 23RD MONTH 7. CORATOMIC-MODEL L500 (LITHIUM) 1ST MONTH THROUGH 23RD MONTH INCLUDES: 1. PROFESSIONAL EVALUATION BY A PHYSICIAN 2. PROVISION OF TRANSMITTER BY THE PROVIDER 3. TWENTY-FOUR HOUR - 7 DAY AVAILABILITY 4. COST OF PHONE CALL, TRANSMITTER, ETC. 5. MAINTENANCE OF RECORDS BY PROVIDER 6. SUBMISSION OF REPORTS TO ONE OR MORE PHYSICIANS INVOLVED IN THE PATIENT'S CARE.		16.00	

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MEDICAID DOLLAR VALUE		
				\$	\$	NS
	W9378		TRANSTELEPHONIC CARDIAC PACEMAKER MONITORING- WITH EKG- ONCE PER WEEK LIMITATION. 1. MERCURY-ZINC BATTERY POWERED PACEMAKERS 1ST MONTH 19TH MONTH THROUGH TO FAILURE. 2. LITHIUM BATTERY POWERED PACEMAKERS 1ST MONTH 3. ARCOLITH 3 (LITHIUM PACEMAKERS) 20TH MONTH THROUGH TO FAILURE 4. ARCOLITH 4 (LITHIUM PACEMAKERS) 28TH MONTH THROUGH TO FAILURE 5. ARCOLITH 6 (LITHIUM PACEMAKERS) 50TH MONTH THROUGH TO FAILURE 6. AMERICAN TECHNOLOGY- MODEL DU15 (LITHIUM) 24TH MONTH THROUGH TO FAILURE 7. CORATOMIC-MODEL L500 (LITHIUM) 24TH MONTH THROUGH TO FAILURE INCLUDES: 1. PROFESSIONAL EVALUATION BY A PHYSICIAN 2. PROVISION OF TRANSMITTER BY THE PROVIDER 3. TWENTY-FOUR HOUR - 7 DAY AVAILABILITY 4. COST OF PHONE CALL, DISPOSABLE ELECTRODES, TRANSMITTER, ETC. 5. MAINTENANCE OF RECORDS BY PROVIDER 6. SUBMISSION OF REPORTS TO ONE OR MORE PHYSICIANS INVOLVED IN THE PATIENT'S CARE 7. RECORD TO INCLUDE SPIKE PLUS PULSE OR ECG	16.00		
	W9379		TRANSTELEPHONIC CARDIAC PACEMAKER MONITORING WITH EKG- ONCE EVERY TWO WEEKS LIMITATION: 1. MERCURY-ZINC BATTERY POWERED PACEMAKERS 16TH MONTH THROUGH 18TH MONTH 2. AMERICAN TECHNOLOGY - ALL MODELS - EXCEPT MODEL DU15 24TH MONTH THROUGH TO FAILURE 3. CORDIS-190 MODEL ONLY 1ST MONTH THROUGH TO FAILURE INCLUDES: 1. PROFESSIONAL EVALUATION BY A PHYSICIAN 2. PROVISION OF TRANSMITTER BY THE PROVIDER 3. TWENTY-FOUR HOUR - 7 DAY AVAILABILITY 4. COST OF PHONE CALL, DISPOSABLE ELECTRODES, TRANSMITTER, ETC. 5. MAINTENANCE OF RECORDS BY PROVIDER 6. SUBMISSION OF REPORTS TO ONE OR MORE PHYSICIANS INVOLVED IN THE PATIENT'S CARE 7. RECORD TO INCLUDE SPIKE PLUS PULSE OR ECG.	16.00		
	W9380		TRANSTELEPHONIC CARDIAC PACEMAKER MONITORING WITH EKG- ONCE EVERY FOUR WEEKS LIMITATION: 1. MERCURY-ZINC BATTERY POWERED PACEMAKERS 2ND MONTH THROUGH 15TH MONTH 2. LITHIUM BATTERY POWERED PACEMAKERS 2ND MONTH THROUGH TO FAILURE 3. ARCOLITH 3 (LITHIUM PACEMAKERS) 2ND MONTH THROUGH 19TH MONTH 4. ARCOLITH 4 (LITHIUM PACEMAKERS) 2ND MONTH THROUGH 27TH MONTH 5. ARCOLITH 6 (LITHIUM PACEMAKERS) 2ND MONTH THROUGH 49TH MONTH 6. AMERICAN TECHNOLOGY - ALL MODELS 1ST MONTH THROUGH 23RD MONTH 7. CORATOMIC - MODEL L500 (LITHIUM) 1ST MONTH THROUGH 23RD MONTH INCLUDES: 1. PROFESSIONAL EVALUATION BY A PHYSICIAN 2. PROVISION OF TRANSMITTER BY THE PROVIDER 3. TWENTY-FOUR HOUR- 7 DAY AVAILABILITY 4. COST OF PHONE CALL, DISPOSABLE ELECTRODES, TRANSMITTER, ETC. 5. MAINTENANCE OF RECORDS BY PROVIDER 6. SUBMISSION OF REPORTS TO ONE OR MORE PHYSICIANS INVOLVED IN THE PATIENT'S CARE 7. RECORD TO INCLUDE SPIKE PLUS PULSE OR ECG.	16.00		
	W9400		THERMOGRAPHY, BREAST (IF BILATERAL, USE MODIFIER 50)	15.00		
N	W9500		PREPARATION OF ALLERGY EXTRACTS—EACH 5CC	8.00		
N	W9760		INITIAL EVALUATION VISIT (NEW ILLNESS) BY A PHYSICAL THERAPIST IN A PHYSICIAN'S OFFICE. PAYABLE ONLY TO THAT PHYSICIAN WITH NO PRIOR AUTHORIZATION REQUIRED. REFER TO CODE 97799 FOR TREATMENT VISITS WHERE PRIOR AUTHORIZATION IS REQUIRED.	7.00	7.00	

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MEDICAID DOLLAR VALUE		
				S	\$	NS
N	W9820		<p>EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) THROUGH AGE 20</p> <ol style="list-style-type: none"> 1. COMPLETE INITIAL OR INTERVAL HISTORY 2. DEVELOPMENTAL ASSESSMENT 3. COMPLETE UNCLOTHED PHYSICAL EXAMINATION BY A PHYSICIAN, OR A NURSE PRACTITIONER UNDER THE DIRECT PERSONAL SUPERVISION OF A PHYSICIAN, TO INCLUDE: <ol style="list-style-type: none"> (A) MEASUREMENTS: HEAD CIRCUMFERENCE TO 25 MONTHS, BLOOD PRESSURE FROM AGE 3 AND OLDER, HEIGHT AND WEIGHT (B) VISION AND HEARING SCREENING (C) NUTRITIONAL ASSESSMENT 4. ASSESSMENT OF IMMUNIZATIONS AND ADMINISTRATION OF IMMUNIZATIONS. (SEE APPROPRIATE PROCEDURE CODE (S) 90705 THROUGH 90709 FOR IMMUNIZATION REIMBURSEMENT.) 5. REFERRAL FOR FURTHER DIAGNOSIS AND TREATMENT OR FOLLOW-UP OF ALL CORRECTABLE ABNORMALITIES UNCOVERED OR SUSPECTED 6. REFERRAL TO A DENTIST FOR CHILDREN AGE 3 AND OLDER 7. APPROPRIATE LABORATORY PROCEDURES PERFORMED OR REFERRED IF MEDICALLY NECESSARY <ol style="list-style-type: none"> (A) HGB. THREE TIMES: 6-8 MONTHS, 2-3 OR 4-6 YEARS AND 10-12 YEARS. (B) URINALYSIS A MINIMUM OF TWICE: 18-24 MONTHS AND 13-15 YEARS. (C) TUBERCULIN THREE TIMES: 6-8 OR 9-12 MONTHS, 4-6 YEARS AND 10-12 OR 13-15 YEARS. <p>MEDICAL RECORDS SHOULD SUBSTANTIATE THE ABOVE SERVICES AND SHOULD DOCUMENT SIGNIFICANT POSITIVE AND NEGATIVE FINDINGS. IT IS RECOMMENDED THAT CONSULTATION AND DISCUSSION WITH THE PATIENT OR FAMILY REGARDING FINDINGS BE AN INTEGRAL PART OF EVERY EXAMINATION.</p> <p>NOTE: LABORATORY PROCEDURES PERFORMED BY A PHYSICIAN FOR HIS PATIENTS IN HIS OFFICE ARE REIMBURSABLE TO THE PHYSICIAN; IF PERFORMED BY OUTSIDE INDEPENDENT LABORATORIES, THE LABORATORY MUST SUBMIT THE CLAIM. LEAD SCREENING TEST SHOULD BE SENT TO THE STATE DEPARTMENT OF HEALTH.</p> <p>NOTE: PROCEDURE CODE W9820 CAN BE USED ONLY ONCE FOR THE SAME PATIENT DURING ANY 12 MONTH PERIOD BY THE SAME PHYSICIAN, GROUP, SHARED HEALTH CARE FACILITY, OR PRACTITIONERS SHARING A COMMON RECORD. IF USED FOLLOWING AN ANNUAL HEALTH MAINTENANCE EXAMINATION (90751, 90752, 90753, 90754, 90761, 90762 AND 90763) WITHIN THE PRECEDING 12 MONTHS BY THE SAME PHYSICIAN, GROUP, SHARED HEALTH CARE FACILITY OR PRACTITIONER SHARING A COMMON RECORD, THIS CODE WILL AUTOMATICALLY BE DOWNGRADED IN PAYMENT TO A FOLLOW UP PREVENTATIVE HEALTH CARE VISIT. REIMBURSEMENT FOR CODE W9820 IS CONTINGENT UPON THE FOLLOWING CONDITIONS: UNLESS A COMPLETED MC-19 FORM ACCOMPANIES THE 1500-NJ CLAIM FORM WITHIN 30 DAYS OF THE DATE OF SERVICE, REIMBURSEMENT WILL BE REDUCED TO THE LEVEL OF AN ANNUAL HEALTH MAINTENANCE EXAMINATION I.E. \$22.00-\$17.00.</p> 	23.00		18.00
	Z4000		DRUG DISPENSING BY MP—PLAN CASE MANAGER (OFFICE ONLY)			

A P P E N D I X B (Medicine)

C O N T E N T

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90215	1	90712	11	95001	9
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90250	2, 14	90724	11	95003	9
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90315	1	90753	11	95041	9
90320	1	90754	11	95042	9
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90360	2	90761	11	95925	10
90370	2	90762	11	96912	7
90415	1	90763	11	97799	7
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90510	6	90844	16	99195	7
90515	6	90847	17	H5025	17
90517	6	90887	17	J2790	11
90550	6	92002	15	W9090	11
90560	6	92004	15	W9095	11
90570	6	92012	15	W9215	16
90600	4	92014	15	W9220	15
90605	4	92018	15	W9230	15
90610	4	92019	15	W9500	9
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90653	5	92065	15	W9820	11

APPENDIX B

(Medicine)

QUALIFIERS

INITIAL VISIT - NEW PATIENT (Discontinued Procedure Codes 9000, 9010, 9020)

90015 When reference is made, in your CPT manual to a New Patient or
90017 Initial Care, the intent of Medicaid is to consider this service as
90020 the Initial Visit.
90215

90220 When the setting for this Initial Visit is an Office or Sheltered
90315 Boarding Home for reimbursement purposes, it excludes preventive
90320 health care for patients through age 20, it is limited to a single
90415 visit and future use of this code will be reimbursed as a Routine or
90420 Follow-Up visit. This is applicable if this examination of the
recipient is by the same physician, group of physicians, involves a
shared health care facility or group physicians sharing a common
record. Reimbursement for an Initial Office Visit also precludes
subsequent reimbursement for an Initial Sheltered Boarding Home
Visit and vice versa.

Reimbursement for an Initial Office Visit or Initial Sheltered
Boarding Home Visit will be disallowed and the fee downgraded to a
routine visit, if an Annual examination, EPSDT examination or office
consultation were billed within a twelve month period, by the same
physician, group, shared health care facility, or practitioners
sharing a common record.

If the setting is a Skilled Nursing, Intermediate Care, Long Term
Care Facility or Hospital, the Initial Visit concept will still
apply when considered for reimbursement purposes despite CPT
reference to the terms Initial Care or Initial Hospital Care as
applying to a new or established patient. Subsequent readmissions to
the same facility may be designated as Initial Visits as long as a
time interval of 30 days or more has elapsed between admissions.

Initial Hospital Visit will be disallowed to the same physician,
group, shared health care facility, or practitioners sharing a com-
mon record who submits a claim for a consultation and transfers the
patient to their service.

It is also to be understood that in order to receive reimbursement
for an Initial Visit, the following minimal documentation must be on
the record regardless of the setting where the examination was per-
formed.

Example:

1. Chief complaint(s)
2. Complete history of the present illness and related systemic review - including recordings of pertinent negative findings.
3. Pertinent past medical history.
4. Pertinent family history
5. A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings.
6. Working diagnoses and treatment plan including ancillary services and drugs ordered.

NOTE: (1) Boarding Home records should be part of the office records.

- (2) If the history and physical examination noted above is not personally performed by the billing physician in a hospital or health care facility, then reimbursement will be downgraded to a routine visit if that criteria is met, e.g., daily hospital care, subsequent skilled nursing visit, etc.

ROUTINE VISIT OR FOLLOW-UP CARE VISIT (Discontinued Procedure Code: 0001, 0002, 0003, 0004)

(Excludes Preventive Health Care for patients through 20 years of age.)

90050 Routine visit or Follow-Up Care Visit is defined as the care and
90060 treatment by a physician, which includes those procedures ordinarily
90070 performed during a health care visit, which is dependent upon the
90250 setting and the physician's discipline.

90260

90270 The setting could be office, hospital, skilled nursing, intermediate
90350 care, long term care facilities, nursing home or boarding home.

90360

90370 In order to document the record for reimbursement purposes, a
90450 progress note for the noted visits should include the following:

90460

90470

1. In an office, or Boarding Home setting.
 - a) Purpose of visit
 - b) Pertinent history obtained.
 - c) Pertinent physical findings including pertinent negative findings based on the above;
 - d) Procedures, if any, with results;
 - e) Lab, x-ray, EKG, etc., ordered with results;
 - f) Diagnosis.
2. In a hospital or long term care facility setting, including Skilled Nursing and Intermediate Care;

- a) Update of symptoms;
- b) Update of physical findings;
- c) Resume of findings of procedures, if any done;
- d) Pertinent positive and negative findings of lab, x-ray, EKG, consultations, etc.;
- e) Additional planned studies, if any, and why;
- f) Treatment changes, if any.

HOME VISITS (Discontinued Procedure Code: 9003)

90150 Home Visit (House Call) - does not apply to Sheltered Boarding Home
 90160 or Nursing Home setting.
 90170

A physician visit limited to care and treatment of an individual who by contemporary standards would be too ill to go to a physician's office and/or is "home bound" due to his/her physical disability. If more than one patient is seen on the visit, the fee for the additional visit will be as if it were performed in the office. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a 90150.

The record and documentation of a home visit shall become part of the office progress notes and shall include, as appropriate, the following information:

1. Purpose of visit;
2. Pertinent history obtained;
3. Pertinent physical findings, including pertinent negative physical findings based on 1) and 2);
4. Procedures, if any performed, with results;
5. Lab, x-ray, ECG, etc, ordered with results;
6. Diagnosis(s) plus treatment plan status relative to present or pre-existing illness(s) plus pertinent recommendations and actions.

Note: The new "Home Visit (House Call)" code does not distinguish between specialist and non-specialist. Also, the Initial Home Visit is being dropped as a separate entity.

ANNUAL HEALTH MAINTENANCE EXAMINATION (Discontinued Procedure Code: 9008)

90760 For reimbursement purposes, the annual health maintenance examination limited to patients age 21 and over must contain as a minimum the following information on the record. It also will be limited to a maximum of one such examination a year and also is limited to an office type setting. It must be justified by Medical Necessity. The record should show:

1. Interval history.
2. Completing or updating the pertinent past medical history, family history and social/personal history.

3. Complete systemic review including all systems and pertinent negative findings. Complete total systems physical examination permitting the deferment of a system for medically acceptable reason, e.g., deferment of pelvic examination in an individual under the care of a gynecologist. Pertinent negative findings of the physical examination are to be recorded.
4. Working diagnosis and treatment plan, including ancillary services and drugs ordered, if applicable.

An Annual examination will be disallowed if an Initial Office Visit, Annual Examination, Initial Boarding Home Visit, or Office Consultation has been performed during the prior twelve months by the same physician, group, shared health care facility or practitioners sharing common records. Routine office visit could then be applicable if criteria are met.

CONSULTATIONS

A consultation is recognized for reimbursement only when performed by a specialist recognized as such by this Program and the request has been made by or through the patient's attending physician and the need for such a request would be consistent with good medical practice. Two types of consultation are recognized for reimbursement - one limited in extent and one comprehensive in scope.

LIMITED CONSULTATION: (Discontinued Procedure Code: 9029)

90600 Appropriate CPT codes which are presently compatible are Codes
 90605 90600, 90605 and 90610. The area being covered for reimbursement
 90610 purposes is "limited" in the sense that it requires less than the
 requirements designated as "comprehensive" as noted below.

COMPREHENSIVE CONSULTATION: (Discontinued Procedure Code: 9030)

90620 In order to receive reimbursement for CPT Code 90620 which replaces the discontinued Code 9030 (consultation comprehensive), the same criteria must be met that had been previously required, namely, the performance of a total systems evaluation by history and physical examination including a total systems review and total system physical examination. The alternative to that would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

Reimbursement for Code 90620 (Comprehensive Consultation) requires the following applicable statements or language essentially similar to those statements to be inserted into Item 34 of the 1500 N.J. Claim Form. The form is to be signed by the provider who performed the consultation.

1. I personally performed a total (all) systems evaluation by history and physical examination, or

2. This consultation utilized 60 or more minutes of my personal time.

Failure to comply with the above will result in the consultation being downgraded to the reimbursement of Code 90610.

The following rules regarding consultations should also be recognized:

1. If a consultation is performed in an inpatient or outpatient setting and the patient is then transferred to the consultant's service during that course of illness then the provider may not, in addition, bill for an Initial Visit if he has or intends to bill for the consultation.
2. If there is no referring physician, then an Initial Visit code should be used instead of a consultation code.
3. If the patient is seen for the same illness on repeated visits, by the same consultant, then these visits are considered as routine visits or follow-up care visits and not as consultations. In addition, the criteria for concurrent care would need to be met to warrant reimbursement.
4. Consultation codes 90600, 90605, 90610 and 90620 will be declined in an Office or Boarding home setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians sharing common records. A routine visit code is applicable under these circumstances.
5. If a prior claim for code 90620 has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the same physician, physician group, shared health care facility or physicians using a common record except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be 90600, 90605, or 90610 if their criteria are met.

SECOND OPINION PROGRAM CONSULTATION

90653YY

A consultation to satisfy the requirements of the mandated "Second Opinion" program will be reimbursed only if the requirements of that program are met and the consultation has been performed by the appropriate Board Certified Specialist who has signed a separate provider agreement and whose selection has been through Prudential's Second Opinion Referral Service. The appropriate CPT code is 90653YY. Reference should be made to Appendix D of the Surgery Section (4.3) of this subchapter for more detail concerning the program. An indicator "S" will be found in the "IND" column of the HCPCS code listing in the Surgery Section to indicate that that procedure requires a Second Opinion Consultation.

THIRD OPINION CONSULTATION

90653ZZ In the event that a patient receives two different points of view relative to a "Second Opinion" procedure, he/she may, if unable to reach a decision, request a Third Opinion. The CPT Procedure Code is 90653ZZ. Note: A Third Opinion consultation must be at the patient's request and under the circumstances described.

PROLONGED DETENTION (Discontinued Procedure Code: 9071)

99150 Prolonged Detention with or without Critical Care will be covered
99151 under CPT 99150, 99151, and 99160 but the service must be consistent
99160 with the following narrative in order to be reimbursed.

The patient's situation requires constant physician attendance which is given by the physician to the exclusion of his other patients and duties and, therefore, for him, represents what is beyond the usual service. This must be verified by the applicable records as defined by the setting and which records must show in the physician's handwriting the time of onset and time of completion of the service. All settings are applicable such as office, hospital, home, sheltered boarding home and nursing home.

Note: This code may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

Note: The basis for this type of claim should be apparent on the 1500 New Jersey claim form. The listed fee of \$37 for specialist, \$32 for non-specialist is per hour.

EMERGENCY ROOM SETTING

A. Physician's Use of Emergency Room Instead of Office:

90050 When a physician sees his/her patient in the Emergency Room
90060 instead of his/her office, the physician must use the same codes
90070 for the visit that would have been used if seen in the physi-
cian's office (90050, 90060 or 90070 only). Records of that
visit should become part of the notes of the office chart.

B. Hospital-Based Emergency Room Physicians:

90510 When patients are seen by hospital-based Emergency Room physi-
90515 cians who are eligible to bill the Medicaid Program, then the
90517 appropriate CPT code is used. The "Visit" codes are limited to
90550 90510, 90515, 90517, 90550, 90560, 90570.
90560
90570

DRAWING OF BLOOD (Discontinued Procedure Code: 9076)

36415 For reimbursement purposes, reference is to collection of blood by venapuncture only and limited to office, home or nursing home. Payment is once per patient visit and will not be applicable if the laboratory study is to be done by the physician's own office. The CPT Procedure Code is 36415.

THERAPEUTIC PHLEBOTOMY (Discontinued Procedure Code: 9400)

99195 Therapeutic Phlebotomy - CPT Code 99195, is reimbursable only in an office setting when performed by a physician and includes all necessary supplies, equipment and all related professional services.

(Do not confuse with code 36415, drawing of blood for laboratory tests.)

THERAPEUTIC APHERESIS (Discontinued Procedure Code: 9416 - included in new code)

36520 Plasma and/or cell exchange CPT code 36520 includes discontinued code 9416. For reimbursement purposes, the service must be performed by or in the presence of the single billing physician and is limited to that physician. It includes all related procedures, patient evaluation, monitoring and treatment of complications and is limited to medically necessary conditions for which this procedure is no longer considered experimental by Medicare.

PUVA THERAPY OF PSORIASIS (Discontinued Procedure Codes: 9423 and 9424)

96912 PUVA Therapy of Psoriasis - CPT 96912 - for reimbursement in an office setting requires during the initial 30-day course of therapy that the visit must include all standard office visit services plus required ultra-violet radiation and is limited to a 30-day course of treatment which includes the cost of the Psoralen.

Repeat second and third 30-day course of treatment does require submitted documentation of medical necessity.

PHYSICAL THERAPY SESSION (Physician's Office) (Discontinued Procedure Code: 9090)

97799
W9760 Physical Therapy Session - present CPT code 97799. Prior authorization is a requirement for reimbursement. Minimum time 30 minutes. Refer to Subchapter 2. (2.13 (a) 3. - Rehabilitative Services) for specifics. The Initial Evaluation Visit is found under code W9760 and does not require prior authorization.

INJECTION POLICY (Discontinued Procedure Code: 9072)

90799

Injection Policy - present CPT code 90799. For reimbursement purposes, this new code refers to any injection whether intradermal, subcutaneous, intramuscular, intravenous or intra-arterial, which is given in an Office, Home, or Sheltered Boarding Home. Reimbursement is on a flat fee basis and is all inclusive for the cost of the service as well as the materials. It is to be administered by the physician or under his/her supervision by his/her designee who must be a person permitted to do so under the law. A visit for the sole purpose of an injection is reimbursable only as an injection and not as an office visit and an injection. However, if the criteria of an office visit can also be met then an injection, if medically indicated, can also be considered as an addition to the visit. All drugs administered must be consistent with the diagnosis and conform to all accepted medical and pharmacological principals in respect to dosage frequency and route of administration.

No reimbursement will be made for:

1. Injections of Vitamins, Liver and Iron or combinations thereof, except in laboratory proven deficiency states requiring parenteral therapy (e.g., Vitamin B-12 in Pernicious Anemia.)
2. Injections given as placebos or those containing amphetamines or derivatives thereof.
3. Injections of estrogens when used in treatment of the Menopausal Syndrome or injections of any type used as treatment for obesity.
4. Injections given as a pre-operative medication or as a local anesthetic which is part of an operative or surgical procedure since these injections are normally included in the listed fee for the procedure.
5. Intravenous and Intra-arterial injections are reimbursable only when performed by the physician.

INJECTIBLE DRUGS - Reimbursable Per Se

Drugs otherwise reimbursable which are to be administered by injection and which will not require prior authorization, are:

1. Those given in Long Term Care Facilities by facility personnel and written for on the order sheet by the physician.
2. Parenteral antineoplastic drugs F.D.A. approved.
3. Insulin for self-administration.

The injectible drugs in Item 2 can then be obtained by a prescription written in the patient's name and then given by the physician who files his claim under code 90799.

Prior authorization from the Medical Consultant of the Local Medicaid District Office is required for:

1. Immune Serum Globulin (ISG) when used for a medically acceptable purpose and is not available free from the New Jersey State Department of Health or other agency.
2. Hymenoptera Venom for immunization.
3. Unlisted immunization.
4. Drugs to be administered to a patient by other than the physician or his employee. (Family, VNA, etc.).

These injectible drugs can then be obtained by a prescription written in the patient's name. Items 1, 2 and 3 will then be given by the physician who files a claim under code 90799.

In filing a claim, insert Procedure Code 90799 as a separate item in section 24 under the heading Procedure Code. Follow this in 24-D with name, dose of drug and route of administration. In 23-A, give the complete diagnoses for which the injection was given.

ALLERGY TESTING (Discontinued Procedure Codes: 9300X through 9313X)

- 95000 The allowance for these codes is for 10 tests.
95001
- 95002 The allowance for these codes is for 20 tests.
95003
- 95005 Insect sting allergy testing includes test material.
- 95023 Testing in excess of 60 tests will be reimbursable per 20 tests.
- 95040 The allowance for these codes is for each test.
95041
95042
95043
- W9500 Preparation of allergy extracts, each 5 cc - see W9500 in Appendix A of this Medicine Section.

MILEAGE (Discontinued Procedure Code: 9070)

- 99082 CPT code 99082 will require, in order to be reimbursed, a distance in excess of 20 miles round trip. It may not be used for Hospital or

Nursing Home calls and is limited to once per trip regardless of number of patients seen.

BRAIN-STEM-EVOKED RESPONSE TESTING (Discontinued Procedure Codes: 9339 and 9346)

95925 Not reimbursable for initial testing, general screening, research
92280 studies or any situation where usefulness has not been clearly
92585 established and, therefore, is without controversy.

CPT 95925 for reimbursement requires, in addition to code narrative, the interpretation of the study.

CPT 92280 - discontinued code 9339 - for reimbursement purposes refers to a visual brain-stem-evoked response (VBR) with interpretation. Reimbursable to hospital outpatient department as a hospital charge or to a qualified provider (office setting). The study must be personally performed by any of the following disciplines trained and experienced with VBR testing, namely Ophthalmologists, Optometrists, Neurologists, Neurosurgeons, and Psychiatrists.

Criteria for testing:

1. Inconclusive test results by standard vision testing for:
 - a) neonates and infants at risk for vision loss.
 - b) children and adults who cannot perform behavioral testing.
2. Suspected organic neurologic lesion within or proximal to the visual pathway.

CPT - 92585 - discontinued code 9346 - for reimbursement purposes refers to auditory brain-stem-evoked-response (ABR) with interpretation. Reimbursable to hospital outpatient department as a hospital charge or to a qualified provider (office setting). The study must be personally performed by any of the following disciplines trained and experienced in ABR, namely Otologists, Otolaryngologists, Neurologists, Psychiatrists, Neurosurgeons as well as a Certified Audiologist employed by any of the aforementioned individuals.

Criteria for testing:

1. Inclusive test results by standard audiometric testing for:
 - a) neonates and infants at risk for hearing loss.
 - b) children and adults who cannot perform behavioral testing
2. Suspected organic neurologic lesion within or proximal to the auditory pathways beyond the peripheral organs. Includes unilateral sensorineural hearing loss with medical evidence or retro-cochlear pathology.

INFANT, CHILD AND ADOLESCENT CARE

90701 Immunization Procedures - The reimbursement for an immunization procedure includes the service and the materials. If the criteria for an office visit can also be met, then the immunization and the office visit may be claimed utilizing the appropriate procedure codes.

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90707 In the event there is the need for a specific immunization not listed as a covered service, the provider should obtain prior authorization from the Medicaid District Office prior to the administration of the vaccine.

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90724 Early Periodic Screening Diagnosis And Treatment (EPSDT) is found under code W9820 in Appendix A.

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W9090

W9095

W9820

PREVENTIVE HEALTH CARE VISIT - ANNUAL HEALTH MAINTENANCE EXAMINATION
(Discontinued Procedure Code: 9006)

90751 CPT Code 90751, 90752, 90753, 90754, 90761, 90762, and 90763, replaces former code 9006 - Annual Health Maintenance Examination. For reimbursement purposes, these codes appropriately reflect the age groups listed in the CPT narrative. They will reflect old as well as new patients and must include the following information on the chart.

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1. History (complete initial for new patient, interval for established patient) including past medical history, family history, social history, and systemic review.
2. Developmental and nutritional assessment.
3. Complete, unclothed, physical examination to include also the following:
 - (a) measurements: height and weight, blood pressure for children age 3 or older;
 - (b) vision and hearing screening.
4. Assessment of and administration of immunizations appropriate for age and need.
5. Further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected.
6. Referral to a dentist for children age 3 or older.

7. Laboratory procedures performed or referred if medically necessary. Recommendations are:
 - (a) Hgb. twice: 3-6 years; and 10-12 years.
 - (b) Urinalysis at least once between 13-15 years.
 - (c) Tuberculin twice: 4-6 years; and 10-12 or 13-15 years.
8. Anticipatory guidance.
9. Offer of social service assistance; if requested, direct patient to county social service worker.

Note: Medical records should substantiate the above services and should document significant positive and negative findings. Discussion and consultation with the patient or family regarding findings should be an integral part of every examination. Note: Annual health maintenance codes 90751, 90752, 90753, 90754, 90761, 90762, and 90763, apply from age 0 through 20 and may be used only once in a 12-month period. If used following an EPSDT examination performed within the preceding 12 months or more frequently than once in 12 months, these codes will automatically be downgraded in payment to a follow-up office Preventive Health Care Visit if the medical need is justified.

PREVENTIVE HEALTH CARE FOLLOW-UP OFFICE VISIT (Discontinued Procedure Code: 0011)

90764 CPT code 90764 replaces former code 0011, Pediatric Preventive Health Care Office Visit. For reimbursement purposes, this code extends through age 20. This code reflects follow-up office preventive health care for established patients. Reimbursement for this code requires as a minimum the performance of the procedures listed in the following chart as they pertain to the appropriate age group.

AGE ¹	1	2	4	6	9	13	18	25	5	7	10	12	16
	mo	3 mos	5 mos	8 mos	12 mos	17 mos	24 mos	48 mos	6 yrs	9 yrs	11 yrs	15 yrs	20 yrs
HISTORY													
INITIAL	AT FIRST VISIT												
INTERVAL	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS													
HEIGHT & WEIGHT	X	X	X	X	X	X	X	X	X	X	X	X	X
HEAD CIRCUMFERENCE	X	X	X	X	X	X	X						
BLOOD PRESSURE								X	X	X	X	X	X
SENSORY SCREENING													
SIGHT	X	X		X				X or X	X	X	X	X	X
HEARING								X or X					
SYSTEMIC REVIEW	X	X	X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL APPRAISAL	X	X	X	X	X	X	X	X	X	X	X	X	X
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X
PHYSICAL EXAM ₂ (UNCLOTHED)	X	X	X	X	X	X	X	X	X	X	X	X	X
IMMUNIZATIONS ²		X	X	X		X	X		X			X	
PROCEDURES													
*TUBERCULIN TEST ³				X or X					X		X or X		
*HGB OR HEMATOCRIT				X				X or X			X		
*URINALYSIS							X				X		
URINE CULTURE (OPTIONAL)								X	X	X			
OTHERS AS INDICATED													
DISCUSSION AND COUNSELING	X	X	X	X	X	X	X	X	X	X	X	X	X
DENTAL SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X
REFER FOR INITIAL DENTAL EXAM								X					

The above is endorsed by the Maternal and Child Health Program of the New Jersey State Department of Health. Service rendered must be documented in record.

¹If child comes under care for first time at any point on the schedule or if any items are not accomplished at the suggested age the schedule should be brought up-to-date.

²Review of immunizations at each visit and administration of immunizations appropriate for age and need. (See appropriate procedure code(s) for immunization reimbursement.)

³May be indicated more frequently in certain areas. Should be administered prior to or simultaneously with measles immunization.

⁴Further diagnosis, treatment and follow-up by referral to self or other appropriate professional, of all correctible abnormalities suspected or uncovered.

⁵Offer of social service assistance; if requested, direct patient to county social service worker.

*These items are recommended.

ROUTINE NEWBORN CARE - WELL BABY (Discontinued Procedure Code: 9035)

90285 CPT Code 90285 - Routine Hospital Newborn Care. For reimbursement purposes, code 90285 requires as a minimum routine newborn care by a physician other than the physician(s) rendering maternity service, complete initial and complete discharge physical examination, conference(s) with the parent(s), all documented in the records.

NEWBORN CARE - "SICK" BABY

90250 For sick babies use appropriate subsequent hospital care code:
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90270

1. Routine Visit Care - 90250, 90260 and 90270

99150 2. If Prolonged Detention Codes are applicable - 99150, 99151 or
99151 99160
99160

CENTRAL AUDITORY FUNCTION

92589 Evaluation of Central Auditory Function by "Completing Sentences," "Filtered Speech," "Binaural Fusion," or "Rapidly Alternating Speech" (per test). Testing must be performed by an Audiologist in an environment that meets ANSI-1977 standards.

EYE CARE PROFESSIONAL SERVICES

Within the restrictions of their respective licensure, the eligible providers of eye care are:

1. Physicians recognized by the New Jersey Health Services Program in accordance with the definitions in Subchapter 1. (1.1) and in the Vision Care Manual, Subchapter 1. (1.2) as specialists. Specialty recognition must be as an ophthalmologist.
2. Any person who is licensed by the New Jersey State Board of Optometry to engage in the practice of optometry, or similarly licensed by a comparable agency of the State in which he performs such functions.
3. An ophthalmologist or optometrist in another State who is duly licensed in that State.

4. Independent outpatient health facilities approved by the New Jersey Medicaid Program to render eye care services.
5. Hospitals meeting the definition of "approved hospital" as described in the Hospital Services Manual (10:52-1.1 - Definitions).

COMPREHENSIVE EYE EXAMINATION (Discontinued Procedure Code: 5400)

92002 Comprehensive Eye Examination - CPT Codes 92002 or 92012 are comparable to discontinued code 5400 comprehensive eye examination, but
 92012 for reimbursement purposes, the use of these codes requires as a minimum a comprehensive eye examination which shall include, with or without cycloplegics and with or without a post-cycloplegic visit, the following:

1. Detailed case history
2. External and internal (ophthalmoscopic) examination.
3. Refraction (objective and subjective).
4. Gross visual fields (central and peripheral).
5. Tonometry (when indicated for patients under 35; mandatory for all patients over 35). The specific method used should be identified (that is, the finger palpation test is not acceptable).
6. Binocular coordination testing (distance and near),
7. The diagnosis (Ocular deficiency or deformity, visual or muscular anomaly, and so forth),
8. Recommendations.

COMPREHENSIVE EYE EXAMINATION WITH DIAGNOSTIC FIELDS (Discontinued Procedure Code: 5401)

92004 Comprehensive Eye Examination with Diagnostic Fields - CPT codes
 92014 92004 or 92014 are comparable to discontinued Medicaid code 5401, Comprehensive Eye Examination with Diagnostic Fields. For reimbursement purposes, it shall include all the criteria of procedure codes 92002 or 92012, including complete Diagnostic Visual Field.

Note: These codes are not routinely reimbursable for a complete comprehensive eye examination. Patients should be selected for this additional service based upon history and ophthalmologic findings during the examination, if the physical examination suggests the presence of optic or motor nerve abnormalities, or if other significant physical findings are present and documented, diagnostic visual fields studies may be selectively employed to establish or confirm the diagnosis and/or the degree of impairment.

Note: A comprehensive eye examination with or without diagnostic fields is limited to once a year. Additional such visits will be downgraded to office visits if its criteria is met. Code 90050, Established Patient, Limited Service, is applicable.

INDEPENDENT OFFICE PROCEDURES

Independent Office Procedures - CPT codes 92018, 92019, 92020, 92065, 92081, 92082, 92083, 92100, 92260, W9220, and W9230 are not reimbursable when performed on the same day as CPT codes 90050, 92002, 92002AP, 92004, 92004AP, 92012, 92012AP, 92014, 92014AP or W9215. The use of these codes precludes billing for any type of office visit on the same day.

PSYCHIATRIC SERVICES

Reimbursement will be made only for services personally performed by physicians who are providers to the program. Services performed by psychiatric nurses, psychiatric social workers, etc., are not reimbursable as physician services and may not be claimed in their own right or as physician services.

Prior authorization will be required after the initial consultation for all psychiatric services rendered to patients in long-term care facilities and all facilities covered under the Rooming and Boarding House Act of 1979. Refer to Subchapter 2. (2.11 - Psychiatric Services - originally printed as NJHSP Newsletter, Volume 325, dated January 4, 1982).

Only under exceptional circumstances will more than one mental health procedure be reimbursable per day for the same recipient by the same physician, group of physicians, shared health care facility, physicians and/or psychologists sharing a common record.

INITIAL COMPREHENSIVE PSYCHIATRIC EVALUATION (Discontinued Procedure Code: 9056)

90801 This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable. No more than one claim for the code 90801 is reimbursable per the same recipient, per the same physician, per year.

INDIVIDUAL PSYCHOTHERAPY - 25 Minute Session (Discontinued Procedure Code: 9051)

90843 This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient and/or family member.

INDIVIDUAL PSYCHOTHERAPY - 50 Minute Session (Discontinued Procedure Code: 9050)

90844 This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member.

FAMILY THERAPY (Discontinued Procedure Code: 9064)

90847 This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

FAMILY THERAPY (Discontinued Procedure Code: 9062)

9084722 This code requires for reimbursement purposes a minimum of 80 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

FAMILY CONFERENCE (Discontinued Procedure Code: 9065)

90887 This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient, family member or caretaker. The CPT narrative otherwise remains applicable.

GROUP PSYCHOTHERAPY (Discontinued Procedure Code: 9053)

H5025 This code requires for reimbursement purposes a minimum of 90 minutes of direct clinical involvement with the patient as a member of a group of which 10 minutes can be used for documentation. The maximum number of the group is 8 and the reimbursement is per person per group session.

APPENDIX C

(Medicine)

MODIFIERS

Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are listed below:

<u>MODIFIER CODE</u>	<u>DESCRIPTION</u>
AP	Determination of "Refractive State" was not performed in the course of diagnostic ophthalmological examination.
LT	<u>Left Side:</u> Used to identify procedures performed on the left side of the body.
RT	<u>Right Side:</u> Used to identify procedures performed on the right side of the body.
WM	<u>Midwifery:</u> Used to identify procedures performed by certified nurse midwives by adding the modifier 'WM' to the procedure code.
YY	<u>Second Surgical Opinion</u>
ZZ	<u>Third Surgical Opinion</u>
22	<u>Unusual Services:</u> When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.
26	<u>Professional Component:</u> Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure code.
50	<u>Bilateral Procedures:</u> Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number.

MODIFIER
CODE

DESCRIPTION

- 75 Concurrent Care Services Rendered by More than One Physician:
When the patient's condition requires the additional services of more than one physician, each physician may identify his or her services by adding the modifier '75' to the basic service performed.
- 76 Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '76' to the repeated service.
- 77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier '77' to the repeated service.

10:54—4.3 HCPCS CODES FOR SURGERY

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	\$ NS	
	10000		0	13.00	11.00	3.
	10003		0	13.00	11.00	3.
	10020		0	13.00	11.00	3.
N	10040		0	18.00	16.00	3.
	10060		0	13.00	11.00	3.
	10061		30	48.00	42.00	4.
	10080		0	30.00	26.00	4.
	10100		0	13.00	11.00	3.
	10101		30	34.00	29.00	3.
	10120		0	18.00	16.00	3.
	10121		30	34.00	29.00	4.
	10140		0	18.00	16.00	3.
	10141		30	48.00	42.00	3.
	10160		0	13.00	11.00	3.
	11000		0	13.00	11.00	4.
	11001		0	6.00	5.00	3.
	11040		0	13.00	11.00	3.
	11041		0	13.00	11.00	3.
	11042		0	16.00	14.00	3.
	11043		0	16.00	14.00	3.
	11044		0	48.00	42.00	3.
	11100		0	13.00	11.00	4.
	11400		15	18.00	16.00	3.
	11401		15	22.00	20.00	3.
	11402		15	27.00	24.00	3.
	11403		30	32.00	27.00	3.
	11404		30	32.00	27.00	3.
	11406		30	32.00	27.00	3.
	11420		15	18.00	16.00	3.
	11421		15	22.00	20.00	3.
	11422		15	27.00	24.00	3.
	11423		30	32.00	27.00	3.
	11424		30	32.00	27.00	3.
	11426		30	32.00	27.00	3.
	11440		15	18.00	16.00	3.
	11441		15	22.00	20.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	\$ NS	
	11442		15	27.00	24.00	3.
	11443		30	32.00	27.00	3.
	11444		30	32.00	27.00	3.
	11446		30	32.00	27.00	3.
	11600		90	37.00	32.00	3.
	11601		90	47.00	42.00	3.
	11602		90	61.00	53.00	3.
	11620		90	61.00	53.00	4.
	11621		90	90.00	79.00	4.
	11622		90	121.00	105.00	4.
	11640		90	90.00	79.00	4.
	11641		90	121.00	105.00	4.
	11642		90	150.00	131.00	4.
	11643		90	175.00	170.00	4.
	11644		90	175.00	170.00	4.
	11646		90	175.00	170.00	4.
	11700		0	13.00	11.00	3.
	11701		0	19.00	16.00	3.
	11710		0	13.00	11.00	3.
	11711		0	19.00	16.00	3.
	11730		0	10.00	10.00	3.
	11750		30	42.00	37.00	3.
	11770		30	151.00	131.00	4.
	11771		30	151.00	131.00	4.
	11772		30	151.00	131.00	4.
	12001		0	18.00	16.00	3.
	12002		0	24.00	21.00	3.
	12004		0	30.00	26.00	3.
	12011		0	18.00	16.00	3.
	12013		0	24.00	21.00	3.
	12014		0	30.00	26.00	3.
	12031		30	30.00	26.00	3.
	12032		30	48.00	42.00	4.
	12041		30	30.00	26.00	3.
	12042		30	67.00	59.00	4.
	12051		30	38.00	33.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	12052		30	67.00	59.00	4.
	13100		30	34.00	29.00	4.
	13101		30	68.00	63.00	4.
	13120		30	48.00	42.00	4.
	13121		30	106.00	92.00	4.
	13131		30	67.00	59.00	4.
	13132		30	145.00	126.00	4.
	13150		30	38.00	33.00	4.
	13151		30	82.00	71.00	4.
	13152		30	193.00	168.00	4.
	13300		30	242.00	210.00	4.
	14000		60	97.00	84.00	4.
	14001		60	145.00	126.00	3.
	14020		60	145.00	126.00	4.
	14021		60	193.00	168.00	3.
	14040		60	193.00	168.00	4.
	14041		60	242.00	210.00	4.
	14060		60	242.00	210.00	4.
	14061		60	290.00	252.00	4.
	14300		60	242.00	210.00	4.
	15050		0	30.00	26.00	4.
	15100		45	121.00	105.00	3.
	15101		45	61.00	53.00	4.
	15120		45	182.00	158.00	4.
	15121		45	61.00	53.00	4.
	15200		45	90.00	79.00	4.
	15220		45	151.00	131.00	4.
	15240		45	151.00	131.00	4.
	15260		45	206.00	179.00	4.
	15500		45	121.00	105.00	4.
	15505		45	182.00	158.00	4.
	15510		45	242.00	210.00	4.
	15515		45	302.00	263.00	4.
	15600		45	61.00	53.00	4.
	15610		45	89.00	77.00	4.
	15620		45	121.00	105.00	4.
	15630		45	150.00	129.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	15700		45	121.00	105.00	4.
	15710		45	181.00	158.00	4.
	15720		45	242.00	210.00	4.
	15730		45	301.00	263.00	4.
N	15745		90	452.00		13.
	15760		45	113.00	99.00	4.
	15770		60	203.00	177.00	4.
C	15780		90	135.00	119.00	4.
C	15781		90	30.00	26.00	4.
C	15782		90	30.00	26.00	4.
C	15820		30	271.00	236.00	4.
C	15822		30	181.00	158.00	4.
C	15824		30	226.00	197.00	4.
C	15826		30	181.00	158.00	4.
C	15828		45	BR	BR	4.
	15840		90	452.00	394.00	4.
	15845		90	542.00	473.00	4.
	16000		0	13.00	11.00	3.
	16010		0	18.00	16.00	3.
	16015		0	45.00	40.00	3.
	16020		0	9.00	8.00	0.
	16025		0	14.00	11.00	0.
	16030		0	18.00	16.00	0.
	17000		0	8.00	6.00	3.
	17010		0	11.00	8.00	3.
	17100		0	18.00	15.00	3.
	17105		0	27.00	24.00	3.
	17110		0	8.00	6.00	3.
	17200		0	8.00	6.00	3.
	17304		30	25.00	21.00	3.
	17305		30	8.00	6.00	3.
	17310		30	BR	BR	3.
	17380		0	8.00	6.00	3.
	19000		0	13.00	11.00	3.
	19020		14	61.00	53.00	3.
	19100		0	21.00		0.
	19101		0	61.00		3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	19120		30	103.00	89.00	3.	
	19120	50	30	121.00	105.00	3.	
	19140		30	103.00	89.00	3.	
	19140	50	30	121.00	105.00	3.	
	19160		30	103.00	89.00	3.	
	19160	50	30	121.00	105.00	3.	
	19180		45	163.00	142.00	3.	
	19200		60	362.00	315.00	5.	
	19240		60	332.00	289.00	5.	
	19260		60	332.00	289.00	10.	
	19271		60	473.00	413.00	13.	
C	19318		90	178.00	142.00	6.	
C	19318	50	90	242.00	210.00	4.	
C	19325		90	121.00	105.00	4.	
C	19325	50	90	163.00	142.00	4.	
	19350		45	91.00	79.00	3.	
	20000		0	18.00	16.00	3.	
	20005		0	45.00	40.00	4.	
	20200		0	30.00	26.00	3.	
	20205		0	61.00	53.00	3.	
N	20220		0	45.00	40.00	3.	
N	20225		0	45.00	40.00	3.	
	20240		0	30.00		3.	
	20245		0	90.00	79.00	6.	
	20250		0	90.00	79.00	6.	
	20251		0	90.00	79.00	6.	
N	20520		7	51.00	45.00	3.	
N	20550		0	13.00	11.00	0.	
N	20600		0	13.00	11.00	3.	
N	20605		0	13.00	11.00	3.	
N	20610		0	13.00	11.00	3.	
	20650		0	55.00	47.00	4.	
	20660		0	18.00	13.00	3.	
	20661		0	109.00	95.00	3.	
	20662		0	109.00	95.00	3.	
	20663		0	109.00	95.00	3.	
	20670		0	24.00	21.00	3.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
N	20680		21	121.00	105.00	4.	
N	20680	52	21	61.00	53.00	4.	
	20802		60	BR		3.	
	21020		90	604.00	525.00	11.	
	21030		60	121.00	105.00	4.	
	21041		90	316.00	276.00	5.	
	21045		90	274.00	256.00	6.	
	21050		90	301.00	263.00	5.	
	21060		90	362.00	315.00	5.	
	21200		90	332.00	289.00	7.	
	21202		90	332.00	289.00	7.	
	21210		90	149.00	130.00	7.	
	21215		90	332.00	289.00	7.	
	21230		60	261.00	226.00	7.	
	21300		0	40.00	35.00	0.	
	21315		30	30.00	26.00	3.	
	21320		90	61.00	53.00	4.	
	21325		90	90.00	79.00	5.	
	21330		90	145.00	126.00	5.	
	21335		90	216.00	189.00	5.	
	21346		90	182.00	158.00	5.	
	21347		90	236.00	205.00	5.	
	21355		30	42.00	37.00	3.	
	21360		90	121.00	105.00	5.	
	21365		90	235.00	205.00	5.	
	21385		90	BR		11.	
	21387		90	BR		11.	
	21390		90	BR		11.	
	21395		90	BR		11.	
	21421		90	121.00	105.00	5.	
	21451		30	20.00	18.00	3.	
	21454		90	145.00	126.00	5.	
	21461		90	121.00	105.00	5.	
	21462		90	242.00	210.00	5.	
	21480		0	18.00	16.00	3.	
	21485		90	54.00	48.00	5.	
	21490		90	180.00	160.00	5.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	NS	ANES BASIC UNITS
	21501		30	BR	BR	3.
	21510		30	90.00	75.00	4.
	21511		30	90.00	75.00	4.
	21550		0	13.00	11.00	4.
	21555		15	18.00	16.00	3.
	21600		60	90.00	79.00	4.
	21620		60	211.00	184.00	4.
	21630		90	422.00	394.00	6.
	21700		60	211.00	184.00	5.
	21705		60	272.00	236.00	6.
	21720		60	151.00	131.00	5.
	21725		60	151.00	131.00	5.
	21740		90	BR	BR	11.
	21800		30	24.00	21.00	3.
	21820		30	24.00	21.00	3.
	22010		0	13.00	11.00	4.
N	22310		90	75.00		3.
	22315		90	200.00		5.
	22325		90	483.00		8.
	22326		90	483.00		8.
	22327		90	483.00		8.
	22505		0	61.00	53.00	5.
S	22550		90	665.00	578.00	8.
S	22552		90	665.00	578.00	8.
S	22555		90	376.00	327.00	8.
S	22560		90	665.00	578.00	7.
S	22561		90	665.00	578.00	7.
S	22565		90	489.00	408.00	7.
S	22600		90	573.00	499.00	8.
S	22615		90	573.00	499.00	8.
S	22640		90	573.00	499.00	8.
S	22645		90	483.00	420.00	8.
S	22655		90	573.00	499.00	8.
S	22700		90	489.00	408.00	7.
S N	22800		90	936.00	814.00	13.
S N	22801		90	936.00	814.00	13.
S N	22840		90	936.00	814.00	13.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	NS	ANES BASIC UNITS
	22910		90	378.00	330.00	5.
	23000		60	151.00	131.00	4.
	23030		30	BR	BR	3.
	23031		0	13.00	11.00	3.
	23040		60	200.00	173.00	5.
	23044		60	200.00	173.00	5.
	23065		0	13.00	11.00	4.
	23100		60	200.00	173.00	5.
	23101		60	200.00	173.00	5.
	23105		60	200.00	173.00	5.
	23106		60	200.00	173.00	5.
	23110		60	113.00	99.00	3.
	23120		60	134.00	117.00	4.
	23125		60	249.00	217.00	4.
	23170		30	90.00	75.00	4.
	23172		30	90.00	75.00	4.
	23174		30	90.00	75.00	4.
	23184		60	211.00	184.00	4.
	23185		60	211.00	184.00	4.
	23190		60	211.00	184.00	4.
	23221		90	422.00	394.00	6.
	23330		0	18.00	16.00	3.
	23350		0	18.00	16.00	3.
	23355		0	61.00	53.00	3.
	23356		60	284.00	247.00	4.
	23357		0	75.00	65.00	3.
	23400		90	274.00	260.00	6.
	23410		90	272.00	236.00	5.
	23420		90	295.00	280.00	5.
	23450		90	308.00	276.00	5.
	23455		90	362.00	315.00	5.
	23470		90	393.00	341.00	5.
	23472		90	604.00		10.
	23480		90	182.00	158.00	5.
	23500		30	41.00	35.00	3.
	23505		90	61.00	53.00	4.
	23510		90	81.00	70.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
	23515		90	151.00	131.00		5.
	23520		0	30.00	26.00		3.
	23525		90	61.00	53.00		4.
	23532		90	182.00	158.00		5.
	23540		0	30.00	26.00		3.
	23545		45	61.00	53.00		4.
	23550		90	182.00	158.00		5.
	23570		30	41.00	35.00		3.
	23580		90	223.00	192.00		4.
	23600		30	61.00	53.00		3.
	23605		90	121.00	105.00		3.
	23610		90	141.00	123.00		3.
	23615		90	211.00	184.00		4.
	23650		0	26.00	23.00		0.
	23655		45	61.00	53.00		4.
	23660		90	242.00	210.00		5.
	23700		0	61.00	53.00		4.
	23800		90	393.00	341.00		5.
	23900		90	483.00	420.00		10.
	23920		90	362.00	315.00		8.
	23930		30	BR	BR		3.
	23931		0	13.00	11.00		3.
	24000		60	200.00	173.00		3.
	24065		0	13.00	11.00		4.
	24101		60	200.00	173.00		3.
	24102		90	200.00	173.00		3.
	24105		60	90.00	79.00		3.
	24130		60	134.00	117.00		3.
	24134		30	90.00	75.00		4.
	24135		30	90.00	75.00		4.
	24136		30	90.00	75.00		4.
	24137		30	90.00	75.00		4.
	24138		30	90.00	75.00		4.
	24139		30	90.00	75.00		4.
	24140		60	211.00	184.00		4.
	24144		60	211.00	184.00		4.
	24145		60	211.00	184.00		4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
	24146		60	211.00	184.00		4.
	24151		90	422.00	394.00		6.
	24305		90	151.00	131.00		4.
	24310		30	242.00	210.00		3.
	24320		90	302.00	263.00		4.
	24330		90	121.00	105.00		3.
	24331		90	121.00	105.00		3.
	24340		90	242.00	210.00		3.
	24360		90	332.00	289.00		3.
	24363		90	604.00			3.
	24400		90	242.00	210.00		5.
	24410		90	211.00	184.00		3.
	24435		90	332.00	289.00		4.
	24505		90	121.00	105.00		3.
	24510		90	145.00	126.00		3.
	24515		90	211.00	184.00		4.
	24535		90	103.00	89.00		3.
	24540		90	145.00	126.00		3.
	24545		90	211.00	184.00		4.
	24575		90	211.00	184.00		4.
	24576		30	40.00	35.00		3.
	24577		90	72.00	63.00		3.
	24578		90	121.00	105.00		3.
	24579		90	211.00	184.00		4.
	24600		0	61.00	53.00		0.
	24610		45	83.00	72.00		3.
	24615		90	242.00	210.00		3.
	24620		90	121.00	105.00		3.
	24635		90	211.00	184.00		4.
	24650		90	61.00	53.00		3.
	24660		90	86.00	76.00		3.
	24665		90	151.00	131.00		3.
	24670		30	44.00	41.00		3.
	24680		90	77.00	66.00		3.
	24685		90	151.00	131.00		3.
	24700		0	61.00	53.00		3.
	24800		90	302.00	263.00		3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	24900		90	211.00	184.00	4.
	24920		90	160.00	138.00	4.
	24925		0	32.00	27.00	3.
	24930		90	182.00	158.00	4.
	24940		90	302.00	263.00	4.
	25005		30	121.00	105.00	3.
	25028		30	BR	BR	3.
	25031		0	13.00	11.00	3.
	25040		60	120.00	104.00	3.
	25041		60	120.00	104.00	3.
	25065		0	13.00	11.00	4.
	25085		60	182.00	158.00	3.
	25100		60	182.00	158.00	3.
	25101		60	182.00	158.00	3.
	25110		30	90.00	79.00	3.
	25111		30	90.00	79.00	3.
	25112		30	90.00	79.00	3.
	25115		60	226.00	197.00	3.
	25118		90	211.00	184.00	3.
	25145		30	90.00	75.00	4.
	25146		30	90.00	75.00	4.
	25150		60	211.00	184.00	4.
	25151		60	211.00	184.00	4.
	25153		60	211.00	184.00	4.
	25210		60	151.00	131.00	3.
	25246		0	18.00	16.00	3.
	25260		90	121.00	105.00	3.
	25270		90	90.00	79.00	3.
	25280		90	151.00	131.00	4.
	25295		60	113.00	99.00	3.
	25330		90	332.00	289.00	3.
	25350		90	206.00	179.00	3.
	25355		90	206.00	179.00	3.
	25360		90	182.00	158.00	3.
	25370		90	211.00	184.00	3.
	25390		90	242.00	210.00	3.
	25405		90	242.00	210.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	25505		90	72.00	63.00	3.
	25510		90	90.00	82.00	3.
	25515		90	151.00	131.00	3.
	25535		90	61.00	53.00	3.
	25540		90	77.00	66.00	3.
	25545		90	151.00	131.00	3.
	25565		90	121.00	105.00	3.
	25570		90	145.00	126.00	3.
	25575		90	211.00	184.00	3.
	25600		30	59.00	50.00	3.
	25605		90	72.00	63.00	3.
	25610		90	76.00	66.00	3.
	25611		90	113.00	99.00	3.
	25620		90	151.00	131.00	3.
	25628		90	182.00	158.00	3.
	25630		30	72.00	63.00	3.
	25635		30	72.00	63.00	3.
	25660		0	61.00	53.00	3.
	25675		0	61.00	53.00	3.
	25676		90	182.00	158.00	3.
	25700		0	61.00	53.00	4.
	25800		90	272.00	236.00	3.
	25900		90	182.00	158.00	3.
	25905		90	160.00	138.00	4.
	25907		0	32.00	27.00	3.
	25909		90	182.00	158.00	4.
	25920		90	151.00	131.00	3.
	25927		90	151.00	131.00	3.
	26010		0	18.00	16.00	3.
	26011		0	42.00	37.00	3.
	26020		0	24.00	21.00	3.
	26025		30	145.00	126.00	3.
	26030		30	217.00	189.00	3.
	26032		30	217.00	189.00	3.
	26040		60	61.00	53.00	3.
	26045		60	182.00	158.00	3.
	26055		30	121.00	105.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	26060		0	24.00	21.00		3.
	26070		60	120.00	104.00		3.
	26075		60	60.00	53.00		3.
	26080		60	60.00	53.00		3.
	26120		60	182.00	158.00		3.
	26160		30	61.00	53.00		3.
	26230		60	90.00	79.00		4.
	26235		60	90.00	79.00		4.
	26236		60	90.00	79.00		4.
	26255		90	274.00	256.00		6.
	26261		90	274.00	256.00		6.
	26350		90	121.00	105.00		3.
	26410		90	61.00	53.00		3.
	26440		60	113.00	99.00		3.
	26445		60	113.00	99.00		3.
	26540		90	176.00	153.00		3.
	26545		90	176.00	153.00		3.
	26560		45	182.00	158.00		3.
	26561		45	242.00	210.00		3.
	26562		45	302.00	263.00		3.
	26565		90	113.00	100.00		3.
	26567		90	113.00	100.00		3.
	26570		90	149.00	130.00		7.
	26574		90	149.00	130.00		7.
	26600		30	30.00	26.00		3.
	26610		90	61.00	53.00		3.
	26610	51	90	79.00	68.00		3.
	26615		90	90.00	79.00		3.
	26641		0	30.00	26.00		3.
	26655		45	30.00	26.00		3.
	26670		0	30.00	26.00		0.
	26675		0	30.00	26.00		3.
	26680		45	61.00	53.00		3.
	26685		90	121.00	105.00		3.
	26720		30	22.00	19.00		3.
	26725		45	48.00	42.00		3.
	26730		45	72.00	63.00		3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	26735		60	90.00	79.00		3.
	26750		30	29.00	25.00		3.
	26760		30	48.00	42.00		3.
	26765		45	72.00	63.00		3.
	26775		0	18.00	16.00		3.
	26780		45	30.00	26.00		3.
	26785		90	61.00	53.00		3.
	26841		90	151.00	131.00		3.
	26860		90	151.00	131.00		3.
	26910		90	121.00	105.00		3.
	26951		45	61.00	53.00		3.
	26952		45	61.00	53.00		3.
	26990		30	BR	BR		3.
	26991		0	13.00	11.00		3.
	27001		0	121.00	105.00		3.
	27010		45	151.00	131.00		4.
	27015		90	202.00	175.00		3.
	27030		90	242.00	210.00		6.
	27031		90	242.00	210.00		6.
	27033		90	242.00	210.00		6.
	27040		0	13.00	11.00		4.
	27054		90	393.00	341.00		5.
	27062		60	121.00	105.00		3.
	27066		60	211.00	184.00		4.
	27080		90	121.00	105.00		4.
	27086		0	18.00	16.00		3.
	27093		0	18.00	16.00		0.
	27125		90	483.00	420.00		6.
	27126		90	483.00	420.00		6.
N	27130		90	845.00	735.00		6.
N	27131		90	845.00	735.00		6.
	27135		90	483.00	420.00		6.
	27161		90	378.00	329.00		5.
	27165		90	483.00	420.00		6.
	27170		90	332.00	289.00		4.
	27175		30	151.00	131.00		3.
	27177		90	362.00	315.00		6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	\$ NS	
	27179		90	340.00	259.00	6.
	27190		30	92.00	70.00	3.
	27200		30	36.00	30.00	3.
	27210		30	81.00	58.00	3.
	27220		30	48.00	42.00	3.
	27224		90	302.00	263.00	4.
	27232		90	246.00	216.00	4.
	27234		90	362.00	315.00	6.
	27236		90	362.00	315.00	6.
N	27240		90	182.00	158.00	4.
	27242		90	362.00	315.00	5.
	27250		90	121.00	105.00	0.
	27252		90	121.00	105.00	4.
	27253		90	332.00	289.00	6.
	27256		0	55.00	47.00	3.
	27257		45	109.00	95.00	4.
	27258		90	332.00	289.00	6.
	27275		0	69.00	60.00	3.
	27284		90	453.00	394.00	6.
	27290		90	604.00	525.00	15.
	27295		90	483.00	420.00	10.
	27301		30	BR	BR	3.
	27310		90	211.00	184.00	3.
	27311		90	211.00	184.00	3.
	27323		0	13.00	11.00	4.
	27331		90	211.00	184.00	3.
	27332		90	284.00	247.00	3.
	27334		90	332.00	289.00	3.
	27335		90	332.00	289.00	3.
	27340		60	90.00	79.00	3.
	27345		60	182.00	158.00	4.
	27350		90	211.00	184.00	3.
	27360		60	211.00	184.00	4.
	27361		60	211.00	184.00	4.
	27370		0	18.00	16.00	3.
	27373		0	61.00	53.00	3.
	27385		90	211.00	184.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	\$ NS	
	27390		45	121.00	105.00	3.
	27391		45	182.00	158.00	3.
	27405		90	277.00	240.00	3.
	27407		90	277.00	240.00	3.
	27409		90	378.00	329.00	3.
	27410		90	331.00	285.00	3.
	27414		90	428.00	372.00	3.
	27420		90	302.00	263.00	3.
	27422		90	302.00	263.00	3.
	27424		90	302.00	263.00	3.
	27435		90	211.00	184.00	3.
	27444		90	393.00	341.00	6.
	27445		90	604.00	525.00	3.
	27447		90	604.00	525.00	3.
	27448		90	393.00	341.00	5.
	27450		90	393.00	341.00	5.
	27454		90	378.00	329.00	4.
	27455		90	272.00	236.00	4.
	27457		90	272.00	236.00	4.
	27460		90	362.00	315.00	4.
	27462		90	362.00	315.00	4.
	27465		90	332.00	289.00	5.
	27466		90	332.00	289.00	4.
	27472		90	332.00	289.00	4.
	27475		90	242.00	210.00	4.
	27477		90	242.00	210.00	4.
	27479		90	302.00	263.00	4.
N	27485		90	197.00	172.00	3.
	27502		90	182.00	158.00	4.
	27504		90	205.00	177.00	5.
	27506		90	272.00	236.00	4.
	27508		30	70.00	62.00	3.
	27510		90	121.00	105.00	4.
	27512		90	242.00	210.00	5.
	27520		30	62.00	57.00	3.
	27522		90	91.00	79.00	3.
	27524		90	211.00	184.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	27530		30	74.00	65.00		3.
	27532		90	121.00	105.00		3.
	27534		90	145.00	126.00		3.
	27536		90	242.00	210.00		3.
	27550		45	90.00	79.00		0.
	27552		45	90.00	79.00		3.
	27554		45	91.00	79.00		3.
	27560		0	72.00	63.00		0.
	27562		0	72.00	63.00		3.
	27564		45	55.00	47.00		4.
	27566		90	211.00	184.00		3.
	27570		0	61.00	53.00		3.
	27580		90	393.00	341.00		3.
	27590		90	272.00	236.00		4.
	27592		90	182.00	158.00		4.
	27594		0	24.00	21.00		4.
	27596		90	272.00	236.00		4.
	27598		90	182.00	158.00		4.
	27603		30	BR	BR		3.
	27604		0	13.00	11.00		3.
	27610		60	182.00	158.00		3.
	27611		60	182.00	158.00		3.
	27613		0	13.00	11.00		4.
	27620		60	182.00	158.00		3.
	27625		90	211.00	184.00		3.
	27630		30	90.00	79.00		3.
	27640		60	211.00	184.00		4.
	27641		60	211.00	184.00		4.
	27648		0	61.00	53.00		3.
	27650		90	227.00	197.00		4.
	27658		90	121.00	105.00		3.
	27659		90	121.00	105.00		3.
	27664		90	90.00	79.00		3.
	27665		90	90.00	79.00		3.
	27685		90	151.00	131.00		4.
	27686		90	202.00	175.00		3.
	27690		90	182.00	158.00		3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	27695		90	302.00	263.00		3.
	27698		90	227.00	197.00		3.
	27700		90	249.00	216.00		3.
	27702		90	604.00			3.
	27705		90	272.00	236.00		3.
	27707		90	113.00	100.00		3.
	27712		90	288.00	251.00		3.
	27715		90	332.00	289.00		4.
	27724		90	332.00	289.00		4.
	27740		90	302.00	263.00		3.
	27742		90	439.00	382.00		3.
	27752		90	121.00	105.00		3.
	27754		90	145.00	126.00		3.
	27756		90	211.00	184.00		3.
	27760		90	79.00	68.00		3.
	27762		90	79.00	68.00		3.
	27764		90	105.00	91.00		3.
	27766		90	151.00	131.00		3.
	27781		30	45.00	39.00		3.
	27782		90	61.00	53.00		3.
	27784		90	121.00	105.00		3.
	27788		90	79.00	68.00		3.
	27790		90	105.00	91.00		3.
	27792		90	151.00	131.00		3.
	27802		90	121.00	105.00		3.
	27804		90	161.00	140.00		3.
	27806		90	161.00	140.00		3.
	27810		90	121.00	105.00		3.
	27812		90	145.00	126.00		3.
	27814		90	211.00	184.00		3.
	27818		90	121.00	105.00		3.
	27820		90	141.00	123.00		3.
	27822		90	242.00	210.00		3.
	27823		90	242.00	210.00		3.
	27832		90	164.00	142.00		3.
	27840		45	61.00	53.00		0.
	27842		45	61.00	53.00		3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	27844		45	152.00	131.00	3.
	27846		90	305.00	263.00	3.
	27850		0	61.00	53.00	3.
	27852		60	284.00	247.00	4.
	27860		0	61.00	53.00	3.
	27870		90	302.00	263.00	3.
	27880		90	242.00	210.00	3.
	27882		90	155.00	137.00	4.
	27884		0	24.00	21.00	4.
	27886		90	242.00	210.00	3.
	27888		90	242.00	210.00	3.
	28001		0	13.00	11.00	3.
	28002		0	24.00	21.00	3.
	28008		60	61.00	53.00	3.
	28010		0	24.00	21.00	3.
	28011		0	37.00	32.00	3.
	28020		60	109.00	95.00	3.
	28022		60	109.00	95.00	3.
	28024		60	37.00	32.00	3.
	28080		30	121.00	105.00	3.
	28090		30	90.00	79.00	3.
	28092		30	61.00	53.00	3.
	28100		60	121.00	105.00	4.
	28108		60	121.00	105.00	4.
	28114		90	242.00	210.00	3.
	28120		60	90.00	79.00	4.
	28121		60	90.00	79.00	4.
	28122		60	90.00	79.00	4.
	28123		60	90.00	79.00	4.
	28124		60	90.00	79.00	4.
	28130		90	211.00	184.00	3.
	28140		60	121.00	105.00	3.
	28150		90	90.00	79.00	3.
	28160		90	90.00	79.00	3.
	28190		0	18.00	16.00	3.
	28192		30	34.00	29.00	4.
	28193		30	34.00	29.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	28200		90	121.00	105.00	3.
	28208		90	61.00	53.00	3.
	28220		60	113.00	99.00	3.
	28222		60	139.00	119.00	3.
	28225		60	113.00	99.00	3.
	28226		60	139.00	119.00	3.
	28230		30	42.00	37.00	3.
	28232		60	139.00	119.00	3.
	28234		60	139.00	119.00	3.
	28240		30	61.00	53.00	3.
	28262		90	121.00	105.00	3.
	28280		45	61.00	53.00	3.
	28285		90	90.00	79.00	3.
N	28288		21	72.00	63.00	3.
	28290		60	90.00	79.00	3.
	28292		90	139.00	121.00	3.
	28294		90	141.00	123.00	3.
	28306		90	113.00	100.00	3.
	28308		90	113.00	100.00	3.
	28315		60	55.00	47.00	3.
	28400		30	68.00	59.00	3.
	28405		90	90.00	79.00	3.
	28410		90	113.00	99.00	3.
	28415		90	151.00	131.00	3.
	28430		30	82.00	72.00	3.
	28435		90	90.00	79.00	3.
	28440		90	113.00	99.00	3.
	28450		30	41.00	36.00	3.
	28455		90	61.00	53.00	3.
	28460		90	90.00	79.00	3.
	28465		90	121.00	105.00	3.
	28470		30	18.00	16.00	3.
	28475		90	42.00	37.00	3.
	28480		90	63.00	56.00	3.
	28485		90	90.00	79.00	3.
N	28490		30	18.00	16.00	3.
	28495		30	30.00	26.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	28500		45	90.00	79.00	3.
	28510		30	18.00	16.00	3.
	28515		30	30.00	26.00	3.
	28520		45	79.00	63.00	3.
	28540		45	61.00	53.00	0.
	28545		45	61.00	53.00	3.
	28550		45	107.00	92.00	3.
	28555		90	211.00	184.00	3.
	28570		45	61.00	53.00	0.
	28575		45	61.00	53.00	3.
	28580		45	107.00	92.00	3.
	28585		90	211.00	184.00	3.
	28600		45	61.00	53.00	0.
	28605		45	61.00	53.00	3.
	28610		45	104.00	91.00	3.
	28630		45	61.00	53.00	0.
	28640		45	104.00	91.00	3.
	28645		90	121.00	105.00	3.
	28660		0	13.00	11.00	0.
	28670		45	18.00	16.00	3.
	28675		60	47.00	40.00	3.
	28715		90	272.00	236.00	3.
	28725		90	182.00	158.00	3.
	28740		90	166.00	126.00	3.
N	28750		90	90.00	79.00	3.
N	28755		90	90.00	79.00	3.
	28760		90	200.00	173.00	3.
	28800		90	211.00	184.00	3.
	28805		90	211.00	184.00	3.
	28810		90	121.00	105.00	3.
	28820		45	42.00	37.00	3.
	28820	51	45	63.00	56.00	3.
	28825		45	42.00	37.00	3.
	28825	51	45	63.00	56.00	3.
	29000		0	109.00	95.00	3.
	29010		0	79.00	68.00	3.
	29015		0	90.00	79.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	29020		0	79.00	68.00	3.
	29025		0	90.00	79.00	3.
	29035		0	79.00	68.00	3.
	29040		0	90.00	79.00	3.
	29055		0	79.00	68.00	3.
	29065		0	30.00	26.00	3.
	29075		0	18.00	16.00	3.
	29085		0	18.00	16.00	3.
	29125		0	18.00	16.00	3.
	29305		0	79.00	68.00	3.
	29325		0	90.00	79.00	3.
	29345		0	53.00	42.00	3.
	29355		0	47.00	42.00	3.
	29405		0	42.00	37.00	3.
	29425		0	47.00	42.00	3.
	29450		0	24.00	21.00	3.
	29455		0	37.00	32.00	3.
	29505		0	48.00	42.00	3.
	29515		0	42.00	37.00	3.
	29580		0	18.00	16.00	3.
	29700		0	14.00	12.00	3.
	29705		0	14.00	12.00	3.
	29710		0	18.00	16.00	3.
	29715		0	18.00	16.00	3.
	29720		0	26.00	21.00	3.
	29730		0	9.00	8.00	3.
	29740		0	9.00	8.00	3.
	29750		0	9.00	8.00	3.
	29751		0	15.00	13.00	3.
	30000		0	24.00	21.00	3.
	30020		0	30.00	26.00	3.
	30100		0	13.00	11.00	3.
	30110		15	37.00	32.00	3.
	30111		15	37.00	32.00	3.
	30115		30	105.00	89.00	3.
	30116		30	105.00	89.00	3.
	30120		60	132.00	113.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	30140		90	42.00	37.00	3.
	30300		0	13.00	11.00	3.
	30320		0	32.00	26.00	4.
C	30400		90	211.00	184.00	4.
C	30410		90	362.00	315.00	4.
C	30420		90	407.00	355.00	4.
C	30430		45	66.00	59.00	4.
	30500		90	151.00	131.00	4.
C	30520		90	182.00	158.00	4.
	30540		60	45.00	39.00	4.
	30545		90	272.00	236.00	4.
	30560		0	18.00	16.00	3.
	30580		90	135.00	118.00	4.
	30600		30	90.00	79.00	3.
	30620		90	182.00	158.00	4.
	30800		0	13.00	11.00	3.
	30901		0	24.00	21.00	3.
	30902		0	61.00	53.00	3.
	30903		0	24.00	21.00	3.
	30904		0	61.00	53.00	3.
	30905		0	37.00	32.00	3.
	30906		0	24.00	21.00	3.
	30915		30	182.00	158.00	5.
	31000		0	18.00	16.00	3.
	31001		0	24.00	21.00	3.
	31020		90	72.00	63.00	4.
	31021		90	121.00	105.00	4.
	31030		90	242.00	210.00	4.
	31031		90	320.00	278.00	4.
	31050		30	61.00	53.00	4.
	31070		30	121.00	105.00	4.
	31075		90	242.00	210.00	4.
	31080		90	242.00	210.00	4.
	31090		90	302.00	263.00	4.
	31200		90	121.00	105.00	4.
	31201		90	121.00	105.00	4.
	31205		90	121.00	105.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	31225		90	363.00	315.00	5.
	31230		90	363.00	315.00	5.
	31300		90	332.00	289.00	6.
	31320		60	176.00	152.00	6.
	31360		90	513.00	446.00	6.
	31365		90	694.00	604.00	6.
	31370		90	393.00	341.00	6.
	31375		90	393.00	341.00	6.
	31380		90	393.00	341.00	6.
	31382		90	393.00	341.00	6.
	31400		90	254.00	221.00	6.
	31420		90	332.00	289.00	6.
	31500		0	42.00	37.00	5.
	31510		0	16.00	14.00	6.
	31515		0	61.00	53.00	3.
	31525		0	48.00	42.00	6.
	31526		0	48.00	42.00	6.
	31530		30	121.00	105.00	6.
	31531		30	121.00	105.00	6.
	31535		30	61.00	53.00	6.
	31536		30	61.00	53.00	6.
	31540		90	121.00	105.00	6.
	31541		90	121.00	105.00	6.
	31560		90	183.00	158.00	6.
	31561		90	183.00	158.00	6.
	31570		90	121.00	105.00	6.
	31571		90	121.00	105.00	6.
	31580		90	454.00	393.00	6.
	31582		90	504.00	437.00	6.
	31600		15	121.00	105.00	6.
	31601		15	121.00	105.00	6.
	31603		15	121.00	105.00	6.
	31610		15	301.00	263.00	6.
	31620		0	85.00	74.00	6.
	31621		0	85.00	74.00	6.
	31625		0	97.00	84.00	6.
	31626		0	97.00	84.00	6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
	31635		30	139.00	121.00	6.	
	31640		30	139.00	121.00	6.	
	31645		0	85.00	74.00	6.	
	31646		0	42.00	37.00	6.	
	31650		0	90.00	79.00	6.	
	31651		0	42.00	37.00	6.	
M	31656		0	90.00	79.00	6.	
	31708		0	30.00	26.00	3.	
	31710		0	36.00	32.00	3.	
	31715		0	30.00	26.00	3.	
	31750		90	271.00	236.00	6.	
	31760		90	271.00	236.00	11.	
	31770		90	361.00	315.00	11.	
	31775		90	361.00	315.00	11.	
	31800		90	271.00	236.00	11.	
	31805		90	271.00	236.00	11.	
	31820		30	90.00	79.00	6.	
	32000		0	18.00	16.00	3.	
	32020		0	121.00	105.00	4.	
	32035		90	242.00	210.00	13.	
	32036		90	242.00	210.00	13.	
	32100		90	202.00	168.00	13.	
	32110		90	302.00	263.00	13.	
	32120		90	302.00	263.00	13.	
	32124		90	272.00	236.00	13.	
	32140		90	302.00	263.00	13.	
	32150		90	302.00	263.00	13.	
	32151		90	302.00	263.00	13.	
	32160		90	322.00	269.00	13.	
	32200		90	302.00	263.00	13.	
	32220		90	403.00	336.00	13.	
	32310		90	423.00	368.00	15.	
	32400		0	21.00		0.	
	32405		0	42.00		3.	
	32420		0	42.00		3.	
	32440		90	604.00	525.00	13.	
	32480		90	604.00	525.00	13.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
	32485		90	361.00	315.00	11.	
	32490		90	604.00	525.00	13.	
	32500		90	483.00	420.00	13.	
	32700		0	90.00	79.00	6.	
	32705		0	90.00	79.00	6.	
	32900		90	332.00	289.00	10.	
	32940		90	281.00	245.00	10.	
	32960		0	30.00	26.00	3.	
	33010		0	25.00		3.	
	33011		0	25.00		3.	
	33020		90	410.00		20.	
	33025		90	410.00		20.	
	33050		90	410.00		20.	
	33100		90	718.00		20.	
	33120		90	905.00		20.	
N	33200		90	328.00		20.	
N	33206		90	328.00		6.	
N	33207		90	328.00		6.	
	33210		0	246.00		6.	
	33219		30	144.00		6.	
	33300		90	513.00		20.	
	33310		90	512.00		20.	
	33400		90	820.00		20.	
	33405		90	1025.00		20.	
	33407		90	656.00		20.	
	33420		90	615.00		20.	
	33425		90	980.00		20.	
	33430		90	1025.00		20.	
	33450		90	900.00		20.	
	33460		90	1025.00		20.	
	33465		90	1025.00		20.	
	33470		90	656.00		20.	
	33474		90	820.00		20.	
	33478		90	980.00		20.	
	33480		90	1440.00		20.	
	33483		90	1440.00		20.	
	33485		90	1440.00		20.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE \$	NS	ANES BASIC UNITS
	33490		90	1640.00		20.
	33492		90	1640.00		20.
N	33510		90	1025.00		20.
	33511		90	1310.00		20.
	33512		90	1560.00		20.
	33513		90	1560.00		20.
	33525		90	1310.00		20.
	33528		90	1560.00		20.
	33542		90	1025.00		20.
	33640		90	820.00		20.
	33681		90	820.00		20.
	33690		90	410.00		20.
	33692		90	1150.00		20.
	33702		90	1025.00		20.
	33730		90	1025.00		20.
	33735		90	656.00		20.
	33750		90	615.00		20.
	33762		90	615.00		20.
	33766		90	615.00		20.
	33802		90	615.00		20.
	33803		90	615.00		20.
	33810		90	1025.00		20.
	33812		90	1025.00		20.
	33820		60	410.00		15.
	33840		90	615.00		20.
	33860		90	1150.00		20.
	33865		90	1440.00		20.
	33870		90	1530.00		20.
	33875		90	620.00		15.
	33950		90	BR		20.
	33970		7	271.00		6.
	33972		7	35.00		6.
	34001		60	275.00		6.
	34051		60	275.00		6.
	34101		60	275.00		6.
	34151		60	275.00		6.
	34201		60	275.00		6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE \$	NS	ANES BASIC UNITS
	34401		60	383.00		6.
	34421		60	246.00		5.
	34471		30	168.00		5.
	34490		60	234.00		5.
	35001		90	650.00		6.
	35002		90	650.00		6.
	35011		90	410.00		6.
	35013		90	410.00		6.
	35021		90	820.00		20.
	35022		90	820.00		20.
	35081		90	759.00		15.
	35082		90	835.00		15.
	35111		90	680.00		13.
	35112		90	680.00		13.
	35121		90	760.00		13.
	35122		90	760.00		13.
	35131		90	660.00		13.
	35132		90	660.00		13.
	35162		60	362.00	315.00	5.
	35201		60	410.00		6.
	35206		60	410.00		5.
	35211		90	675.00		11.
	35216		90	675.00		11.
	35221		90	675.00		13.
	35226		60	410.00		5.
	35231		60	410.00		6.
	35236		60	410.00		5.
	35241		90	675.00		11.
	35246		90	675.00		11.
	35251		90	675.00		13.
	35256		60	410.00		5.
	35261		60	410.00		6.
	35266		60	410.00		5.
	35271		90	675.00		11.
	35276		90	675.00		11.
	35281		90	675.00		13.
	35286		60	410.00		5.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	35301		90	615.00			10.
	35311		90	723.00			10.
	35331		90	677.00			20.
	35341		90	677.00			20.
	35351		90	677.00			20.
N	35371		90	472.00			10.
N	35381		90	472.00			10.
	35501		90	650.00			6.
	35506		90	650.00			6.
	35507		90	650.00			6.
	35509		90	650.00			6.
	35511		90	650.00			6.
	35516		90	410.00			6.
	35521		90	555.00			20.
	35526		90	820.00			20.
	35531		90	759.00			15.
	35536		90	759.00			15.
	35541		90	759.00			15.
	35546		90	759.00			15.
	35548		90	759.00			15.
	35549		90	759.00			15.
	35556		90	554.00			8.
	35558		90	555.00			20.
	35565		90	759.00			15.
	35566		90	554.00			8.
	35571		90	554.00			8.
	35601		90	650.00			6.
	35606		90	650.00			6.
	35612		90	650.00			6.
	35616		90	410.00			6.
	35621		90	555.00			20.
	35626		90	820.00			20.
	35631		90	759.00			15.
	35636		90	759.00			15.
	35641		90	759.00			15.
	35646		90	759.00			15.
	35656		90	554.00			8.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	35661		90	555.00			20.
	35665		90	759.00			15.
	35666		90	554.00			8.
	35671		90	554.00			8.
	36000		0	30.00			3.
	36001		0	50.00			3.
N	36010		0	85.00			3.
	36100		0	103.00			5.
	36101		0	154.00			5.
	36120		0	110.00			5.
	36140		0	62.00			5.
	36145		30	253.00	220.00		5.
	36160		0	70.00			5.
	36200		0	95.00			5.
	36210		0	110.00			5.
	36220		0	155.00			5.
	36240		0	115.00			5.
	36250		0	135.00			5.
	36400		0	13.00	11.00		0.
	36405		0	18.00	16.00		0.
N	36415		0	1.80	1.80		0.
	36420		0	24.00	21.00		0.
	36425		0	18.00	16.00		0.
	36430		0	13.00	11.00		0.
	36431		0	30.00	26.00		0.
	36440		0	30.00	26.00		0.
	36450		0	151.00			0.
	36470		0	10.00	8.00		0.
	36471		0	18.00	16.00		0.
	36485		0	45.00			5.
	36500		0	127.00			3.
N	36520		0	37.00			0.
	36600		0	8.00	6.00		0.
	36620		0	20.00	16.00		0.
	36625		0	61.00	52.00		0.
	36800		30	182.00	158.00		5.
	36810		30	182.00	158.00		5.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				S	NS	
	36815		30	182.00	158.00	5.
	36820		30	182.00	158.00	5.
	36821		30	253.00	220.00	5.
	36825		90	470.00	409.00	5.
	36830		90	362.00	315.00	5.
	36835		60	362.00	315.00	3.
	36860		30	131.00	114.00	5.
	36861		30	131.00	114.00	5.
	37140		90	677.00		10.
	37145		90	677.00		10.
	37160		90	677.00		10.
	37180		90	677.00		10.
	37181		90	677.00		10.
	37400		30	205.00		8.
	37420		60	410.00		10.
	37440		60	410.00		10.
	37460		30	246.00		10.
	37520		60	410.00		10.
	37540		60	410.00		10.
	37560		30	123.00		8.
	37600		30	205.00		6.
	37606		90	BR	BR	7.
	37609		0	72.00		3.
	37615		30	205.00		6.
	37620		90	410.00		10.
M	37650		30	103.00		4.
	37660		90	238.00		8.
	37700		30	103.00	88.00	3.
	37720		30	144.00	122.00	3.
	37721		30	222.00	189.00	3.
	37730		30	205.00	174.00	3.
	37731		30	308.00	262.00	3.
	37780		30	54.00	46.00	3.
	37785		15	31.00	26.00	3.
	38100		45	302.00	263.00	7.
	38200		0	42.00	37.00	3.
	38300		0	30.00	26.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				S	NS	
	38305		0	61.00	53.00	3.
	38381		90	362.00	315.00	13.
	38500		0	30.00	26.00	3.
	38510		30	61.00	53.00	4.
	38520		30	61.00	53.00	4.
	38700		60	242.00	210.00	6.
	38701		60	363.00	315.00	6.
	38720		60	242.00	210.00	6.
	38745		60	182.00	158.00	3.
	38760		60	211.00	184.00	4.
	38765		60	302.00	263.00	6.
	38780		90	363.00	315.00	6.
	38790		0	55.00	47.00	3.
	38791		0	85.00	74.00	3.
	39000		90	181.00	158.00	8.
	39010		90	362.00	315.00	13.
	39050		90	316.00	276.00	13.
	39060		90	362.00	315.00	13.
	39200		90	483.00	420.00	13.
	39220		90	483.00	420.00	13.
	39400		0	181.00	158.00	6.
	39502		90	362.00	315.00	7.
	39520		90	423.00	368.00	13.
	39530		90	423.00	368.00	13.
	39540		90	518.00	449.00	13.
	40490		0	13.00	11.00	4.
	40500		90	242.00	210.00	6.
	40510		90	151.00	131.00	4.
	40520		90	72.00	63.00	4.
	40530		90	151.00	131.00	4.
	40700		90	302.00	263.00	6.
	40701		90	423.00	368.00	6.
	40702		90	181.00	158.00	6.
	40720		90	302.00	263.00	6.
	40740		90	423.00	368.00	6.
	40800		0	18.00	16.00	3.
	40804		0	18.00	16.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	40805		30	34.00	29.00	4.
	40808		0	13.00	11.00	4.
	40830		0	18.00	16.00	3.
	41000		0	42.00	37.00	5.
	41100		0	18.00	16.00	4.
	41105		0	29.00	26.00	5.
	41108		0	13.00	11.00	4.
	41115		0	11.00	9.00	3.
	41120		90	242.00	210.00	6.
	41130		90	242.00	210.00	6.
	41135		60	483.00	420.00	6.
	41140		90	362.00	315.00	6.
	41150		90	BR	BR	6.
	41800		0	18.00	16.00	5.
	42000		0	18.00	16.00	3.
	42100		0	18.00	16.00	3.
	42120		90	207.00	180.00	6.
	42140		0	18.00	16.00	3.
	42200		90	203.00	176.00	6.
	42205		90	393.00	341.00	6.
	42215		90	203.00	176.00	6.
	42220		90	332.00	289.00	6.
	42225		90	332.00	289.00	6.
	42235		90	101.00	88.00	6.
	42300		0	42.00	37.00	3.
	42305		0	85.00	72.00	5.
	42310		0	42.00	37.00	5.
	42320		0	42.00	37.00	3.
	42330		0	29.00	26.00	3.
	42335		30	60.00	53.00	4.
	42340		30	121.00	105.00	4.
	42400		0	21.00		0.
	42405		30	29.00	26.00	3.
	42410		60	182.00	158.00	5.
	42415		60	242.00	210.00	5.
	42420		60	362.00	315.00	5.
	42425		60	242.00	210.00	5.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	42440		60	182.00	158.00	5.
	42500		60	151.00	131.00	5.
	42505		60	215.00	187.00	5.
	42550		0	13.00	11.00	3.
	42600		60	151.00	131.00	5.
	42650		0	13.00	11.00	3.
	42700		0	37.00	32.00	5.
	42720		0	61.00	53.00	5.
	42725		0	151.00	131.00	5.
	42800		0	18.00	16.00	3.
	42802		0	29.00	26.00	3.
	42804		0	39.00	26.00	3.
	42806		0	39.00	26.00	3.
	42810		30	90.00	79.00	5.
	42815		30	211.00	184.00	5.
S	42820		30	79.00	68.00	5.
S	42821		30	103.00	89.00	5.
S	42825		30	79.00	68.00	5.
S	42826		30	103.00	89.00	5.
S	42830		30	55.00	47.00	5.
S	42831		30	55.00	47.00	5.
S	42835		30	55.00	47.00	5.
S	42836		30	55.00	47.00	5.
S N	42860		30	37.00	32.00	5.
N	42860	52	30	22.00	19.00	5.
	42870		30	61.00	53.00	5.
	42880		30	131.00	79.00	4.
	42900		30	37.00	32.00	4.
	42950		60	242.00	210.00	6.
	42960		30	42.00	37.00	5.
	42961		30	42.00	37.00	5.
	42962		30	42.00	37.00	5.
	42970		30	42.00	37.00	5.
	42971		30	42.00	37.00	5.
	42972		30	42.00	37.00	5.
	43000		90	181.00	158.00	6.
	43020		90	181.00	158.00	6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	43045		90	242.00	210.00	13.
	43100		90	453.00	393.00	15.
	43101		90	453.00	393.00	15.
	43110		90	604.00	525.00	13.
	43120		90	604.00	525.00	13.
	43130		90	252.00	218.00	6.
	43135		90	252.00	218.00	6.
	43200		0	85.00	74.00	4.
	43202		0	97.00	84.00	4.
	43215		15	121.00	105.00	4.
	43217		15	121.00	105.00	4.
	43220		0	85.00	74.00	4.
	43220	76	0	42.00	37.00	4.
	43235		0	151.00	131.00	4.
	43239		0	163.00	142.00	4.
	43247		15	151.00	131.00	4.
	43251		15	151.00	131.00	4.
	43255		0	163.00	142.00	4.
	43258		0	163.00	142.00	4.
	43262		0	181.00	157.00	4.
	43268		0	151.00	131.00	4.
	43300		90	453.00	394.00	15.
	43320		90	483.00	420.00	13.
	43321		90	483.00	420.00	13.
	43330		90	483.00	420.00	13.
	43331		90	483.00	420.00	13.
	43350		90	242.00	210.00	13.
	43351		90	242.00	210.00	13.
	43352		90	242.00	210.00	13.
	43400		90	302.00	263.00	6.
	43410		90	211.00	184.00	6.
	43415		90	393.00	341.00	13.
	43420		90	272.00	236.00	6.
	43425		90	393.00	341.00	13.
	43450		0	35.00	32.00	3.
	43451		0	18.00	16.00	3.
	43453		0	35.00	32.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	43453	76	0	18.00	16.00	4.
	43455		0	85.00	74.00	4.
	43455	76	0	61.00	53.00	4.
	43460		0	51.00	44.00	4.
	43500		45	242.00	210.00	7.
	43520		45	211.00	184.00	7.
	43600		0	61.00		0.
	43605		45	242.00	210.00	7.
	43610		45	290.00	256.00	7.
	43620		90	573.00	499.00	7.
	43630		60	423.00	368.00	7.
	43635		60	476.00	413.00	7.
	43638		60	423.00	368.00	7.
	43640		60	370.00	320.00	7.
N	43760		0	13.00	11.00	0.
N	43765		0	13.00	11.00	0.
	43800		45	242.00	210.00	7.
	43810		45	272.00	236.00	7.
	43820		45	272.00	236.00	7.
	43825		45	384.00	334.00	7.
	43830		45	242.00	210.00	7.
	43832		45	242.00	210.00	7.
	43840		45	272.00	236.00	7.
	43850		60	393.00	341.00	7.
	43855		60	393.00	341.00	7.
	43860		60	393.00	341.00	7.
	43865		60	393.00	341.00	7.
	43870		45	242.00	210.00	7.
	44000		45	211.00	184.00	6.
	44005		90	316.00	275.00	6.
	44020		60	302.00	263.00	6.
	44025		60	302.00	263.00	6.
	44040		60	302.00	263.00	6.
	44050		90	272.00	236.00	6.
	44110		60	302.00	263.00	6.
	44111		60	332.00	289.00	6.
	44120		60	332.00	289.00	6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	44125		60	272.00	236.00		6.
	44130		90	302.00	263.00		7.
	44131		90	302.00	263.00		7.
	44140		90	362.00	315.00		6.
	44143		90	242.00	210.00		8.
	44150		90	604.00	525.00		7.
	44155		90	604.00	525.00		7.
	44160		90	604.00	525.00		7.
	44310		90	302.00	263.00		6.
	44314		90	604.00	525.00		7.
	44316		90	753.00	655.00		7.
	44320		90	242.00	210.00		8.
	44340		90	24.00	21.00		6.
	44345		60	121.00	105.00		6.
	44360		0	151.00	131.00		4.
	44361		0	163.00	142.00		4.
	44363		15	153.00	133.00		4.
	44364		15	153.00	133.00		4.
	44366		0	163.00	142.00		4.
	44369		0	163.00	142.00		4.
	44600		45	272.00	236.00		6.
	44605		90	281.00	213.00		6.
	44610		90	301.00	229.00		6.
	44620		90	211.00	184.00		6.
	44640		45	211.00	184.00		6.
	44680		90	316.00	275.00		6.
	44800		45	211.00	184.00		6.
	44820		45	362.00	315.00		6.
	44850		45	211.00	184.00		6.
	44900		45	182.00	158.00		6.
	44950		45	211.00	184.00		6.
	44960		45	211.00	184.00		6.
	45000		15	61.00	53.00		4.
	45020		30	90.00	79.00		6.
	45110		90	544.00	473.00		7.
	45112		90	544.00	473.00		7.
	45116		90	435.00	378.00		6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	45120		90	544.00	473.00		7.
	45130		90	326.00	284.00		4.
	45135		90	544.00	473.00		7.
	45150		90	108.00	95.00		4.
	45170		90	217.00	189.00		4.
	45300		0	18.00	16.00		3.
	45300	76	0	13.00	11.00		3.
	45302		0	18.00	16.00		3.
	45305		0	30.00	26.00		3.
	45307		15	42.00	37.00		4.
	45310		7	48.00	42.00		4.
	45310	76	7	30.00	26.00		4.
	45315		7	61.00	53.00		4.
	45315	22	15	76.00	65.00		4.
	45317		0	25.00	15.00		4.
	45360		0	97.00	84.00		4.
	45365		0	109.00	95.00		4.
	45370		0	121.00	105.00		4.
	45378		0	109.00	95.00		4.
	45380		0	121.00	105.00		4.
	45385		0	151.00	131.00		4.
	45500		90	181.00	158.00		4.
	45505		90	181.00	158.00		4.
	45521		30	45.00	39.00		0.
	45540		90	272.00	236.00		4.
	45550		90	393.00	341.00		8.
	45560		60	121.00	105.00		4.
	45800		90	272.00	236.00		6.
	45820		90	393.00	341.00		6.
	45900		0	13.00	11.00		3.
	46000		30	90.00	79.00		4.
	46030		0	12.00	11.00		3.
	46040		15	61.00	53.00		4.
	46045		15	61.00	53.00		4.
	46050		0	30.00	26.00		4.
	46060		90	151.00	131.00		4.
	46080		0	30.00	26.00		4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	46200		90	90.00	79.00	4.
	46210		30	30.00	26.00	3.
	46211		90	121.00	105.00	4.
	46220		15	14.00	13.00	4.
	46230		15	37.00	32.00	4.
	46250		90	139.00	121.00	4.
	46255		90	151.00	131.00	4.
	46257		90	163.00	142.00	4.
	46258		90	163.00	142.00	4.
M N	46260		90	206.00	179.00	4.
	46261		90	163.00	142.00	4.
	46262		90	163.00	142.00	4.
	46270		30	90.00	79.00	4.
	46275		90	244.00	210.00	4.
	46280		90	305.00	263.00	4.
	46285		30	61.00	53.00	4.
	46320		0	25.00	21.00	4.
	46500		0	15.00	10.00	3.
	46600		0	13.00	10.00	3.
	46602		0	13.00	10.00	3.
	46606		0	13.00	10.00	3.
	46608		15	42.00	37.00	4.
	46610		7	48.00	42.00	4.
	46612		7	61.00	53.00	4.
	46700		90	242.00	210.00	4.
	46705		0	26.00	22.00	4.
	46730		90	264.00	229.00	6.
	46735		90	421.00	366.00	7.
	46750		90	242.00	210.00	4.
	46751		90	242.00	210.00	4.
	46753		30	150.00	131.00	4.
	46760		90	301.00	263.00	4.
	46900		0	37.00	32.00	3.
	46910		0	37.00	32.00	3.
	46910	76	0	6.00	5.00	3.
	46920		0	37.00	32.00	3.
N	46930		30	147.00	126.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	46932		0	37.00	32.00	3.
N	46933		30	147.00	126.00	4.
	46935		90	139.00	121.00	4.
	46945		15	30.00	26.00	3.
	46946		15	90.00	79.00	3.
	47000		0	35.00		3.
	47100		45	211.00	184.00	3.
	47120		45	393.00	341.00	13.
	47135		90	BR		39.
	47300		60	272.00	236.00	7.
	47350		45	272.00	236.00	7.
	47360		45	272.00	236.00	7.
	47400		45	393.00	341.00	7.
	47420		45	332.00	289.00	7.
	47440		45	393.00	341.00	7.
	47460		45	393.00	341.00	7.
	47480		45	242.00	210.00	7.
	47500		0	43.00	37.00	3.
S	47600		45	302.00	263.00	7.
S	47605		45	314.00	273.00	7.
S	47610		45	362.00	315.00	7.
	47630		0	75.00	64.00	3.
	47700		45	252.00	218.00	7.
	47720		60	302.00	263.00	7.
	47740		60	328.00	284.00	7.
	47760		90	362.00	315.00	7.
	47780		90	428.00	371.00	7.
	47800		90	453.00	394.00	7.
	48000		60	242.00	210.00	7.
	48020		60	393.00	341.00	7.
	48100		0	21.00	18.00	3.
	48102		0	65.00		3.
	48120		60	289.00	246.00	7.
	48140		60	332.00	289.00	7.
	48145		60	302.00	263.00	7.
	48150		60	483.00	420.00	7.
	48155		60	483.00	420.00	7.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	48500		60	302.00	263.00	7.
	48520		60	302.00	263.00	7.
	48540		60	302.00	263.00	7.
N	49000		45	211.00	184.00	6.
	49020		45	217.00	189.00	6.
	49040		45	272.00	236.00	7.
	49060		45	217.00	189.00	6.
	49080		0	30.00	26.00	3.
	49081		0	18.00	16.00	3.
	49180		0	61.00		0.
	49200		60	380.00	331.00	6.
	49300		15	85.00	74.00	4.
	49302		15	121.00	105.00	6.
	49303		15	121.00	105.00	6.
	49400		0	30.00	26.00	3.
	49401		0	13.00	11.00	3.
	49420		30	182.00	158.00	5.
	49421		30	182.00	158.00	5.
	49425		60	410.00		5.
M	49430		0	30.00	26.00	3.
	49440		0	26.00	22.00	3.
	49500		45	182.00	158.00	4.
	49500	50	45	272.00	236.00	4.
S	49505		45	182.00	158.00	4.
S	49505	50	45	272.00	236.00	4.
S	49510		45	211.00	184.00	4.
S	49515		45	193.00	168.00	4.
S	49520		45	211.00	184.00	4.
S	49525		45	182.00	158.00	4.
S	49530		45	182.00	158.00	4.
S	49550		45	182.00	158.00	4.
S	49552		45	182.00	158.00	4.
S	49555		45	211.00	184.00	4.
S	49560		45	211.00	184.00	6.
S	49565		45	234.00	204.00	6.
S	49570		45	151.00	131.00	4.
S	49575		45	151.00	131.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
S	49580		45	155.00	134.00	4.
S	49581		45	182.00	158.00	4.
S	49590		45	151.00	131.00	4.
	49610		60	259.00	225.00	7.
	49611		60	259.00	225.00	7.
	49900		30	121.00	105.00	7.
	50020		90	272.00	236.00	6.
	50040		90	393.00	341.00	6.
	50045		90	393.00	341.00	6.
	50060		90	302.00	263.00	6.
	50075		90	340.00	294.00	6.
	50100		90	332.00	289.00	6.
	50120		90	393.00	341.00	6.
	50125		90	393.00	341.00	6.
	50130		90	393.00	341.00	6.
	50200		0	30.00		3.
	50205		30	155.00	132.00	4.
	50220		90	393.00	341.00	6.
	50230		90	393.00	341.00	6.
	50234		90	483.00	420.00	7.
	50236		90	483.00	420.00	7.
	50240		90	332.00	289.00	6.
	50280		90	362.00	315.00	6.
	50360		60	720.00		8.
	50365		60	1200.00		8.
	50366		60	1200.00		8.
	50380		60	720.00		8.
	50390		0	30.00	26.00	3.
	50392		2	75.00		4.
	50398		0	15.00	13.00	0.
	50400		90	423.00	368.00	6.
	50500		90	393.00	341.00	6.
	50520		90	272.00	236.00	6.
	50525		90	272.00	236.00	6.
	50526		90	272.00	236.00	6.
	50540		90	339.00	295.00	6.
	50600		90	362.00	315.00	6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
	50610		90	362.00	315.00	6.	
	50620		90	362.00	315.00	6.	
	50630		90	380.00	331.00	6.	
	50650		90	393.00	341.00	6.	
	50700		90	393.00	341.00	6.	
	50715		90	237.00	206.00	6.	
	50716		90	305.00	265.00	6.	
	50740		90	423.00	368.00	6.	
	50760		90	423.00	368.00	6.	
	50780		90	423.00	368.00	6.	
	50781		90	513.00	446.00	6.	
	50800		90	423.00	368.00	6.	
	50801		90	513.00	446.00	6.	
	50860		90	362.00	315.00	6.	
	50861		90	453.00	394.00	6.	
	50900		90	272.00	236.00	6.	
	50920		90	237.00	206.00	6.	
	50972		0	18.00		0.	
	51000		0	30.00	26.00	3.	
	51005		0	30.00	26.00	3.	
	51010		30	43.00	37.00	3.	
N	51010	76	0	15.00	13.00	0.	
	51020		90	272.00	236.00	5.	
	51040		90	242.00	210.00	5.	
	51050		90	272.00	236.00	5.	
	51080		90	151.00	131.00	5.	
	51520		90	211.00	184.00	5.	
	51525		90	393.00	341.00	5.	
	51530		90	302.00	263.00	5.	
	51550		90	362.00	315.00	6.	
	51555		90	362.00	315.00	6.	
	51565		90	483.00	420.00	6.	
	51570		90	665.00	578.00	8.	
	51580		90	665.00	578.00	8.	
	51590		90	665.00	578.00	8.	
	51597		90	753.00	655.00	7.	
	51600		0	13.00	11.00	3.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
N	51700		0	13.00	11.00	3.	
N	51720		0	13.00	11.00	3.	
N	51725		0	36.00	32.00	3.	
N	51726		0	36.00	32.00	3.	
N	51736		0	36.00	32.00	3.	
N	51741		0	72.00		3.	
	51800		90	302.00	263.00	6.	
	51840		90	302.00	263.00	6.	
	51865		90	272.00	236.00	6.	
	51880		90	151.00	131.00	3.	
	51900		90	272.00	236.00	3.	
	51920		90	272.00	236.00	3.	
	52000		0	30.00	26.00	3.	
	52000	22	0	61.00	53.00	3.	
	52000	76	0	18.00	16.00	3.	
	52005		0	61.00	50.00	3.	
	52005	22	0	87.00	75.00	3.	
N	52010	22	0	91.00	79.00	3.	
	52204		0	42.00	37.00	3.	
	52224		0	36.00	32.00	3.	
	52234		30	90.00	79.00	3.	
	52235		30	182.00	158.00	5.	
	52240		30	182.00	158.00	5.	
	52250		30	108.00	95.00	3.	
	52260		0	54.00	47.00	3.	
	52270		45	61.00	53.00	3.	
	52275		45	61.00	53.00	3.	
	52276		45	61.00	53.00	3.	
	52290		30	61.00	53.00	3.	
	52300		30	61.00	53.00	3.	
	52310		30	61.00	53.00	3.	
	52315		30	61.00	53.00	3.	
	52320		30	145.00	126.00	3.	
	52330		30	103.00	89.00	3.	
	52332		30	75.00	64.00	3.	
	52340		30	182.00	158.00	5.	
	52500		90	211.00	184.00	3.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	52601		90	393.00	341.00	5.
	53000		15	61.00	53.00	3.
	53010		30	121.00	105.00	3.
	53020		15	18.00	16.00	3.
	53025		15	18.00	16.00	3.
	53040		30	61.00	53.00	3.
	53080		15	72.00	63.00	3.
	53085		60	121.00	105.00	3.
	53220		60	211.00	184.00	3.
	53230		60	211.00	184.00	3.
	53235		60	211.00	184.00	3.
	53260		15	30.00	26.00	3.
	53265		15	61.00	53.00	3.
	53270		15	30.00	26.00	3.
	53400		90	426.00		3.
	53405		90	426.00		3.
	53410		60	242.00	210.00	3.
	53420		90	426.00		3.
	53425		90	426.00		3.
	53430		60	242.00	210.00	3.
	53440		45	242.00	210.00	3.
	53460		60	121.00	105.00	3.
	53502		60	121.00	105.00	3.
	53505		60	121.00	105.00	3.
	53510		60	121.00	105.00	3.
	53515		60	121.00	105.00	3.
	53520		90	121.00	105.00	3.
	53600		0	13.00	11.00	3.
	53601		0	8.00	6.00	3.
	53620		0	15.00	15.00	3.
	53621		0	11.00	9.00	3.
	53640		0	17.00	15.00	3.
	53660		0	9.00	8.00	3.
	53661		0	8.00	6.00	3.
	53670		0	13.00	11.00	3.
	54000		0	18.00	16.00	3.
	54001		0	18.00	16.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	54100		0	13.00	11.00	3.
	54120		60	121.00	105.00	3.
	54125		60	242.00	210.00	4.
	54130		90	BR	BR	6.
	54150		15	13.00	11.00	3.
	54152		15	61.00	53.00	3.
	54160		15	13.00	11.00	3.
	54161		30	97.00	84.00	3.
	54300		60	90.00	79.00	3.
	54304		60	393.00	341.00	3.
	54308		60	242.00	210.00	3.
	54400		60	393.00		3.
	54440		30	BR	BR	3.
	54500		0	13.00	11.00	3.
	54505		0	30.00	26.00	3.
	54520		30	121.00	105.00	3.
	54521		30	163.00	142.00	3.
	54530		30	271.00	236.00	3.
	54600		30	121.00	105.00	3.
	54600	22	30	181.00	158.00	3.
	54620		30	61.00	53.00	3.
	54640		30	242.00	210.00	4.
	54645		30	61.00	53.00	3.
	54700		0	61.00	53.00	3.
	54800		0	13.00	11.00	3.
	54820		30	61.00	53.00	3.
	54840		45	121.00	105.00	3.
	54860		45	121.00	105.00	3.
	54900		90	182.00	158.00	3.
	54901		90	242.00	210.00	3.
	55000		0	13.00	11.00	0.
	55040		45	121.00	105.00	3.
	55060		45	81.00	70.00	3.
	55100		0	30.00	26.00	3.
	55120		15	30.00	26.00	3.
	55150		45	121.00	105.00	3.
	55180		45	121.00	105.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	55200		30	61.00	53.00	3.
N	55250		30	90.00	79.00	3.
	55400		90	182.00	158.00	3.
	55401		90	242.00	210.00	3.
N	55450		30	42.00	37.00	3.
	55500		45	109.00	95.00	3.
	55530		45	121.00	105.00	3.
	55540		45	193.00	168.00	4.
	55600		45	182.00	158.00	4.
	55650		90	362.00	315.00	6.
	55700		0	30.00	26.00	3.
	55705		0	110.00	105.00	4.
	55720		60	121.00	105.00	4.
	55740		60	182.00	158.00	4.
	55801		90	393.00	341.00	6.
	55810		90	513.00	446.00	6.
	55821		90	393.00	341.00	6.
	55831		90	393.00	341.00	6.
	55840		90	513.00	446.00	6.
	55845		90	398.00	347.00	6.
	56000		0	30.00	26.00	3.
	56100		0	18.00	16.00	3.
	56200		45	90.00	79.00	3.
	56400		0	18.00	16.00	3.
	56420		0	30.00	26.00	3.
	56440		30	72.00	63.00	3.
	56600		0	13.00	11.00	3.
	56620		60	182.00	158.00	4.
	56625		60	272.00	236.00	4.
	56635		90	483.00	420.00	6.
	56636		90	483.00	420.00	6.
	56640		90	483.00	420.00	6.
	56641		90	483.00	420.00	6.
	56680		30	48.00	42.00	3.
	56700		30	48.00	42.00	3.
	56740		30	90.00	79.00	3.
	56800		30	81.00	70.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	57000		30	79.00	68.00	4.
	57010		30	79.00	68.00	4.
	57020		0	24.00	21.00	3.
	57100		0	13.00	11.00	3.
	57110		60	242.00	210.00	4.
	57120		60	242.00	210.00	4.
	57130		30	61.00	53.00	3.
N	57160		0	15.00	15.00	3.
	57200		60	48.00	42.00	4.
	57210		60	48.00	42.00	4.
	57220		60	121.00	105.00	4.
	57230		60	121.00	105.00	4.
	57240		60	151.00	131.00	4.
	57250		60	151.00	131.00	4.
	57260		60	242.00	210.00	4.
	57268		60	272.00	236.00	4.
	57270		60	272.00	236.00	6.
	57280		60	212.00	184.00	6.
	57291		60	281.00	245.00	6.
	57292		60	281.00	245.00	6.
	57300		90	302.00	263.00	6.
	57305		90	302.00	263.00	6.
	57310		60	272.00	236.00	3.
	57330		90	272.00	236.00	3.
	57400		0	13.00	11.00	3.
	57410		0	13.00	11.00	3.
	57450		0	85.00	74.00	4.
N	57451		45	182.00	158.00	6.
N	57452		0	21.00		3.
N	57454		0	34.00		3.
	57500		0	18.00	16.00	3.
	57510		0	13.00	11.00	3.
	57511		0	24.00	21.00	3.
	57520		45	85.00	74.00	3.
	57530		45	90.00	79.00	4.
	57545		45	242.00	210.00	6.
	57550		45	242.00	210.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS	IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS						\$	NS	
	57600		0	30.00	26.00	3.		58900		45	211.00	184.00	6.
	57620		0	30.00	26.00	3.		58920		45	242.00	210.00	6.
	57700		0	90.00	79.00	4.		58925		45	242.00	210.00	6.
	57720		45	90.00	79.00	4.		58940		45	242.00	210.00	6.
	57800		0	30.00	26.00	3.	N	58982		45	182.00	158.00	6.
	57820		15	72.00	63.00	3.	N	58983		45	182.00	158.00	6.
	58100		0	18.00	16.00	3.		59000		0	37.00		3.
	58120		15	72.00	63.00	3.	N	59020		0	30.00		0.
	58140		45	272.00	236.00	6.	N	59025		0	15.00		0.
	58145		45	272.00	236.00	6.	N	59025	22	0	9.00		0.
S N	58150		45	332.00	289.00	6.		59100		45	121.00	105.00	3.
M S	58180		45	272.00	236.00	6.	N	59105		45	272.00	236.00	6.
N	58205		90	604.00	525.00	8.	N	59106		45	272.00	236.00	6.
N	58210		90	604.00	525.00	8.		59120		60	272.00	236.00	6.
N	58240		90	753.00	655.00	8.		59121		60	272.00	236.00	6.
S N	58260		45	332.00	289.00	6.		59125		60	272.00	236.00	6.
S N	58265		45	332.00	289.00	6.		59126		60	272.00	236.00	6.
S N	58270		45	332.00	289.00	6.		59130		60	272.00	236.00	6.
N	58300		30	57.00	54.00	3.		59160		45	72.00	63.00	3.
N	58300	WM	30		23.80	0.		59300		0	90.00	79.00	3.
N	58301		0	15.00	15.00	3.		59305		0	90.00	79.00	3.
N	58301	WM	0		11.50	0.	N	59400		60	236.00	210.00	4.
	58320		0	30.00	26.00	3.	N	59400	WM	42		165.20	4.
	58340		0	30.00	26.00	3.	N	59410		60	160.00	144.00	4.
M	58400		45	242.00	210.00	6.	N	59410	WM	42		112.00	4.
M	58410		45	242.00	210.00	6.		59420		0	8.00	7.00	0.
	58520		45	211.00	184.00	6.		59420	WM	0		5.60	0.
N	58600		45	211.00	184.00	6.		59420	22WM	0		15.40	0.
N	58605		45	151.00	131.00	6.		59420	22	0	22.00	17.00	0.
	58700		45	211.00	184.00	6.		59430		0	13.00	11.00	0.
	58720		45	242.00	210.00	6.		59430	WM	0		9.10	0.
	58740		45	272.00	236.00	6.		59500		45	369.00	326.00	7.
	58752		45	211.00	184.00	6.		59520		45	290.00	257.00	7.
	58800		15	132.00	114.00	4.		59521		45	369.00	326.00	7.
	58805		45	242.00	210.00	4.		59541		45	369.00	326.00	7.
	58820		15	106.00	91.00	4.		59561		45	446.00	394.00	7.
	58822		45	211.00	184.00	6.		59581		45	446.00	394.00	7.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
	59800		30	42.00	37.00	3.	
	59801		45	79.00	68.00	3.	
	59810		45	37.00	32.00	3.	
	59811		45	79.00	68.00	3.	
	59820		45	105.00	91.00	3.	
	59830		45	121.00	105.00	3.	
N	59840		45	79.00	68.00	3.	
N	59841		45	79.00	68.00	3.	
N	59850		45	79.00	68.00	3.	
N	59851		45	79.00	68.00	3.	
	60000		0	48.00		4.	
	60200		45	182.00	158.00	6.	
	60220		45	272.00	236.00	6.	
	60240		45	332.00	289.00	6.	
	60245		45	302.00	263.00	6.	
	60252		90	386.00	336.00	6.	
	60254		90	573.00	499.00	6.	
	60260		45	290.00	252.00	6.	
	60261		45	338.00	294.00	6.	
	60280		45	211.00	184.00	6.	
	60500		45	362.00	315.00	6.	
	60505		60	350.00	303.00	13.	
	60540		90	393.00	341.00	10.	
	60550		90	415.00	360.00	10.	
	60555		90	498.00	432.00	10.	
M	60600		60	362.00	316.00	6.	
M	60605		60	415.00	360.00	10.	
	61000		0	30.00	26.00	3.	
	61020		0	20.00	18.00	5.	
	61026		0	40.00	35.00	5.	
	61050		0	24.00	21.00	3.	
	61105		30	121.00	105.00	9.	
	61106		0	121.00	105.00	5.	
	61120		90	121.00	105.00	9.	
	61130		0	81.00	69.00	3.	
	61151		0	30.00	26.00	3.	
	61154		90	362.00	315.00	11.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
	61156		90	362.00	315.00	11.	
	61210		30	150.00	130.00	9.	
	61250		30	242.00	210.00	9.	
	61251		30	362.00	315.00	9.	
	61310		90	573.00	499.00	11.	
	61320		90	423.00	368.00	9.	
	61321		90	423.00	368.00	9.	
	61330		90	513.00	446.00	11.	
	61450		90	573.00	499.00	11.	
	61460		90	634.00	551.00	11.	
	61510		90	513.00	446.00	11.	
	61512		90	513.00	446.00	11.	
	61518		90	604.00	525.00	11.	
	61526		90	573.00	499.00	11.	
	61534		90	423.00	368.00	11.	
	61544		90	423.00	368.00	11.	
	61546		90	513.00	446.00	11.	
	61548		90	254.00	221.00	4.	
	61550		90	271.00	236.00	11.	
	61552		90	362.00	315.00	11.	
	61570		90	BR	BR	11.	
	61702		90	604.00	525.00	11.	
	62000		90	302.00	263.00	11.	
	62010		90	302.00	263.00	11.	
	62100		90	BR	BR	11.	
	62120		90	362.00	315.00	11.	
	62141		90	423.00	368.00	11.	
	62180		90	634.00	551.00	11.	
	62220		90	362.00	315.00	11.	
	62223		90	362.00	315.00	11.	
	62223	62	0	290.00	252.00	11.	
	62225		90	108.00	95.00	11.	
	62230		90	326.00	284.00	11.	
	62256		90	108.00	95.00	11.	
	62270		0	13.00	11.00	3.	
	62274		0	30.00	26.00	0.	
	62278		0	30.00	26.00	0.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
N	62279		0	51.00	44.00	0.	
	62280		0	74.00	62.00	0.	
	62284		0	61.00	53.00	4.	
	62286		0	90.00	70.00	5.	
	62290		0	61.00	53.00	4.	
	62291		0	61.00	53.00	4.	
N	62292		30	302.00		7.	
N	62293		30	302.00		7.	
S	63001		90	665.00	578.00	10.	
S	63003		90	665.00	578.00	10.	
S	63005		90	665.00	578.00	10.	
S	63010		90	435.00	394.00	8.	
S	63015		90	665.00	578.00	10.	
S	63016		90	665.00	578.00	10.	
S	63017		90	665.00	578.00	10.	
S	63020		90	362.00	315.00	10.	
S	63030		90	362.00	315.00	8.	
S	63040		90	362.00	315.00	10.	
S	63041		90	362.00	315.00	10.	
S	63042		90	362.00	315.00	8.	
S	63060		90	362.00	315.00	10.	
S	63075		90	362.00	315.00	10.	
	63185		90	573.00	499.00	8.	
	63194		90	665.00	578.00	8.	
	63195		90	665.00	578.00	8.	
	63196		90	665.00	578.00	8.	
	63197		90	665.00	578.00	8.	
	63210		90	694.00	604.00	8.	
	63215		90	694.00	604.00	8.	
	63220		90	694.00	604.00	8.	
	63700		90	393.00	341.00	8.	
	63702		90	393.00	341.00	8.	
	63704		90	483.00	420.00	8.	
	63706		90	483.00	420.00	8.	
	63740		90	361.00	315.00	8.	
	64405		0	30.00	26.00	0.	
	64410		0	13.00	11.00	0.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				S	\$	NS	
	64412		0	30.00	26.00	0.	
	64413		0	30.00	26.00	0.	
	64415		0	30.00	26.00	0.	
	64417		0	30.00	26.00	0.	
	64420		0	18.00	16.00	0.	
	64425		0	30.00	26.00	0.	
	64430		0	30.00	26.00	0.	
	64435		0	30.00	26.00	0.	
	64440		0	30.00	26.00	0.	
	64445		0	30.00	26.00	0.	
	64450		0	13.00	11.00	0.	
	64508		0	30.00	26.00	0.	
	64510		0	30.00	26.00	0.	
	64520		0	30.00	26.00	0.	
	64530		0	30.00	26.00	0.	
	64600		0	37.00	32.00	0.	
	64605		0	48.00	42.00	0.	
	64620		0	18.00	16.00	0.	
	64680		0	74.00	62.00	0.	
	64702		90	79.00	68.00	3.	
	64704		90	105.00	91.00	3.	
	64708		90	242.00	210.00	3.	
	64712		90	258.00	220.00	4.	
	64713		90	258.00	220.00	4.	
	64714		90	258.00	220.00	4.	
	64716		90	393.00	341.00	5.	
	64718		90	211.00	184.00	3.	
	64721		90	158.00	137.00	3.	
	64732		30	182.00	158.00	3.	
	64734		30	182.00	158.00	3.	
	64744		30	121.00	105.00	5.	
	64746		30	121.00	105.00	4.	
	64774		30	42.00	37.00	3.	
	64776		30	53.00	45.00	3.	
	64782		30	79.00	68.00	3.	
	64784		30	131.00	114.00	4.	
	64802		60	302.00	263.00	6.	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	64803		60	321.00	279.00	6.
M	64804		60	423.00	368.00	10.
M	64806		60	573.00	499.00	10.
M	64818		60	272.00	236.00	7.
M	64819		60	332.00	289.00	7.
	64831		90	79.00	68.00	3.
	64834		90	105.00	91.00	3.
	64835		90	158.00	137.00	3.
	64836		90	158.00	137.00	3.
	64856		90	210.00	183.00	3.
	64858		90	158.00	137.00	4.
	64861		90	158.00	137.00	6.
	64862		90	158.00	137.00	6.
	64864		90	394.00	342.00	5.
	64866		90	513.00	446.00	5.
	64868		90	513.00	446.00	5.
	64870		90	513.00	446.00	5.
	65091		30	211.00	184.00	6.
	65093		30	242.00	210.00	6.
	65101		30	211.00	184.00	6.
	65103		30	211.00	184.00	6.
	65105		30	211.00	184.00	6.
	65110		60	182.00	158.00	6.
	65112		60	315.00	274.00	6.
	65140		30	242.00	210.00	6.
	65205		0	13.00	11.00	3.
	65210		0	18.00	16.00	3.
	65220		0	13.00	11.00	3.
	65222		0	18.00	16.00	3.
	65230		45	242.00	210.00	6.
	65235		45	242.00	210.00	6.
	65240		45	302.00	263.00	6.
	65245		45	302.00	263.00	6.
	65270		15	30.00	26.00	4.
	65280		30	182.00	158.00	8.
	65285		45	211.00	174.00	6.
	65300		15	61.00	53.00	6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	65400		30	151.00	131.00	6.
	65420		30	121.00	105.00	6.
	65426		30	121.00	105.00	6.
	65435		0	30.00	26.00	3.
	65600		0	151.00	131.00	3.
	65710		90	453.00	394.00	8.
	65720		90	453.00	394.00	8.
	65725		90	453.00	394.00	8.
	65730		90	432.00	376.00	8.
	65740		90	432.00	376.00	8.
	65745		90	432.00	376.00	8.
	65750		90	432.00	376.00	8.
	65800		0	18.00	16.00	3.
	65805		0	18.00	16.00	3.
	65820		30	182.00	158.00	6.
	65825		30	182.00	158.00	6.
	66020		0	90.00	79.00	6.
	66150		45	272.00	236.00	6.
	66160		45	272.00	236.00	6.
	66165		45	242.00	210.00	6.
N	66170		45	272.00	236.00	6.
N	66170	22	45	272.00		6.
	66500		30	121.00	105.00	6.
	66505		30	121.00	105.00	6.
	66600		45	272.00	236.00	6.
	66605		45	302.00	263.00	6.
	66625		45	211.00	184.00	6.
	66635		45	182.00	158.00	6.
	66680		45	101.00	87.00	6.
	66700		30	151.00	131.00	6.
	66740		45	242.00	210.00	6.
	66761		30	121.00		6.
	66800		45	121.00	105.00	6.
	66801		45	90.00	79.00	6.
	66820		45	121.00	105.00	6.
	66830		30	112.00		6.
	66840		30	151.00	131.00	6.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
N	66920		90	393.00	341.00		8.
N	66930		90	393.00	341.00		8.
N	66940		90	393.00	341.00		8.
	66983		90	513.00	446.00		8.
	66984		90	513.00	446.00		8.
	67005		90	393.00			8.
	67010		90	393.00			8.
	67015		15	151.00	131.00		4.
	67036		90	544.00			8.
	67102		90	362.00			7.
	67103		90	362.00			7.
	67104		90	362.00	315.00		6.
	67106		30	182.00			6.
	67107		90	544.00	473.00		6.
	67108		90	544.00	473.00		6.
	67109		30	151.00	131.00		6.
	67120		30	182.00	158.00		6.
	67144		30	121.00	105.00		6.
	67146		30	121.00	105.00		6.
	67213		30	362.00			6.
	67216		30	182.00			6.
	67311		30	272.00	236.00		5.
	67312		30	302.00	263.00		5.
	67313		30	302.00	263.00		5.
	67400		30	242.00	210.00		6.
	67405		30	242.00	210.00		6.
	67412		30	272.00	236.00		6.
	67413		30	272.00	236.00		6.
	67420		30	272.00	236.00		6.
	67505		0	30.00	26.00		3.
	67700		0	13.00	11.00		3.
	67800		15	30.00	26.00		4.
	67801		15	42.00	37.00		4.
	67805		15	50.00	43.00		4.
	67810		0	13.00	11.00		4.
	67825		0	20.00	20.00		4.
	67830		90	121.00	105.00		4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			ANES BASIC UNITS
				\$	\$	NS	
	67840		15	18.00	16.00		3.
	67901		60	272.00	236.00		4.
	67902		60	182.00	158.00		4.
	67915		15	30.00	26.00		3.
	67917		30	182.00	158.00		4.
	67922		15	30.00	26.00		3.
	67924		30	182.00	158.00		4.
	67961		60	227.00	197.00		4.
	67966		60	242.00	210.00		4.
	67971		60	242.00	210.00		4.
	67973		60	362.00	315.00		4.
	67974		60	411.00	357.00		4.
	68100		0	18.00	16.00		3.
	68110		15	30.00	26.00		3.
	68115		15	30.00	26.00		3.
	68320		30	242.00	210.00		6.
	68325		30	272.00	236.00		6.
	68400		15	48.00	42.00		3.
	68420		15	37.00	32.00		3.
	68500		45	242.00	210.00		4.
	68505		45	242.00	210.00		4.
	68520		45	242.00	210.00		4.
	68540		45	253.00	221.00		4.
	68700		45	90.00	79.00		4.
	68720		60	272.00	236.00		5.
	68760		15	30.00	26.00		4.
	68800		0	8.00	7.00		3.
	68820		0	13.00	11.00		3.
	68825		0	30.00	26.00		4.
	68830		15	13.00	11.00		0.
	68840		0	8.00	7.00		3.
	68850		0	21.00	19.00		3.
	69000		0	24.00	21.00		3.
	69005		15	61.00	53.00		4.
	69020		0	18.00	16.00		3.
	69100		0	13.00	11.00		3.
	69110		90	76.00	66.00		4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	69120		90	151.00	131.00	4.
	69140		90	182.00	158.00	4.
	69145		0	13.00	11.00	3.
	69150		90	169.00	147.00	6.
	69155		90	242.00	210.00	6.
	69200		0	13.00	11.00	0.
	69205		0	30.00	26.00	4.
	69300		90	121.00	105.00	4.
	69301		90	169.00	147.00	4.
	69320		90	242.00	210.00	4.
	69400		0	9.00	8.00	3.
	69405		0	9.00	8.00	3.
	69420		0	24.00	21.00	4.
	69420	20	0	61.00	53.00	4.
	69420	20 50	0	90.00	79.00	4.
	69433		7	37.00	32.00	3.
	69433	50	0	48.00	42.00	3.
	69440		30	242.00	210.00	5.
	69450		30	332.00	289.00	4.
	69501		90	242.00	210.00	5.
	69505		90	423.00	368.00	5.
	69511		90	423.00	368.00	5.
	69530		90	604.00	525.00	5.
	69540		15	37.00	32.00	3.
	69601		90	302.00	263.00	5.
	69602		90	302.00	263.00	5.
	69603		90	302.00	263.00	5.
	69610		0	24.00	21.00	3.
	69620		90	280.00	252.00	5.
	69631		90	403.00	351.00	5.
	69632		90	403.00	351.00	5.
	69636		90	483.00	420.00	5.
	69641		90	483.00	420.00	5.
	69642		90	483.00	420.00	5.
	69643		90	483.00	420.00	5.
	69644		90	483.00	420.00	5.
	69650		90	302.00	263.00	5.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				\$	NS	
	69660		90	393.00	341.00	5.
	69670		90	280.00	252.00	5.
	69700		60	121.00	105.00	5.
	69720		90	362.00	315.00	5.
	69740		90	435.00	378.00	5.
	69801		90	393.00	341.00	5.
	69820		90	423.00	368.00	5.
	69840		90	254.00	221.00	5.
	69905		90	393.00	341.00	5.
L	M0900		90	BR	BR	5.
L	M0902		0	38.00	26.00	0.
L	T5015		60	144.00		8.
L	T6005		0	18.00	16.00	3.
L	T6500		60	214.00		6.
L	T6951		7	121.00	105.00	5.
L	T6952		7	121.00	105.00	5.
L	T6960		90	465.00	405.00	5.
L	W1250		0	18.00	16.00	3.
L	W1650		0	24.00	21.00	3.
L	W1650	22	0	37.00	32.00	3.
L	W2600		90	151.00	131.00	3.
L	W2610		90	242.00	210.00	3.
L	W2620		90	90.00	79.00	3.
L	W2650		0	21.00	21.00	0.
L	W2655		0	5.00	5.00	0.
L	W3705		30	163.00	142.00	5.
L	W3710		30	145.00	126.00	5.
L	W3715		30	145.00	126.00	5.
L	W3720		30	217.00	189.00	5.
L	W4150		0			4.
L	W4650		90	103.00	89.00	4.
L	W5650		0	15.00	15.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				S	\$ NS	
L	W5750		0	30.00	28.00	0.
L	W5760		15	72.00	63.00	3.
L	W5760	76	15	48.00	42.00	3.
L	W5850		30	66.00	61.00	3.
L	W5920		0	51.00	44.00	0.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		ANES BASIC UNITS
				S	\$ NS	
L	W5930		45	30.00	26.00	3.
L	W6499		0			3.
L	Z0250	WM	0		40.00	0.

APPENDIX A (CODES AND NARRATIVES NOT FOUND IN CPT-4)

SURGERY

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	FOLLOW UP DAYS	SURG VALUE			BASIC UNITS
					\$	\$	NS	
	M0900		EXCISION REVISION OR REMOVAL OF A-V SHUNT ANASTOMOSIS WITH OR WITHOUT GRAFT	90	BR	BR		5.
	M0902		DECLOTTING OF INTERNAL A-V SHUNT ANASTOMOSIS OF GRAFT WITH OR WITHOUT BALLOON CATHETER, ARTERY AND/OR VEIN	0	38.00	26.00		0.
	T5015		RENAL TRANSPLANTATION, IMPLANTATION OF GRAFT, WITH IMMUNOSUPPRESSANT THERAPY, WITH RECIPIENT SPLENECTOMY AND RECIPIENT NEPHRECTOMY, UNILATERAL AND BILATERAL	60	1,440.00	0		8.
	T6005		SPINAL PUNCTURE, LUMBAR DIAGNOSTIC, FOR DECOMPRESSION INCLUDING HYDRODYNAMICS	0	18.00	16.00		3.
	T6500		RESUTURING OF DISLOCATED INTRAOCULAR LENS, REQUIRING AN INCISION	60	214.00			6.
	T6951		MYRINGOTOMY WITH INSERTION OF COLLAR BUTTON, UNILATERAL	7	121.00	105.00		5.
	T6952		MYRINGOTOMY WITH INSERTION OF COLLAR BUTTON, BILATERAL	7	121.00	105.00		5.
	T6960		MASTOIDECTOMY, MODIFIED RADICAL OR RADICAL, WITH SKIN GRAFT	90	465.00	405.00		5.
	W1250		EXCISION OF NAIL, PARTIAL OR COMPLETE, INCLUDING NAIL BED OR NAIL FOLD, WITH OR WITHOUT EXCISION OF SUBUNGUAL EXOSTOSIS E.G. FOR FUNGUS INFECTION OR CHRONIC PARONYCHIA.	0	18.00	16.00		3.
	W1650		EXCISION OF PLANTAR VERRUCA, SINGLE SITE UNILATERAL	0	24.00	21.00		3.
	W1650	22	EXCISION OF PLANTAR VERRUCA, MULTIPLE SITES UNILATERAL	0	37.00	32.00		3.
	W2600		ARTHROPLASTY, LESSER TOES, WITH OR WITHOUT TENDON TRANSFER	90	151.00	131.00		3.
	W2610		ARTHROPLASTY- HALLUX VALGUS WITH IMPLANT (SWANSON OR SEEBURGER)	90	242.00	210.00		3.
	W2620		PLASTIC OR RECONSTRUCTIVE SURGERY, TOE, ONE JOINT	90	90.00	79.00		3.
	W2650		CASTING FOR MOLDED SHOES	0	21.00	21.00		0.
	W2655		CASTING FOR ARCH SUPPORT	0	5.00	5.00		0.
	W3705		EXPLORATION AND RESECTION OF FALSE ANEURYSM (DUE TO RUPTURE OF PRIOR ARTERIO-VEINUS FISTULA) LOWER EXTREMITY	30	163.00	142.00		5.
	W3710		SHUNT, VENOUS, EXTERNAL, SURGICAL REVISION FOR RENAL DIALYSIS (REQUIRES INSERTION OF CANNULA) UPPER EXTREMITY WITH EMBOLECTOMIES	30	145.00	126.00		5.
	W3715		SHUNT, BOTH VENOUS AND ARTERIAL, EXTERNAL, SURGICAL REVISION, FOR RENAL DIALYSIS (REQUIRES INSERTION OF CANNULA) UPPER EXTERMITY	30	145.00	126.00		5.

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	FOLLOW UP DAYS	SURG VALUE			ANES BASIC UNITS
					\$	\$	NS	
	W3720		SHUNT, BOTH VENOUS AND ARTERIAL, EXTERNAL, SURGICAL REVISION FOR RENAL DIALYSIS (REQUIRES INSERTION OF CANNULA) UPPER EXTREMITY WITH EMBOLECTOMIES	30	217.00	189.00	5.	
	W4150		ANESTHESIA FOR TEETH EXTRACTION	0			4.	
	W4650		INTERNAL HEMORRHOIDECTOMY	90	103.00	89.00	4.	
	W5650		REMOVAL OF A FOREIGN BODY FROM THE VAGINA OF A CHILD	0	15.00	15.00	3.	
	W5750		VABRA ASPIRATION BIOPSY	0	30.00	28.00	0.	
	W5760		INSERTION OF FLETCHER APPLICATOR FOR CESIUM IMPLANT, INITIAL	15	72.00	63.00	3.	
	W5760	76	INSERTION OF FLETCHER APPLICATOR FOR CESIUM IMPLANT, SUBSEQUENT	15	48.00	42.00	3.	
	W5850		REMOVAL OF AN I.U.D. FOLLOWED AT THE SAME VISIT BY THE INSERTION OF A NEW INTRACERVICAL OR INTERUTERINE DEVICE FOR CONTRACEPTION. (INCLUDES COST OF DEVICE AND POST-INSERTION VISIT.)	30	66.00	61.00	3.	
	W5920		CAUDAL ANESTHESIA (EPIDURAL BLOCK) LIMITED TO OBSTETRICAL CASES ONLY ELIGIBLE FOR REIMBURSEMENT ONLY WHEN GIVEN BY OTHER THAN THE DELIVERY PHYSICIAN.	0	51.00	44.00	0.	
	W5930		MANUAL REMOVAL OF PLACENTA BY OTHER THAN THE PHYSICIAN EFFECTING DELIVERY	45	30.00	26.00	3.	
	W6499		ANESTHESIA FOR ECT OR CAT SCAN				3.	
	Z0250	WM	HOME DELIVERY PACK - USED BY CNM	0		40.00	0.	

APPENDIX B

(Surgery)

QUALIFIERS

For reimbursement purposes certain Medicaid restrictions are still applicable. They are:

HCPCS
Code

Qualifiers

- 10040 Limited to severe acne. For less than severe acne, utilize a procedure code for an office visit.
- 15745 Myocutaneous flap procedure for plastic reconstruction of major defect; includes preparation of site and all associated procedures; (this code may be used for major post-mastectomy breast reconstruction). If a free graft is required for a donor site, then a 20% increase in fee is allowed.
- 20220 (Core Biopsy) includes preliminary needle aspiration or attempt
20225 local anesthesia, collection and preparation of material, interpretation and report. (For interpretation only by pathologist, use 85100 or 85101.)
- 20520 Removal of foreign body in muscle, with anesthesia (includes hematoma) (other than by needle aspiration).
- 20550 If office visit is performed in addition must be documented and not included in time spent for PRV 20550.
- 20600 One or more joints same visit include medication. If office visit is
20605 performed in addition, must be documented on the record and may not
20610 include time spent for PRV 20600, 20605 or 20610.
- 2068052 Removal of metal band, plate, screw, or nail- Use only when done in outpatient setting.
- 20680 Removal of metal band, plate, screw or nail- Use only when done in inpatient hospital setting.
- 22310 Vertebral body, any level, one or more, without reduction-including orthopedic or neurosurgical consultation or initial hospital visit.
- 22800 Second Opinion Procedures
22801 Spinal Fusions for scoliosis in a child or young adult do not require a second opinion.

HCPCS
Code

Qualifiers

- 22840 Second Opinion Procedures
- Spinal Fusions for scoliosis in a child or young adult do not require a second opinion.
- 27130 Hip cup replacement prosthesis or removal of same (Charnley low
27131 friction arthroplasty or McKee Ferrar Procedure) (Trapezoidal 28
 Total Hip Replacement).
- 27240 Intertrochanteric, simple, with or without closed reduction, with
 fixation or traction (If daily visits charged this additional charge
 not allowable).
- 27485 The removal and re-insertion of staples at same operation, are
 included in the allowance.
 For removal of staples only, 50% of allowance is reimbursable.
 Freeing of bone adhesions, callous or synostosis independent proce-
 dure, see Ostectomy.
- 28288 Rasping technique (ostectomy) with or without tenotomy.
- 28490 Phalanx, or phalanges, great toe, simple, closed reduction (Use of
 shoe, plaster or metal mold, strapping, casting, bandaging).
- 28750 Toe, one or more joints
28755
- 33200 Initial or subsequent total replacement when total removal prior to
 subsequent insertion of a pacemaker at a new site, add 50% of value
 of Code 33210 and combine surgeries.
- 33206 Initial subsequent total replacement - when total removal prior to
33207 subsequent insertion of pacemaker at a new site, add 50% of value of
 Code 33219 and combine surgeries. One Surgical Assistant at 15% of
 the fee is allowed. Only the assistant internist or assistant car-
 diologist is eligible for follow-up care.
- 33510 Allow one assistant at 20%.
- 35371 For uncomplicated or localized incisional revision of peripheral
35381 artery; for arteriosclerotic plaque use PRV 33201.
- 36010 Use this code for insertion of Hickman Catheter or equivalent.
- 36415 For reimbursement purposes, reference is to collection of blood by
 venapuncture only and limited to office, home or nursing home.
 Payment is once per patient visit and will not be applicable if the
 laboratory study is to be done by the physician's own office.

HCPCS
Code

Qualifiers

- 36520 Therapeutic Apheresis: Services must be performed by or in the presence of the single billing physician and is limited to that physician. It includes all related procedures, patient evaluation, monitoring and treatment of complications and is limited to medically necessary conditions for which this procedure is no longer considered experimental by Medicare.
- 42860 Excision of tonsil tags - use only when done in inpatient setting.
- 4286052 Excision of tonsil tags - use only when done in office setting.
- 43760 Gastrostomy tube replacement (Ineligible during 45-day post-operative period) with dilation of the stoma.
43765
- 46260 Radical Hemorrhoidectomy, White head type, including removal of entire pile bearing area is a Medical Necessity Procedure.
- 46930 Single or multiple, internal and external, in hospital
46933
- 49000 Do not use this PRV when any other definitive surgery is performed/nor any 50% allowance.
- 5101076 Replacement or reinsertion of suprapubic catheter. Limited to office, home, or sheltered boarding home visit setting and includes physician's cost of catheter.
- 51700 To obtain drug replacement of DMSO used for FDA approved diagnosis
51720 obtain Prior Authorization (P.A.) for a prescription from Medicaid District Office and enter the P.A. number and FDA approved diagnosis on the prescription made out in the patient's name.
- 51725 Cystometrogram, Uroflometric Study, or any single element of an
51726 Urodynamic study, allow only 50% when performed at same operative
51736 sessions as major surgery.
51741
- 5201022 See 52005 or 5200522, and add detention time beyond time required for usual catheterization, see 99150.
- 55250 Primary Sterilization (Family Planning) Procedure:
55450
- Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 2 (2.14 (a) thru (d) Sterilization). Policy originally published as New Jersey Health Services Program Newsletter P-334, dated 5/17/82, with subsequent revisions.
- 57160 Insertion of pessary for uterine support or prolapse or malposition.

HCPCS
Code

Qualifiers

- 57451 Primary Sterilization (Family Planning). Procedure by laparoscopy or culdoscopy with or without dilation and curettage (independent procedure).
- Note: Tubal Surgery for primary sterilization performed at time of Caesarean Section carries no additional reimbursement.
- Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 2 (2.14 (a) thru (d) Sterilization). Policy originally published as New Jersey Health Services Program Newsletter P-334, dated 5/17/82, with subsequent revisions.
- 57452 Reimbursable only if one or more of the following guidelines are
57454 present, in which case a statement is to be written in 24 D/E of the 1500-N.J. claim form.
- (1) Patient must have a current pap smear reported as class 2 or higher or;
 - (2) Patients who have had surgery for uterine cancer or;
 - (3) Patients who were exposed in utero to Diethylstilbestrol.
- 58150 Complete hysterectomy form, FD-189, must be attached to the
58180 1500-N.J. claim form. Refer to the roster of CPT codes to identify
58205 procedures subjected to Second Opinion and Medical Necessity regula-
58210 tions. See Subchapter 2 (2.14 (a) thru (d) Sterilization). Orig-
58240 inally published as New Jersey Health Services Program Newsletter
58260 P-334, dated 5/17/82, and subsequent revisions, and Newsletter
58265 P-404, dated 9/17/84.
58270
- 58300 Includes cost of device and post insertion visit. Service provided
58300WM by certified nurse midwife use code 58300 with modifier WM also limited to within 6 weeks post-partum period.
- 58301 Limited to within 6 weeks post-partum period. Service provided by
58301WM certified nurse midwife use code 58301 with modifier WM.
- 58600 Primary Sterilization (Family Planning) Procedure
- Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 2 (2.14 (a) thru (d) Sterilization) or New Jersey Health Services Program Newsletter P-334, 5/17/82 and subsequent revisions.
- Note: Tubal sterilization procedure at the time of caesarean section, will carry no additional allowance.

HCPCS
Code

Qualifiers

58605 Primary Sterilization (Family Planning) Procedure: post-partum during the same hospitalization and performed by any surgical method or approach by the same physician or group effecting the vaginal delivery (or abortion).

Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 2 (2.14 (a) thru (d) Sterilization) or New Jersey Health Services Newsletter P-334, 5/17/82 and subsequent revisions.

58982 Primary Sterilization. (Family Planning) Procedure. Procedure by
58983 Laparoscopy with or without dilation and curettage.

Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 2 (2.14 (a) thru (d) Sterilization) or New Jersey Health Services Program Newsletter P-334, dated 5/17/82, and subsequent revisions.

59020 This study is reimbursable only to the physician who is in direct physical attendance to the patient during the complete procedure, in a hospital inpatient or outpatient setting. (Not reimbursable if patient goes into labor.)

59025 For high risk pregnancy, limited to third trimester.
5902522

Note: Complete diagnosis in standard nomenclature, gestational age with etiology of high risk must be clearly stated on the claim form. Claims for code 59020 and/or 59025 are limited to twice per pregnancy. Utilize code 59025 when service rendered in physician's office; utilize code 5902522 when rendered in hospital outpatient department setting.

59105 See Subchapter 2 (2.1-Abortions). Policy originally published as
59106 NJHSP Newsletter, Volume P-268 "Policy Regarding Medicaid Reimbursement for Abortions". FD-179 form must be attached to 1500-N.J. claim form.

59400 Specific dates of all visits are to be listed on the 1500-N.J. claim
59400WM form.

NOTE: Reimbursement will be decreased by the fee for the initial ante-partum visit (59420-22) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent ante-partum visit (59420) which is less than seven.

HCPCS
Code

Qualifiers

NOTE: If medical necessity dictates, corroborated by the record, then additional visits above seven ante-partum may be reimbursed under a (routine or follow-up home or office visit). The claim form should clearly indicate the reason for the medical necessity and date for each home or office visit listed.

NOTE: Service provided by certified nurse midwife use 59400 with WM modifier.

59410 Full term or premature following completion of at least 28 weeks of
59410WM gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 60th post-partum day following delivery and out of hospital. Include delivery date on the 1500-N.J. claim form. Service provided by certified nurse midwife use code 59410 with WM modifier.

59840 See Subchapter 2 (2.1-Abortions). Policy originally published as
59841 NJHSP Newsletter, Volume P-268, "Policy Regarding Medicaid Reim-
59850 bursement for Abortions" FD-179 form must be attached to the
59851 1500-N.J. claim form.

NOTE: Trimester of pregnancy must be identified on the 1500-N.J. claim form by using modifier "WY" for 1st trimester or "WZ" for 2nd trimester.

62279 Epidural anesthesia, use for pregnancy or intractable pain,
including insertion of catheter or cannula. There is a flat fee unless surgery is necessary. Then in anesthesia formula (basic & time) for surgical procedure.

62292 FDA, eligibility criteria apply for 62292. FDA approval pending
62293 for 62293.

66170 This is a Laser Arconphoto coagulation procedure. Allow 50% and
6617022 25% for 2nd and 3rd repeat procedures within 90 days.

66920 When a trabeculectomy (Code 66170) is done at the same time as this
66930 procedure, then it's reimbursement is limited to a maximum of 50%
66940 of the fee listed under Code 66170.

APPENDIX C

(Surgery)

MODIFIER
CODE

DESCRIPTION

- AA Anesthesia: Anesthesia services personally furnished by anesthesiologist are identified by adding the modifier 'AA' to the procedure number.
- LT Left Side: Use to identify procedures performed on the left side of the body.
- RT Right Side: Use to identify procedures performed on the right side of the body.
- WM Midwifery: Use to identify procedures performed by certified nurse midwives by adding the modifier 'WM' to the procedure code.
- WY 1st Trimester: Use to identify trimester when rendering a legal abortion procedure by adding the modifier 'WY' to the procedure code.
- WZ 2nd Trimester: Use to identify trimester when rendering a legal abortion procedure by adding the modifier 'WZ' to the procedure code.
- 20 Microsurgery: When the surgical service is performed using the techniques of microsurgery, including the aid of an operating microscope, modifier '20' may be added to the surgical procedure. The use of this modifier is not warranted when surgery is done with the aid of a magnifying loupe or magnifying binoculars worn by the surgeon. A special report may be appropriate to document the necessity of the microsurgical approach.
- 22 Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.
- 23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '23' to the procedure code of the basic service.
- 47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier '47' to the basic service.

MODIFIER

CODE

DESCRIPTION

- 50 Bilateral Procedures: Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number.
- 51 Multiple Procedures: When multiple procedures are performed at the same operative session, the major procedure may be reported as listed. The secondary, additional, or lesser procedure(s) may be identified by adding the modifier '51' to the secondary procedure number(s).
- 52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
- 62 Two Surgeons: Under certain circumstances the skill of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances the separate services may be identified by adding the modifier '62' to the procedure number used by each surgeon for reporting his/her services.
- 66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier '66' to the basic procedure number used for reporting services.
- 75 Concurrent Care Services Rendered by More than One Physician: When the patient's condition requires the additional services of more than one physician, each physician may identify his or her services by adding the modifier '75' to the procedure code for the basic service performed.
- 76 Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '76' to the repeated service.

MODIFIER

CODE

DESCRIPTION

- 77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier '77' to the repeated service.
- 80 Assistant Surgeon: Surgical assistant services are identified by adding this modifier '80' to the usual procedure number(s).

APPENDIX D

MEDICAID SECOND OPINION PROGRAM (Originally Published as Newsletter P-329, March 22, 1982 and Newsletter P-339, October 4, 1982).

BACKGROUND

As adopted in the N.J.A.C. (10:52-1.3; 10:54:-1.2), the New Jersey Medicaid Program, in an effort to promote quality health care and to contain costs, instituted a mandatory Second Opinion Program for certain elective surgical procedures. The procedures affected include hysterectomy, cholecystectomy, tonsillectomy and/or adenoidectomy, hernia repair, laminectomy and spinal fusion.

A Second Opinion will not be required for:

1. Herniorrhaphies involving a child or young adult 18 years of age or under. However, a second opinion is required for an umbilical herniorrhaphy in a child under the age of five and for any herniorrhaphy involving an adult.
2. Spinal Fusion for scoliosis in a child or young adult.
3. New Jersey Medicaid recipients with Health Services Program (HSP Medicaid) case numbers with the first and second digits of 90 or the third and fourth digits of 60 and residing out of state at the discretion of the New Jersey Department of Human Services.

The outcome of the Second Opinion has no bearing on payment. Once the Second Opinion is rendered, the patient retains the right to decide whether or not to proceed with the surgery. However, failure to obtain a Second Opinion for these procedures will result in a denial of the surgeon's and hospital's claim.

PROGRAM REQUIREMENTS

1. A Second Opinion is required only for the surgical procedures listed and only when they are considered to be elective.
2. A Second Opinion is required regardless of the setting in which the procedure is to be performed (inpatient hospital, outpatient hospital, independent clinic or physician's office).
3. A Second Opinion is not required if the patient is eligible for both Medicare and Medicaid coverage.
4. If the operating physician determines that the need for surgery is urgent or is an emergency, no Second Opinion is required. Urgent or emergency is defined for Second Opinion purposes to mean that to delay surgery in order to meet the protocol of Second Opinion would result in a significant threat to the patient's health or life. Reimbursement will be made only if a specific statement is attached to all claim

forms by the operating physician certifying that the Second Opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

5. If a patient is already hospitalized, a Second Opinion is not required if the surgical procedure is performed for an emergency or urgent condition or if the procedure becomes urgent or an emergency during the course of hospitalization, regardless of the patient's admission diagnosis.

However, a Second Opinion is required for any of the six procedures to be done on an elective basis even if the recommendation for surgery is made during an inpatient stay. In this case, the patient should be discharged and follow the process described below for obtaining a Second Opinion. If the patient decides to have surgery, he/she can then be scheduled for readmission.

6. The Prudential Insurance Company functions as the Medicaid Second Opinion Referral Center. A Second Opinion must be arranged through this Center. A physician-ordered consultation does not meet the Program's definition of a Second Opinion and no Authorization for Payment will be granted based on such a consultation. The only exception to this policy involves Second Opinions arranged and paid for by other third party payers (see Item 8).
7. In order to prevent claim denials as a result of situations where one of the elective surgical procedures is scheduled and performed before the Second Opinion requirements has been met, it is suggested that the elective surgery not be scheduled until after the Second Opinion has been rendered.
8. A Second Opinion is required for any of the six elective procedures whenever the New Jersey Medicaid Program is to be billed for any portion of the hospital or physician claim. Therefore, if a Medicaid patient is covered by other insurance (except when Medicare coverage is involved) which makes only partial payment on the claim, the Medicaid Program will not make supplementary payment unless the Second Opinion requirement has been met. However, the Medicaid Program will make payment on the claim if the operating physician and hospital receive documentation that a Second Opinion was arranged and paid by another insurer. A copy of this documentation must be attached to the Medicaid claim.
9. All Second Opinion Providers must be board certified by the American Specialty Boards in the appropriate specialty and have a signed Second Opinion Provider Agreement with the New Jersey Division of Medical Assistance and Health Services.

The physician agrees when completing the Second Opinion Provider Agreement not to perform surgery on the individual to whom he has given a Second Opinion, and not to make a referral unless requested by the patient and then only to a surgeon with whom the Second Opinion physician has no financial involvement. Eligible physicians who are

interested and have not received a Second Opinion Provider Agreement application should contact the Medicaid Second Opinion Referral Center at (800) 582-5936.

10. Reimbursement will not be made for a Second Opinion rendered to a patient who is not Medicaid eligible. The issuance of a Medicaid Second Opinion Referral Form to the patient by the Medicaid Second Opinion Referral Center does not guarantee the patient's eligibility on the date of the Second Opinion or subsequent surgery. The patient's Medicaid eligibility must be verified by checking the patient's current New Jersey Medicaid Validation Form before rendering any service.

ACTION

If a physician recommends that a Medicaid patient undergo one of the elective Second Opinion procedures, the following process must be initiated:

At the time a recommendation for surgery is made, the First Opinion physician or the patient's operating surgeon will give the patient a bilingual Medicaid Second Opinion Program brochure which explains the program and the steps for obtaining a Second Opinion. The physician should check the appropriate box on the brochure to indicate the procedure being recommended.

Physicians should contact The Prudential Insurance Company, Provider Reorder Unit, P. O. Box 471, Millville, N.J., 08332 to request an initial supply of the brochure.

The patient must then follow the instructions outlined in the brochure to contact the Medicaid Second Opinion Referral Center and obtain a Second Opinion. The Referral Center will ensure that the Second Opinion physician is a Board Certified specialist in the appropriate field (ENT, General Surgery, Internal Medicine, Neurology, Neurosurgery, OB/GYN, Orthopedics or Pediatrics) who has signed a Medicaid Second Opinion Provider Agreement.

At the time the Second Opinion is rendered, the Second Opinion physician may contact the First Opinion physician or the patient's operating surgeon to discuss the patient's medical history and the results of previous diagnostic studies. The Second Opinion physician will document the results of the Second Opinion on the Medicaid Second Opinion Referral Form. A copy of this report will be forwarded by the Medicaid Second Opinion Referral Center to the referring physician.

If the patient wishes to proceed with the surgery, the operating physician must contact the Referral Center to receive an Authorization for Payment prior to proceeding with the surgery. A copy of the consultation report, as well as authorization for physician and hospital payment, will then be sent to the operating physician. At the time the patient's hospital admission is arranged the operating physician must give the hospital its copy of the Authorization for Payment. Neither the physician nor hospital claim associated with one of the Second Opinion procedures will be paid unless attached to the hard-copy claim is an Authorization for Payment or

documentation of a Second Opinion arranged through another insurer, or a specific statement from the operating physician certifying that the Second Opinion requirement was not met and substantiating the urgent or emergency nature of the surgery. The Second Opinion will be valid for a period of one year from the date the Second Opinion is rendered.

THIRD OPINION

If, as a result of the Second Opinion, the patient is given a conflicting opinion regarding the need for the elective surgery, the patient may contact the Medicaid Second Opinion Referral Center and arrange for a Third Opinion. However, if the Third Opinion is physician initiated, it will be considered a physician consultation and reimbursed according to the current Medicaid fee schedule for consultative services.

PHYSICIAN CLAIM SUBMISSION

The operating surgeon, upon receipt of the Second Opinion Authorization for Payment, will go through the normal process for arranging the surgery ensuring that the hospital receives its copy of the authorization. If the patient should change physicians after the authorization has been released, the newly designated operating physician may contact the Medicaid Second Opinion Referral Center for a copy.

Once the surgery is performed, the physician must attach to the Physician's Claim Form (1500-N.J.) either the operating physician's copy of the Authorization for Payment, or a statement certifying as to the urgent or emergency nature of the procedure. No Second Opinion authorization or certification will be required for the anesthesiologist or assistant surgeon claim.

HOSPITAL CLAIM SUBMISSION

Any hospital claim (inpatient or outpatient) involving one of these surgical procedures must be billed on a hard-copy claim form with either the hospital copy of the Authorization for Payment for elective procedures, or a copy of the operating physician's statement certifying as to the urgent or emergency nature of the surgery. To ensure payment for claims involving one of the select procedures, the hospital should obtain the Authorization for Payment from the operating surgeon before scheduling the patient's admission or surgery.

If you have any questions regarding the Medicaid Second Opinion Program, you may contact the Medicaid Second Opinion Referral Center at (800) 582-5936 (Toll Free).

TEXT OF MEDICAID SECOND OPINION PROGRAM BROCHURE (FD-266)

Your doctor has recommended that you or a member of your family have one of the following operations:

1. Hysterectomy
2. Cholecystectomy
3. Hernia Repair
4. Tonsillectomy/Adenoidectomy
5. Laminectomy
6. Spinal Fusion

The New Jersey Medicaid Program requires that you receive a Second Opinion. This booklet explains what a Second Opinion is, why it is needed and how you go about getting one.

WHAT IS A SECOND OPINION?

A Second Opinion means that before you have one of the elective operations listed above, you must be seen and examined by another doctor who is a specialist in that field. The second doctor will discuss the results of the examination with you and give his/her professional opinion on whether the operation is necessary.

No matter what the second doctor's opinion is, the decision whether or not to have the operation is up to you.

WHY A SECOND OPINION?

It has been found that some recommended elective operations are not always necessary.

An "Elective" operation is an operation that is not needed immediately and can usually be scheduled at your convenience.

In order to prevent you as a Medicaid patient from having an unnecessary operation, the New Jersey Medicaid Program will not pay any bills for certain operations unless you have had a Second Opinion. Of course, if your doctor determines that you require an immediate operation to avoid a major risk to your life or health, a Second Opinion is not required.

HOW DO I GET A SECOND OPINION?

1. Contact the Medicaid Second Opinion Referral Center by calling (900) 582-5936.
2. Be sure to have the following information handy when you call the Referral Center: Your Health Services Program Case/Person number (the number on your

Medicaid card) and the name, address and telephone number of the doctor who recommended surgery.

3. The Referral Center will give you the name, specialty, address and telephone number of three Medicaid Second Opinion Doctors.
4. The Referral Center will mail to you a Second Opinion Referral Form. The top part will have been filled out by the Referral Center and will include the names of the three Second Opinion Doctors that were given to you by telephone.
5. It is YOUR responsibility to choose one of the doctors and to make the appointment for the Second Opinion if you wish to have Medicaid pay for the operation.
6. Once an appointment is made, if for any reason you are unable to keep it or wish to cancel, please contact the Second Opinion Doctor's office.
7. At the time of the Second Opinion appointment, you must give the doctor the Medicaid Second Opinion Referral Form which you received in the mail.
8. The Doctor will fill in his/her name and the date of the appointment. You will then be asked to sign the statement which allows medical information to be shared with the doctor who recommended the operation and the doctor who is going to perform it.
9. After the Second Opinion doctor finishes his/her examination (including laboratory tests and X-rays, if needed), the doctor will discuss with you his/her opinion on the need for surgery. The Second Opinion doctor will take care of completing the Medicaid Second Opinion Referral Form and returning it to the Medicaid Referral Center.

NOW IT'S UP TO YOU

Once you have had the Second Opinion, it is your choice whether or not to have the operation. If the second doctor's opinion is that you should not have the operation and you want further medical advice, you may call the Referral Center and arrange for a third opinion.

If you decide to have the operation any time in the next year, you will not need to get another Second Opinion, even if you change doctors. All you must do is tell the doctor who is going to do the surgery that you have already had a Second Opinion. If, however, your doctor recommends that you have one of the other elective operations listed in this booklet, you must follow the same instructions and arrange for a Second Opinion.

If you have any questions regarding the Medicaid Second Opinion Program, please contact the Medicaid Second Opinion Referral Center at the toll-free number, (800) 582-5936.

10:54—4.4 HCPCS CODES FOR RADIOLOGY/ULTRASOUND

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE		IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$				OFFICE \$	HOSP. BASED \$
	70002		50.00	31.50		70470		125.00	35.00
	70003		110.00	54.00	N	70470	52	75.00	21.00
	70020		50.00	27.00		70480		125.00	35.00
	70021		50.00	27.00		70481		125.00	35.00
	70030		15.00	7.20		70482		125.00	35.00
	70040		30.00	14.40	N	70482	52	75.00	21.00
	70050		40.00	18.00		70486		125.00	35.00
	70100		15.00	5.40		70487		125.00	35.00
	70110		20.00	9.00		70488		125.00	35.00
	70120		15.00	7.20	N	70488	52	75.00	21.00
	70130		20.00	10.80		70490		125.00	35.00
	70140		15.00	5.40		70491		125.00	35.00
	70150		20.00	9.00		70492		125.00	35.00
	70160		15.00	5.40	N	70492	52	75.00	21.00
	70170		20.00	7.20	M N	71010		10.00	3.60
	70171		25.00	22.50	M N	71020		15.00	5.40
	70190		15.00	5.40	M N	71030		20.00	9.00
	70200		25.00	9.00	M N	71034		20.00	9.00
	70210		20.00	5.40		71040		30.00	10.80
	70220		25.00	9.00		71041		50.00	18.00
	70240		15.00	7.20		71060		40.00	14.40
	70250		15.00	5.40		71061		55.00	22.50
	70260		25.00	9.00		71090			BR
	70300		5.00	1.80		71100		15.00	5.40
	70310		10.00	3.60		71110		20.00	9.00
	70320		15.00	7.20		71120		15.00	5.40
	70328		13.00	5.40		71130		20.00	7.20
	70330		20.00	9.00		71250		125.00	35.00
	70350		8.00	3.60		71260		125.00	35.00
	70360		10.00	3.60		71270		125.00	35.00
	70370		20.00	9.00	N	71270	52	75.00	21.00
	70380		15.00	5.40		72010		40.00	16.20
	70390		15.00	7.20		72040		15.00	5.40
	70391		30.00	13.50		72050		20.00	7.20
	70450		125.00	35.00		72052		25.00	9.00
	70460		125.00	35.00		72070		15.00	5.40

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$
	72080		15.00	5.40
	72100		20.00	7.20
	72110		25.00	9.00
	72114		20.00	7.20
	72125		125.00	35.00
	72126		125.00	35.00
	72128		125.00	35.00
	72129		125.00	35.00
	72131		125.00	35.00
	72132		125.00	35.00
N	72170		15.00	5.40
	72180		15.00	7.20
	72190		20.00	7.20
	72192		125.00	35.00
	72193		125.00	35.00
N	72194		125.00	35.00
N	72194	52	75.00	21.00
	72200		20.00	5.40
	72220		15.00	5.40
	72240		40.00	22.50
	72241		80.00	45.00
	72255		40.00	22.50
	72256		80.00	45.00
	72265		40.00	22.50
	72266		80.00	45.00
	72270		60.00	35.10
	72271		100.00	45.00
	72285		50.00	22.50
	72286		90.00	45.00
	72295		50.00	22.50
	72296		90.00	45.00
	73000		10.00	3.60
	73010		15.00	5.40
	73020		15.00	3.60
	73030		15.00	5.40
	73040		15.00	10.80
	73041		45.00	36.00

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$
	73050		18.00	7.20
	73060		15.00	5.40
	73070		15.00	3.60
	73080		15.00	5.40
	73085		15.00	10.80
	73086		45.00	36.00
	73090		10.00	3.60
	73092		20.00	8.00
	73100		10.00	3.60
	73110		15.00	5.40
	73115		15.00	10.80
	73116		45.00	36.00
	73120		10.00	3.60
	73130		15.00	5.40
	73140		5.00	3.60
N	73500		18.00	5.40
N	73510		20.00	7.20
	73520		25.00	7.20
	73525		15.00	10.80
	73526		45.00	36.00
	73530		30.00	9.00
	73540		15.00	7.20
	73550		15.00	5.40
	73560		15.00	3.60
	73562		15.00	5.40
	73580		15.00	10.80
	73581		45.00	36.00
	73590		15.00	3.60
	73592		20.00	8.00
	73600		10.00	3.60
	73610		13.00	5.40
	73615		15.00	10.80
	73616		45.00	36.00
	73620		10.00	3.60
	73630		13.00	5.40
	73650		10.00	3.60
	73660		5.00	3.60

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE		IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$				OFFICE \$	HOSP. BASED \$
	74000		10.00	5.40		74460		25.00	9.00
	74010		15.00	7.20		74461		45.00	16.20
	74020		15.00	7.20		74470		20.00	9.00
	74150		125.00	35.00		74471		40.00	21.60
	74160		125.00	35.00	M N	74710		25.00	9.00
N	74170		125.00	35.00		74720		20.00	7.20
N	74170	52	75.00	21.00		74740		20.00	9.00
N	74220		20.00	9.00		74741		40.00	18.00
N	74240		40.00	14.40		74760		25.00	10.80
N	74241		45.00	16.20		74761		40.00	18.00
N	74245		50.00	19.80	M N	75500			35.10
N	74250		30.00	10.80		75501		120.00	86.40
	74260		25.00	10.80		75505			35.10
	74270		30.00	13.50		75506		125.00	86.40
	74280		40.00	16.20	M N	75507			45.00
	74290		35.00	9.00		75509		150.00	99.90
	74300		40.00	10.80		75520		150.00	118.80
	74305		25.00	10.80		75524		150.00	118.80
	74310		40.00	16.20		75528		225.00	151.20
	74320		25.00	9.00		75600			16.20
	74321		70.00	52.00		75601		95.00	67.50
N	74330		23.00	23.00		75605			27.00
	74400		35.00	12.60		75606		125.00	86.40
	74405		50.00	18.00		75620			16.20
	74410		40.00	14.40		75621		95.00	51.30
	74415		75.00	18.00		75622			16.20
	74420		35.00	9.00		75623		100.00	67.50
	74425		20.00	9.00		75625			27.00
	74426		35.00	18.00		75626		100.00	67.50
	74430		15.00	9.00		75627			35.10
	74431		25.00	18.00		75628		125.00	86.40
	74440		20.00	9.00		75630			30.00
	74441		70.00	31.50		75631		125.00	50.00
	74450		20.00	9.00		75650			35.10
	74451		40.00	18.00		75651		125.00	99.90
	74455		20.00	16.20		75652			35.10
	74456		35.00	22.50		75653		125.00	99.90

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$
	75654			35.10
	75655		125.00	99.90
	75656			40.50
	75657		225.00	135.00
	75658			30.00
	75659		150.00	99.90
	75661		150.00	72.90
	75663		225.00	113.40
	75665			31.50
	75667		130.00	67.50
	75669		150.00	72.90
	75671			54.00
	75672		150.00	99.90
	75673		225.00	113.40
	75676			27.00
	75677		125.00	67.50
	75678		150.00	72.90
	75680			40.50
	75681		150.00	99.90
	75682		225.00	118.80
	75685			27.00
	75686		125.00	99.90
	75687		150.00	108.00
	75690			27.00
	75691		125.00	99.90
	75692		150.00	108.00
	75695			40.50
	75696		150.00	118.80
	75697		225.00	135.00
	75705			35.10
	75706		125.00	99.90
M N	75710			13.50
	75711		65.00	51.30
	75712		125.00	54.00
	75716			22.50
	75717		100.00	86.40
	75718		150.00	94.50

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$
	75722			27.00
	75722	51		40.00
	75723		120.00	86.40
	75723	51	200.00	80.00
	75724			40.50
	75725		150.00	118.80
	75726			35.10
	75727		125.00	99.90
	75728		150.00	118.80
	75731			29.70
	75732		125.00	99.90
	75733			43.20
	75734		200.00	135.00
	75736			27.00
	75737		125.00	67.50
	75738		125.00	86.40
	75741			27.00
	75742		125.00	86.40
	75743			40.50
	75744		150.00	99.90
	75746			27.00
	75747		125.00	81.00
	75748		70.00	51.30
	75750			35.10
	75751		125.00	86.40
M N	75752			35.10
	75752	25		50.00
	75753		190.00	135.00
	75753	25	155.00	80.00
	75754			51.30
	75755		275.00	170.10
	75756			16.20
	75757		125.00	86.40
	75801			18.00
	75802		95.00	67.50
	75803			22.50
	75804		145.00	86.40

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>	
			<u>OFFICE \$</u>	<u>HOSP. BASED \$</u>
	75805			21.60
	75806		95.00	67.50
	75807			29.70
	75808		145.00	91.80
	75810			22.50
	75811		85.00	67.50
	75820			18.00
	75821		60.00	35.10
	75822			22.50
	75823		90.00	51.30
	75825			22.50
	75826		60.00	51.30
	75827			22.50
	75828		60.00	51.30
	75831			24.30
	75832		110.00	56.70
	75833			37.80
	75834		125.00	86.40
	75840			24.30
	75841		125.00	67.50
	75842			37.80
	75843		150.00	118.00
	75845			21.60
	75846		125.00	67.50
	75847		110.00	56.70
	75850			18.00
	75851		55.00	51.30
	75860			35.10
	75861		125.00	86.40
	75870			27.00
	75871		125.00	67.50
	75880			16.20
	75881		100.00	51.30
	75893		75.00	30.00
	75973		302.00	
	76000		10.00	4.00
	76020		15.00	5.40

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>	
			<u>OFFICE \$</u>	<u>HOSP. BASED \$</u>
	76040		20.00	9.00
	76061		35.00	18.00
	76062		90.00	36.00
	76080		15.00	9.00
	76081		20.00	13.50
	76090		26.00	10.40
	76091		36.00	14.40
	76100		35.00	14.00
	76100	50	50.00	20.00
	76120		30.00	5.40
	76125		5.00	5.00
	76150		4.00	1.60
	76370		75.00	56.00
	76500		16.00	
	76511		40.00	18.00
	76512		60.00	34.20
	76516		40.00	18.00
	76517		60.00	34.20
	76529		BR	BR
	76535		30.00	13.50
	76601		25.00	10.80
	76604		25.00	10.80
	76620		40.00	20.70
	76625		20.00	9.00
	76627		30.00	13.50
	76628		30.00	13.50
	76645		50.00	22.50
	76700		60.00	27.00
	76705		40.00	18.00
	76770		60.00	27.00
	76775		60.00	27.00
	76805		55.00	25.20
	76815		25.00	10.80
	76856		60.00	27.00
	76931		25.00	10.80
	76935		25.00	10.80
	76939		BR	BR

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$
	76943		BR	BR
	76947		25.00	12.50
	76960		75.00	56.00
	77261		22.00	22.00
	77262		34.00	34.00
	77263		45.00	45.00
	77299		BR	BR
N	77400		10.00	7.50
N	77405		20.00	15.00
N	77410		30.00	21.00
	77499		BR	BR
	77761		75.00	30.00
	77762		75.00	30.00
	77763		75.00	30.00
	77776		BR	
	77777		BR	
	77778		BR	
	77789		15.00	6.00
	78000		20.00	4.50
	78001		20.00	5.40
	78003		25.00	9.00
	78006		40.00	22.50
	78010		20.00	13.50
	78110		20.00	13.50
	78120		30.00	13.50
	78130		25.00	18.00
	78135		75.00	18.00
	78160		30.00	9.00
N	78185		50.00	18.00
	78201		40.00	27.00
	78202		60.00	24.00
	78215		40.00	27.00
	78220		90.00	27.00
	78230		35.00	14.00
	78231		35.00	14.00
	78232		35.00	14.00
	78270		25.00	6.30

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$
	78272		40.00	6.30
	78280		30.00	12.60
	78282		30.00	10.80
	78300		60.00	18.00
	78305		75.00	27.00
	78306		75.00	27.00
	78381		60.00	27.00
	78402		50.00	22.50
	78403		BR	BR
	78411		BR	BR
	78414		BR	BR
	78418		50.00	22.50
	78424		50.00	22.50
	78428		BR	BR
	78435		BR	BR
	78455		70.00	28.00
	78455	76	18.00	7.20
	78470		20.00	10.80
N	78580		50.00	27.00
N	78581		50.00	27.00
N	78582		50.00	27.00
N	78584		50.00	27.00
N	78585		75.00	30.00
N	78586		50.00	20.00
N	78587		50.00	20.00
N	78591		50.00	20.00
N	78593		50.00	20.00
N	78594		50.00	20.00
	78600		60.00	27.00
	78601		85.00	34.00
	78605		60.00	27.00
	78606		85.00	34.00
	78610		BR	BR
	78630		75.00	72.00
	78635		85.00	34.00
	78640		75.00	72.00
	78650		75.00	72.00

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$
	78655		35.00	14.00
	78700		40.00	18.00
	78701		65.00	26.00
	78720		35.00	13.50
	78725		30.00	13.50
	78740		50.00	22.50
	78800		137.00	54.80
	78801		137.00	54.80
	78802		60.00	24.00
	78806		60.00	24.00
	78990	BR		
	79000		100.00	67.50
	79020		100.00	45.00
	79030	BR		90.00
	79035	BR		90.00
	79100		30.00	12.00
	79200		45.00	BR
	79300		150.00	BR
	79400		30.00	12.00

IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			OFFICE \$	HOSP. BASED \$
	79900	BR		
L	R0065		20.00	10.80
L N	R0070		26.00	
L	W7200		20.00	7.20
L	W7250		30.00	14.40
L	W7450			24.00
L	W7500		40.00	18.00
L	W7510		20.00	9.00
L	W7625		25.00	10.80
L N	W7700		10.00	7.50
L	W7800		15.00	4.50
L	W7840		35.00	9.00
L	W7845		40.00	22.50
L	W7980		10.00	4.50

**APPENDIX A
(CODES AND NARRATIVES NOT FOUND IN CPT-4)**

RADIOLOGY

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MEDICAID DOLLAR VALUE</u>	
				<u>OFFICE \$</u>	<u>HOSP. BASED \$</u>
	R0065		CIRCULATION TIME, RADIONUCLIDE STUDY	20.00	10.80
N	R0070		TRANSPORTATION OF PORTABLE X-RAY EQUIPMENT AND PERSONNEL TO HOME OR NURSING HOME, PER TRIP TO FACILITY OR LOCATION, ONE PATIENT SEEN	26.00	
	W7200		FOOT, COMPLETE (INCLUDING SPECIAL OS CALCIS VIEWS)	20.00	7.20
	W7250		COLON,AIR CONTRAST ONLY (WITH FLUOROSCOPY BY THE RADIOLOGIST)	30.00	14.40
	W7450		PERCUTANEOUS BONE BIOPSY, UNDER FLUOROSCOPIC GUIDANCE, PROCEDURE REIMBURSABLE TO ONLY ONE PHYSICIAN		24.00
	W7500		PLACENTAL LOCALIZATION (B SCAN) SONOGRAM	40.00	18.00
	W7510		THYROID SONOGRAPHY (A-MODE)	20.00	9.00
	W7625		ABDOMINAL AORTA SONOGRAM (A-MODE)	25.00	10.80
N	W7700		TELERADIO THERAPY TREATMENT, ADDITIONAL AREAS, EACH	10.00	7.50
	W7800		T4 UPTAKE	15.00	4.50
	W7840		LIVER FUNCTION STUDY (ROSE BENGAL)	35.00	9.00
	W7845		PANCREAS SCANNING OR IMAGING	40.00	22.50
	W7980		RADIOACTIVE STUDY, T3 UPTAKE BY RESIN	10.00	4.50

APPENDIX B (Radiology/Ultrasound)

QUALIFIERS

<u>HCPCS Code</u>	<u>*DMP Code</u>	<u>Description</u>
71010 71020 71030 71034	7100 7101 7102 7103	<u>Routine chest x-rays</u> without medical necessity in an office or hospital setting are not reimbursable under Program Guidelines. See Appendix I (Medical Necessity Program) at the end of the manual.
72170	7217	<u>Pelvis x-ray</u> is not eligible for separate payment when performed in conjunction with Complete Lumbosacral Spine x-rays (72110).
73500 73510	7299 7300	Procedure 73520 should be used for <u>Bilateral Hip x-rays</u> when both hips are x-rayed instead of billing separately for each hip (73500, 73510).
74220	7355	<u>Esophagus x-ray</u> is not eligible for separate payment when performed in conjunction with a GI or Small Bowel Series, (74240, 74241, 74245, 74250).
74330	7321	<u>Radiological Monitoring</u> for ERCP type procedure with or without Sphincterotomy as found in procedure codes 43268 and 43262. Covers all required fluoroscopic examinations related to these codes and is reimbursable only when performed by a Radiologist.
74710	7390	" <u>Pelvimetry</u> , with or without placental localization." See Appendix I (Medical Necessity Program) at the end of the manual.

<u>HCPCS Code</u>	<u>*DMP Code</u>	<u>Description</u>
75500	7500	Angiocardiology by cineradiography, S & I only
75507	7504	Angiocardiology by serialography, multiplane, S & I only
75710	7554	Angiography, extremity, unilateral, S & I only
75752	7587	Angiography, coronary, unilateral selective injection, S & I only. See Appendix I (Medical Necessity Program) at the end of the manual.
78585	7839	Procedure 78585 should be used for <u>Lung</u>
78586	7850	<u>Ventilation Studies and Lung Perfusion Stud-</u>
78587	"	<u>ies, both done on same day, not 78586,</u>
78591	"	<u>78587, 78591, 78593, 78594, and 78580, 78581,</u>
78593	"	<u>78582, 78584.</u>
78594	"	
78580	7851	
78581	"	
78582	"	
78584	"	
78185	7870	When Liver and Spleen are imaged together, code 78215 must be used and individual codes 78185 (spleen) and 78201 (liver) may not be claimed in it's place.
77400	7623	<u>Teleradiotherapy Treatment</u>
77405	7624	
77410	7625	1. Includes use of x-ray and other high energy modalities (betatron,) (linear accelerator, etc.) radium, cobalt, and other radioactive substances unless otherwise specified.
W7700	7626	2. Values for treatment of MALIGNANCIES include one year follow-up care unless otherwise specified.
		3. Values for NON-MALIGNANT conditions include 60 days follow-up care unless otherwise specified.
		4. Values include concomitant office visit, but not concomitant surgical, diagnostic radiological, or laboratory procedures.

HCPCS
Code

*DMP
Code

Description

Except where specified, assumes use of super-voltage/ megavoltage or high energy particle sources. Per Treatment- Single or multiple portals, same area.

Simple- benign lesions and most metastatic lesions of appendicular skeleton.

Intermediate- the usual treatment for malignancy, including skin cancer and metastases to the trunk or spine.

Complex - treatment of more complex problems such as Hodgkins disease, central nervous system or head and neck irradiation.

72194
74170

7886

For documented necessary combined abdominal and pelvic body scans, add 50%.

70470 52
70482 52
70488 52
70492 52
71270 52
72194 52
74170 52

7887

Limited C.T., Head or Body for medically necessary follow-up or monitoring.

NOTE: For C.T. Scan guidance (monitoring) performed in conjunction with biopsy, aspiration, puncture, injection of contrast material, placement of tube, stint, drain, etc., use codes with modifier 52.

R0070

7477

Examination at Home, Nursing Home or Boarding Home by portable x-ray. Allowed additional charge for first person only. Reimbursement is limited to a single fee per trip to "home" or facility regardless of number of patients x-rayed and includes return for retakes for technical errors.

APPENDIX C (Radiology/Ultrasound)

MODIFIERS

Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are:

<u>Modifier Code</u>	<u>Description</u>
LT	<u>Left Side</u> : Used to identify procedures performed on the left side of the body.
RT	<u>Right Side</u> : Used to identify procedures performed on the right side of the body.
22	<u>Unusual Services</u> : When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.
25	<u>Digital Radiology</u> (e.g., digital subtraction angiography, digital fluoroscopy, digital radiography). When this technique is utilized the modifier '25' may be appended to the appropriate five digit number of the radiologic procedure to indicate that the digital modality was applied. This modifier would be applied to both the supervision and interpretation service and complete procedure. When the supervision and interpretation service code is utilized and the injection is done by a second physician, the modifier need not be applied to the surgical injection codes.
50	<u>Bilateral Procedure</u> : Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number.
51	<u>Multiple Procedures</u> : When multiple procedures are performed at the same operative session, the major procedure may be reported as listed. The secondary additional, or lesser procedure(s) may be identified by adding the modifier '51' to the secondary procedure number(s).

Modifier
Code

Description

52

Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: Modifier '52' may be utilized with computerized tomography numbers for a limited study or a follow-up study.

76

Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '76' to the repeated service.

77

Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier '77' to the repeated service.

10:54—4.5 HCPCS CODES FOR PATHOLOGY/LABORATORY

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>	<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
N	80003		7.50		82070		4.50
N	80004		7.50		82087		40.00
N	80005		7.50		82088		40.00
N	80006		7.50		82089		40.00
N	80007		7.50		82112		12.60
N	80008		7.50		82137		15.00
N	80009		7.50		82138		15.00
N	80010		7.50		82140		6.00
N	80011		7.50		82141		6.00
N	80012		7.50		82143		4.20
N	80016		7.50		82145		12.00
N	80018		11.00		82150		4.50
N	80019		11.00		82155		4.50
	80031		4.50		82156		2.40
	80032		4.50		82157		34.00
	80033		4.50		82163		25.00
	80052		3.00	N	82173		13.00
N	80055		15.00		82175		7.20
N	80055	22	19.00		82180		3.60
N	80055	52	10.00		82205		12.00
	80061		15.00		82210		12.00
	80061	22	23.00	A	82250		3.00
N	80070		12.00	A	82251		4.50
N	80072		12.00		82265		3.00
	80090		7.80		82270		1.20
N	81000		1.20		82273		6.00
	81010		1.20		82290		3.00
	81030		3.00		82291		3.00
N	82011		3.90		82308		34.00
	82024		30.00	A	82310		3.00
	82030		34.00		82315		3.00
	82035		34.00		82320		3.00
A	82040		1.80		82335		.90
	82055		4.50		82340		3.60
	82060		4.50	N	82365		9.00
	82065		4.50	N	82370		9.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
A	82374		3.30
	82375		6.00
	82380		6.00
	82382		12.00
	82383		12.00
	82384		18.00
	82390		6.00
A	82435		3.00
	82436		3.00
N	82437		9.00
	82438		3.00
A	82465		3.00
	82470		7.00
	82480		4.50
	82486		6.00
	82525		9.00
	82526		9.00
	82533		17.00
	82534		17.00
	82540		3.00
	82545		3.00
	82546		3.00
A	82550		4.80
	82552		4.80
	82555		4.80
A	82565		3.00
	82570		3.00
	82575		4.50
	82595		1.50
	82607		15.00
	82608		15.00
	82626		43.00
	82628		15.00
	82633		60.00
	82634		39.00
	82640		15.00
	82641		15.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
	82643		15.00
	82656		15.00
	82660		9.00
	82670		25.00
	82671		52.00
	82672		25.00
	82673		10.20
	82674		20.00
	82676		10.20
	82677		52.00
	82678		52.00
	82679		34.00
	82705		.60
	82710		7.80
	82715		7.80
	82728		16.00
	82730		5.70
	82746		16.00
	82785		16.00
	82791		6.00
	82792		6.00
	82793		6.00
	82800		5.20
	82801		3.30
	82926		6.00
	82931		6.00
	82941		16.00
	82943		30.00
N	82946		13.00
A	82947		3.00
	82949		.60
	82954		1.50
	82955		6.00
A	82977		4.80
	82985		6.60
	82995		1.80
	82996		3.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>	<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
	82998		18.00		83570		6.00
	83001		17.00		83571		6.00
	83002		17.00		83578		12.60
	83003		16.00		83582		6.00
	83004		16.00		83583		12.00
	83008		34.00		83586		7.50
	83010		12.00		83587		15.00
	83011		12.00		83589		7.50
	83012		12.00		83590		15.00
	83015		10.20		83593		6.00
	83020		6.00		83597		12.00
	83036		6.60		83610		4.20
	83040		3.00	A	83615		4.20
	83050		3.00		83620		4.20
N	83051		1.20		83625		9.00
N	83053		1.20		83626		9.00
	83060		3.00		83629		4.20
	83093		3.00		83631		4.20
	83094		3.00		83632		16.00
	83095		3.00		83645		3.00
	83150		12.00		83650		3.00
	83491		12.60		83655		9.00
	83493		12.60		83660		9.00
	83494		12.60		83661		10.50
	83495		12.60		83670		2.10
	83496		12.60		83675		2.10
	83497		6.00		83680		2.10
	83498		34.00		83690		4.50
	83499		34.00	A	83700		3.00
	83523		15.00		83715		7.50
	83525		12.00		83718		8.00
N	83526		10.00		83720		10.00
	83530		6.00		83725		9.00
A	83540		4.50		83727		17.00
	83545		4.50		83735		4.50
A	83550		7.20		83740		4.50
	83555		7.20		83755		4.50

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>	<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
	83760		4.50		84160		1.80
	83795		.90		84165		6.00
	83825		8.40	A	84170		6.00
	83830		8.40		84180		2.40
	83835		10.20		84185		.60
	83840		4.50		84190		7.50
	83915		6.00		84200		7.50
	83970		54.00		84203		3.00
	83971		12.60		84205		15.00
	84005		3.00		84230		15.00
	84030		6.00		84233		16.00
	84031		6.00		84234		20.00
	84045		20.00		84244		25.00
A	84060		3.60		84246		25.00
	84065		3.60	A	84295		3.90
A	84075		3.60		84300		3.90
	84078		3.60	M	84317		.60
	84080		3.60		84403		32.00
	84090		3.00		84405		32.00
A	84100		3.00		84420		15.00
	84105		3.00		84430		3.60
	84106		1.80		84435		6.00
	84110		7.50		84436		6.00
	84118		3.00		84437		6.00
	84119		3.00		84439		20.00
	84120		7.50		84442		12.00
	84121		7.50		84443		25.00
A	84132		3.90	A	84450		3.00
	84133		3.90		84455		3.00
	84135		12.00	A	84460		3.00
	84136		12.00		84465		3.00
	84138		12.00	A	84478		8.30
	84139		12.00		84479		6.00
	84142		15.00		84480		15.00
	84144		20.00		84481		15.00
	84146		20.00		84485		3.30
A	84155		1.80		84488		3.30

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
	84490		3.30
A	84520		3.00
	84525		3.00
	84540		3.00
	84545		6.00
A	84550		3.00
	84555		3.00
	84560		3.00
	84577		6.00
	84580		2.10
	84583		2.10
	84585		12.00
	84590		6.00
	84605		3.60
	84610		3.60
	84695		12.60
	84701		18.00
	84800		25.00
	84810		12.60
	85000		1.20
	85002		1.20
	85005		3.00
N	85007		2.40
N	85009		1.20
	85012		1.80
N	85014		1.50
N	85018		1.20
	85021		1.80
	85022		8.40
	85027		8.40
	85028		8.40
N	85031		3.00
N	85041		1.20
	85044		1.80
N	85048		1.20
	85095		18.00
	85100		9.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
	85101		9.00
	85102		30.00
	85103		9.00
	85150		1.80
	85170		.60
	85171		.60
	85210		3.00
	85345		1.80
	85347		3.00
	85348		1.20
	85362		3.00
	85363		3.00
	85364		8.40
	85376		5.70
	85377		5.70
	85544		6.00
	85555		4.80
	85557		4.80
	85575		1.80
	85577		1.80
	85580		1.80
	85590		1.80
	85595		1.80
	85610		3.00
	85614		3.00
	85615		4.50
	85650		1.50
	85651		1.50
	85660		1.80
	85700		9.00
	85730		3.00
	85732		3.00
	86000		.90
	86002		1.80
	86004		1.80
	86006		2.70
	86008		6.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
	86009		3.00
	86017		4.20
	86024		3.00
	86028		3.00
	86031		3.00
	86032		3.00
	86033		3.00
	86038		7.80
	86060		3.60
	86063		1.20
	86064		7.80
	86067		7.80
	86068		4.50
	86080		1.80
	86082		1.80
	86090		1.80
	86095		1.80
	86100		1.80
	86105		1.80
	86115		1.80
	86120		3.00
	86140		3.00
N	86151		22.40
	86162		15.60
	86163		7.80
	86164		9.00
	86171		4.50
	86225		13.00
	86244		10.20
	86255		7.80
	86256		9.00
	86277		16.00
	86280		5.40
	86281		3.00
	86285		10.00
	86286		10.00
	86287		10.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
	86291		20.00
	86295		20.00
	86300		3.00
	86305		4.50
	86310		4.50
	86320		10.50
	86329		16.80
	86335		6.00
	86337		12.00
	86376		6.60
	86377		6.60
	86421		60.00
	86422		4.80
	86423		16.00
	86430		1.80
	86490		4.00
	86510		4.00
	86540		4.00
	86585		4.00
A	86592		1.50
	86593		3.00
	86594		6.00
	86595		6.00
	86600		7.80
	86650		12.00
	86660		12.00
	86662		12.00
	86800		17.00
	86812		12.60
	86813		12.60
	87001		9.00
	87015		5.10
N	87040		9.00
N	87045		9.00
N	87060		9.00
N	87070		9.00
	87076		6.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>	<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
	87081		12.00	N	88155		4.20
	87084		3.00	N	88260		85.00
	87086		3.00	N	88261		85.00
	87087		2.70	N	88262		85.00
	87088		2.70	N	88265		85.00
	87101		8.00	N	88267		172.00
	87102		8.00	N	88268		172.00
	87106		8.00	N	88270		172.00
	87116		6.00		88302		6.00
	87117		9.00		88307		12.00
	87140		3.00		88313		4.20
	87143		3.00		88314		9.00
	87145		3.00		88331		15.00
	87147		3.00		88332		9.00
	87151		3.00		88348		BR
	87155		3.00		89050		.90
	87158		3.00		89051		.90
	87164		6.00		89105		6.00
	87166		6.00		89125		.60
	87177		5.10		89132		6.00
N	87184		9.00		89135		6.00
	87188		6.00		89136		6.00
	87190		.60		89141		6.00
	87205		4.20		89160		2.10
	87206		4.20		89205		1.20
	87207		3.00		89300		2.40
	87208		5.10		89310		4.80
	87210		2.40		89320		3.00
	87211		5.10	M	89355		.60
	87220		2.40	N	89360		9.00
	87250		44.00				
	88104		5.40	L M	P2032		1.50
	88106		5.40	L	P2033		3.00
	88107		5.40	L N	P7001		6.00
	88130		3.90				
	88140		2.40				
	88150		3.00	L N	W8200		2.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>	<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MEDICAID DOLLAR VALUE</u>
L N	W8205		9.00	L	W8621		12.60
L N	W8210		12.00	L	W8700		3.00
L A	W8215		4.00	L	W8710		3.00
L	W8225		18.00	L	W8900		10.00
L	W8615		7.80	L	W8920		1.80
L	W8620		7.80	L	W8925		.60

**APPENDIX A
(CODES AND NARRATIVES NOT FOUND IN CPT-4)**

PATHOLOGY/LABORATORY

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MEDICAID DOLLAR VALUE</u>
M	P2032		ICTERUS INDEX, BLOOD	1.50
	P2033		THYMOL TURBIDITY, BLOOD	3.00
N	P7001		CULTURE, BACTERIAL, URINE; QUANTITATIVE, SENSITIVITY STUDY	6.00
N	W8200		GLUCOSE,SERUM (SEPARATE TUBE,GREY TOP)	2.00
			NOTE: SUBMITTED ON SAME CLAIM, AND PERFORMED ON SAME DATE AS CHEMISTRY PROFILES	
N	W8205		3 HR. GLUCOSE TOLERANCE TEST, PER 4 SPECIMENS.	9.00
N	W8210		5 HR. GLUCOSE TOLERANCE TEST, PER 6 SPECIMENS.	12.00
A	W8215		T-4 (THYROXINE) BY IMMUNOASSAY (ENZYME IMMUNOASSAY) (EMIT)	4.00
	W8225		THYROXINE - BINDING GLOBULIN WITH T4 (THYROBINDING-GLOBULIN WITH T4) (RIA) (TBG AND T4)	18.00
	W8615		ANTI-DNA, ANTI - DEOXYRIBONUCLEIC ACID, (CHEMICAL METHOD, NON-RIA)	7.80
	W8620		HERPES SIMPLEX ANTIBODIES : (HERPES SIMPLEX VIRUS, I OR II)	7.80
	W8621		HERPES SIMPLEX VIRUS, I AND II	12.60
	W8700		YEAST SCREEN (NOT DEFINITIVE) FROM URINE, VAGINAL OR THROAT CULTURES ONLY (EG., GERM TUBE)	3.00
	W8710		TRICHOMONAS PREPARATION - SMEAR OR HANGING DROP (SMEAR NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IF PAP SMEAR DONE ON THE SAME DAY).	3.00
	W8900		HOUSE CALL TO HOME BOUND PATIENT IN HOME OR SHELTERED BOARDING HOME FOR PURPOSE OF OBTAINING BLOOD BY VENOUS OR ARTERIAL PUNCTURE. REIMBURSEMENT LIMITED TO ONCE PER TRIP REGARDLESS OF NUMBER OF PATIENTS.	10.00
	W8920		VISIT TO OBTAIN BLOOD SPECIMENS BY VENOUS OR ARTERIAL PUNCTURE "FIRST PERSON IN NURSING HOME."	1.80
	W8925		EACH ADDITIONAL PERSON IN NURSING HOME.	.60

APPENDIX B (PATHOLOGY AND LABORATORY)

QUALIFIERS

1. Chemistry Automated, Multichannel Tests

Applies to CPT Codes: 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. (discontinued codes were 8302 and 8306). For reporting two tests, regardless of method of testing, use appropriate single test code numbers. For any combination of three or more tests among those listed below use the appropriate number 80003 - 80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting (for handling of specimen, see 99000 and 99001).

Albumin	Iron
Alkaline Phosphatase	Lactic Dehydrogenase (LDH)
Bilirubin, Total	Phosphorus
Bilirubin, Direct	Potassium (K)
Blood Urea Nitrogen (BUN)	Protein, Total
Calcium	Sodium (NA)
Carbon Dioxide (CO ₂)	Total Lipids
Chlorides (Cl)	Transaminase, Glutamic Oxalacetic, (SGOT)
Cholesterol	Transaminase, Glutamic Pyruvic, (SGPT)
Creatinine	Triglycerides
Gamma Glutamyl Transpeptidase (GGTP)	T4 by Immune Assay (EMIT)
Glucose (Sugar)	Uric Acid

NOTE: The following calculations and ratios are not eligible for separate or additional reimbursement, and therefore, should not be included in determining the calculations allotted to the above Procedure Codes.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

NOTE: Any additional automated multichannel chemistry tests (other than those listed) performed on same date as Codes 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be reimbursed at the current allowable fee for each added test.

NOTE: Code (W8200) - Glucose (separate tube, gray top) (discontinued code 8607) performed on the same date as the following chemistry profiles 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional \$2.00.

2. Code 80072 -Arthritis Panel (discontinued code 8321)

NOTE: Should include as a minimum four of the following tests:

ASO Titer	Uric Acid
C- Reactive Protein (CRP)	Alkaline Phosphatase
RA Latex (Rheumatoid Arthritis factor)	Calcium

3. Code 80070- Thyroid Panel (discontinued code 8317)

T4 by RIA, plus T3 uptake, resin (T3RU) (RT3U)

NOTE: The following calculations will be included in the fee for the Thyroid Panel:

"T7" Free Thyroxine
Index (FTI), Calculated Free Thyroxine
Index (CFT4) or Calculated Thyroxine
Iodine (T4I)

NOTE: T3 by uptake, resin (T3RU) is eligible for reimbursement only when done in conjunction with T4 by RIA as part of Thyroid profile.

4. Code 80055-52 - Obstetric profile (discontinued code 8332)

NOTE: At least four of the following tests must be included in the profile:

Blood Group (ABO)
RH Factor
Antibody screen (Atypical Antibody Identification)
Complete Blood Count (CBC) (with or without differential)
Serology (STS, VDRL, RPR)

5. Code 80055-Obstetric profile (discontinued code 8333)
with Rubella HI Antibody Titer

6. Code 80055-22 - Expanded Obstetric profile (discontinued code 8335)

NOTE: For reimbursement purposes the following must be included:

Blood Group (ABO)
RH Factor
Antibody Screen (Atypical Antibody Identification)
Complete Blood Count (CBC) (with or without differential)
Serology (STS, VDRL, RPR)
Cytology (Pap Smear)
Urinalysis
Urea Nitrogen (BUN)
Glucose
Sickle Cell
with Rubella HI Antibody Titer

7. Code 81000 - Urinalysis (discontinued code 8936)

NOTE: Stick, dip or tablet tests done on urine are considered part of the urinalysis, and therefore, are not eligible for separate reimbursement. Microscopy is required for reimbursement.

8. Code 86151 - (CEA-RIA) Carcinoembryonic Antigen. (discontinued code 8504)

NOTE: "CEA is not useful to diagnose cancer. Claims are eligible for reimbursement only when CEA is used to follow treated cases of cancer (e.g., gastro-intestinal, breast, lung) primary detection of recurrence, or for estimation of prognosis in certain cases."
(Documentation required)

9. Code 88155 - pap smear (discontinued code 8027)

NOTE: (obtaining specimen not a separate eligible service)

10. Cultures, Codes 87040, 87045, 87060, 87070, 87184, P7001 (discontinued codes 8459, 8976)

NOTE: These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture.

11. Code 82173 and 82946 -Glucagon Tolerance Test (discontinued code 8557)

(Total payment not to exceed \$65.00)

12. Code 83526 - Insulin Tolerance Test (discontinued code 8564)

(Total payment not to exceed \$70.00) (RIA)

13. Code 85031 - Complete Blood Count - CBC (discontinued code 8628)

(Components of a CBC)- maximum fee for any of the following combinations of components is \$3.00. (83051, 83053, 85007, 85009, 85014, 85018, 85041, 85048)

NOTE: For reimbursement purposes includes automated as well as manual.

14. Code 82365 and 82370 (discontinued code 8992) Calculus (stone), Quantitative: (Infra-red spectroscopy) X-ray diffraction.

NOTE: Reimbursement not eligible for chemical methods.

15. Code 82437 and 89360 (discontinued code 8994) Sweat Test

NOTE: Reimbursement not eligible for qualitative tests. For reimbursement purposes includes 82437 or 84295 at no additional cost.

16. Code 82011 (discontinued code 8897) Salicylates, quantitative only.

NOTE: Reimbursement not eligible for screening (Qualitative) tests for salicylates. (82012)

17. Code W8205 and W8210 - Glucose Tolerance (discontinued codes 8723 and 8724)

NOTE: For reimbursement purposes includes all urines for sugar.

18. Code 88260, 88261 and 88262 - Chromosome Analysis; Peripheral blood (discontinued code 8913). Rule out numerical and structural abnormalities.

NOTE: For Medicaid reimbursement purposes must include an average of 20 cells and 2-3 karyotypes analyzed, including banding.

19. Code 88265 - Chromosome Analysis: Various leukemias, bone marrow and peripheral blood (includes Philadelphia Chromosome study). (discontinued code 8913)

NOTE: For reimbursement purposes must include a minimum of 10 cells and 2 karyotypes analyzed, including banding.

20. Code 88267 - Chromosome Analysis: Amniotic Fluid Cells (Prenatal Chromosome Analysis). (discontinued code 8009)

NOTE: For reimbursement purposes must include 20 cells and 2-3 karyotypes analyzed, including banding.

21. Code 88268 and 88270 - Chromosome Analysis: Tissue Biopsy, Abortuses, etc. (discontinued code 8009) (Documentation report required)

NOTE: For reimbursement purposes as a minimum include 15-20 cells and 2-3 karyotypes analyzed, including banding.

22. Code 88280, 88285

NOTE: Additional karyotyping and cells counted are not reimbursable for Medicaid payment.

APPENDIX C (Pathology and Laboratory)

MODIFIERS

Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are:

<u>MODIFIER CODE</u>	<u>DESCRIPTION</u>
22	<u>Unusual Services:</u> When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.
52	<u>Reduced Services:</u> Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
90	<u>Reference (Outside) Laboratory:</u> When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '90' to the usual procedure number.

APPENDIX I

MEDICAL NECESSITY PROGRAM

(This information was originally published in Newsletters: P-217, December 26, 1977; P-298, May 15, 1981; P-354, April 11, 1983.)

The New Jersey Medicaid Program on January 1, 1978, adopted a Medical Necessity Program similar to the Blue Shield Association's Medical Necessity Program and concurrent with its implementation by Blue Shield of New Jersey.

This program was designed to upgrade the quality of care and is the result of a cooperative effort by the Blue Shield Association and the following organizations: The American College of Surgeons, the American College of Physicians, the American College of Radiology, The American Academy of Family Practice, the Council of Medical Specialties, and the American Association of Medical Colleges.

The Medical Necessity Program defines certain Surgical and Diagnostic Procedures which are reimbursable only when acceptable written justification by the physician accompanies the claim form. The medical necessity may be stated in "Remarks" box 34 of the 1500-N.J. Claim Form. If box 34 does not provide sufficient space, an addendum may be attached to the claim form.

Physicians are required to maintain written records that substantiate the use of a given procedure code. These records must be available for review and/or inspection if requested by the New Jersey Medicaid Program.

These procedures fall into the following four categories:

- (1) New procedures of unproven value.
- (2) Established procedures of questionable current usefulness.
- (3) Procedures which tend to be redundant when performed in combination with other procedures.
- (4) Diagnostic procedures which are unlikely to provide a practitioner with additional information when they are repeated.

Unless supporting justification for the following surgical and diagnostic Procedures accompanies the physician's claim, reimbursement will be denied in the following situations:

- (1) If the only purpose for inpatient admission was to provide these procedures, both physician and hospital claims will be denied; if already paid, will be subject to recovery.

- (2) If the only purpose for outpatient admission was to provide these procedures, the hospital's claim and the physician's claim (if applicable) will be denied; if already paid, will be subject to recovery.
- (3) If laboratory procedures (diagnostic studies 1 through 5) are performed on an ambulatory basis by an independent laboratory or a physician, such claims will be denied but may not necessarily include claims for office visits; if already paid, will be subject to recovery.

SURGICAL PROCEDURES

The following Surgical Procedures are not eligible for reimbursement unless the claim form is accompanied by an acceptable written justification supporting the medical necessity.

NOTE: The regulations apply to procedures 14 through 20 only when they are performed under the circumstances given.

- (1) Ligation of internal mammary arteries, unilateral or bilateral
- (2) Radical Hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area
- (3) Omentopexy for establishing collateral circulation in portal obstruction
- (4) Kidney decapsulation, unilateral and bilateral
- (5) Perirenal insufflation
- (6) Nephropexy: fixation or suspension of kidney (independent procedure)
- (7) Circumcision, female
- (8) Hysterotomy, non-obstetrical, vaginal
- (9) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both
- (10) Uterine suspension
- (11) Uterine suspension with presacral sympathectomy
- (12) Hypogastric or presacral neurectomy (independent procedure)
- (13) Ligation of thyroid arteries (independent procedure)
- (14) Fascia lata by stripper, as treatment for lower back pain
- (15) Fascia lata by incision and area exposure, with removal of sheath as treatment for lower back pain

- (16) Ligation of femoral vein, unilateral or bilateral, as treatment for post phlebitic syndrome
- (17) Excision of carotid body tumor, with or without excision of carotid artery, as treatment for asthma
- (18) Sympathectomy, thoracolumbar, unilateral or bilateral, as treatment for hypertension
- (19) Sympathectomy, lumbar, unilateral or bilateral, as treatment for hypertension
- (20) Splanchnicectomy, unilateral or bilateral, as treatment for hypertension
- (21) Fabric wrapping of abdominal aneurysm
- (22) Extra-intracranial arterial bypass for stroke

DIAGNOSTIC PROCEDURES

Routine payment is not permissible for the following Diagnostic Procedures unless the claim is accompanied by an acceptable written justification supporting the medical necessity.

- (1) Basal metabolic rate (BMR)
- (2) Protein bound iodine (PBI)
- (3) Icterus index
- (4) Ballistocardiogram (BCG)
- (5) Phonocardiogram with interpretation and report, and with indirect carotid artery tracing or similar study
- (6) Angiocardiography, using CO2 method, supervision and interpretation only
- (7) Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography
- (8) Angiocardiography, multi-plane, supervision and interpretation in conjunction with cineradiography
- (9) Angiography-coronary, unilateral, selective injection, supervision and interpretation only, single view unless emergency
- (10) Angiography - extremity, unilateral, supervision and interpretation only, single view unless emergency
- (11) Bronchoscopy, with injection of contrast medium for bronchography

(12) Bronchoscopy, with injection of radioactive substance

(13) PRENATAL ULTRASONOGRAPHY

Prenatal ultrasonography will be considered medically necessary when it is documented in the physician's record as being performed for one of the indications outlined by the Society of Obstetrical and Gynecological Ultrasonographers as noted below:

- a. Determination of fetal viability where abortion or intrauterine demise is clinically suspected.
- b. Dating a pregnancy in late registrants or where there is a discrepancy between clinical and historical data in the first trimester.
- c. Determination of placental position in patients with vaginal bleeding or a fetus in an unstable lie.
- d. Evaluation of a pregnancy when there is a discrepancy between uterine size and dates at any stage in pregnancy.
- e. Use prior to amniocentesis to determine the optimal site of needle insertion.
- f. Monitoring fetal growth where intrauterine growth retardation is suspected.
- g. Evaluation when multiple gestation is suspected.
- h. Evaluation when fetal anomaly is suspected.
- i. Determination of fetal size or maturity in breech presentation.
- j. Evaluation of amniotic fluid quantity in cases of oligo-hydramnios, polyhydramnios, and clinically suspected premature rupture of the membranes.
- k. Evaluation of post-term pregnancies.
- l. Evaluation of possible molar pregnancies.
- m. Use as an adjunct to special procedures such as intrauterine transfusion, placental aspiration, and fetoscopy.
- n. Evaluation of pelvic masses during pregnancy.

If ultrasonography is utilized for any other indication, the physician is required to enter in the medical records sufficient documentation of medical necessity.

(14) PRENATAL LABORATORY TESTS

The following procedures are the only laboratory tests routinely considered medically necessary during pregnancy:

- a. CBC
- b. Urinalysis-including microscopic
- c. Blood type and RH factors
- d. Serology
- e. Antibody screening
- f. Rubella Titer

A physician must substantiate in his records the medical need for utilizing any other prenatal laboratory test.

(15) PELVIMETRY, WITH OR WITHOUT PLACENTAL LOCALIZATION

The "Statement on Use of Pelvimetry X-ray Examination" outlined in the FDA Drug Bulletin, Vol. 11, Number 3 dated November, 1981, stated that "Pelvimetry, used to evaluate the relative sizes of the fetal head and maternal pelvis and thus to help decide on the necessity for Cesarean section, can expose the fetus to a significant amount of x-radiation. Pelvimetry should be performed only when the physician caring for the patient feels that pelvimetry will contribute to the decisions concerning diagnosis or treatment. The reason for requesting pelvimetry should be written on the patient's chart".

In accordance with the FDA's recommendations, the New Jersey Medicaid Program has added this procedure to the group of procedure codes requiring evidence of Medical Necessity.

(16) OBSOLETE OR UNRELIABLE DIAGNOSTIC TESTS

The New Jersey Medicaid Program is requiring documentation of medical necessity for those lab and skin tests that Medicare has declared obsolete or unreliable (refer to Medicare Bulletin 80-10, July 1980).

The specific tests listed below will be reimbursed only when written medical justification accompanies the claim form.

Starch, feces, screening

Gastric Analysis, Tubeless

When used to cover the following skin tests:

- a. Skin Test - cat scratch fever

- b. Skin Test - lymphopathia venereum
- c. Skin Test - actinomycosis
- d. Skin Test - brucellosis
- e. Skin Test - leptospirosis
- f. Skin Test - psittacosis
- g. Skin Test - trichinosis

Circulation time, one test

(17) ROUTINE CHEST X-RAYS

The President's Committee on Radiation Exposure has recommended the elimination of all routine x-rays and the utilization of only those radiologic procedures deemed medically indicated. The New Jersey Medicaid Program, in accordance with this recommendation, no longer reimburses physicians for chest x-rays routinely performed in the physician's office as part of an initial evaluation or annual physical examination.

Physicians will continue to be reimbursed for chest x-rays performed in their office for diagnostic purposes. The physician must document the medical necessity for the procedure in the patient record.