Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Physician-Related Services

Billing Instructions

[Chapter 388-531 WAC]

July 2004

Copyright Disclosure

Current Procedural Terminology (CPT™) five digit codes, descriptions, and other data only are copyright 2003 American Medical Association (AMA). All rights reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein. CPT is a trademark of the American Medical Association.

About this publication

This publication supersedes all previous MAA RBRVS Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
July 2004

Table of Contents

Important Contacts vi
Other Important Numbers vii
MAA Billing Instructions viii
Definitions 1

INTRODUCTION

Section A: Procedure Codes/Dx Codes/Noncovered Services/ Managed Care/By Report/Conversion Factors

Procedure Codes A.1
Diagnosis Codes A.1
Grace Period for Discontinued Codes A.2
Noncovered Services A.2
Noncovered Practitioners A.3
Clients Enrolled in MAA's Managed Care Plans A.3
By Report (BR) A.4
Acquisition Cost (AC) A.4
Conversion Factors A.4
National Correct Coding Initiative A.4

PROGRAMS (Guidelines and Limitations)

Section B: Office/Outpatient/Children's Health/Inpatient/ Observation Care/Detoxification/ER/ESRD/Critical Care/Physician Standby/Osteopathic Manipulation/Newborn Care/NICU/PICU/ Oversight/Domiciliary/Rest Home/Custodial Care/Telehealth

Office and Other Outpatient Services B.1
Children's Primary Health Care B.2
Hospital Inpatient and Observation Care Services B.2
Detoxification Services B.4
Emergency Physician-Related Services B.4
End-Stage Renal Disease (ESRD) B.5
Critical Care B.5
Physician Standby Services B.7
Prolonged Services B.8
Osteopathic Manipulative Therapy B.9
Newborn Care B.10
Neonatal Intensive Care Unit (NICU)/Pediatric Intensive Care Unit (PICU) ... B.10

Table of Contents (cont.)

Section B: Continued…

Physician Care Plan Oversight....B.11
Domiciliary, Rest Home, or Custodial Care Services....B.12
Telehealth....B.12

Section C: EPSDT/Immunizations/Immune Globulins/Injections

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)....C.1
Medical Nutrition Therapy....C.7
Fluoride Varnish (Physicians and ARNPs)....C.8
Immunizations – Children....C.8
Immunizations – Adults....C.11
Immune Globulins....C.12
Therapeutic or Diagnostic Injections....C.14
Verteporfin Injection....C.15
Clozaril Case Coordination....C.16

Section D: Vision Care Services

Vision Care Services (Includes Ophthalmological Services)....D.1
Eyeglasses....D.4
Eyeglass Lenses....D.7
Contact Lenses....D.11
Ocular Prosthetics....D.13
Cataract Surgeries....D.14
Strabismus Surgeries....D.14
Where and How Do I Order Eyeglasses and Contacts Lenses?....D.14

Section E: Allergen Immunotherapy/Psychiatric Services/ Podiatric/Radiology/Pathology and Lab

Allergen Immunotherapy....E.1
Psychiatric Services....E.2
Podiatric Services....E.6
Radiology Services....E.8
Pathology and Laboratory....E.12

Table of Contents (cont.)

Section F: Maternity/Chemotherapy/Surgical/Anesthesia/Major Trauma

Maternity Care and Delivery F.1
Tobacco Cessation Performance Measure F.9
Abortion Services (Drug Induced) F.12
Abortion Center Contracts (Facility Fees) F.13
Chemotherapy Services F.14
Hydration Therapy With Chemotherapy F.15
Surgical Services F.16
Registered Nurse First Assistants (RNFA) F.19
Multiple Surgeries F.19
Endoscopy Procedures F.20
Other Surgical Policies F.20
Urology F.22
Bilateral Procedures F.24
Pre/Intra/Post-Operative Payment Splits F.24
Anesthesia F.25
Major Trauma Services F.32

Section G: Physical Therapy/Miscellaneous Services

Physical Therapy G.1
Miscellaneous Services G.8
Cochlear Implants G.9
Vagus Nerve Stimulators G.9
Osseointegrated Implants G.9

Section H: Family Planning/Sterilization/Hysterectomies

Family Planning H.1
Sterilization H.2
How to Complete the Sterilization Consent Form H.5
How to Complete a Client Statement Form H.8
How to Complete a Sterilization Consent Form for a client Age 18-20 ..... H.9
Blank Sterilization Consent Form H.10
Sample of a Regular Sterilization Consent Form H.11
Blank Client Statement Form H.12
Sample of Sterilization Consent Form Needing Client Statement Form H.13
Sample of Client Statement Form H.14
Sample of Sterilization Consent Form for Client Age 18-20 ..... H.15
Hysterectomies H.16

Table of Contents (cont.)

PRIOR AUTHORIZATION

Section I: Prior Authorization

Limitation Extension (LE) I.1
Written/Fax Prior Authorization I.1
Blank Prior Authorization Request Form I.3
Blank PET Scan Prior Authorization Request From I.4
Expedited Prior Authorization (EPA) I.5
MAA-Approved Centers of Excellence (COE) I.20
MAA-Approved Sleep Study Centers I.23
MAA-Approved Inpatient Pain Clinics I.24

FEE SCHEDULES/SUPPLIES/INJECTABLE DRUGS

Section J: Fee Schedules

Site of Service (SOS) Payment Differential J.1
2004 Physician-Related Services Maximum Allowable Fees J.5
Selected HCPCS Procedure Codes J.129

Section K: Medical Supplies and Equipment/Injectable Drug Codes

General Payment Policies K.1
Supplies Included In Office Call (Bundled Supplies) K.2
Supplies Reimbursed Separately When Dispensed From Physician's Office K.4
Injectable Drug Codes K.7

MODIFIERS

Section L: Modifiers

CPT/HCPCS Modifiers L.1
Anesthesia Modifiers L.7

Table of Contents (cont.)

BILLING/CLAIM FORM

Section M: Billing

What is the time limit for billing? M.1
What fee must I bill MAA? M.2
Third Party Liability M.3
Primary Care Case Management (PCCM) Clients M.3
How do I bill for clients eligible for both Medicare and Medicaid? M.4
What general records must be kept? M.8

Section N: How to Complete the HCFA-1500 Claim Form

Guidelines/Instructions N.1
Sample of a Completed HCFA-1500 Claim Form N.6

Important Contacts

A provider may contact MAA's toll-free lines for questions regarding MAA programs. However, MAA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call Provider Enrollment toll-free at:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

Where do I call/look if I have questions regarding…

Policy, payments, denials, or general questions regarding claims processing, or MAA Managed Care?

Provider Relations Unit
(800) 562-6188

http://maa.dshs.wa.gov/provrel

Private insurance or third-party liability, other than MAA Managed Care?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Media Claims Help Desk
(360) 725-1267

Internet Billing (Electronic Claims Submission)?

WinASAP

http://www.acs-gcro.com/WINASAP2003/Software_Download/software_download.html

All other HIPAA transactions

https://wamedweb.acs-inc.com/wa/general/home.do

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway at 1 800 833 2051.

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

-or-

Check out the Department of Printing's web site at:

http://www.prt.wa.gov/ (click on "General Store")

Other Important Numbers

Client Assistance/
Brokered Transportation Hotline **(Clients Only)** 1-800-562-3022

Disability Insurance 1-800-562-6074

Durable Medical Equipment (DME)/Prosthetics
Authorization 1-800-292-8064

Fraud Hotline 1-800-562-6906

MAA Managed Care (Healthy Options) Enrollment 1-800-562-3022

Acute PM&R Authorization FAX 1-360-586-1471

Pharmacy Authorization **(Providers Only)** 1-800-848-2842

Provider Inquiry Hotline **(Providers Only)** 1-800-562-6188

Provider Enrollment 1-866-545-0544

Telecommunications Device For The Deaf (TDD) 1-800-848-5429

Third-Party Resource Hotline 1-800-562-6136

TAKE CHARGE 1-800-770-4334

Provider Field Representatives

(360) 725-1024
(360) 725-1027
(360) 725-1022
(360) 725-1023

MAA Billing Instructions

Access to Baby & Child Dentistry
Acute Physical Medicine & Rehabilitation
Adult Day Health
Ambulatory Surgery Centers
Births in Birthing Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Childbirth Education
Chiropractic Services for Children
Dental Program
Direct Entry
Early Periodic Screening, Diagnosis & Treatment (EPSDT)
Electronic Billing Manual
Family Planning Services
Federally Qualified Health Centers
First Steps Childcare
General Information Booklet
Ground/Air Ambulance Medical Transportation
Healthy Options/Basic Health Plus/ Children's Health Insurance Program Health Care Plans
Hearing Aids and Services
HIV/AIDS Case Management
Home Health Services
Home Infusion Therapy/Parenteral Nutrition
Hospice
Hospital Inpatient
Hospital Outpatient
Indian Health Services
Interpreter Services
Involuntary Treatment Act (ITA) Transportation
Kidney Center Services
Long-Term Acute Care
Maternity Support Services/Infant Case Management
Medical Nutrition Program
Medical Nutrition Therapy
Neurodevelopmental Centers
Nondurable Medical Supplies and Equipment
Nursing Facilities
Occupational Therapy
Oxygen/Respiratory Therapy
Physical Therapy
Physician-Related Services
Planned Home Births
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing Services
Prosthetic & Orthotic Devices
Psychologist
Rural Health Clinics
School Medical Services
Speech/Audiology Program
TAKE CHARGE
Vision Care Services
Wheelchairs, Durable Medical Equipment, and Supplies

For more information on MAA billing instructions, call 1-800-562-6188.

These billing instructions are available through MAA at:

http://maa.dshs.wa.gov
(click on Provider Publications/Fee Schedules)

or the Department of Printing at:

http://www.prt.wa.gov/
(click on "General Store")

Definitions

The sections defines terms and acronyms used in these billing instructions.

Acquisition cost (AC) – The cost of an item excluding shipping, handling, and any applicable taxes.

Acute care – Care provided for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status.

Add-on procedure(s) – Secondary procedure(s) performed in addition to another procedure.

Admitting diagnosis – The medical condition responsible for a hospital admission, as defined by ICD-9-CM diagnostic code. [WAC 388-531-0050]

Assignment – A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization number – A nine-digit number assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Base anesthesia units (BAU) – A number of anesthesia units assigned to a surgical procedure that includes the usual preoperative, intra-operative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

Bundled services – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

By report (BR) – A method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of federal regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community services office (CSO) – An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core provider agreement – The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Covered service – A service that is within the scope of the eligible client's medical care program, subject to the limitations in Chapter 388-531 WAC and other published WAC.

Current procedural terminology (CPT™) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association.

Department – The state Department of Social and Health Services
[WAC 388-500-0005]

Early and periodic screening, diagnosis, and treatment (EPSDT) – Formerly known as the "Healthy Kids" program, means a program providing early periodic screening, diagnosis and treatment to persons younger than 21 years of age who are eligible for Medicaid.
[Refer to WAC 388-500-0005]

EPSDT provider – (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as an EPSDT provider; ***or*** (2) a dentist, dental hygienist, audiologist, or optometrist who is an enrolled Medical Assistance provider and performs all or one component of the EPSDT screening.

Explanation of benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Expedited prior authorization (EPA) – A process designed by MAA to eliminate the need for written prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies the criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

Fee-for-service – The general payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MAA's Managed Care plans or State Children's Health Insurance Program (SCHIP).

Informed consent – Where an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and
(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and
(3) Given the client a copy of the consent form; and
(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and
(5) Given the client oral information about all of the following:
    (a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and
    (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
    (c) The procedure itself, including potential risks, benefits, and consequences.

Inpatient hospital admission – An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

Limitation extension – A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization.

Managed care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum allowable fee – The maximum dollar amount that MAA reimburses a provider for specific services, supplies, and equipment.

Medical assistance administration (MAA) – The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (SCHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medicaid – The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical consultant – Physicians employed by MAA who are authorities on the medical aspects of the Medical Assistance program. As part of their responsibilities, MAA medical consultants:

- Serve as advisors in communicating to the medical community the scope, limit, and purpose of the program.
- Assist in the development of MAA medical policy, procedures, guidelines, and protocols.
- Evaluate the appropriateness and medical necessity of proposed or requested medical treatments in accordance with federal and state law, applicable regulations, MAA policy, and community standards of medical care.
- Serve as advisors to MAA staff, helping them to relate medical practice realities to activities such as claims processing, legislative requests, cost containment, and utilization management.
- Serve as liaisons between MAA and various professional provider groups, health care systems (such as HMOs), and other State agencies.
- Serve as expert medical and program policy witnesses for MAA at fair hearings.

Medical identification card – The form DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically necessary – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Newborn – To assist providers in billing CPT codes with "newborn" in the description, MAA defines newborns as younger than 1 year of age.

Noncovered service or charge – A service or charge not reimbursed by the department.

Patient identification code (PIC) – An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birth date, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Pound indicator (#) – A symbol (#) indicating a procedure code listed in MAA's fee schedules that is not covered.

Prior authorization – Written MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. *Expedited prior authorization and limitation extensions are forms of prior authorization.*

Professional component – The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

Provider or provider of service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Relative value unit (RVU) – A unit that is based on the resources required to perform an individual service. RBRVS RVUs are comprised of three components – physician work, practice expense, and malpractice expense.

Remittance and status report (RA) – A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Resource based relative value scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

RBRVS maximum allowable amount – The Medicare Fee Schedule relative value unit, multiplied by the statewide geographic practice cost index, times the applicable conversion factor.

Revised code of Washington (RCW) – Washington State laws.

Technical component – The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

Third party – Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual and customary fee – The rate that may be billed to the Department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge billed to the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington administrative code (WAC) – Codified rules of the State of Washington.

Introduction

Procedure Codes

The following types of procedure codes are used within these Physician-Related Services Billing Instructions:

- Current Procedure Terminology (CPT™); and
- Level II Healthcare Common Procedure Coding System (HCPCS).

Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all MAA-covered services. **Due to copyright restrictions, MAA publishes only the official brief CPT descriptions. To view the full CPT description, please refer to your current CPT manual.**

☞ **Note:** MAA specifies in these billing instructions when MAA's guidelines differ from CPT. MAA adopts Medicare's guidelines and policies whenever possible.

Diagnosis Codes

MAA uses ICD-9-CM diagnosis codes for physician-related services. Providers are required to use the code of the highest specificity (5-digit codes) from the ICD-9-CM manual when available.

MAA does not cover the following diagnosis codes when billed as the primary diagnosis:

- E codes (Supplementary Classification);
- M codes (Morphology of Neoplasms); and
- Most V codes.

MAA reimburses providers for only those covered procedure codes and diagnosis codes that are within their scope of practice.

CPT codes and descriptions only are copyright 2003 American Medical Association

Grace Period for Discontinued Codes

Effective for dates of service on and after January 1, 2005, MAA will adopt Medicare's policy eliminating the grace period for discontinued CPT and HCPCS procedure codes and ICD-9-CM diagnosis codes.

Noncovered Services [WAC 388-531-1900]

Procedures that are noncovered are noted with a pound (#) indicator in the Nonfacility Setting (NFS) and Facility Setting (FS) columns in the fee schedule.

If a client has extenuating medical circumstances that are not covered under the client's MAA program and the medical provider feels MAA should take these into consideration for coverage, the provider must submit a written request to MAA for an Exception to Rule (ETR). **A sample form is located on page I.3.** The provider may use the sample form or submit equivalent information to MAA at the address listed below.

Send written requests for ETR to:

MAA – Division of Medical Management
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

The following are examples of administrative costs and/or services not covered separately by MAA:

- Missed or canceled appointments;
- Mileage;
- Take-home drugs;
- Educational supplies or services;
- Copying expenses, reports, client charts, insurance forms;
- Service charges/delinquent payment fees;
- Telephoning for prescription refills; and
- Other areas as specified in this fee schedule.

CPT codes and descriptions only are copyright 2003 American Medical Association

Noncovered Practitioners [WAC 388-531-0250]

MAA does not reimburse for services performed by any of the following practitioners:

- Acupuncturists;
- Naturopaths;
- Homeopathists;
- Herbalists;
- Masseurs, masseuses;
- Christian Science practitioners or theological healers;
- Counselors (i.e., M.A. and M.S.N.);
- Sanipractors;
- Those who have a master's degree in social work (M.S.W.), except those employed by an FQHC;
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010;
- Any other licensed practitioners providing services that are not within the scope of the practitioner's license; and
- Any other licensed practitioners providing services that the practitioner is not trained to provide.

Clients Enrolled in MAA's Managed Care Plans

Many MAA clients are enrolled in one of MAA's managed care plans. These clients have an HMO identifier in the HMO column on their DSHS Medical ID card. They also receive an ID card from the managed care plan in which they are enrolled. Clients enrolled in one of MAA's managed care plans must obtain services through their managed care plan.

☞ **Note:** A client's enrollment can change monthly. Prior to serving a managed care client, make sure you receive approval from both the plan and the client's primary care provider (PCP), if required.

Send claims to the client's managed care plan for payment. Call the client's HMO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 388-502-0160.

CPT codes and descriptions only are copyright 2003 American Medical Association

By Report (BR)

Services with a **BR** indicator in the fee schedule (Section J) with billed charges of $1,100.00 or greater require a detailed report for payment purposes. Attach the report to the claim. **DO NOT** attach a report to the claim for services with a BR indicator with billed charges under $1,100.00 unless requested by MAA.

Acquisition Cost (AC)

Drugs with an **AC** indicator in the fee schedule (Section J) with billed charges of $1,100.00 or greater, or supplies with billed charges of $50.00 or greater, require a manufacturer's invoice for payment purposes. Attach the invoice to the claim. **DO NOT** attach an invoice to the claim for procedure codes with an AC indicator for drugs with billed charges under $1,100.00, or supplies with billed charges under $50.00, unless requested by MAA.

Conversion Factors

These conversion factors multiplied by the Relative Value Units (RVUs) establish the rates in this fee schedule.

	7/1/98	7/1/99	7/1/00	7/1/01	7/1/02	7/1/03	7/1/04
Maternity	$43.19	$44.20	$45.33	$45.34	$45.59	$45.59	$44.46
Anesthesia	$12.75	$12.96	$15.10	$15.49	$15.70	$20.23	$20.24
Children's Primary Health Care	$39.11	$37.49	$35.89	$36.52	$35.62	$35.62	$34.25
Adult Primary Health Care	$23.67	$22.47	$21.17	$21.27	$20.44	$25.00	$25.00
All Other Procedure Codes	$22.27	$21.93	$22.37	$22.41	$22.75	$22.75	$22.67
Clinical Lab Multiplication Factor	.667	.689	.694	.720	.719	.810	.797

National Correct Coding Initiative

MAA continues to evaluate and implement the National Correct Coding Initiative (NCCI) policy. This policy was created by the Centers for Medicare and Medicaid Services (CMS) to promote national correct coding methodologies. CCI assists MAA in controlling improper coding that may lead to inappropriate payment. MAA bases coding policies on the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national professional societies, the analysis and review of standard medical and surgical practices, and review of current coding practices. These correct coding policies do not necessarily supercede any other specific MAA coding, coverage, or payment policies, unless specifically stated. Visit the NCCI on the web at http://www.cms.hhs.gov/physicians/cciedits/default.asp? - comp.

CPT codes and descriptions only are copyright 2003 American Medical Association

Programs (Guidelines/Limitations)

Office and Other Outpatient Services

[Refer to WAC 388-531-0950]

In addition to the limitations on services indicated in the fee schedule, the following limitations apply:

MAA covers:

- One office or other outpatient visit per non-institutionalized client, per day for an individual provider (except for call-backs to the emergency room per WAC 388-531-0500).

  ✓ Certain procedures are included in the office call and cannot be billed separately.

Example:	Ventilation management (CPT codes 94656, 94657, 94660, and 94662) is not reimbursed separately when billed in addition to an Evaluation and Management (E&M) service, even if the E&M service is billed with modifier 25.

  ✓ Bill the appropriate level of E&M history and physical procedure **prior to performing dental surgery** in an outpatient setting. For clients assigned to an MAA managed care plan, bill MAA directly for history and physical claims for dental surgery with the appropriate ICD-9-CM dental diagnosis code. Indicate in the *Comments* section of the claim form that the service is a history and physical prior to dental surgery.

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.

- One physical examination per client, per year for clients with developmental disabilities as identified on the DSHS medical ID card. Use HCPCS procedure code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an annual exam.

CPT codes and descriptions only are copyright 2003 American Medical Association

Children's Primary Health Care (CPT codes 99201-99215)

- MAA pays a higher reimbursement rate for primary health care performed in the office setting (CPT codes 99201-99215) for children 20 years of age and younger. These are the only services that are reimbursed at the higher rate.

- If a child who is younger than one year of age **has not been issued** an individual Patient Identification Code (PIC), use the mother's or the father's PIC, and put a "B" in field 19 on the HCFA-1500 claims form. **In addition, you must add modifier HA to CPT codes 99201-99215 only** in order for the service to be reimbursed at the higher fee. If the mother is enrolled in an MAA managed care plan, newborns will be enrolled in the same managed care plan as their mother.

Hospital Inpatient and Observation Care Services

(CPT codes 99217-99239)
[Refer to WAC 388-531-0750]

MAA covers:

- One inpatient hospital call per client, per day for the same or related diagnoses. If the call is included in the global surgery reimbursement, MAA does not reimburse separately. (See the Surgical Services Section; page F.16 for information on global surgery policy.)

- Professional inpatient services (CPT codes 99221-99223) during the global surgery follow-up period only if they are performed on an emergency basis and are unrelated to the original surgery. Use modifier 24 to indicate that the service is unrelated to the original surgery.

> ☞ **Note:** MAA reimburses providers for CPT codes 99221-99223 for scheduled hospital admissions during the follow-up period only when billed with a modifier 24.

- A hospital admission (CPT codes 99221-99223) billed by a psychiatrist in combination with one of the following:

  - ✓ A psychiatric diagnostic or evaluative interview examination (CPT code 90801); or

  - ✓ For children 20 years of age and younger, an interactive psychiatric diagnostic interview exam (CPT code 90802).

CPT codes and descriptions only are copyright 2003 American Medical Association

MAA does not cover:

- A hospital admission (CPT codes 99221-99223) and a planned surgery when billed in combination. The hospital admission is included in the global fee for the surgery.

- Inpatient or observation care services [including admission and discharge services (CPT codes 99234-99236)] for stays of less than 8 hours on the same calendar date.

Other Guidelines:

- When a client is admitted for observation care for less than 8 hours and is discharged on the same calendar date, providers must bill using CPT codes 99218-99220. MAA does not reimburse providers separately for discharge services.

- When a client is admitted for observation care and is discharged on a different calendar date, providers must bill using CPT codes 99218-99220 **and** observation discharge CPT code 99217.

- When a client qualifies for an inpatient hospital admission and is discharged on a different calendar date, providers must bill using CPT codes 99221-99233 **and** hospital discharge day management CPT code 99238 or 99239.

- When a client qualifies for an inpatient hospital admission and is discharged on the same calendar date, providers must bill using CPT codes 99234-99236. MAA does not reimburse providers separately for hospital discharge day management services.

- Providers must satisfy the documentation requirements for both admission to and discharge from inpatient or observation care in order to bill CPT codes 99234-99236. The length of time for observation care or treatment status must also be documented.

CPT codes and descriptions only are copyright 2003 American Medical Association

Detoxification Services

For clients receiving alcohol and/or drug detoxification services in an MAA-enrolled hospital-based detoxification center, providers must bill as follows:

Procedure Code-Modifier	Brief Description	Limitations
H0009	Alcohol and/or drug services [*bill for the initial admission*]	Limited to one per hospitalization. Restricted to ICD-9-CM diagnosis codes 292.0-292.9, 303.0-305.03, 305.2-305.93, and 790.3
H0009-TS	Alcohol and/or drug services with follow-up service modifier [*bill for any follow-up days*]	

☞ **Note**: Bill MAA directly for clients enrolled in an MAA managed care plan.

Emergency Physician-Related Services (CPT codes 99281-99285)

[Refer to WAC 388-531-0500]

- For services performed by the physician assigned to, or on call to, the emergency department, bill MAA using CPT codes 99281-99285.

☞ **Note**: For multiple emergency room (ER) visits on the same day with related diagnoses, the time(s) of the additional visit(s) must be noted in the *Comments* section of the claim form.

- MAA does not reimburse emergency room physicians for hospital admissions (e.g., CPT codes 99221-99223) or after-hours services (e.g., CPT codes 99050, 99052, or 99054).

- Physicians who perform emergency room services **must not** bill modifier 54 when billing MAA for surgical procedures.

- Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of office visit code without modifier 55.

CPT codes and descriptions only are copyright 2003 American Medical Association

End-Stage Renal Disease (ESRD)

(CPT codes 90935, 90937, 90945, and 90947)

- Reimbursement is limited to one dialysis procedure per day.

- If a separately identifiable service is performed on the same day as a dialysis service, you may bill any of the following E&M procedures codes with modifier 25:

  - ✓ 99201-99205 Office or Other Outpatient Visit: New Patient;
  - ✓ 99211-99215 Office or Other Outpatient Visit: Established Patient;
  - ✓ 99221-99223 Initial Hospital Care: New or Established Patient;
  - ✓ 99238-99239 Hospital Discharge Day Management Services;
  - ✓ 99241-99245 Office or Other Outpatient Consultations: New or Established Patient; and
  - ✓ 99291-99292 Critical Care Services.

- Reimbursement for any other E&M service performed on the same day is included in the reimbursement for the dialysis service.

Critical Care (CPT codes 99291-99292)

[Refer to WAC 388-531-0450]

☞ **Note:** For neonatal or pediatric critical care services, see page B.10.

What is critical care?

Critical care is the direct delivery and constant attention by a provider(s) for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s); to treat single or multiple vital organ system failure; and/or to prevent further life threatening deterioration of the patient's condition.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E&M codes.

CPT codes and descriptions only are copyright 2003 American Medical Association

Billing for Critical Care

When billing for critical care, providers must bill using CPT codes 99291-99292:

- For the provider's attendance during the transport of critically ill or critically injured clients 25 months of age or older to or from a facility or hospital.

- To report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the client and cannot provide services to any other patient during the same period of time.

> ☞ **Note:** Surgery, stand-by, or lengthy consultation on a stable client does not qualify as critical care.

Where is critical care performed?

Critical care is usually performed in a critical care area of a hospital, such as a(n):

- Coronary care unit;
- Intensive care unit;
- Respiratory care unit; or
- Emergency care facility.

MAA covers:

- A maximum of 3 hours of critical care per client, per day.

- Critical care provided by the attending physician who assume(s) responsibility for the care of a client during a life-threatening episode.

- Critical care services provided by more than one physician if the services involve multiple organ systems (unrelated diagnosis). However, in the emergency room, payment for critical care services is limited to one physician.

CPT codes and descriptions only are copyright 2003 American Medical Association

The following services (with their corresponding CPT codes) are included in critical care. Do not bill these separately:

- Vascular access procedures (36000, 36410, 36415 - 36416, 36540, and 36600);
- Gastric intubation (43752 and 91105);
- Chest x-rays (71010, 71015, and 71020);
- Temporary transcutaneous pacing (92953);
- The interpretation of cardiac output measurements (93561-93562);
- Ventilator management (94656-94657, and 94660-94662);
- Pulse oximetry (94760-94762); or
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090).

Physician Standby Services (CPT code 99360)

[Refer to WAC 388-531-1250]

MAA covers physician standby services when those services are requested by another physician and involve prolonged physician attendance without direct (face-to-face) client contact.

☞ **Note:** The standby physician cannot provide care or services to other patients during the standby period.

Limitations

- Standby services of less than 30 minutes are not covered.
- After the first 30 minutes, subsequent periods of standby services are covered only when a full 30 minutes of standby is provided for each unit billed.

CPT codes and descriptions only are copyright 2003 American Medical Association

MAA does not cover physician standby services when:

- The provider performs a surgery that is subject to the "global surgery policy" (refer to page F.16);
- Billed in addition to any other procedure code, with the exception of CPT codes 99431 and 99440; or
- When the service results in an admission to a neonatal intensive care unit (CPT 99295) on the same day.

Prolonged Services (CPT codes 99354-99357)

[Refer to WAC 388-531-1350]

MAA covers prolonged services:

- Up to three hours per client, per diagnosis, per day.

> ☞ **Note:** The time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the provider and the client, whether or not the services were continuous.

- Only when the provider performs one of the services listed below for the client on the same day:

Prolonged CPT Code	Other CPT Code(s)
99354	99201-99215, 99241-99245, 99301-99350
99355	99354 and one of the E&M codes required for 99354
99356	99221-99233, 99251-99255, 99261-99263
99357	99356 and one of the E&M codes required for 99356

> ☞ **Note:** Both the prolonged services CPT code **and** any of the "Other CPT Codes" listed above **must** be billed on the **same** claim.

CPT codes and descriptions only are copyright 2003 American Medical Association

Osteopathic Manipulative Therapy (CPT codes 98925-98929)

[Refer to WAC 388-531-1050]

MAA covers:

- Ten (10) osteopathic manipulations per client, per calendar year.

- Osteopathic Manipulative Therapy (OMT) services only when provided by an osteopathic physician licensed under chapter 18.71 RCW.

- OMT services by body regions. Body regions are defined as:

  - ✓ head
  - ✓ thoracic
  - ✓ sacral
  - ✓ lower extremities
  - ✓ rib cage
  - ✓ cervical
  - ✓ lumbar
  - ✓ pelvic
  - ✓ upper extremities
  - ✓ abdomen and viscera

- One OMT procedure code in the range 98925-98929 per client, per day. Bill using the CPT code that describes the number of body regions involved. For example, if three body regions are manipulated, bill one unit of CPT code 98926.

- An E&M service (billed with modifier 25) in addition to the OMT, under one of the following circumstances:

  - ✓ When a provider diagnoses the condition requiring OMT and provides the therapy during the same visit;
  - ✓ When the existing condition fails to respond to OMT or significantly changes, requiring E&M services beyond those considered included in the manipulation codes; or
  - ✓ When the provider treats the client for a condition unrelated to the OMT during the same encounter.

  Justification for the E&M and OMT services must be documented and retained in the client's record for review.

☞ **Note:** MAA **does not cover** physical therapy services performed by osteopathic physicians.

CPT codes and descriptions only are copyright 2003 American Medical Association

Newborn Care

To assist providers in billing CPT codes with "newborn" in the description, MAA defines a newborn as younger than one year of age.

MAA covers:

- One newborn evaluation per newborn using either CPT code 99431 (hospital) or 99432 (birthing center or home births).
- Subsequent hospital care (other than initial evaluation or discharge) using CPT code 99433.
- Discharge services using either CPT code 99238 or 99239 for newborns admitted and discharged on different days.
- One newborn evaluation and discharge per newborn performed on the same day using CPT code 99435.

☞ **Note:** MAA covers circumcisions (CPT codes 54150 and 54160) **only** with medical ICD-9-CM diagnosis codes 605 (Phimosis), 607.1 (Balanoposthitis), or 607.81 (Balanitis Xerotica).

Neonatal Intensive Care Unit (NICU)/ Pediatric Intensive Care Unit (PICU) (CPT codes 99293-99296)

[Refer to WAC 388-531-0900]

NICU/PICU care includes management, monitoring, and treatment of the neonate/infant including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematological maintenance, parent/family counseling, case management services, and personal direct supervision of the health care team's activities.

MAA covers:

- One NICU/PICU service per client, per day.
- NICU/PICU services when directing the care of a neonate/infant in a NICU/PICU. These codes represent care beginning with the date of admission to the NICU/PICU.

☞ **Note:** Once the infant is no longer considered critically ill, hospital care CPT codes 99231-99233 (>2500 grams) or 99298-99299 (<2500 grams) must be used.

CPT codes and descriptions only are copyright 2003 American Medical Association

- Newborn resuscitation (CPT code 99440) in addition to NICU/PICU services.

- The provider's attendance during the transport of critically ill or critically injured pediatric clients 24 months of age or younger to or from a facility or hospital (CPT code 99289 or 99290).

The following services (with their corresponding CPT codes) are included in neonatal or pediatric critical care. Do not bill these separately:

- Bladder catheterization (53670);
- Central (36555 and 36490) or peripheral vessel catheterization (36000);
- Continuous positive airway pressure (CPAP) (94660);
- Endotracheal intubation (31500);
- Initiation and management of mechanical ventilation (94656 and 94657);
- Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762);
- Lumbar puncture (62270);
- Oral or nasogastric tube placement (43752);
- Other arterial catheters (36140 and 36620);
- Umbilical arterial catheterization (36660);
- Umbilical venous catheterization (36510);
- Suprapubic bladder aspiration (51000);
- Surfactant administration, intravascular fluid administration (90780 and 90781);
- Transfusion of blood components (36430 and 36440); or
- Vascular punctures (36420 and 36600).

Physician Care Plan Oversight **(CPT codes 99375, 99378, and 99380)**
[Refer to WAC 388-531-1150]

MAA covers:

- Physician care plan oversight services once per client, per month.

  - ✓ A plan of care must be established by the home health agency, hospice, or nursing facility.
  - ✓ The provider must perform 30 or more minutes of oversight services for the client each calendar month.

CPT codes and descriptions only are copyright 2003 American Medical Association

MAA does not cover:

- Physician care plan oversight services of less than 30 minutes per calendar month (CPT codes 99374, 99377, and 99379).

- Physician care plan oversight services provided by more than one provider during the global surgery reimbursement period, unless the care plan oversight is unrelated to the surgery.

Domiciliary, Rest Home, or Custodial Care Services

CPT codes 99301-99316 are **not** appropriate E&M codes for use in place of service 13 (Assisted Living) or 14 (Group Home). Providers must use CPT codes 99321-99333 for E&M services provided to clients in these settings.

Telehealth

What is telehealth?

Telehealth is when a health care practitioner uses interactive real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.

Using telehealth when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telehealth allows MAA clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

The following services are **not** covered as telehealth:

- Email, telephone, and facsimile transmissions;
- Installation or maintenance of any telecommunication devices or systems;
- Home health monitoring; or
- "Store and forward" telecommunication based services. (Store and forward is the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site).

Who is eligible for telehealth?

Fee-for-service clients are eligible for medically necessary covered health care services delivered via telehealth. The referring provider is responsible for determining and documenting that telehealth is medically necessary. As a condition of payment, the client must be present and participating in the telehealth visit.

CPT codes and descriptions only are copyright 2003 American Medical Association

MAA will not pay separately for telehealth services for clients enrolled in a managed care plan. Clients enrolled in an MAA managed care plan will have a plan indicator in the HMO column on their DSHS Medical ID Card. Managed care enrollees must have all services arranged and provided by their primary care providers (PCP). Contact the managed care plan regarding whether or not the plan will authorize telehealth coverage. It is not mandatory that the plan reimburse for telehealth.

When does MAA cover telehealth?

MAA covers telehealth through the fee-for-service program when it is used to substitute for a face-to-face, "hands on" encounter for only those services specifically listed on page B.14.

Originating Site (Location of Client)

What is an "originating site"?

An originating site is the physical location of the eligible MAA client at the time the professional service is provided by a physician or practitioner through telehealth. Approved originating sites are:

- The office of a physician or practitioner;
- A hospital;
- A critical access hospital;
- A rural health clinic (RHC); and
- A federally qualified health center (FQHC).

Is the originating site reimbursed for telehealth?

Yes. The originating site is reimbursed a $20 facility fee per completed transmission.

How does the originating site bill MAA for the facility fee?

- Hospital Outpatient: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the maximum allowable fee schedule. To receive reimbursement for the facility fee, outpatient hospital providers must bill revenue code 0789 on the same line as HCPCS code Q3014.

- Hospital Inpatient: When the originating site is an inpatient hospital, there is no reimbursement to the originating site for the facility fee.

- Critical Access Hospitals: When the originating site is a critical access hospital outpatient department, payment is separate from the cost-based reimbursement methodology. To receive reimbursement for the $20.00 facility fee, critical access hospitals must bill revenue code 0789 on the same line as HCPCS code Q3014.

CPT codes and descriptions only are copyright 2003 American Medical Association

- FQHCs and RHCs: When the originating site is an FQHC or RHC, bill for the facility fee using HCPCS code Q3014. This is not considered an FQHC or RHC service and is not paid as an encounter, and is not reconciled in the monthly gross adjustment process.

- Physicians' Offices: When the originating site is a physician's office, bill for the facility fee using HCPCS code Q3014.

If a provider from the originating site performs a separately identifiable service for the client on the same day as telehealth, documentation for both services must be clearly and separately identified in the client's medical record.

Distant Site (Location of Consultant)

What is a "distant site"?

A distant site is the physical location of the physician or practitioner providing the professional service to an eligible MAA client through telehealth.

Who is eligible to be reimbursed for telehealth services at a distant site?

MAA reimburses the following provider types for telehealth services provided within their scope of practice to eligible MAA clients:

- Physicians (including Psychiatrists); and
- Advanced Registered Nurse Practitioners (ARNPs).

What services are covered using telehealth?

Only the following services are covered using telehealth:

- Consultations (CPT codes 99241-99275);
- Office or other outpatient visits (CPT 99201-99215);
- Psychiatric intake and assessment (CPT code 90801);
- Individual psychotherapy (CPT codes 90804-90809); and
- Pharmacologic management (CPT codes 90862).

> ☞ **Note**: Refer to other sections of these billing instructions for specific policies and limitation on these CPT codes.

CPT codes and descriptions only are copyright 2003 American Medical Association

How does the distant site bill MAA for the services delivered through telehealth?

The payment amount for the professional service provided through telehealth by the provider at the distant site is equal to the current fee schedule amount for the service provided.

Use the appropriate CPT codes **with modifier GT** (via interactive audio and video telecommunications system) when submitting claims to MAA for payment.

CPT codes and descriptions only are copyright 2003 American Medical Association

This page intentionally left blank.

CPT codes and descriptions only are copyright 2003 American Medical Association

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients 20 years of age and younger in order to identify physical and/or mental health problems. If a physical or mental health problem is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

MAA's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary;
- Safe and effective; and
- Not experimental.

Who can provide EPSDT screenings?

- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health (DOH); and
- Registered nurses working under the guidance of a physician or ARNP.

☞ **Note:** DOH no longer provides training to nurses for EPSDT screenings.

☞ **Note:** Only physicians, PAs and ARNPs can diagnose and treat problems found in a screening.

Who is eligible for EPSDT screenings?

MAA covers EPSDT screenings provided to clients who:

- Are 20 years of age and younger; and
- Present a DSHS Medical ID card with one of the identifiers listed on the following page:

CPT codes and descriptions only are copyright 2003 American Medical Association

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP – CHIP	CNP – State Children's Health Insurance Program
CNP - Emergency Medical Only	CNP - Emergency Medical Only (Covered only when the service is related to the emergent condition.)
LCP – MNP	Limited Casualty Program – Medically Needy Program

☞ **Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

Are clients enrolled in one of MAA's Managed Care plans eligible for EPSDT?

Yes! EPSDT screenings are included in the scope of service provided by MAA's managed care plans. Clients who are enrolled in one of MAA's managed care plans will have an identifier in the HMO column on their DSHS Medical ID card.

Please refer managed care clients to their respective managed care plan's primary care provider (PCP) for coordination of necessary preventive health care services and medical treatments, including EPSDT services. Clients can contact their plan by calling the telephone number indicated on their DSHS Medical ID card.

Do not bill MAA for EPSDT services. They are included in the managed care plan's reimbursement.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column on their DSHS Medical ID card will be "PCCM." These clients must obtain or be referred for services through the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider (PCP) would be in a plan setting.

☞ **Note:** To prevent billing denials, please check the client's DSHS Medical ID card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtained from the PCCM.

CPT codes and descriptions only are copyright 2003 American Medical Association

Billing for Infants Not Yet Assigned a Patient Identification Code (PIC)

Use the PIC of either parent for a newborn if the infant has not yet been issued a PIC. Enter indicator **B** in the *Comments* section of the claim form to indicate that the parent's PIC is being used for the infant. When using a parent's PIC for twins or triplets, etc., identify each infant separately (i.e., twin A, twin B), using a *separate claim form* for each. **Note: For parents enrolled in an MAA managed care plan, the plan is responsible for providing medical coverage for the newborn.**

What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What is included in an EPSDT screening?

At a minimum, EPSDT screenings must include:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:
    - ✓ How to clean teeth as they erupt;
    - ✓ How to prevent baby bottle tooth decay;
    - ✓ How to look for dental disease;
    - ✓ Information on how dental disease is contracted;
    - ✓ Preventive sealant; and
    - ✓ Application of fluoride varnish, when appropriate;
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

Licensed providers may perform these components separately; however, MAA encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

CPT codes and descriptions only are copyright 2003 American Medical Association

Additional Screening Components

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening components listed on the previous page:

- Appropriate audiometric tests (CPT codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, and 84203).

How often should EPSDT screenings occur?

The following is Washington State's schedule for health screening visits:

- Five total screenings during the first year of the infant's life. Below is a recommended screening schedule for children from birth to one year of age.

  - ✓ 1st Screening: Birth to 6 weeks old
  - ✓ 2nd Screening: 2 to 3 months old
  - ✓ 3rd Screening: 4 to 5 months old
  - ✓ 4th Screening: 6 to 7 months old
  - ✓ 5th Screening: 9 to 11 months old

- Three screening examinations are required between the ages of 1 and 2 years.
- One screening examination is required per 12-month period for children ages 2 through 6.
- One screening examination is required per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

> ☞ **Note:** If a client is placed in foster care or is placed in the care of a relative, MAA will reimburse providers for an EPSDT screen without regard to the periodicity schedule above.

Foster Care Children

MAA reimburses providers an enhanced flat fee of $120.00 per EPSDT screening exam for foster care clients who receive their medical services through MAA's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

To receive the enhanced rate, providers **must** bill the appropriate EPSDT code with modifier 21 in order to identify foster care clients.

MAA reimburses providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier 21.

CPT codes and descriptions only are copyright 2003 American Medical Association

Note: A child placed outside of the home in the care of a relative does not qualify as a foster care client. However, MAA reimburses providers for an EPSDT screening exam without regard to the periodicity schedule for these clients using MAA's normal maximum allowable fee for EPSDT procedures. Providers must indicate "**EPSDT screen performed for child in relative care**" in the *Comments* section of the claim form.

To receive the enhanced rate, providers are required to use either:

- The DSHS "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)]; **or**
- Another charting tool with equivalent information.

To obtain copies of the Well Child Examination forms:

- Submit the request form provided on page C.17 to:

Medical Assistance Administration
PO Box 45530
Olympia, WA 98504-5530
FAX (360) 753-7315

-OR-

- Download an electronic copy of the Well Child Examination forms, go to:

http://www1.dshs.wa.gov/dshsforms/forms/eforms.html

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For clients who are…	Must be scheduled within…
MAA's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs)	Infants - within the first 2 years of life.	21 days of request.
	Children – two years and older.	Six weeks of request.
	Receiving Foster Care – Upon placement	30 days of request, or sooner for children younger than 2 years of age.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	Birth through 20 years of age	14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

CPT codes and descriptions only are copyright 2003 American Medical Association

EPSDT interperiodic screenings

Note: MAA no longer reimburses providers for interperiodic screenings. If a client is seen for a suspected health problem, providers must bill these services using the appropriate level Evaluation & Management (E&M) procedure code, with the ICD-9-CM diagnosis code that accurately describes the sign(s), symptom(s), or condition(s) found. **It is no longer necessary to bill using modifier EP for these services**.

What if a medical problem is identified during an EPSDT screening?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate MAA provider or MAA's Managed Care Plan provider, if applicable, for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

Note: If the provider is using the parent's PIC code to bill E&M codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider must use modifier HA in order to be reimbursed at the higher rate for EPSDT services. **Modifier HA must be the first modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

Referrals

Chiropractic Services
Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services
Eligible clients may go to a dental provider without an EPSDT screen or referral.

CPT codes and descriptions only are copyright 2003 American Medical Association

Orthodontics
Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. MAA reimburses for orthodontics for children with cleft lip or palates or severe handicapping malocclusions only. MAA does not reimburse for orthodontic treatment for other conditions.

Fetal Alcohol Syndrome (FAS) Screening
FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, and/or a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screen, every child six months of age or older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children can be referred to a diagnostic clinic if there is known in-utero exposure to alcohol, or there is suspicion of facial characteristics of FAS or microcephaly.

Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

MAA reimburses the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

CPT Procedure Code	Brief Description	Limitations
97802	Medical nutrition, indiv, initial	1 unit = 15 minutes; maximum of 2 hours (8 units) per year
97803	Med nutrition, indiv, subseq	1 unit = 15 minutes; maximum of 1 hour (4 units) per day
97804	Medical nutrition, group	1 unit = 15 minutes; maximum of 1 hour (4 units) per day

CPT codes and descriptions only are copyright 2003 American Medical Association

Fluoride Varnish (HCPCS code D1203)

Fluoride varnish is a type of topical fluoride that acts to retard, arrest, and reverse the caries process. It is applied up to three times in a 12-month period to all surfaces of the teeth. The teeth absorb the fluoride varnish, strengthening the enamel and helping prevent cavities.

Who may prescribe the fluoride varnish?

- Dentists;
- Physicians;
- Physician Assistants (PA); or
- Advanced Registered Nurse Practitioners (ARNP).

Who is eligible?

All Medicaid-eligible clients, age 18 years and younger, may receive fluoride varnish applications. Clients with disabilities age 19 and older are also eligible.

Are managed care clients eligible?

Clients whose DSHS Medical ID cards have an identifier in the HMO column are enrolled in one of MAA's managed health care plans. These clients **are eligible for fluoride varnish applications** through fee-for-service. Bill MAA directly for fluoride varnish applications.

Immunizations - Children

(This applies to clients age 20 years and younger. For clients age 21 years and older, refer to "Immunizations-Adults" on page C.11.)

Immunizations under the EPSDT program are usually given in conjunction with a screening exam. Do not bill an Evaluation and Management (E&M) code unless there is a separate, identifiable diagnosis that is different from the immunization.

Immunizations covered under the EPSDT program are listed in the vaccine table on page C.10. For children age 18 years and younger, the vaccines that are shaded in the table are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program. MAA does not reimburse providers for these vaccines.

Providers must bill for the administration of the vaccine and for the cost of the vaccine itself as detailed on the following page:

CPT codes and descriptions only are copyright 2003 American Medical Association

Clients age 18 years and younger – Vaccines that are identified by shading

- These vaccines are available at no cost from DOH. Therefore, MAA reimburses providers for an administration fee only.
- Bill for the administration of the vaccine by reporting the procedure code given with modifier SL (e.g. 90707 SL).
- DO NOT bill CPT codes 90471 or 90472 for the administration of the vaccine.

Clients age 18 years and younger – Vaccines not identified by shading

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with non-shaded vaccines. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Clients age 19-20 years – All Vaccines

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is shaded or not. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

☞ **Note:** Only Health Departments may bill CPT code 99211 when an immunization is the only service provided.

CPT codes and descriptions only are copyright 2003 American Medical Association

Vaccines that are shaded in the table are available at no cost from DOH through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children age 18 years and younger.
MAA does not reimburse providers for these vaccines.

CPT	Vaccine
90585	Bcg vaccine, percut
90586	Bcg vaccine, intravescial
90632	Hep a vaccine, adult im
90633	Hep a vacc, ped/adol, 2 dose
90636	Hep a/Hep B vacc (adult)
90646	Hib vaccine, prp-d, im
90647	Hib vaccine, prp-omp, im
90648	Hib vaccine, prp-t, im
90655	Flu vacc split pres free 6-35 months
90656	Flu vacc split pres free 3 years and above
90657	Flu vaccine, 6-35 mo, im
90658	Flu vaccine, 3 yrs, im
90659	Flu vaccine, whole, im
90660	Flu vacc, nasal
90665	Lyme disease vaccine, im
90669	Pneumococcal vacc, ped<5
90675	Rabies vaccine, im
90676	Rabies vaccine, id
90690	Typhoid vaccine, oral
90691	Typhoid vaccine, im
90692	Typhoid vaccine, h-p, sc/id
90700	Dtap vaccine, im
90701	Dtp vaccine, im
90702	Dt vaccine <7, im
90703	Tetanus vaccine, im
90704	Mumps vaccine, sc
90705	Measles vaccine, sc
90706	Rubella vaccine, sc
90707	Mmr vaccine, sc
90708	Measles-rubella vaccine, sc
90709	Rubella & mumpsvaccine, sc
90712	Oral poliovirus vaccine
90713	Poliovirus, ipv, sc
90715	TdaP, 7 years and older, intramuscular
90716	Chicken pox vaccine, sc
90717	Yellow fever vaccine, sc
90718	Td vaccine >7, im
90720	Dtp/hib vaccine, im
90725	Cholera vaccine, injectable
90732	Pneumoccocal vacc, adult/ill *(requires prior authorization)*
90733	Meningococcal vaccine, sc
90734	Meningococcal vacc, intramuscular *(requires prior authorization)*
90735	Encephalitis, vaccine, sc
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose, im
90744	Hep b vacc ped/adol 3 dose, im
90746	Hep b vaccine, adult, im
90747	Hep b vacc, ill pat 4 dose, im
90748	Hep b/hib vaccine, im
90749	Vaccine toxoid

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

CPT codes and descriptions only are copyright 2003 American Medical Association

Immunizations-Adults

(This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to "Immunizations-Children" on page C.8.)

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given.
- MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

CPT	Immunization	CPT	Immunization
90585	Bcg vaccine, precut	90707	Mmr vaccine, sc
90586	Bcg vaccine, intravesical	90708	Measles-rubella vaccine, sc
90632	Hep a vaccine, adult im	90709	Rubella & mumps vaccine, sc
90636	Hep a/hep b vacc, adult im	90712	Oral poliovirus vaccine
90645	Hib vaccine, hboc, im	90713	Poliovirus, ipv, sc
90646	Hib vaccine, prp-d, im	90715	TdaP, 7 years and older, Intramuscular
90647	Hib vaccine, prp-omp, im	97716	Chicken pox vaccine, sc
90648	Hib vaccine, prp-t, im	90717	Yellow fever vaccine, sc
90656	Flu vacc split pres free 3 years and above	90718	Td vaccine >7, im
90658	Flu vaccine, 3 yrs, im	90720	Dtp/hib vaccine, im
90660	Flu vacc, nasal	90725	Cholera vaccine, injectable
90665	Lyme disease vaccine, im	90732	Pneumococcal vacc, adult/ill ***(requires prior authorization)***
90675	Rabies vaccine, im	90733	Meningococcal vaccine, sc
90676	Rabies vaccine, id	90734	Meningococcal vacc, intramuscular ***(requires prior authorization)***
90690	Typhoid vaccine, oral	90735	Encephalitis vaccine, sc
90691	Typhoid vaccine, im	90740	Hepb vacc, ill pat 3 dose, im
90692	Typhoid vaccine, h-p, sc/id	90746	Hep b vaccine, adult, im
90700	Dtap vaccines, im	90747	Hepb vacc, ill pat 4 dose, im
90701	Dtp vaccine, im	90748	Hep b/hib vaccine, im
90703	Teanus vaccine, im	90749	Vaccine toxoid
90704	Mumps vaccine, sc		
90706	Rubella vaccine, sc		

CPT codes and descriptions only are copyright 2003 American Medical Association

Immune Globulins

Note: MAA does not reimburse immune globulins that are obtained free of charge.

- **RespiGam** – Do not bill CPT code 90379 for RespiGam. You must use HCPCS code J1565.

- **Synagis** (CPT code 90378)

  ✓ Bill one unit for each 50 mg of Synagis used.

  ✓ MAA covers Synagis for those clients 11 months of age and younger from December 1 - April 30 of any given year without prior authorization (PA).

  ✓ PA is required for all other time periods and for all other age groups.

  Requests for authorization must be submitted in writing to:

  MAA-Division of Medical Management
  Attn: Synagis Program
  PO Box 45506
  Olympia, WA 98504-5506
  FAX: (360) 725-2141

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1 ml syringes used. Bill each 1 ml syringe used as 1 unit.

- **Varicella Zoster** (CPT code 90396) - Each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.

CPT codes and descriptions only are copyright 2003 American Medical Association

- **Rabies Immune Globulin (RIG)** (CPT codes 90375-90376)

  ✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

Pounds	Dose
0-17	1 ml
18-34	2 ml
35-50	3 ml
51-67	4 ml
68-84	5 ml
85-100	6 ml
101-117	7 ml
118-134	8 ml
135-150	9 ml

Pounds	Dose
151-167	10 ml
168-184	11 ml
185-200	12 ml
201-217	13 ml
218-234	14 ml
235-250	15 ml
251-267	16 ml
268-284	17 ml
285-300	18 ml

  ✓ RIG is sold in either 2 ml or 10 ml vials.
  ✓ One dose is allowed per episode.
  ✓ Bill one unit for each 2 ml vial used per episode.

  Examples:

  ✓ If a client weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or
  ✓ If a client weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

- **Correct Coding for Various Immune Globulins –** Bill MAA for immune globulins using the HCPCS procedure codes listed below. MAA does not reimburse for the CPT codes listed in the Noncovered CPT Code column below.

Noncovered CPT Code	Covered HCPCS Code
90281	J1460-J1560
90283	J1563
90291	J0850
90379	J1565
90384	J2790
90385	J2790
90386	J2792
90389	J1670

CPT codes and descriptions only are copyright 2003 American Medical Association

Therapeutic or Diagnostic Injections

(CPT codes 90782-90784, 90788, and 90799)
[Refer to WAC 388-531-0950]

- MAA reimburses providers for injection procedures and/or injectable drug products provided to a client only when the injectable drug used is from office stock purchased by the provider from a pharmacist or drug manufacturer. Providers must not bill MAA for drugs obtained free of charge (e.g. free samples).

- If no other service is performed on the same day, a subcutaneous or intramuscular injection (CPT code 90782) or an intramuscular antibiotic injection (CPT code 90788) can be billed in addition to an injectable drug code.

- When a subcutaneous or intramuscular injection (CPT code 90782) or an intramuscular antibiotic injection (CPT code 90788) is provided on the same day as an Evaluation & Management (E&M) service, the injections are bundled into the E&M service and are not reimbursed separately.

- Intra-arterial injections (CPT code 90783) and intravenous therapeutic or diagnostic injections (CPT code 90784) are reimbursed separately even when provided on the same day as an E&M service. Separate payment for the drug is allowed using the appropriate HCPCS injection drug code. However, these injections are not reimbursed separately if provided in conjunction with IV infusion therapy services (CPT codes 90780 and 90781).

☞ **Note:** Drugs must be billed using the HCPCS drug codes and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review. For billing information and reimbursement of chemotherapy services, see page F.14.

Hyalgan/Synvisc

- MAA reimburses only orthopedic surgeons and rheumatologists for Hyalgan or Synvisc.

- MAA allows a maximum of 5 Hyalgan or 3 Synvisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to your claim.

- This series of injections may be repeated at 12-week intervals.

CPT codes and descriptions only are copyright 2003 American Medical Association

- Providers must bill for Hyalgan and Synvisc using the following HCPCS codes:

HCPCS Code	Description	Limitations
J7317	Sodium hyaluronate, 20-25 mg, for intra-articular injection (Hyalgan)	Maximum of 5 injections Maximum of 5 units (1 unit = 1 injection of 20-25 mg)
J7320	Hylan G-F 20, 16 mg, for intra-articular injection (Synvisc)	Maximum of 3 injections Maximum of 3 units (1 unit = 1 injection of 16 mg)

- Hyalgan and Synvisc injections are covered for treatment of osteoarthritis of the knee only with the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg.
715.18	Osteoarthritis, localized, primary, other specified sites.
715.26	Osteoarthritis, localized, secondary, lower leg.
715.28	Osteoarthritis, localized, secondary, other specified sites
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg.
715.38	Osteoarthritis, localized, not specified whether primary or secondary, other specified sites.
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg.
715.98	Osteoarthritis, unspecified whether generalized or localized, other specified sites.

- The injectable drugs must be billed after all injections are completed. The drugs are billed as a maximum of 5 units for Hyalgan or a maximum of 3 units for Synvisc (per knee).

- Bill CPT injection code 20610 each time an injection is given, up to a maximum of 5 injections for Hyalgan or 3 injections for Synvisc.

- **You must bill both the injection CPT code and HCPCS drug code on the same claim form.**

Verteporfin Injection (HCPCS code J3395)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

CPT codes and descriptions only are copyright 2003 American Medical Association

Clozaril Case Coordination

- Providers must bill for Clozaril case coordination using CPT code 90862 (pharmacologic management).
- MAA reimburses only physicians, psychiatrists, ARNPs, and pharmacists for Clozaril case coordination.
- MAA reimburses providers for one unit of Clozaril case coordination per week.
- MAA reimburses providers for Clozaril case coordination when billed with ICD-9-CM diagnosis codes 295 – 295.9 only.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case coordination.

CPT codes and descriptions only are copyright 2003 American Medical Association

FORMS AND PUBLICATIONS REQUEST

Medical Assistance Administration
Attn: Tamarra Paradee
Mailstop: 45530
P.O. Box 45530
Olympia, WA 98504-5530
Fax: (360) 753-7315

Ship to Name:	
Company:	
Street:	
P.O. Box:	Suite:
City:	
State:	Zip Code:
Fax #:	Telephone:

Form Name	Form Order Number	# of Tablets/25 Sheets per Tablet
Infancy 2-4 Weeks	13-683	
Infancy 2 Months	13-683A	
Infancy 4 Months	13-683B	
Infancy 6 Months	13-683C	
Infancy 9 Months	13-683D	
Infancy 12 Months	13-683E	
Early Childhood 18 Months	13-684	
Early Childhood 2 Years	13-684A	
Early Childhood 3 Years	13-684B	
Early Childhood 4 Years	13-684C	
Late Childhood 5 Years	13-685	
Late Childhood 6 Years	13-685A	
Late Childhood 8 Years	13-685B	
Late Childhood 10 Years	13-685C	
Late Childhood 12 Years	13-685D	
Adolescence 14 Years	13-686	
Adolescence 16 Years	13-686A	
Adolescence 18 Years	13-686B	

Vision Care Services (Includes Ophthalmological Services)

Eligibility for Vision Care Services

Clients with one of the following identifiers on their DSHS Medical ID cards are eligible for vision care services:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP - CHIP	Categorically Needy Program – State Children's Health Insurance Program
GAU - No Out of State Care	General Assistance-Unemployable -No Out of State Care ADATSA
LCP-MNP	Limited Casualty Program -Medically Needy Program

Limited Coverage for Vision Care Services

Clients with the following identifier on their Medical ID cards are eligible **ONLY** for those services directly related to a qualifying emergency medical condition:

Medical Program Identifier	Medical Program
CNP - Emergency Medical Only	Categorically Needy Program – Emergency Medical Only (*Covered only when the service is related to the emergent condition.*)
LCP-MNP Emergency Medical Only	Limited Casualty Program - Medically Needy Program *(Covered only when the service is related to the emergent condition)*

For clients with the following identifier on their DSHS Medical ID card, MAA pays only the Medicare premiums and copay.

Medical Program Identifier	Medical Program
QMB-Medicare Only	Qualified Medicare Beneficiary *(Medicare Premiums/Copays Only)*

No Coverage for Vision Care Services

Clients with Family Planning Only and TAKE CHARGE identifiers on their Medical ID cards are not eligible for vision care service.

CPT codes and descriptions only are copyright 2003 American Medical Association

Are clients enrolled in an MAA managed care plan eligible for vision care services?

Clients with an identifier in the HMO column on their DSHS Medical ID card are enrolled in one of MAA's managed care plans. **Eye exams**, **refractions**, and/or **visual fields** must be requested and provided directly through the client's managed care plan. Clients can contact their plans by calling the telephone number listed on their DSHS Medical ID card.

Frames, lenses, and contact lenses must be ordered from MAA's contractor (see page D.14). These items are reimbursed fee-for-service. Eligibility, coverage, and billing guidelines found in these billing instructions apply to managed care clients.

Primary Care Case Management (PCCM) clients will have a PCCM identifier in the HMO column of their DSHS Medical ID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in the "referring provider" field of the claim form.

Note: For further information on MAA's managed care plans, see MAA's Web site: http://maa.dshs.wa.gov/HealthyOptions

What services are covered and how often?

- **Eye examinations, refractions, and fitting fees**

MAA reimburses providers for medically necessary eye examinations, refractions, eyeglasses (frames and lenses), and fitting fees as follows:		
Asymptomatic clients	Adults (21 year or older)	Once every 24 months
Asymptomatic clients	Children (20 years or younger)	Once every 12 months
Clients with developmental disabilities ***(DSHS Medical ID card will have an "X" in the DD Client column)***	Adults and Children	Once every 12 months

Note: The provider must document the diagnosis and/or treatment in the client's record to justify the frequency of examinations and other services.

MAA limits eyeglass reimbursement to specific contract frames and contract lenses. MAA reimburses providers for a fitting fee for frames, lenses, and contact lenses provided by, or obtained through, the contractor (see page D.14). If the client has a serviceable frame that meets MAA's size and style requirements, MAA will pay for a fitting fee.

CPT codes and descriptions only are copyright 2003 American Medical Association

Under what circumstances would the above limits NOT apply?

- **Change in prescription (spherical equivalent of ±1 diopter):** The 24-month limitation does not apply to a change in prescription spherical equivalent of ±1 diopter.

- **Clients in nursing facilities:** MAA reimburses for services provided to clients in a nursing facility. Services must be ordered by the client's attending physician and documented in the client's care plan.

- **Eye examinations relating to medical conditions:** MAA reimburses for examinations relating to medical conditions (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.) as often as medically necessary.

- **Eye exam due to lost or broken glasses:**

  MAA reimburses for eye exams within two years of the last exam when no medical indication exists and **both** of the following are documented in the client's record:

  ✓ The glasses or contacts are broken or lost; and
  ✓ The last exam was 18 months ago or longer.

  ☞ **Note:** Bill for eye exams due to lost or broken glasses using MAA's Expedited Prior Authorization (EPA) process. See Section I.

- **Visual field exams (CPT codes 92081-92083):** MAA reimburses providers for visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. MAA does not reimburse providers for visual field exams that are done by simple confrontation. Use Medicare criteria for billing visual field services for MAA clients.

  Documentation in the record must show:

  ✓ The extent of the testing;
  ✓ Medical necessity; and
  ✓ The medical basis for the frequency of testing.

Program Limitations

Special Ophthalmological Services - Bilateral Indicator: MAA considers special ophthalmological services to be bilateral if they are routinely provided on both eyes. For MAA purposes, this includes CPT code 92015, determination of refractive state. Do not use bilateral modifier 50 or modifiers LT and RT for these services since payment is based on a bilateral procedure.

CPT codes and descriptions only are copyright 2003 American Medical Association

Evaluation and Management (E&M) Procedures: Use E&M codes for eye examinations for a medical problem, not for the prescription of eyeglasses or contact lenses. ICD-9-CM diagnosis codes 367.0-367.9 and "V" codes are not appropriate when billing E&M services.

What services are not covered?

MAA does not cover:

- E&M services and an eye exam on the same day;
- Nursing home visits and an eye exam on the same day;
- Any services with prescriptions over two years old;
- Missed appointments;
- Orthoptics and visual training therapy; or
- Group vision screening for eyeglasses (except for EPSDT services).

Eyeglasses

When does MAA cover eyeglasses (frames and/or lenses)?

MAA covers eyeglasses (frames and/or lenses) when the:

- Client's condition that requires correction in one or both eyes is stable;
- Prescription is less than two years old; and
- Minimum correction need is documented and meets one of the following:

  - ✓ Sphere power equal to, or greater than, ± 0.50 diopters; or
  - ✓ Astigmatism power equal to, or greater than, ± 0.50 diopters.

MAA limits reimbursement for eyeglasses to specific contract frames, lenses, and contact lenses. MAA pays providers a fitting fee only for frames, lenses, and contact lenses provided by or obtained through MAA's contractor (see page D.14). However, if the client owns serviceable frames that meet MAA's size and style requirements, MAA will pay for a fitting fee.

☞ **Note:** Refer to page D.7 for requests for lenses only.

CPT codes and descriptions only are copyright 2003 American Medical Association

How often does MAA cover eyeglasses (lenses/frames)?

MAA covers eyeglasses as follows:

Clients	Limitations
21 years of age or older	Once every 24 months
20 years of age or younger	Once every 12 months
With developmental disabilities (all ages) ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Once every 12 months
Who have been unable to adjust to contact lenses after 30 days (all ages)	As medically necessary *(The provider must document the client's inability to adjust and the client must return the original contact lenses to the provider.)*

Replacements

MAA reimburses providers for replacement eyeglasses (lenses/frames) that have been broken or lost as follows:

Clients	Limitations
21 years of age and older	Requires MAA's expedited prior authorization (see Section I)
20 years of age and younger	Does not require MAA's prior authorization
With developmental disabilities (all ages) ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Does not require MAA's prior authorization

Repairs

Use CPT code 92390 to bill for materials used for eyeglasses repair (specify materials billed in the *Comments* section on the claim form).

Eyeglass repair includes replacement of frame front, temple(s), soldering, and/or hinge repair. MAA covers incidental repairs to a client's eyeglass frames when both of the following apply:

- The repair or adjustment is not typically provided to the public at no cost (such as tightening and/or straightening the frame, or replacing a hinge screw); and

- The cost of the repair does not exceed MAA's cost for replacement frames.

Eyeglass repair parts and materials may be ordered from the state contractor or any manufacturer of optical devices and will be paid up to MAA's maximum allowable fee for repair.

CPT codes and descriptions only are copyright 2003 American Medical Association

Additional Options

Nonallergenic frames

If the client has a medically diagnosed allergy to metal, MAA covers coating the frames to make them nonallergenic.

Upgrades

MAA does not allow clients to upgrade eyeglass frames and pay only the upgrade costs in order to avoid MAA's contract limitations.

Back-up eyeglasses

MAA covers back-up eyeglasses when contact lenses are the client's primary visual correction aid (see Contact Lenses section, page D.11) as follows:

Clients	Limitations
20 years of age or younger	One pair every two years
21 years of age or older	One pair every six years

Durable or Flexible Frames

MAA covers pre-approved special frames called "durable" or "flexible" frames through MAA's contracted supplier when a client:

- Is diagnosed with a seizure disorder that results in frequent falls; or
- Has a medical history that has resulted in two or more broken eyeglass frames in a 12-month period.

☞ **Note:** For durable or flexible frames, bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.

What is not covered?

MAA **does not cover** the following eyeglasses:

- Eyeglasses upgraded at private expense to avoid MAA's contractual limitations;
- Two pairs of eyeglasses in lieu of multifocals; or
- Non-medically necessary eyeglasses.

CPT codes and descriptions only are copyright 2003 American Medical Association

Eyeglass Lenses

What is covered?

MAA covers the following eyeglass lenses and lens treatments through MAA's contractor:

- **One pair of:**
  - ✓ Single vision;
  - ✓ Round or flat top D-style bifocals; or
  - ✓ Trifocals (25 mm or 28 mm).
- **Glass Lenses (in clear only)** in eye-size 54 millimeters or smaller for all contract frames or noncontract serviceable frames owned by MAA clients.
- **Plastic Lenses (in clear only)** in all sizes to fit all contract frames or noncontract frames owned by MAA clients. Plastic lenses can be up to any prescription power. (For information on tinted lenses, see page D.8.)
- **Treating Plastic Lenses for Scratch Resistance** only when the client:
  - ✓ Is 20 years of age or younger; or
  - ✓ Has a developmental disability (check the client's DSHS Medical ID card for an "X" in the DD column).

Requests for lenses only

MAA covers only lenses when the:

- Eyeglass frames are serviceable*;
- Lenses are medically necessary; and
- Size and style of the required lenses meet MAA's contract requirements.

***Note:** Due to time, exposure to elements, and concealed damage, working with noncontract frames owned by MAA clients can be unpredictable. MAA's contractor does not accept responsibility for these frames.

CPT codes and descriptions only are copyright 2003 American Medical Association

Which eyeglass lenses and lens treatments require medical justification?

Medical justification and/or ICD-9-CM diagnosis code(s) must be clearly written on the order form to the contractor for the following lenses:

- **Bifocal Lenses Replaced with Single Vision Lenses - or - Trifocal Lenses Replaced with Bifocal Lenses or Single Vision Lenses**

  A client may be unable to adjust quickly to lens changes. Therefore, MAA requires all of the following before allowing lenses to be replaced as specified above:

  ✓ A client must attempt and be unable to adjust to the bifocals or trifocals for at least 60 days; and
  ✓ The original bifocal or trifocal lenses are returned to the provider.

  A statement from the attending physician must be in the client's record indicating that the treatable condition(s) is stable before new lenses are allowed.

- **High-Index Lenses for Refractive Change**

  MAA covers high-index lenses when the client requires a refractive correction of ± 8 diopters or greater.

  ☞ **Note:** For high-index lenses, bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.

- **Tinting of Plastic Lenses**

  MAA covers the tinting of plastic lenses only when:

  ✓ The client's medical need is diagnosed and documented as a chronic eye condition (expected to last longer than 3 months) causing photophobia; and
  ✓ MAA's contracted lens supplier does the tinting.

CPT codes and descriptions only are copyright 2003 American Medical Association

When billing MAA for tinting of plastic lenses, use the appropriate ICD-9-CM code from the following list:

Medical Conditions	ICD-9-CM Diagnosis Codes
Chronic iritis, iridocyclitis (uveitis)	364.10-364.11 and 364.50-364.59
Optic atrophy and/or optic neuritis causing photophobia	377.1-377.63
Chronic corneal keratitis	370.00-370.07
Glaucoma	365.00-365.9
Rare photo-induced epilepsy conditions	345.00-345.9
Migraine disorder	346.00-346.2
Diabetic retinopathy	362.01-362.02

- **Glass Photochromatic Lenses (includes photogray lenses)**

Plastic photochromatic lenses are not allowed.

MAA covers glass photochromatic lenses only when the client's medical need is diagnosed and documented as related to either of the following:

- ✓ Ocular albinism; or
- ✓ Blindness.

When billing MAA for photochromatic lenses, use the appropriate ICD-9-CM code from the following list:

Medical Conditions	ICD-9-CM Diagnosis Codes
Albinism	270.2
Retinitis pigmentosa	362.74
Optic atrophy and/or optic neuritis	377.10-377.63

- **Polycarbonate Lenses**

MAA covers polycarbonate lenses when a client:

- ✓ Is blind in one eye and needs protection for the other eye, regardless of whether a vision correction is required;
- ✓ Is 20 years of age or younger and diagnosed with strabismus or amblyopia; or
- ✓ Has a developmental disability, regardless of the client's age.

CPT codes and descriptions only are copyright 2003 American Medical Association

When billing MAA for polycarbonate lenses, use the appropriate ICD-9-CM code from the following list:

Medical Conditions	ICD-9-CM Diagnosis Codes
Persons who are blind in one eye and need protection for the other eye	369.60-369.69 and 369.71-369.73
Infants/toddlers with motor ataxia	331.89, 334.0-334.9, 781.2, and 781.3
Amblyopia	368.01-368.03
Children with strabismus	378.00-378.9

Replacements

- MAA covers lens replacement for lost, broken, or stolen lenses as follows:

Clients	Limitations
21 years of age and older	Requires MAA's expedited prior authorization (see Section I)
20 years of age and younger	Does not require MAA's prior authorization
With developmental disabilities (all ages) ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Does not require MAA's prior authorization

- MAA covers lens replacements without regard to time limits when all of the following apply:

  ✓ One of the following caused the vision change:

    - Eye surgery;
    - The effect(s) of prescribed medication; or
    - One or more diseases;

  ✓ Both the eye condition and the treatment have stabilized; and

  ✓ The lens correction has at least one diopter difference between the old and new prescriptions. (Replacement lenses are limited to one pair of eyeglasses.)

CPT codes and descriptions only are copyright 2003 American Medical Association

Which lenses are not covered?

MAA does not cover the following eyeglass lenses:

- High index lenses with correction less than 8 diopters;
- Second or replacement lenses during pregnancy due to unstable refractive changes;
- Plastic photochromatic lenses;
- Glass lenses of prescription power ± 8 diopters;
- Varilux or other progressive addition-type multifocals, including blended bifocals; or
- Sunglasses.

Contact Lenses

How often does MAA cover contact lenses?

MAA covers contact lens replacements once every 12 months.

What is covered?

MAA covers the following contact lenses:

- **Gas permeable or daily wear soft contact lenses** as the client's primary refractive correction method if a client has a spherical correction of ± 6.0 diopters. (Use ICD-9-CM codes 367.0 or 367.1.)

- **Therapeutic contact bandage lenses** only when needed immediately after either of the following:

  - ✓ Eye injury (ICD-9-CM codes 871.0-871.9); or
  - ✓ Eye surgery (CPT codes 65091-67599, 68020-68399).

- **Lenticular, aspheric, and myodisc contact lenses** when the client has one or more of the following:

  - ✓ Multiple cataract surgeries on the same eye;
  - ✓ Aphakia;
  - ✓ Keratoconus with refractive error of ± 10 diopters; or
  - ✓ Corneal softening (e.g., bullous keratopathy).

CPT codes and descriptions only are copyright 2003 American Medical Association

When billing MAA for lenticular, aspheric, and myodisc contact lenses, use the appropriate ICD-9-CM code from the following list:

Medical Conditions	ICD-9-CM Diagnosis Codes
Aphakia	379.31, 743.35
Keratoconus	371.60-371.62, 743.41
Multiple cataract surgeries on the same eye (12-month limit does not apply)	366.00-366.09, 366.17-366.9
Corneal softening, such as caused by bullous keratopathy	371.23

- **Soft toric contact lenses** (daily wear) for clients with astigmatism requiring a cylinder correction of ± 1 diopter. They must also meet the spherical requirement of ± 6 diopters (use ICD-9-CM codes 367.20, 367.21, or 367.22 for astigmatism).

☞ **Note:** MAA does not cover contact lenses if the client's ocular condition makes it inadvisable for the client to use contact lenses.

Replacements

MAA covers the replacement of broken or lost contacts when both of the following are documented in the client's record:

- Copy of current prescription (must not be older than 17 months); and
- The date of last dispense.

☞ **Note:** For replacement contact lenses, bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.

Which contact lenses are not covered?

- Contact lenses for a client who has received MAA-covered eyeglasses within the past two years, unless the provider can document the medical necessity; or
- Disposable contact lenses.

☞ **Note:** MAA does not allow clients to upgrade contact lenses and pay only the upgrade costs in order to avoid MAA's contract limitations

CPT codes and descriptions only are copyright 2003 American Medical Association

Billing for Fitting Fees

Bill using the following CPT codes for fitting fees for contact lenses:

CPT Procedure Code	Brief Description
92070	Fitting of contact lens (does not include any follow-up days)
92310 92311 92312 92313	Contact lens fitting (does not include any follow-up days)

Ocular prosthetics

When does MAA cover ocular prosthetics?

MAA covers ocular prosthetics when the ocular prosthetics are medically necessary and provided by any of the following providers:

- An Ophthalmologist;
- An Ocularist; or
- An Optometrist who specializes in orthotics.

For ocular prosthetics, bill using one of the following HCPCS procedure codes:

HPCS Code	Description
V2623	Prosthetic, eye, plastic, custom
V2624	Polishing/resurfacing of ocular prosthesis
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2627	Scleral cover shell
V2628	Fabrication and fitting of ocular conformer
V2630	Anterior chamber intraocular lens
V2631	Iris, supported intraocular lens
V2632	Posterior chamber intraocular lens

CPT codes and descriptions only are copyright 2003 American Medical Association

Cataract Surgeries

When does MAA cover cataract surgery?

MAA covers cataract surgery when it is medically necessary and the provider clearly documents the need in the client's file.

MAA considers the surgery medically necessary when the client has either of the following:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or

- One or more of the following conditions:

  - ✓ Dislocated or subluxated lens;
  - ✓ Intraocular foreign body;
  - ✓ Ocular trauma;
  - ✓ Phacogenic glaucoma;
  - ✓ Phacogenis uveitis; or
  - ✓ Phacoanaphylactic endopthalmitis.

Strabismus Surgeries

When does MAA cover strabismus surgery?

MAA covers surgical procedures for strabismus (CPT codes 67311-67340) for clients 17 years of age and younger only.

Where and How Do I Order Eyeglasses and Contact Lenses?

Who is MAA's eyeglass contractor?

MAA's eyeglass contractor is Airway Optical (Washington State Department of Correctional Industries).

Eyeglasses and contact lenses, including therapeutic soft contact (bandage) lenses, are covered for eligible MAA clients through Airway Optical only. MAA does not reimburse any other optical manufacturer or provider for frames, lenses, or contact lenses.

CPT codes and descriptions only are copyright 2003 American Medical Association

Mail or fax completed prescriptions and/or purchase orders for sample kits, eyeglass frames, lenses, and contact lenses to:

Airway Optical
11919 West Sprague Avenue
PO Box 1959
Airway Heights, WA 99001-1959
Customer Service: 1-888-606-7788
Fax: 1-888-606-7789

General Ordering Information

- Airway Optical will supply prescription order forms upon request. Please call Airway Optical's toll-free number at (888) 606-7788 or fax (888) 606-7789 to order additional forms. **Please do not photocopy the order forms as it makes them illegible**.

- All prescriptions must be **legible** and include the prescribing provider's name and return address. Airway Optical will mail the eyeglasses to the prescribing provider.

- Providers must mail or fax eyeglass orders, along with a copy of the client's DSHS Medical ID card **with the client's address removed or blacked out**, to the contractor. The provider must ensure the copy of the Medical ID card is legible and is for the current month.

- MAA requires Airway Optical to process prescriptions within 10 business days (including shipping and handling time) after receipt of a properly completed order. MAA allows 20 business days for completing special orders (e.g., polycarbonate, high index, etc). Airway Optical must notify the provider when a prescription cannot be processed within either of these specified delivery timeframes.

- Include the appropriate diagnosis code on all order forms for eyeglass and contact lenses. If the appropriate diagnosis code is not included on the form, the contractor is required to reject and return the order.

- The contractor will reject and return an order for any client for whom MAA has already purchased a pair of lenses and/or complete frames within the applicable benefit period (12 or 24 months, as appropriate). Similarly, the contractor will reject an order for contact lenses for a client if MAA has already paid for contact lenses or eyeglasses for that client within the past 12 months.

- To obtain general information, or to inquire about overdue prescriptions, call the contractor at: 1-888-606-7788.

CPT codes and descriptions only are copyright 2003 American Medical Association

This page intentionally left blank.

CPT codes and descriptions only are copyright 2003 American Medical Association

Allergen Immunotherapy

[Refer to WAC 388-531-0950(10)]

Reimbursement for antigen/antigen preparation (CPT codes 95145-95149, 95165, and 95170) is per dose.

Service Provided	What should I bill?
Injection and antigen/antigen preparation for allergen immunotherapy	✓ One injection (CPT code 95115 or 95117); and ✓ One antigen/antigen preparation (CPT codes 95145-95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	✓ CPT codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	✓ CPT code 95144 for single dose vials; or ✓ CPT code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	✓ CPT code 95144
Allergists who billed the complete services (CPT codes 95120-95134) and used treatment boards	✓ One antigen/antigen preparation (CPT 95145-95149, 95165, and 95170); and ✓ One injection (CPT code 95115 or 95117).
Physician injects one dose of a multiple dose vial	✓ Bill for the total number of doses in the vial and an injection code
Physician or another physician injects the remaining doses at subsequent times	✓ Bill only the injection service

Reimbursement for an allergist billing both an injection and either CPT code 95144 or 95165 is the injection plus the fee of CPT code 95165, regardless of whether CPT code 95144 or 95165 is billed. The allergist may bill an Evaluation and Management (E&M) procedure code for conditions not related to allergen immunotherapy.

CPT codes and descriptions only are copyright 2003 American Medical Association

Psychiatric Services

[Refer to WAC 388-531-1400]

Note: These billing instructions are not for use by Psychologists. Refer to MAA's Psychologist Billing Instructions for a description of the psychology program. To view the billing instructions online, go to http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

General Guidelines

- MAA reimburses a maximum of one psychiatric service procedure code per client, per day.

- Psychiatrists must bill using one procedure code for the total time spent on direct client care during each visit. Making inpatient rounds is considered direct client care and includes any one of the following:

  - ✓ Brief (up to one hour) individual psychotherapy (CPT codes 90804-90807, 90810-90813*, 90816-90819, and 90823-90827*);
  - ✓ Family psychotherapy (CPT code 90847);
  - ✓ Group psychotherapy (CPT codes 90853 and 90857);
  - ✓ Electroconvulsive therapy (CPT codes 90870-90871); or
  - ✓ Pharmacological management (CPT code 90862).

- When performing both psychotherapy services and an E&M service during the same visit, use the appropriate psychiatric procedure code that includes the E&M services [e.g., CPT code 90805 (outpatient psychotherapy with E&M) or CPT code 90817 (inpatient psychotherapy with E&M)].

- A psychiatrist may bill for a medical physical examination in the hospital (CPT codes 99221-99233) in addition to a psychiatric diagnostic or evaluation interview examination (CPT code 90801 for adults or 90802 for children).

- MAA reimburses psychiatrists for the CPT codes listed in the following tables only when billed in combination with the diagnoses listed in the table. **For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.**

- Psychiatric sleep therapy is not covered.

***Interactive psychotherapy is limited to clients 20 years of age and younger.**

CPT codes and descriptions only are copyright 2003 American Medical Association

Inpatient Hospital

Inpatient CPT Codes	Must be billed in combination with:
Psychiatric Services	
90816-90819, 90823-90827*, 90845, 90847, 90853-90871, 90899	Any MAA covered diagnosis code in the following range: **ICD-9-CM 290-319**
Inpatient	
99217-99239	All MAA covered diagnosis codes
Inpatient Consultation	
99251-99275	All MAA covered diagnosis codes
Case Management	
99371-99373	All MAA covered diagnosis codes
*Codes 90823-90827 are limited to clients 20 years of age and younger. **All inpatient psychiatric services must be coordinated by either the local RSN or the client's MAA managed care plan.**	

Outpatient Hospital

Outpatient CPT Codes	Must be billed in combination with:
Psychiatric Services	
90804-90807, 90810-90813*, 90845, 90847, 90853-90871, 90899 The above procedure codes (except 90862) are subject to a limit of 12 hours per client, per calendar year.	Any MAA covered diagnosis code in the following range: **ICD-9-CM 290-319**
Outpatient	
99201-99215	Any MAA covered diagnosis codes except **ICD-9-CM 290-319**
Outpatient Consultation	
99241-99245	Any MAA covered diagnosis codes except **ICD-9-CM 290-319**
Emergency Room Consultation	
99281-99285	All MAA covered diagnosis codes except **ICD-9-CM 290-319**
Nursing Facility Services	
99301-99316	All MAA covered diagnosis codes except **ICD-9-CM 290-319**
Domiciliary/Rest Home Services	
99321-99333	All MAA covered diagnosis codes except **ICD-9-CM 290-319**
Standby Services	
99360	All MAA covered diagnosis codes except **ICD-9-CM 290-319**
Case Management Services	
99371-99373	All MAA covered diagnosis codes
* Codes 90810-90813 are limited to clients 20 years of age and younger. **Any other outpatient psychiatric services must be coordinated by either the local RSN or the client's MAA managed care plan.**	

CPT codes and descriptions only are copyright 2003 American Medical Association

Limitations for Inpatient and Outpatient Psychiatric Services:

- MAA does not reimburse the same provider for psychiatric procedure codes and E&M procedure codes on the same date of service unless there are two separate visits and the diagnoses are completely unrelated.

- MAA reimburses psychiatrists and psychiatric ARNPs for only those procedure codes and diagnosis codes that are within their scope of practice.

- MAA reimburses psychiatric ARNPs for the following psychiatric services only:

  - ✓ 90801 - Psychiatric Diagnostic Interview Examination;
  - ✓ 90802 - Interactive Psychiatric Diagnostic Interview Examination; and
  - ✓ 90862 - Pharmacological management.

- MAA limits outpatient psychotherapy and electroconvulsive therapy in any combination to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy.

- Family therapy is covered only when the client is present.

- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year unless a change in the client's condition occurs resulting in a new mental health diagnosis.

- Outpatient psychiatric services are not allowed for clients on the General Assistance Unemployable (GAU) program, except for medication adjustment (CPT code 90862). GAU clients must seek psychiatric services through their local Community Mental Health Center.

- Individual psychotherapy, interactive services (CPT codes 90810-90813 and 90823-90827) may be billed only for clients age 20 and younger.

CPT codes and descriptions only are copyright 2003 American Medical Association

Involuntary Treatment Act (ITA)

Physicians may provide psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or psychiatrist within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using either CPT code 90801 or 90802.

- A day's rounds, along with any one of the following, constitute direct client care: narcosynthesis, brief (up to one hour) individual psychotherapy, multiple/family group therapy, group therapy, or electroconvulsive therapy.

- Payment is made if the date of service is within 30 days from the date of detention.

- An extension form is required after 20 days of care. Extension approvals can be from the Regional Support Network (RSN), as well as the state hospital.

- A court may request another physician or psychiatrist evaluation.

- The ITA form must include identification of the county of commitment, as well as some identification (signature or initials) of the County Designee completing the form. The physician or psychiatrist must complete Section I of the ITA Patient Claim Information form (DSHS 13-628x). If you need copies of this referral form, mail or fax a written request on letterhead to Department of Printing Fulfillment, Mail Stop 47100, PO Box 47100, Olympia, WA 98504-7100, fax: (360) 586-8831.

- MAA reimburses for physician and psychiatrist evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT code 99075) for time spent doing court testimony.

  ☞ **Note:** One unit = 10 minutes. A maximum of five units is allowed.

- Additional costs for court testimony are reimbursed from county ITA administrative funds.

CPT codes and descriptions only are copyright 2003 American Medical Association

Podiatric Services [Refer to WAC 388-531-1300]

- MAA reimburses podiatrists for only those procedure codes and diagnosis codes that are within their scope of practice.

- MAA reimburses for routine foot care only when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires an M.D., D.O., or podiatrist to perform this care.

  Examples of a medical condition include, but are not limited to:

  ✓ Limitation of ambulation due to mycosis.
  ✓ Likelihood that absence of treatment will result in significant medical complications.

- MAA reimburses podiatrists for only the orthotics listed below. If prior authorization (PA) or expedited prior authorization (EPA) is required, see Section I:

Procedure Code	Brief Description	Limitations
L3000	Ft insert ucb berkeley shell	EPA Required
L3030	Foot arch support remov prem	EPA Required
L3100	Hallus-valgus nght dynamic s	
L3140	Abduction rotation bar shoe	
L3150	Abduct rotation bar w/o shoe	
L3170	Foot plastic heel stabilizer	PA Required
L3215	Orthopedic ftwear ladies oxf	EPA Required
L3219	Orthopedic mens shoes oxford	EPA Required
L3230	Custom shoes depth inlay	PA Required
L3310	Shoe lift elev heel/sole neo	EPA Required
L3320	Shoe lift elev heel/sole cor	EPA Required
L3334	Shoe lifts elevation heel /i	EPA Required
L3340	Shoe wedge sach	PA Required
L3350	Shoe heel wedge	PA Required
L3360	Shoe sole wedge outside sole	PA Required
L3400	Shoe metatarsal bar wedge ro	PA Required
L3410	Shoe metatarsal bar between	PA Required
L3420	Full sole/heel wedge btween	PA Required
L3430	Shoe heel count plast reinfor	

☞ **Note:** If the description of the orthotic code indicates the code is for a single orthotic or impression casting of one foot, either modifier RT or LT **must** be included on the claim. Providers must use an appropriate procedure code with the word "pair" in the description when billing for fabrications, casting, or impressions of both feet.

CPT codes and descriptions only are copyright 2003 American Medical Association

- MAA reimburses podiatrists for an Evaluation and Management (E&M) code and an orthotic on the same day if the E&M service performed has a separately identifiable diagnosis and is documented in the client's medical record.

- Medicare does not reimburse for orthotics and casting. You may bill MAA directly for those services without submitting a Medicare denial, unless the client's Medical ID card indicates *QMB - Medicare only*, in which case the orthotics and casting is not covered by MAA.

- Biomechanical evaluation (the evaluation of the foot that includes various measures and manipulations necessary for the fitting of an orthotic) is included in the orthotic fee.

Limitations

- Local nerve blocks for subregional anatomic areas (such as the ankle and foot) are included in the reimbursement for the surgical procedure and are not reimbursed separately.

- Reimbursement for debridement of nails is limited to a maximum of one treatment in a 60-day period.

- MAA reimburses podiatrists for covered, diagnostic, radiologic services of the ankle and foot only when the client is examined before the x-ray is ordered.

What is not covered?

- X-rays for soft tissue diagnosis;

- Bilateral x-rays for unilateral condition;

- X-rays in excess of two views;

- X-rays that are ordered before the client is examined;

- X-rays for any part of the body other than the foot or ankle;

- Treatment of flat feet; and

- Treatment of fungal (mycotic) disease.

CPT codes and descriptions only are copyright 2003 American Medical Association

Radiology Services
[Refer to WAC 388-531-1450]

General Limitations on Radiology Services

The following services are not usually considered medically necessary and may be subject to post-pay review:

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for a unilateral condition; and
- X-rays in excess of two views.

Other Limitations

- PET Scans and MRI/MRAs are limited to one per day.
- Multiple CT Scans are allowed only if done at different times of the day or if modifiers LT or RT are attached.

Contrast Material

Contrast material (HCPCS code A4647) is not reimbursed separately, except in the case of low-osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections for clients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.
- A history of asthma or allergy.
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.
- Generalized severe debilitation.
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS procedure code A4644, A4645, or A4646. The brand name of the LOCM and the dosage must be documented in the client's record.

Radiopharmaceutical Diagnostic Imaging Agents

When performing nuclear medicine procedures, separate payment is allowed for radiopharmaceutical diagnostic imaging agents.

CPT codes and descriptions only are copyright 2003 American Medical Association

Outpatient MRIs

You must bill using MAA's Expedited Prior Authorization (EPA) process for all outpatient MRIs. See Section I.

Outpatient PET Scans

MAA does not accept CPT codes for PET scans (CPT codes 78608-78609, 78459, and 78491-78492).

Providers **must** use one of the HCPCS codes from the range G0030-G0047, G0125, G0210-G0218, G0220-G0234, and G0253-G0254 when billing for PET scans.

> **Exception:** PET scan CPT code 78810 may be used after written/fax prior authorization has been obtained and **only** when there is no other appropriate HCPCS code to describe the procedure being performed.

All outpatient PET scans require some form of prior authorization. The following PET scans require EPA: HCPCS codes G0125, G0210-G0218, G0220-G0234, G0253-G0254, and G0276. The following PET scans require prior authorization: HCPCS codes G0030-G0047 and CPT code 78810.

For details on prior authorization for PET scans, refer to Section I.

Mammograms

MAA has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms (CPT code 76092 and add-on code 76083). For clients age 40 and over, one annual screening mammogram is allowed. Other screening mammograms may be allowed if determined to be medically necessary and are documented in the client's record.

Radiology Modifiers for Bilateral Procedures

- Bill the procedure on two separate lines using modifier 50 on one line only.
- Bill **modifier LT or RT** on separate lines when a radiological procedure is performed on the right and/or left side or extremity.
- Do not use modifier 50, LT, or RT if the procedure is defined as bilateral.

CPT codes and descriptions only are copyright 2003 American Medical Association

Anesthesia for Radiological Procedures [Refer to WAC 388-531-0300 (2) and (7)]

General anesthesia is allowed for radiological procedures for children and/or non-cooperative clients when the medically necessary procedure cannot be performed unless the client is anesthetized.

Providers **must** use the anesthesia CPT code 01922 when providing general anesthesia for non-invasive imaging or radiation therapy. **Do not** bill the radiological procedure code (e.g., CPT code 71010) with an anesthesia modifier to bill for the anesthesia procedure. When using CPT code 01922 for non-invasive imaging or radiation therapy:

- The client must be 17 years of age or younger; or
- A statement of the client-specific reasons why the procedure cannot be performed without anesthesia services must be kept in the client's medical record and made available to MAA on request.

Nuclear Medicine

When billing MAA for nuclear medicine, the multiple surgery rules are applied when the coding combinations listed below are billed:

- For the same client, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice; or

- With other codes that are subject to the multiple surgery rules, not just when billed in the combinations specified below:

  - ✓ CPT code 78306 (bone imaging; whole body) and CPT code 78320 (bone imaging; SPECT);

  - ✓ CPT code 78802 (radionuclide localization of tumor; whole body), CPT code 78803 (tumor localization; SPECT), and CPT code 78804 (radiopharmaceutic localization of tumor requiring 2 or more days); or

  - ✓ CPT code 78806 (radionuclide localization of abscess; whole body) and 78807 (radionuclide localization of abscess; SPECT).

CPT codes and descriptions only are copyright 2003 American Medical Association

Consultation on X-Ray Examination

When billing a consultation, the consulting physician must bill the specific x-ray code with modifier 26 (professional component).

> **For example:** The primary physician would bill with the global chest x-ray (CPT code 71020) or the professional component (CPT code 71020-26), and the consulting physician would bill only for the professional component of the chest x-ray (e.g., CPT code 71020-26).

Portable X-Rays

- Portable x-ray services furnished in a client's home or nursing facility are limited to the following tests:

  ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  ✓ Chest or abdominal films that do not involve the use of contrast media; or
  ✓ Diagnostic mammograms.

- To bill for transportation of equipment, bill either HCPCS code R0070 (one patient, one unit) or HCPCS code R0075 (multiple patients, multiple units).

> ☞ **Note:** MAA's reimbursement for R0070 and R0075 includes setup.

Heart Catheterizations

When a physician performs cardiac catheterization in a setting where the physician does not own the equipment (e.g., a hospital or ASC), MAA reimburses providers for the appropriate **procedure code with modifier 26 (professional component) only**. To bill using either the global or technical components, providers must have a contract with MAA certifying they perform heart catheterizations in their office and that they own their own equipment.

Use cardiac catheterization and angiography to report services individually. It is not appropriate to bill with modifier 51 (multiple procedures) with any of these codes.

CPT codes and descriptions only are copyright 2003 American Medical Association

Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid.

MAA reimburses laboratories for Medicare-approved tests only.

CLIA Certification

All facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number on file with MAA in order to receive reimbursement from MAA.

To obtain a CLIA certificate and number, or to resolve questions concerning your CLIA certification, call (206) 361-2805 or write to:

Department of Health
Office of Laboratory Quality Assurance
1610 NE 150th Street
Shoreline, Washington 98155
(206) 361-2805
(206) 361-2813 FAX

Reference Laboratory

If a laboratory sends a specimen to a reference (outside) lab, you may bill for the reference lab. However, the reference lab provider number must be entered in the performing provider number field. The reference lab must be CLIA-certified and have an active CLIA identification number on file with MAA. Use modifier 90.

Cancer Screens (HCPCS codes G0101-G0107 and G0120-G0122)

HCPCS Code	Limitations	Payable Only With Diagnosis Code(s)
G0101	Females only *[Use for Pap smear professional services]*	V25-V25.3, V25.4-V25.9, and V76.2
G0102	Bundled	N/A
G0103	Males age 50 and older Once every 12 months	Any valid ICD-9-CM code other than high risk

CPT codes and descriptions only are copyright 2003 American Medical Association

HCPCS Code	Limitations	Payable Only With Diagnosis Code(s)
G0104	Clients age 50 and older Allowed once every 48 months	Any valid ICD-9-CM code other than high risk
G0105*	Clients at high risk for colorectal cancer One every 24 months Must use modifier 53 if procedure is discontinued.	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72.
G0106	Clients age 50 and older and not a high risk Once every 48 months	Any valid ICD-9-CM code other than high risk
G0107	Clients age 50 and older Once every 12 months (1-3 simultaneous determinations)	Any valid ICD-9-CM code other than high risk
G0120	Clients age 50 and older who are at high risk for colorectal cancer Once every 24 months Must use modifier 53 if procedure is discontinued.	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72.
G0121*	Once every 48 months	Any valid ICD-9-CM code other than high risk
G0122	None	Any valid ICD-9-CM code other than high risk

***Note**: Per Medicare guidelines, MAA's payment is reduced when billed with modifier 53 (discontinued procedure).

Coding and Payment Policies

- Pathology and laboratory services must be provided either by a pathologist or by technologists who are under the supervision of a physician.
- Physicians must bill using their provider number for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its provider number for any services performed in its facility.
- MAA reimburses for one blood draw fee (CPT code 36415-36416, or 36540) per day.
- MAA reimburses for one catheterization for collection of a urine specimen (HCPCS code P9612) per day.
- CPT codes 85007, 85009, 85014, 85018, 85021, 85027, 85041, and 85048 are included in the complete blood count procedure.

CPT codes and descriptions only are copyright 2003 American Medical Association

- CPT codes 81001-81003 and 81015 are not allowed in combination with urinalysis procedure 81000.
- CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime.
- Do not bill with modifier 26 if the description in CPT indicates professional services only.
- Reimbursement for lab tests includes handling, packaging and mailing fee. Separate reimbursement is not allowed.

☞ **Note:** Laboratory claims must include an appropriate medical diagnosis code. The ordering provider must give the appropriate medical diagnosis code to the performing laboratory at the time the tests are ordered. **MAA does not reimburse a laboratory for procedures with ICD-9-CM diagnosis codes V72.5 and V72.6.**

Drug Screens

MAA reimburses for drug screens only when:

- ✓ Medically necessary and ordered by a physician as part of a medical evaluation; or
- ✓ Drug and alcohol screens are required to assess suitability for medical tests or treatment.

- MAA does not reimburse for screens to monitor any of the following:
  - ✓ Program compliance in either a residential or outpatient drug or alcohol treatment program;
  - ✓ Drug or alcohol use by a client when the screen is performed by a provider in a private practice; or
  - ✓ Suspected drug use by clients living in a residential setting such as a group home.
- For clients in the Division of Alcohol and Substance Abuse (DASA) contracted methadone treatment programs, drug screens are reimbursed through a contract issued by DASA, not through MAA.

CPT codes and descriptions only are copyright 2003 American Medical Association

Laboratory Services Referred by Community Mental Health Center (CMHC) or DASA-Contracted Providers

When CMHC or DASA-contracted providers refer clients enrolled in an MAA managed care plan for laboratory services, the laboratory **must bill MAA directly.** The following conditions apply:

- The laboratory service is medically necessary;
- The laboratory service is **directly** related to the client's mental health or alcohol and substance abuse;
- The laboratory service is referred by a CMHC or DASA-contracted provider who has a core provider agreement with MAA; and
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis.

To bill for laboratory services, laboratories **must** put the seven-digit CMHC or DASA-contracted referring provider identification number assigned by MAA in the "referring provider" field of the claim form.

CMHC and DASA-contracted services are excluded from MAA's managed care contracts.

Automated Multi-Channel Tests

MAA reimburses for CPT lab panel codes 80048, 80050, 80051, 80053, 80061, 80069, and 80076. The individual automated multi-channel tests are:

Procedure Code	Brief Description
82040	Albumin; serum
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Calcium; total
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol, serum, total
82550	Creatine kinase (CK)
82565	Creatine; blood
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83615	Lactate dehydrogenase (LD) (LDH)
84075	Phosphatase, alkaline
84100	Phosphorous inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum

CPT codes and descriptions only are copyright 2003 American Medical Association

Procedure Code	Brief Description
84450	Transferase; apartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Tryglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
85004	Automated diff wbc count
85007	Bl smear w/diff wbc count
85009	Manual diff wbc count b-coat
85027	Complete cbc, automated

- You may bill a combination of panels and individual tests not included in the panel. <u>However, do not bill separately for any individual tests that are included in the panel</u>. Duplicate tests will be denied. Panel codes must be billed if all individual tests in the panel are performed.

- Each test and/or panel must be billed on a separate line.

- All automated/non-automated tests must be billed on the same claim form when performed for a client by the same provider on the same day. For laboratory services that exceed the lines allowed per claim, see below.

Billing for laboratory services that exceed the lines allowed

- Providers who bill on hardcopy HCFA-1500 claim forms are allowed up to 6 lines per claim. Direct entry, magnetic tape, or electronic submitters are allowed 50 lines per claim. **Use additional claim forms if the services exceed the lines allowed**. Enter the statement: “Additional services” in field 19 when billing on a hardcopy HCFA-1500 claim form or in the *Comments* section when billing electronically. Total each claim separately.

- If MAA pays a claim with one or more automated/non-automated lab tests, providers must bill any additional automated/non-automated lab tests for the same date of service on a blue Adjustment Request form (DSHS 525-109). Make sure you adjust the claim with the paid automated/non-automated lab tests using the comment "**additional services.**"

CPT codes and descriptions only are copyright 2003 American Medical Association

Reimbursement for Automated Multi-Channel Tests

For individual automated multi-channel tests, providers are paid on the basis of the total number of individual automated multi-channel tests performed for the same client, on the same day, by the same laboratory.

- When all the tests in a panel are not performed, each test must be billed as a separate line item on the claim form.
- When there are additional automated multi-channel tests not included in a panel, each additional test must be billed as a separate line item on the claim form.
- Bill any other individual tests as a separate line item on the claim form.

Reimbursement is based on the total number of tests.

For example:

- If five individual automated tests are billed, the reimbursement is equal to the internal code's maximum allowable fee.
- If five individual automated tests and a panel are billed, MAA reimburses providers separately for the panel at the panel's maximum allowable. Reimbursement for the individual automated tests, less any duplicates, is equal to the internal code's maximum allowable fee.

If one automated multi-channel test is billed, reimbursement is at the individual procedure code or internal code's maximum allowable fee, whichever is lower. The same applies if the same automated multi-channel test is performed with modifier 91 (see page E.19 for information on modifier 91).

Non-automated Multi-Channel

Organ and disease panels (CPT codes 80055 and 80074) do not include automated multi-channel tests. If all individual tests in the panel are not performed, reimbursement is the individual procedure code maximum allowable fee or billed charge, whichever is lower.

CPT codes and descriptions only are copyright 2003 American Medical Association

The non-automated multi-channel tests are:

CPT Code	Brief Description
83718	Assay of lipoprotein
84443	Assay thyroid stim hormone
85025	Automated hemogram
85651	Rbc sed rate, nonautomated
86255	Fluorescent antibody, screen
86430	Rheumatoid factor test
86592	Blood serology, qualitative
86644	CMV antibody
86694	Herpes simplex test
86705	Hep b core antibody, test
86709	Hep a antibody, igm
86762	Rubella antibody
86777	Toxoplasma antibody
86803	Hep c ab test, confirm
86850	RBC antibody screen
86900	Blood typing, ABO
86901	Blood typing, Rh(D)
87340	Hepatitis b surface ag, eia

Laboratory Modifiers

Modifier QP

Modifier QP indicates documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT-recognized panel, other than automated profile CPT codes 80002-80019, G0058, G0059, and G0060. MAA recognizes this modifier as ***informational only***. **This modifier is <u>not</u> appropriate to use for billing repeat tests or to indicate the test was not done as a panel.**

Modifier 90

<u>Reference (Outside) Laboratory</u>: When a laboratory sends a specimen to a reference (outside) laboratory, the referring laboratory may bill for the reference laboratory (pass-through billing) by adding modifier 90 to the laboratory procedure code. *The reference laboratory provider number must be entered in the performing number field on the claim form. Both labs must be CLIA-certified.*

CPT codes and descriptions only are copyright 2003 American Medical Association

Modifier 91

Repeat Clinical Laboratory Diagnostic Test

Add modifier 91 to the laboratory procedure code when it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results.

Do not use this modifier when tests are rerun:

- To confirm initial results;
- Due to testing problems with specimens or equipment;
- For any reason when a normal, one-time, reportable result is all that is required; or
- When there are standard procedure codes available that describe the series of results (e.g., glucose tolerance test, evocative/suppression testing, etc.).

Modifier 91 affects payments. Duplicate tests billed on the same day for the same client will be denied unless modifier 91 is used.

Clinical Laboratory Codes

Some clinical laboratory codes have both a professional component and a technical component. If performing only the technical component, do not bill with a modifier. The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. Refer to MAA's fee schedule (section J) for those codes with both a technical and professional component.

Pap Smears

For professional services related to Pap smears, refer to the Cancer Screens Section (page E.12).

- Use CPT codes 88147-88154, 88164-88167, and P3000-P3001 for conventional Pap smears.

- MAA reimburses for thin layer preparation CPT codes 88142-88143 and 88174-88175. MAA does not reimburse providers for HCPCS codes G0123-G0124 and G0141-G0148. MAA reimburses for thin layer Paps at Medicare's payment levels. Thin layer preparation and conventional preparation CPT codes cannot be billed in combination.

- Use CPT codes 88141 and 88155 in conjunction with codes 88142-88143 and 88164-88167.

CPT codes and descriptions only are copyright 2003 American Medical Association

- Use the appropriate medical diagnosis if a condition is found.

- MAA reimburses providers for one routine Pap smear per client, per calendar year only. MAA considers routine Pap smears to be those billed with an ICD-9-CM diagnosis of V76.2. Any additional routine Pap smears will be denied.

HIV Testing

MAA reimburses providers for HIV testing (CPT codes 87534-87539) for ICD-9-CM diagnosis codes 042 or V08 only.

STAT Lab Charges

When the laboratory tests listed on the following page are performed on a STAT basis, the provider may bill **HCPCS code S3600** (Stat laboratory request). Reimbursement is limited to one STAT charge per episode (not once per test). Tests must be ordered STAT and payment is limited to only those that are needed to manage the client in a true emergency. The laboratory report must contain the name of the provider who requested the STAT. The medical record must reflect the medical necessity and urgency of the service.

Note: "STAT" must be clearly indicated by the provider and must be documented in the laboratory report and the client's record. Tests generated from the emergency room do not automatically justify a STAT order. Use **HCPCS code S3600** with the procedure codes on the following page.

CPT codes and descriptions only are copyright 2003 American Medical Association

The STAT charge is paid only with the tests listed below:

Procedure Code	Brief Description
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen, qualitate/multi
80101	Drug screen, single
80156	Assay, carbamazepine, total
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay primidone
80192	Assay of procainamide
80194	Assay of procainamide
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis, nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urnalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay, glucose, blood quant
83615	Lactate (LD) (LDH) enzyme
83663	Test urine for lactose

Procedure Code	Brief Description
83735	Assay of magnesium
83874	Assay of myoglobin
83880	Natriuretic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84157	Assay of protein, other
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST)(SGOT)
84484	Assay of troponin, quant
84512	Troponin qualitative
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85004	Automated diff wbc count
85007	Differential WBC count
85027	Automated hemogram
85032	Manual cell count, each
85046	Automated hemogram
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation, vte
85384	Fibrinogen
85396	Clotting assay, whole blood
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear gram stain
87210	Smear, wet mount, saline/ink
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
89051	Body fluid cell count

CPT codes and descriptions only are copyright 2003 American Medical Association

This page intentionally left blank.

CPT codes and descriptions only are copyright 2003 American Medical Association

Maternity Care and Delivery

Prenatal Assessments No Longer Covered

Effective for dates of service on and after July 1, 2004, MAA no longer reimburse providers for prenatal assessments. If a client is seen for reasons other than routine antepartum care, providers must bill using the appropriate Evaluation and Management (E&M) procedure code with a medical diagnosis code. E&M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied.

Exception: Providers must bill E&M codes for antepartum care if only 1-3 antepartum visits are done, as discussed later in these billing instructions.

Confirmation of Pregnancy

If a client presents with signs or symptoms of pregnancy and the purpose of the client's visit is to confirm the pregnancy, bill this visit using the appropriate level E&M code, assuming that the obstetrical (OB) record is not initiated. If the OB record is initiated at this visit, then the visit is considered part of the global OB package and must not be billed separately.

If some other source has confirmed the pregnancy and the provider wants to do his/her own confirmation, bill this visit using the appropriate level E&M code, assuming that the OB record is not initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately.

If the purpose of the client's visit is to confirm the pregnancy and the OB record is not initiated, bill using the diagnosis code(s) for the signs and/or symptoms the client is having [e.g. suppressed menstruation (ICD-9-CM diagnosis code 626.8)]. Do not bill using the pregnancy diagnosis codes (e.g. V22.0-V22.2) unless the OB record is initiated at this visit. If the OB record is initiated at this visit, the visit is considered part of the global package.

Global (Total) Obstetrical Care

Global OB care (CPT codes 59400, 59510, 59610, or 59618) includes:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill** using one of the global OB procedure codes.

Note: **Do not** bill MAA for maternity services until all care is completed.

CPT codes and descriptions are copyright 2003 American Medical Association

Unbundling Obstetrical Care

In the situations described below, you may not be able to bill MAA for global OB care. In these cases, it may be necessary to "unbundle" the OB services and bill the antepartum, delivery, and postpartum care separately, as MAA may have paid another provider for some of the client's OB care, or you may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to your practice late in the pregnancy…

- If the client has had antepartum care elsewhere, you must not bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care bills for the services that he/she performed. Therefore, if you bill the global OB package, you are billing for some antepartum care that another provider has claimed.

- OR -

- If the client did not receive any antepartum care prior to coming to your office, bill the global OB package.

  In this case, you may actually perform all of the components of the global OB package in a short time. MAA does not require you to perform a specific number of antepartum visits in order to bill for the global OB package.

If your client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy…

Only those services you actually provided to these clients may be billed to MAA.

If your client changes insurance during her pregnancy…

Often, a client is fee-for-service at the beginning of her pregnancy, and then is enrolled in an MAA managed care plan for the remainder of her pregnancy. MAA is responsible for reimbursing only those services provided to the client while she is on fee-for-service. The plan reimburses for services provided after the client is enrolled with the plan.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. You must unbundle the services and bill the antepartum, delivery, and postpartum care separately.

CPT codes and descriptions are copyright 2003 American Medical Association

Antepartum Care

Per CPT guidelines, MAA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history;
- Physical examination;
- Recording of weight and blood pressure;
- Recording of fetal heart tones;
- Routine chemical urinalysis; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

Coding for Antepartum Care Only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of **E&M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

  Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a **total** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the “to and from” fields.

- If the client had a **total** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the “to and from” fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).

CPT codes and descriptions are copyright 2003 American Medical Association

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

Note: Do not bill MAA until all antepartum services are complete.

Coding for Deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, you must bill MAA using one of the following CPT codes:

- 59409 (vaginal delivery only);
- 59514 (cesarean delivery only);
- 59612 [vaginal delivery only, after previous cesarean delivery (VBAC)]; or
- 59620 [cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery (attempted VBAC)].

If you do not provide antepartum care, but perform the delivery and provide postpartum care, bill MAA one of the following CPT codes:

- 59410 (vaginal delivery, including postpartum care);
- 59515 (cesarean delivery, including postpartum care);
- 59614 (VBAC, including postpartum care); or
- 59622 (attempted VBAC, including postpartum care).

Coding for Postpartum Care Only

If it is necessary to unbundle the OB package and bill for postpartum care only, you must bill MAA using CPT code 59430 (postpartum care only).

If you provide all of the antepartum and postpartum care, but do not perform the delivery, bill MAA for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

CPT codes and descriptions are copyright 2003 American Medical Association

Additional Monitoring for High-Risk Conditions

When providing **additional monitoring** for high-risk conditions in excess of the CPT guidelines for normal antepartum visits, bill using E&M **codes 99211-99215 with modifier TH.** The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

A condition that is classifiable as high-risk **alone** does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits. **For example:**

> Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier TH, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.

Labor Management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed all of the client's antepartum care, admitted the client to the hospital during labor, delivered the baby, and performed the postpartum care, **do not** bill MAA for the hospital admission or for labor management. These services are included in the global OB package.

If, however, you performed all of the client's antepartum care and admitted the client to the hospital during labor, but another provider (outside of your group practice) takes over delivery, you must unbundle the global OB package and bill separately for antepartum care, the hospital admission, and the time spent managing the client's labor. The client must be in active labor and admitted to a hospital when the referral to the delivering provider is made.

CPT codes and descriptions are copyright 2003 American Medical Association

To bill for labor management in the situation described above, bill MAA for one of the hospital admission CPT **codes 99221-99223 with modifier TH**. In addition to the hospital admission, MAA reimburses providers for **up to three hours** of labor management using prolonged services CPT **codes 99354-99357 with modifier TH**. Reimbursement for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice**.

Note: The hospital admission code and the prolonged services code(s) **must** be billed on the same claim form.

High-Risk Deliveries

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, MAA reimburses providers an additional add-on fee. Bill the high-risk add-on fee by **adding modifier TG to the delivery code** (e.g. 59400 TG or 59409 TG).

Modifier TG: Complex/high level of care

The ICD-9-CM diagnosis code **must clearly** demonstrate the medical necessity for the high-risk delivery add-on (e.g. a diagnosis of fetal distress). A normal delivery diagnosis is not paid an additional high-risk add-on fee, even if the mother had a high-risk condition during the antepartum period.

Bill only ONE line of service (e.g. 59400 TG) to receive reimbursement for BOTH the delivery and the high-risk add-on. DO NOT bill the delivery code (e.g. 59400) on one line of the claim form and the high-risk add-on (e.g. 59400 TG) on a second line of the claim form.

A physician who provides stand-by attendance for high-risk delivery can bill CPT code 99360 and resuscitation CPT code 99440, when appropriate.

Note: MAA **does not** reimburse an assistant surgeon, RNFA, or co-surgeon for a high-risk delivery add-on. Reimbursement is limited to one per client, per pregnancy (even in the case of multiple births).

CPT codes and descriptions are copyright 2003 American Medical Association

Consultations

If another provider refers a client during her pregnancy for a consultation, bill MAA using consultation CPT codes 99241-99255. If a follow-up consultation is necessary, bill using CPT codes 99261-99263. You **must** list the referring physician's name and MAA-assigned provider number in the "Referring Physician" field on the claim form.

If the consultation results in the decision to perform surgery (i.e. a cesarean section), MAA reimburses the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill MAA the appropriate consultation code.

- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill MAA the appropriate **consultation code with modifier 57** (e.g. 99241-57).

MAA does not reimburse the consulting physician if the following applies:

- If the consulting physician performs the cesarean section and does the consultation **the day before or the day of the cesarean section**, the consultation is bundled within payment for the surgery. **Do not bill** MAA for the consultation in this situation.

Bill consultations with an appropriate ICD-9-CM medical diagnosis code. You must demonstrate the medical necessity (i.e. sign, symptom, or condition). MAA does not reimburse providers for a consultation with a normal pregnancy diagnosis code (e.g. V22.0-V22.2).

MAA reimburses consulting OB/GYN providers for an external cephalic version (CPT code 59412) and a consultation when performed on the same day.

General Obstetrical Payment Policies and Limitations

- MAA reimburses a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, you must bill using the delivery-only code (CPT code 59409 or 59612) for each additional baby. Reimbursement for each additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form as "twin A" or "twin B," etc.

- MAA reimburses for multiple births by cesarean delivery at 100% for the first baby. No additional reimbursement will be made for additional babies.

CPT codes and descriptions are copyright 2003 American Medical Association

- An assistant surgeon may bill for an assist at c-section by adding modifier 80, 81, or 82 to the delivery only code (e.g. 59514-80). Reimbursement is 20% of the delivery-only code's maximum allowance.

- Physician assistants (PA) must bill for an assist at c-section **on the same claim form** as the physician performing the delivery by adding modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80). The claim must be billed using the delivering physician's provider number.

- RNFAs assisting at c-sections may **only** bill using CPT code 59514 or 59620 with modifier 80.

- To bill for anesthesia during delivery, see the Anesthesia Section (page F.26).

- For deliveries in a birthing center, refer to MAA's Births in Birthing Centers Billing Instructions. For deliveries in a home birth setting, refer to MAA's Planned Home Births Billing Instructions.

Note: Maternity Support Services/Infant Case Management (MSS/ICM) is a program designed to help pregnant women and their newborns gain access to medical, social, educational and other services. This program provides a variety of services for both the woman and/or her child in the home or clinic throughout pregnancy and up to 60 days after delivery. For information on MSS/ICM, call MAA's Family Services Section at (360) 725-1655.

For your convenience, a table summarizing "Billing MAA for Maternity Services" is included on the following pages.

CPT codes and descriptions are copyright 2003 American Medical Association

Global (Total) Obstetrical (OB) Care

Service	Procedure Code/Modifier	Summary of Description	Limitations
Confirmation of pregnancy	99201-99215	Office visits	Code the sign or symptom (e.g. suppressed menstruation)
Global OB care	59400	Total OB care, vaginal delivery	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple bills must be billed with the appropriate delivery-only code.
	59510	Total OB care, c-section	
	59610	Total OB care, VBAC	
	59618	Total OB care, attempted VBAC	

Antepartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Antepartum care (bill **only one** of these codes to represent the total number of times you saw the client for antepartum care)	99201-99215 TH	Offices visits, antepartum care 1-3 visits only, with OB service modifier	Limited to 3 units when used for routine antepartum care. Must bill with modifier TH.
	59425	Antepartum care, 4-6 visits	Limited to one unit per client, per pregnancy, per provider
	59426	Antepartum care, 7+ visits	Limited to one unit per client, per pregnancy, per provider.

Deliveries

Service	Procedure Code/Modifier	Summary of Description	Limitations
Delivery only	59409	Vaginal delivery only	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.
	59514	C-Section delivery only	
	59612	VBAC delivery only	
	59620	Attempted VBAC delivery only	
Delivery with postpartum care	59410	Vaginal delivery including postpartum care	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.
	59515	C-Section delivery with postpartum care	
	59614	VBAC including postpartum care	
	59622	Attempted VBAC including postpartum care	

CPT® codes and descriptions are copyright 2003 American Medical Association

Postpartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Postpartum care only	59430	Postpartum care only	Must not be billed with any other codes that include postpartum care; limited to one per client, per pregnancy.

Additional Monitoring for High-Risk Conditions

Service	Procedure Code/Modifier	Summary of Description	Limitations
Additional visits for antepartum care due to high-risk conditions	99211-99215 TH	Office visits with OB service modifier	Must not be billed with a normal pregnancy diagnosis (V22.0-V22.2); diagnosis must detail need for additional visits; must be billed with modifier TH.

Labor Management

Service	Procedure Code/Modifier	Summary of Description	Limitations
Labor management (may only be billed when another provider takes over and delivers the infant)	99221-99223 TH	Hospital admit services with OB services modifier	Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; **must not be billed by delivering provider**. Admit code with modifier TH and the prolonged services code(s) **must be billed on the same claim form.**
	+99356 **Limited to 1 unit**	Prolonged services, inpatient setting, 1st hour	
	+99357 **Limited to 4 units**	Prolonged services, inpatient setting, each add'l 30 minutes	

High-Risk Deliveries

Service	Procedure Code/Modifier	Summary of Description	Limitations
High-risk delivery *[Not covered for assistant surgeons, co-surgeons, or RNFA]*	Add modifier TG to the delivery code (e.g. 59400 TG)	Complex/high level of care	Diagnosis must demonstrate medical necessity; not paid with normal delivery diagnosis; limited to one per client, per pregnancy. Bill only **ONE** line of service (e.g. 59400 TG) for **BOTH** the delivery and high-risk add-on.

CPT® codes and descriptions are copyright 2003 American Medical Association

Smoking Cessation for Pregnant Women

MAA reimburses providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit for tobacco dependent eligible pregnant women.

What is Smoking Cessation Counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy, as needed (see next page); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling.

Managed Care: Tobacco dependent, pregnant women who are enrolled in a managed care plan must have services arranged and referred by their primary care provider (PCP). Clients covered under a managed care plan will have a plan indicator in the HMO column on their Medical Identification card. Do not bill MAA for Smoking Cessation Counseling as it is included in the managed care plans' reimbursement rates.

Who is eligible to be reimbursed for smoking cessation counseling?

MAA will reimburse only the following providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians;
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

CPT codes and descriptions are copyright 2003 American Medical Association

What is covered?

MAA allows one smoking cessation counseling session per client, per day, up to 10 sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on the following page.

MAA covers two levels of counseling:

- Basic counseling (approximately 15 minutes) which includes Steps 1-3 on previous page; and
- Intensive counseling (approximately 30 minutes) which includes Steps 1-5 on previous page.

Use the most appropriate procedure code from the following chart when billing for smoking cessation:

CPT Procedure Code	Brief Description	Restricted to Diagnoses:
99401	Preventive counseling, indiv [approximately 15 minutes]	648.43 (antepartum) 648.44 (postpartum)
99402	Preventive counseling, indiv [approximately 30 minutes]	648.43 (antepartum) 648.44 (postpartum)

A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. MAA covers pharmacotherapy for smoking cessation as follows:

- MAA covers Zyban® only;
- The product must be prescribed by a physician, ARNP, or PA;
- The client for whom the product is prescribed must be 18 years of age or older;
- The **pharmacy provider must obtain prior authorization** from MAA when filling the prescription for pharmacotherapy; and
- The provider must include both of the following on the client's prescription:

  - ✓ The client's estimated or actual delivery date; and
  - ✓ Notation that the client is participating in smoking cessation counseling.

To obtain prior authorization for Zyban®, pharmacy providers must call:

Drug Utilization and Review
1-800-848-2842

CPT codes and descriptions are copyright 2003 American Medical Association

Smoking Cessation Form Here

CPT codes and descriptions are copyright 2003 American Medical Association

Abortion Services (Drug Induced)

- Methotrexate and misoprostol are two drugs approved by the Food and Drug Administration (FDA) for use in inducing abortions.

  ✓ J9260 Methotrexate sodium, 50 mg
  ✓ S0191 Misoprostol, oral, 200 mcg

- When these drugs are used for abortion services, providers must bill using the appropriate ICD-9-CM abortion diagnosis code. Other medical services (laboratory, history/physical, ultrasound, etc.) performed at the time of the drug administration must be billed on the same claim as the abortion drugs.

- Rho(D) immune globulin must be billed using the appropriate HCPCS codes.

- **RU-486 Abortion Drug**

  MAA pays for RU-486 for medically induced abortions provided through physicians' offices using the codes in the following table. Office visits, laboratory tests, and diagnostic tests performed for the purpose of confirming pregnancy, gestational age, and successful termination must be billed on the same claim form as the abortion drugs.

Bill HCPCS Code	Description
S0190	Mifepristone, oral, 200 mg
S0191	Misoprostol, oral, 200 mcg

Abortion Center Contracts (Facility Fees)

- For providers who currently have an abortion center contract with MAA, facility fees are payable only for surgical abortions. Do not bill facility fee charges for drug-induced abortions not requiring surgical intervention.

- Contracted facility fee reimbursement includes all room charges, equipment, supplies, and drugs (including anti-anxiety, anesthesia, and pain medications, but excluding Rho(D) immune globulins). **Reimbursement is limited to one special agreement facility fee per client, per abortion.** The facility fee is not payable per visit, even though a particular procedure or case may take several days or visits to complete.

CPT codes and descriptions are copyright 2003 American Medical Association

Chemotherapy Services [Refer to WAC 388-531-0950(11)]

Chemotherapy Administration

When chemotherapy is administered in the physician's office, but there is no face-to-face contact with the physician, CPT E&M code 99211 may be used to bill for this service if:

- The physician personally supervises the services furnished by office medical staff; and
- The client's medical record reflects the physician's active participation in or management of treatment.

If a significant, separately identifiable E&M service is performed on the same day as chemotherapy administration, the appropriate E&M code may be reported in addition to the chemotherapy administration codes (CPT codes 96400-96549).

Chemotherapy administration, push technique (CPT code 96408), may be reported **for each drug administered.**

Chemotherapy Drugs

The following reimbursement guidelines apply to chemotherapy drugs (HCPCS codes J9000-J9999):

- MAA's maximum allowable fee per unit is based on the HCPCS description of the chemotherapy drug.
- MAA's maximum allowable fee is equal to 86% of the average wholesale price (AWP) or Medicare's rates, whichever is less.
- Preparation of the chemotherapy drug is included in the administration of the drug.

Billing for Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, MAA reimburses providers for the total number of units contained in the vial. **For example:**

> If a total of 150 mg of Etoposide is required for the therapy, and two 100 mg single dose vials are used to obtain the total dosage, then the total of the two 100 mg vials is reimbursed. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If MAA's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

CPT codes and descriptions are copyright 2003 American Medical Association

Billing for Multi-Dose Vials:

For multi-dose vials, bill **only** the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, MAA reimburses providers for only the amount of drug administered to the client. **For example:**

> If a total of 750 mg of Cytarabine is required for the therapy, and is taken from a 2,000 mg multi-dose vial, then only the 750 mg administered to the client is reimbursed. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If MAA's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

Unlisted Drugs:

When it is necessary to bill MAA for a chemotherapy drug using an unlisted drug code, you must report the National Drug Code (NDC) of the drug administered to the client. MAA uses the NDC when unlisted drug codes are billed in order to appropriately price the claim. Claims must include:

- The dosage (amount) of the drug administered to the client; and
- The 11-digit NDC of the office-administered drug.

For claims billed using a paper HCFA-1500 claim form, list the required information in field 19 of the claim form.

For claims billed using an electronic HCFA-1500 claim form, list the required information in the *Comments* section of the claim form.

For claims billed using an electronic 837P claim form, list the required NDC information in DRUG IDENTIFICATION Loop 2410, LIN02, and LIN03. List the dosage given to the client in the *Comments* section of the claim form.

Note: If there is an assigned HCPCS code for the administered drug, you **must bill** MAA using the appropriate HCPCS code. **DO NOT** use an unlisted drug code to bill for a drug that has an assigned HCPCS code. MAA will recoup payment for any drugs paid using an unlisted drug code if an assigned HCPCS code exists for the administered drug.

CPT codes and descriptions are copyright 2003 American Medical Association

Invoice Requirements

A copy of the manufacturer's invoice showing the **actual acquisition cost** of the drug must be attached to the claim **ONLY** when billed charges exceed $1,100.00 per line item. If billed charges are less than $1,100.00 per line item, **DO NOT** attach the invoice or any other paperwork to your claim. If needed, MAA will request any other necessary documentation after receipt of the claim.

This requirement applies to **all drugs** administered in the provider's office, including those drugs with an assigned CPT or HCPCS code, and those drugs billed using either unlisted drug code J3490 or J9999.

A copy of any manufacturer's invoices for all drugs (regardless of billed charges) must be maintained in the client's record and made available to MAA upon request.

Oral Anti-Emetic Drugs

In order to bill MAA for oral anti-emetic drugs (HCPCS codes Q0163-Q0181) the drug must be:

- Part of a chemotherapy regimen;
- Administered or prescribed for use immediately before, during, or within 48 hours after administration of the chemotherapy drug;
- Billed using one of the ICD-9-CM diagnosis codes 140.0-239.9 (excluding 210.0-229.9) or V58.1; and
- Submitted on the same claim form with one of the chemotherapy drug codes (HCPCS codes J8530-J9999).

Hydration Therapy with Chemotherapy

Intravenous (IV) infusion of saline (CPT codes 90780-90781) is not reimbursed separately when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate reimbursement is allowed for IV infusion when administered separately from the chemotherapy infusion. In this case, bill using the IV infusion code with modifier 59.

CPT codes and descriptions are copyright 2003 American Medical Association

Surgical Services [Refer to WAC 388-531-1700]

Global surgery reimbursement includes all the following services:

- The surgical procedure;
- For major surgeries (90-day global period), preoperative visits (all sites of service) that occur the day before or the day of the surgery;
- For minor surgeries (less than 90-day global period), preoperative visits (all sites of service) that occur on the day of surgery;
- Services by the primary surgeon (all sites of service) during the postoperative period;
- Postoperative dressing changes, including:
  - ✓ Local incision care and removal of operative packs;
  - ✓ Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints;
  - ✓ Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes; and
  - ✓ Change and removal of tracheostomy tubes.
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

> ☞ **Note:** Casting materials are not part of the global surgery policy and are paid separately.

Global Surgery Reimbursement

- The global surgery reimbursement period applies to any provider who participates in the surgical procedure. These providers include:
  - ✓ The surgeon;
  - ✓ The assistant surgeon (modifiers 80, 81, or 82);
  - ✓ Two surgeons (modifier 62);
  - ✓ Team surgeons (modifier 66); and
  - ✓ Anesthesiologists and CRNAs.

CPT codes and descriptions are copyright 2003 American Medical Association

- The following procedure codes are bundled within the payment for the surgical procedure during the global period:

Procedure Code	Summary of Description
E&M Services	
99211-99223	Office visits, initial hospital observation care, and initial hospital inpatient care.
99231-99239	Subsequent hospital care, observation or inpatient care services, and hospital discharge services.
99241-99245	Office consultations
99251-99255	Initial inpatient consultations
99261-99263	Follow-up inpatient consultations
99271-99275	Confirmatory consultations
99291-99292	Critical care services.
99301-99303	Comprehensive nursing facility assessments
99311-99316	Subsequent nursing facility care
99331-99333	Domiciliary, rest home, or custodial care services
99347-99350	Home services
99374-99377	Care plan oversight services
Ophthalmological Services	
92012-92014	General ophthalmological services

The E&M codes listed above may be allowed if there is a separately identifiable reason for the additional E&M service unrelated to the surgery. In these cases, the E&M code must be billed with one of the following modifiers:

Modifier	Description
24	Unrelated E&M service by the same physician during a postoperative period (reason for the E&M service must be unrelated to the procedure)
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure (reason for the E&M service must be unrelated to the procedure)
57	Decision for surgery (only applies to surgeries with a 90-day global period)
79	Unrelated procedure or service by the same physician during the postoperative period

- Professional inpatient services (CPT codes 99221-99223) are payable only during the global follow-up period if they are performed on an emergency basis (i.e. they are not payable for scheduled hospital admissions).

CPT codes and descriptions are copyright 2003 American Medical Association

- Bundled procedure codes are not payable during the global surgery reimbursement period.

- A provider (other than the surgeon) who provides all postoperative care (including all inpatient postoperative care) before discharge, must bill subsequent hospital care codes (CPT codes 99231-99233) for the inpatient hospital care, and the surgical code with modifier 55 for the post-discharge care. The surgeon must bill the surgery code with modifier 54.

- Providers who perform only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level E&M code. These services are not included in the global surgical reimbursement.

- The provider who performs the emergency room service must bill for the surgical procedure without using modifier 54.

- Preoperative and postoperative critical care services provided during a global period for a seriously ill or injured client are not considered related to a surgical procedure and are paid separately when all of the following apply:

  - ✓ The client is critically ill or injured and requires the constant attendance of the provider;
  - ✓ The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and
  - ✓ The client is potentially unstable or has conditions that could pose a significant threat to life or risk of prolonged impairment.

  Bill the appropriate critical care codes with either modifier 24 or 25.

- MAA allows separate reimbursement for:

  - ✓ The initial evaluation to determine need for surgery;
  - ✓ Preoperative visits that occur two or more days before the surgery;
  - ✓ Postoperative visits for problems unrelated to the surgery;
  - ✓ Postoperative visits for services that are not included in the normal course of treatment for the surgery; and
  - ✓ Services of other providers, except when more than one provider furnishes services that are included in a global package (see modifiers 54 and 55).

CPT codes and descriptions are copyright 2003 American Medical Association

Registered Nurse First Assistants (RNFA)

Registered Nurse First Assistants (RNFAs) are allowed to assist at surgeries within their scope of practice. Use modifier 80 to bill MAA for these services. Current RNFA providers who want to assist at surgeries need to submit their Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing to:

Provider Enrollment
PO Box 45562
Olympia, Washington 98504-5562

New RNFA providers must meet the following criteria:

- Licensed in Washington State as a Registered Nurse in good standing;
- Work under the direct supervision of the performing surgeon; and
- Submit the following documentation to MAA along with the Core Provider Agreement:
  - ✓ Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing;
  - ✓ Proof of Allied Health Personnel privileges in the hospital where the surgeries are performed; and
  - ✓ Certification as an RNFA from the Certification Board of Perioperative Nursing.

RNFAs who are current providers or who wish to bill only for cesarean sections (CPT codes 59514 and 59620) **do not need** to submit the Certification as an RNFA from the Certification Board Perioperative Nursing.

Multiple Surgeries

When multiple surgeries are performed on the same client, during the same operative session, MAA reimburses providers as follows:

- 100% of MAA's maximum allowable fee for the most expensive procedure; plus,
- 50% of MAA's maximum allowable fee for each of the second through the fifth procedures.

To expedite payment of your claims, bill all surgeries performed during the same operative session on the same claim.

If a partial payment is made on a claim with multiple surgeries, you must adjust your paid claim using a blue Adjustment Request form (DSHS 525-109).

CPT codes and descriptions are copyright 2003 American Medical Association

Endoscopy Procedures

Endoscopy procedures are paid as follows:

- When multiple endoscopies from the same endoscopy group are performed on the same day, the procedure with the highest maximum allowable fee is paid the full amount. The second, third, etc., are paid at the maximum allowable amount minus the base endoscopy procedure's allowed amount.

- When multiple endoscopies from different endoscopy groups are billed, the multiple surgery rules detailed above apply.

- When payment for other procedures within an endoscopy group is less than the endoscopy base code, no payment is made.

- MAA does not reimburse for an E&M visit on the same day as the diagnostic or surgical endoscopy procedure unless there is a separately identifiable service unrelated to the endoscopy procedure. If appropriate, bill the E&M code with modifier 25.

Other Surgical Policies

- Use modifiers 80, 81 and/or 82 to bill for an assistant surgeon. An assist at major surgery is paid at 20% of the surgical procedure's maximum allowable fee. The multiple surgery rules apply for surgery assists.

- A properly completed consent form must be attached to all claims for sterilization and hysterectomy procedures (see Section H).

- MAA reimburses for the use of an operating microscope (CPT code 69990) only when billed with one of the following CPT codes:

  - ✓ 61304-61546;
  - ✓ 61550-61711;
  - ✓ 62010-62100;
  - ✓ 63081-63308;
  - ✓ 63704-63710; or
  - ✓ 64831-64907.

CPT codes and descriptions are copyright 2003 American Medical Association

- The surgeries listed in the following table are limited as follows:

CPT Code(s)	Description	Limitations
11960	Insertion of tissue expander(s)	Limited to ICD-9-CM diagnoses: ✓ V10.3; ✓ 140.0-239.9; ✓ 757.6; ✓ 759.4; ✓ 906.5-906.9; or, ✓ 940.0-949.5.
11970	Replace tissue expander	
11971	Remove tissue expander(s)	
19160	Removal of breast tissue	
19162	Remove breast tissue, nodes	
19180	Removal of breast	
19182	Removal of breast	
19316	Suspension of breast	
19340	Immediate breast prosthesis	
19342	Delayed breast prosthesis	
19350	Breast reconstruction	
19357	Breast reconstruction	
19361	Breast reconstruction	
19364	Breast reconstruction	
19366	Breast reconstruction	
19367	Breast reconstruction	
19368	Breast reconstruction	
19369	Breast reconstruction	
19370	Surgery of breast capsule	
19371	Removal of breast capsule	
19380	Revise breast reconstruction	

- Subcutaneous hormone pellet implantation (CPT code 11980) is payable only with ICD-9-CM diagnosis codes 174-174.9 or 257.2.

- Salpingostomies (CPT codes 58673 and 58770) are payable only for a tubal pregnancy (ICD-9-CM diagnosis code 633.1, 633.10, and 633.11).

- Modifier 53 must be used when billing for incomplete colonoscopies (CPT code 45378, or HCPCS codes G0105 or G0121). Do not bill incomplete colonoscopies as sigmoidoscopies. Modifier 53 indicates that the physician elected to terminate a surgical procedure. Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 or HCPCS codes G0105 or G0121 only. It is "informational only" for all other surgical procedures.

Epiphyseal

Epiphyseal surgical procedures (CPT codes 25450, 25455, 27185, 27475, 27477-27485, 27742, and 27730-27740) are allowed only for clients age 17 and younger.

CPT codes and descriptions are copyright 2003 American Medical Association

Closure of Enterostomy

Mobilization of splenic flexure (CPT code 44139) is not reimbursed when billed with enterostomy procedures (CPT codes 44625 and 44626). CPT code 44139 must be used only in conjunction with partial colectomy (CPT codes 44140 through 44147).

Angioscopy

MAA reimburses for one unit of angioscopy (CPT code 35400), per session.

Apheresis

Therapeutic apheresis (CPT codes 36511-36512) includes payment for all medical management services provided to the client on the date of service. MAA reimburses for only one unit of either CPT code per client, per day, per provider.

Separate payment is not allowed for the following procedures on the same date that therapeutic apheresis services are provided, unless they are billed with modifier 25:

- Established patient office and other outpatient visits (CPT codes 99211-99215);
- Subsequent hospital care (CPT codes 99231-99233); and
- Follow-up inpatient consultations (CPT codes 99261-99263).

Do not bill apheresis management when billing for critical care time (CPT codes 99291-99292).

Urology

Circumcisions (CPT codes 54152 and 54161)

Circumcisions are only allowed for one of the following diagnoses:

- Phimosis (ICD-9-CM 605);
- Balanoposthitis (ICD-9-CM 607.1); or
- Balnitis Xerotica (ICD-9-CM 607.81).

CPT codes and descriptions are copyright 2003 American Medical Association

Urinary Tract Implants

Prior to inserting a urinary tract implant (CPT code 51715), the provider must:

- Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.
- Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.
- Administer and evaluate a skin test for collagen sensitivity (CPT code 95028) over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client's record.

Refer to Section K for those urinary tract implants covered by MAA. **All services provided and implant codes must be billed on the same claim form**

Urological Procedures with Sterilizations in the Description

These procedures may stop in MAA's payment system as a result of MAA's effort to remain in compliance with federal sterilization consent form requirements. If the surgery is not being done for the purpose of sterilization, or the sterilizing portion of the procedure is not being performed, a sterilization consent form is not required. However, you must note one of the following in the *Comments* section of your claim:

- Not sterilized; or
- Not done primarily for the purpose of sterilization.

Indwelling Catheter

- Separate payment is allowed for insertion of a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office.
- Bill for the insertion of the indwelling catheter using CPT code 51702 or 51703.
- MAA reimburses providers for insertion of an indwelling catheter only when performed in an office setting.
- Insertion of an indwelling catheter is bundled when performed on the same day as a major surgery.
- Insertion of an indwelling catheter is bundled when performed during the post-operative period of a major surgery.

CPT codes and descriptions are copyright 2003 American Medical Association

Bilateral Procedures

- If a procedure is done bilaterally and is not identified by its terminology as a bilateral procedure, bill the procedure with modifier 50. Bill as a single line item on the claim.
- If a procedure is done bilaterally and is identified by its terminology as bilateral (e.g. CPT codes 27395 or 52290), do not bill the procedure with modifier 50.
- Use Modifiers LT and RT to indicate left and right for unilateral procedures.

Pre-/Intra-/Postoperative Payment Splits

Pre-, intra-, and postoperative payment splits are made when modifiers 54, 55, and 56 are used.

MAA has adopted Medicare's payment splits, as listed below. If Medicare has not assigned a payment split to a procedure, MAA uses a payment split of 10% / 80% / 10%.

Code Range	Operative System	Pre-	Intra-	Postoperative
10000 - 19499	Integumentary	10%	71%	19%
20000 - 29909	Musculoskeletal	10%	69%	21%
30000 - 32999	Respiratory	10%	76%	14%
33010 - 37788	Cardiovascular	09%	84%	07%
37790 - 37799	Cardiovascular	08%	83%	09%
38100 - 38115	Hemic/Lymphatic	11%	73%	16%
38120 - 38300	Hemic/Lymphatic	09%	84%	07%
38305 - 38999	Hemic/Lymphatic	11%	73%	16%
39000 - 39599	Mediastinum/Diaphragm	09%	84%	07%
40490 - 43641	Digestive	09%	81%	10%
43651 - 43652	Digestive	11%	76%	13%
43653 - 49999	Digestive	09%	81%	10%
50010 - 53899	Urinary	08%	83%	09%
54000 - 55980	Male Genital	10%	80%	10%
56300 - 56399	Laparoscopy/Hysteroscopy	09%	81%	10%
56405 - 58999	Female Genital	12%	74%	14%
59000 - 59899	Maternity	17%	60%	23%
60000 - 60605	Endocrine	09%	82%	09%
60650 - 60699	Endocrine	09%	84%	07%
61000 - 64999	Nervous System	11%	76%	13%
65091 - 68899	Eye/Occular	10%	70%	20%
69000 - 69979	Auditory	07%	79%	14%

CPT codes and descriptions are copyright 2003 American Medical Association

Anesthesia [Refer to WAC 388-531-0300]

General Anesthesia

- MAA requires providers to use anesthesia CPT codes 00100-01999 to bill for anesthesia services paid with base and time units. Providers **must not use** the surgical procedure code with an anesthesia modifier to bill for the anesthesia procedure.

- MAA reimburses for CPT code 01922 for noninvasive imaging or radiation therapy when:

  - ✓ The client is 17 years of age or younger; or
  - ✓ There are client-specific reasons why the procedure cannot be performed without anesthesia services. Documentation must be kept in the client's medical record.

- MAA reimburses providers for covered anesthesia services performed by one of the following:

  - ✓ Anesthesiologist;
  - ✓ Certified registered nurse anesthetist (CRNA); or
  - ✓ Other providers who have a contract with MAA to provide anesthesia services.

- For each client, the anesthesia provider must:

  - ✓ Perform a pre-anesthetic examination and evaluation;
  - ✓ Prescribe the anesthesia plan;
  - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, induction and emergence;
  - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform are done by a qualified individual as defined in program operating instructions;
  - ✓ Monitor the course of anesthesia administration at frequent intervals;
  - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
  - ✓ Provide indicated post-anesthesia care.

- In addition, the anesthesia provider may direct no more than four anesthesia services concurrently. The anesthesia provider may not perform any other services while directing these services, other than attending to medical emergencies and other limited services as allowed by Medicare policy.

- The anesthesia provider must document in the client's medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate these requirements.

CPT codes and descriptions are copyright 2003 American Medical Association

- Anesthesia time begins when the anesthesia provider starts to physically prepare the client for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed as long as there is continuous monitoring of the client within the blocks of time. Examples of this include, but are not limited to: time a client spends in an anesthesia induction room or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesia provider or surgeon is no longer in constant attendance (i.e. when the client can be safely placed under postoperative supervision).

- Do not bill CPT codes 01953 or 01996 with an anesthesia modifier or with the time in the "units" field. MAA has assigned flat fees for these codes.

- MAA allows the following two anesthesia codes published in the American Society of Anesthesiology (ASA) Relative Value Guide (RVG):

ASA Code	Description
02100	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
02101	Anesthesia for diagnostic or therapeutic nerve blocks and injections-patient in the prone position (when block or injection is performed by a different provider)

Use these ASA codes only when a provider, other than the one performing the block or the injection, administers anesthesia.

- MAA does not adopt any other ASA RVG codes that are not included in the CPT book. Bill all other anesthesia codes according to the descriptions published in the CPT book. When there are differences in code descriptions between the CPT book and the ASA RVG, MAA follows CPT code descriptions.

- MAA does not reimburse providers for anesthesia services when these services are billed using the CPT surgery, radiology, and/or medicine codes with anesthesia modifiers. **Continue to use the appropriate anesthesia modifier with anesthesia CPT and ASA codes.**

Exception: Anesthesia providers may bill CPT Pain Management/Other Services procedure codes that are not paid with base and time units. These services are reimbursed as a procedure using RBRVS methodology. Do not bill time in the unit field or use anesthesia modifiers.

- When billing anesthesia for surgical abortions (CPT code 01964), you must indicate in the *Comments* section of the claim form "voluntary or induced abortion."

- Do not bill CPT codes 00800-00882 or 00920-00952 for abortions, hysterectomies, or sterilization procedures. Use the appropriate CPT code.

CPT codes and descriptions are copyright 2003 American Medical Association

- When multiple surgical procedures are performed during the same period of anesthesia, bill the surgical procedure with the greatest base value, along with the total time in whole minutes.

- When more than one anesthesia provider is present, MAA pays each provider 50% of the allowed amount. MAA limits reimbursement in this circumstance to 100% of the total allowed reimbursement for the service.

- Providers must report the number of actual anesthesia minutes (calculated to the next whole minute) in the appropriate field of the claim form. MAA calculates the base units.

Regional Anesthesia

- Bill MAA the appropriate procedure code (e.g. epidural CPT code 62319) with no time units and no anesthesia modifier. MAA determines payment by using the procedure's maximum allowable fee, not anesthesia base and time units.

- Local nerve block CPT code 64450 (other than digital and metacarpal) for subregional anatomic areas (such as the hand, wrist, ankle, foot and vagina) is included in the global surgical package and is not reimbursed separately.

Other

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.

- MAA follows Medicare's policy to not reimburse surgeons for anesthesia services. Claims for anesthesia services with modifier 47 will be denied. Under Medicare's payment policy, **separate reimbursement** for local, regional, or digital block or general anesthesia administered by the surgeon is not allowed. These services are considered included in the RBRVS payments for the procedure.

- When billing for anesthesia services using CPT **unlisted anesthesia code 01999**, **providers must attach documentation** (operative report) **to their claim** indicating what surgical procedure was performed that required the anesthesia in order to receive reimbursement. MAA will determine payment amount after review of the documentation.

CPT codes and descriptions are copyright 2003 American Medical Association

Anesthesia for Maternity [Refer to WAC 388-531-0300(9)]

- MAA reimburses a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or cesarean section delivery.

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).

- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.

- CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for 01968 and an additional base of 5 is allowed for 01969, in conjunction with the base of 6 for 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code. For example, if an epidural anesthetic is given to a client in labor for three hours while a vaginal delivery is still planned, the provider will report 01967 with a total time of 180 minutes. If the provider decides a cesarean section is then necessary, and the cesarean portion of the procedure takes an additional 30 minutes, the provider will report CPT code 01968 with a total time of 30 minutes on another line of the claim form. The provider will be reimbursed for a grand total of 9 base units and 210 minutes.

- The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT codes 01962, 01963, 01964 and 01969.

- Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately.

Anesthesia Payment Calculation for Services Paid with Base and Time Units

- MAA's current anesthesia conversion factor is $20.24.

- Anesthesia time is paid using **one minute per unit**.

- Total anesthesia reimbursement is calculated by adding the base value for the anesthesia procedure with the actual time. Bill time in **total minutes** only, rounded to the next whole minute. Do not bill the procedure's base units.

CPT codes and descriptions are copyright 2003 American Medical Association

The following table illustrates how to calculate the anesthesia payment:

Payment Calculation	
A.	Multiply base units by 15.
B.	Add total minutes to value from step A.
C.	Divide anesthesia conversion factor by 15, to obtain the rate per minute.
D.	Multiply total from Step B by the rate per minute in Step C.

Anesthesia conversion factor is based on 15-minute time units.

Anesthesia for Dental

General anesthesia is allowed when provided by an anesthesiology provider for dental admissions. Providers must use CPT anesthesia **code 00170** with the appropriate anesthesia modifier to bill for dental anesthesia.

Note: Bill MAA directly for dental anesthesia for all clients, including those enrolled in an MAA managed care plan.

Pain Management Services

- Pain Management services and selected surgical services that are commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services are paid using MAA's-assigned maximum allowable fee for the procedure code.

- Do not use anesthesia modifiers when billing for pain management and other services payable using MAA's-assigned maximum allowable fee. MAA denies claims for these services billed with an anesthesia modifier.

- Two postoperative procedures are allowed for pain management. Only one (1) unit may be billed per procedure. Do NOT bill time.

See next page for Pain Management Procedure Codes

CPT codes and descriptions are copyright 2003 American Medical Association

Due to copyright restrictions, MAA publishes only official brief CPT descriptions
To view the full CPT description, please refer to your current CPT manual.

The listings shown below are not guaranteed to be all-inclusive, and are provided for convenience purposes only.

The codes listed in the following table with an asterisk (*) are limited to two (2) during the postoperative period while the client is admitted to the hospital. Do not bill modifier 59 with any of these procedure codes.

Procedure Code	Brief Description
11981*	Insert drug implant device
11982*	Remove drug implant device
11983*	Remove/insert drug implant
20526*	Ther injection, carpal tunnel
20550	Inject tendon/ligament/cyst
20551	Inject tendon origin/insert
20552	Inject trigger point, 1 or 2
20553	Inject trigger points, >3
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20610	Drain/inject, joint/bursa
20612	Aspirate/inj ganglion cyst
27096	Inject sacroiliac joint
61790*	Treat trigeminal nerve
62264*	Epidural lysis on single day
62270	Spinal fluid tap, diagnostic
62272	Drain spinal fluid
62273*	Treat epidural spine lesion
62280*	Treat spinal cord lesion
62281*	Treat spinal cord lesion
62282*	Treat spinal canal lesion
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
62310*	Inject spine c/t
62311*	Inject spine l/s (cd)
62318*	Inject spine w/cath, c/t
62319*	Inject spine w/cath l/s (cd)
62350*	Implant spinal canal cath
62351*	Implant spinal canal cath
62355*	Remove spinal canal cath
62360*	Insert spine infusion device
62361*	Implant spine infusion pump

Procedure Code	Brief Description
62362*	Implant spine infusion pump
62365*	Remove spine infusion device
63650*	Implant neuroelectrodes
63655*	Implant neuroelectrodes
63660*	Revise/remove neuroelectrode
63685*	Implant neuroreceiver
63688*	Revise/remove neuroreceiver
64400*	Injection for nerve block
64402*	Injection for nerve block
64405*	Injection for nerve block
64408*	Injection for nerve block
64410*	Injection for nerve block
64412*	Injection for nerve block
64413*	Injection for nerve block
64415*	Injection for nerve block
64416*	Injection for nerve block
64417*	Injection for nerve block
64418*	Injection for nerve block
64420*	Injection for nerve block
64421*	Injection for nerve block
64425*	Injection for nerve block
64430*	Injection for nerve block
64435*	Injection for nerve block
64445*	Injection for nerve block
64446*	Injection for nerve block
64447*	Injection for nerve block
64448*	Injection for nerve block
64449*	Injection for nerve block
64450*	Injection for nerve block
64470*	Inj paravertebral c/t
64472*	Inj paravertebral c/t add-on

CPT codes and descriptions are copyright 2003 American Medical Association

Procedure Code	Brief Description
64475*	Inj paravertebral l/s
64476*	Inj paravertebral l/s add-on
64479*	Inj foramen epidural add-on
64480*	Inj foramen epidural add-on
64483*	Inj foramen epidural l/s
64484*	Inj forament epidural add-on
64505*	Injection for nerve block
64508*	Injection for nerve block
64510*	Injection for nerve block
64517*	N block stellage ganglion
64520*	Injection for nerve block
64530*	Injection for nerve block
64550*	Apply neurostimulator
64553*	Implant neuroelectrodes
64555*	Implant neuroelectrodes
64560*	Implant neuroelectrodes
64561*	Implant neuroelectrodes
64565*	Implant neuroelectrodes
64573*	Implant neuroelectrodes
64575*	Implant neuroelectrodes
64577*	Implant neuroelectrodes
64580*	Implant neuroelectrodes
64581*	Implant neuroelectrodes
64585*	Revised/remove neuroelectrode
64590*	Implant neuroreceiver
64595*	Revise/remove neuroreceiver
64600*	Injection treatment of nerve
64605*	Injection treatment of nerve
64610*	Injection treatment of nerve
64612*	Destroy nerve, face muscle
64613*	Destroy nerve, spine muscle
64620*	Injection treatment of nerve
64622*	Destr paravertbrl nerve l/s
64626*	Destr paravertbrl nerve c/t
64627*	Destr paravertbrl nerve add-on
64630*	Injection treatment of nerve

Procedure Code	Brief Description
64640*	Injection treatment of nerve
64680*	Injection treatment of nerve
64681*	Injection treatment of nerve
64802*	Remove sympathetic nerves
64804*	Remove sympathetic nerves
64809*	Remove sympathetic nerves
64818*	Remove sympathetic nerves

Other Services

Procedure Code	Brief Description
36400	Drawing blood
36420	Establish access to vein
36425	Establish access to vein
36555	Insert non-tunnel cv cath
36566	Insert tunneled cv cath
36568	Insert tunneled cv cath
36580	Replace tunneled cv cath
36584	Replace tunneled cv cath
36589	Removal tunneled cv cath
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
36660	Insertion catheter, artery
62263	Lysis epidural adhesions
62287	Percutaneous diskectomy
63600	Remove spinal cord lesion
75998	Fluoroscope examination
76000	Fluoroscope examination
76003	Needle localization by x-ray
76005	Fluoroguide for spine inject
76496	Fluoroscopic procedure
93503	Insert/place heart catheter
95970	Analyze neurostim, no prog
95990	Spin/brain pump refil & main

These codes are paid as a procedure using MAA's maximum allowable fee, not with base units and time.

CPT codes and descriptions are copyright 2003 American Medical Association

Major Trauma Services

Payment enhancements apply to nongovernmental Trauma Services. Physicians and clinical providers on the Trauma teams of governmental hospitals receive enhancements on a per patient basis. See page F.35 for a list of the Designated Trauma Services. Page F.36 lists the Department of Health's (DOH) categories of Physician and Clinical Providers for the Trauma Response Teams.

Payment Limitations for Major Trauma

To receive enhanced payment, DOH must identify the facility as a Designated Trauma Services. The facility's staff must maintain a quality improvement program and submit trauma registry data as prescribed by DOH. Verification of trauma service designation and patients' Injury Severity Score (ISS) is done by DOH.

Enhanced payments are limited to services provided by a member of a Designated Trauma Services Trauma Response Team for MAA clients who require major trauma services. Enhanced payments are limited to services performed in the hospital.

These enhancements are for fee-for-service MAA clients only.

Additional funds are available for treatment related to major trauma at Designated Trauma Services; however, **modifier ST must be entered on the claim form to receive the enhanced payment**.

Note: The current Injury Severity Score (ISS) is 13 or greater for adults, and 9 or greater for pediatric clients (through 14 years of age only) and for transferred patients. Enhanced payment is available if the client meets these criteria.

Non-Designated Centers and Providers

Physicians and clinical providers not identified by DOH as Designated Trauma Services are reimbursed using MAA's maximum allowable fee schedule. A non-designated clinic that becomes designated during the course of the year must notify MAA at the address below of the change of status.

Medical Assistance Administration
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562
(866) 545-0544

CPT codes and descriptions are copyright 2003 American Medical Association

Billing

Professional providers must bill MAA for qualified trauma services by **adding modifier ST to the appropriate procedure code.** If it is necessary to bill using **two or more modifiers**, **add modifier 99** to the detail line along with all other applicable modifiers, including ST. **Modifier 99 must be listed in the FIRST position in the modifier field.** Billing all modifiers with modifier 99 ensures appropriate payment. Claims billed inappropriately must be rebilled on MAA's blue Adjustment Request Form (DSHS 525-109).

For Additional Information

For information on **trauma service designation, trauma registry, and/or injury severity scores (ISS)**, contact:

Chris Williams
Department of Health
Office of Emergency Medical & Trauma Prevention
(360) 705-6735 or 1-800-725-1834.

For information on **reimbursement**, contact:

John Hanson, Hospital Rates Unit Manager
Medical Assistance Administration
Hospital/Managed Care Rates Section
(360) 725-1834

For information on a specific **Medicaid trauma claim**, contact:

MAA's Provider Relations Unit
1-800-562-6188

CPT codes and descriptions are copyright 2003 American Medical Association

DESIGNATED TRAUMA SERVICES

Nongovernmental Facilities:

Auburn Regional (Auburn)
Cascade Medical (Leavenworth)
Central Washington (Wenatchee)
Darrington (Darrington)
Deaconess (Spokane)
Deer Park (Deer Park)
Emanual (Portland)
Good Samaritan (Puyallup)
Grays Harbor Community (Aberdeen)
Gritman Memorial (Moscow, Idaho)
Harrison Memorial (Bremerton)
Highline Community (Burien)
Holy Family (Spokane)
Inter-Island (Friday Harbor)
Kadlec (Richland)
Mary Bridge's (Tacoma)
Mt. Carmel (Colville)
Northwest (Seattle)
Our Lady of Lourdes (Pasco)
Overlake (Bellevue)
Providence (Centralia)
Providence (Everett - Colby)
Providence (Toppenish)
Sacred Heart (Spokane)
St. Francis (Federal Way)
St. Johns (Longivew)
St. Joseph (Bellingham)
St. Joseph (Chewelah)
St. Joseph (Lewiston)
St. Mary Med. Ctr. (Walla Walla)
St. Peter's (Olympia)
Southwest Wash. (Vancouver)
Sunnyside Community (Sunnyside)
Tri-State Memorial (Clarkston)
Valley (Spokane)
Walla Walla General (Walla Walla)
Yakima Valley/Prov Yak Med (Yakima)

Governmental Facilities and their Trauma Service Level:

Level 1:
Harborview (Seattle)
Oregon Health Sciences (Portland)
* Designated by Oregon only

Level 2:
None

Level 3:
Island (Anacortes)
Kennewick General (Kennewick)
Skagit Valley (Mt. Vernon)
Valley Med. Ctr. (Renton)
Whidbey General (Coupeville)

Level 4:
Cascade Valley (Arlington)
Evergreen Hospital (Kirkland)
Forks Community (Forks)
Jefferson General (Pt. Townsend)
Kittitas Valley (Cle Elum)
Klickitat Valley (Goldendale
Lake Chelan Community (Chelan)
Lewis Co. Hosp. Dist. #1 (Morton)
Lincoln (Davenport)
Mason General (Shelton)
Mid Valley (Omak)
Newport Comm. Hospital (Newport)
North Valley (Tonasket)
Ocean Beach (Ilwaco)
Okanogan-Douglas (Brewster)
Olympic Mem. Hospital (Pt. Angeles)
Othello Community (Othello)
Prosser Memorial (Prosser)
Pullman Memorial (Pullman)
Samaritan (Moses Lake)
Skyline (White Salmon)
Stevens Memorial (Edmonds)
Valley General (Monroe)
Willapa Harbor Hosp. (South Bend)

Level 5:
Columbia Basin (Ephrata)
Coulee Community (Grand Coulee)
Dayton General (Dayton)
East Adams Rural (Ritzville)
Ferry Co. Memorial (Republic)
Garfield County (Pomeroy)
Kittitas Hosp. Dist. #2 (Cle Elum)
Mark Reed (McCleary)
Odessa Memorial (Odessa)
Quincy Valley (Quincy)Whitman County (Colfax)

CPT codes and descriptions are copyright 2003 American Medical Association

PHYSICIAN/CLINICAL PROVIDER LIST

Advanced Registered Nurse Practitioner
Anesthesiologist
Certified Registered Nurse Anesthetist
Cardiologist
Critical Care Physician
Emergency Physician
Family/General Practice Physician with
Trauma Training
Gastroenterologist
General Surgeon
Gynecologist
Hand Surgeon
Hematologist
Infectious Disease Specialist
Internal Medicine
Nephrologist
Neurologist
Neurosurgeon
Obstetrician
Ophthalmologist
Oral/Maxillofacial Surgeon
Orthopedic Surgeon
Pathologist
Pediatric Surgeon
Pediatrician
Physiatrist
Physician Assistant
Plastic Surgeon
Pulmonologist
Radiologist
Thoracic Surgeon
Urologist
Vascular Surgeon

Note: Many procedures are not included in major trauma services enhanced payment.

CPT codes and descriptions are copyright 2003 American Medical Association

This page intentionally left blank.

CPT codes and descriptions are copyright 2003 American Medical Association

Physical Therapy

Which providers are eligible to provide physical therapy?
[Refer to WAC 388-545-500(1)]

- Licensed physical therapists or physiatrists; or
- Physical therapist assistants supervised by licensed physical therapists.

Where must physical therapy services be provided?
[WAC 388-545-500(3)(a)(f)]

MAA reimburses eligible providers for physical therapy services provided as part of an outpatient treatment program in the following settings:

- In an office, home, or outpatient hospital setting;

  ☞ **Note**: Physical therapy may be performed by a home health agency as described in Chapter 388-551 WAC, or as part of an acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC.

- In a neurodevelopmental center;

- In a school district or educational service district facility as part of an individual education plan (IEP) or individualized family service plan (IFSP), as described in WAC 388-537-0100; or

- For children two years of age and younger with disabilities, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

Continued on next page…

CPT codes and descriptions are copyright 2003 American Medical Association

Referral and Documentation Process

Adults (Age 21 and older) [Refer to WAC 388-545-500 (5)]

Providers must document in a client's medical record that physical therapy services provided to clients age 21 and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger)

The EPSDT screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's medical record.

The provider must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the referred child.

CPT codes and descriptions are copyright 2003 American Medical Association

Coverage [WAC 388-545-500(4)]

MAA reimburses providers for only those covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, PA, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards.

> ☞ **Note**: MAA does not limit covered physical therapy services for clients 20 years of age and younger.

Coverage for adults (age 21 and older) [Refer to WAC 388-545-500 (8)]

MAA covers without prior authorization the following physical therapy services per client, per diagnosis:

- One physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year;
- 48 physical therapy program units per calendar year;
- One visit to instruct the client in the application of transcutaneous electrical neurostimulator (TENS) per lifetime.
- Two DME needs assessments per calendar year (in addition to the 48 program units). Two 15-minute units are allowed per DME needs assessment;
- One wheelchair needs assessment per calendar year (in addition to the two DME needs assessment). Four 15-minute units are allowed per wheelchair assessment).

CPT codes and descriptions are copyright 2003 American Medical Association

MAA covers up to 96 physical therapy program units per calendar year in addition to the original 48 units only when:

- The client is diagnosed with one of the following conditions:

ICD-9-CM Diagnosis Codes	Condition
315.3-315.9, 317-319	Medically necessary conditions for individuals identified as having developmental disabilities
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
758.0	Down syndrome
781.2 - 781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800 - 829.1	Surgeries involving extremities – Fractures
851 - 854.1	Intracranial injuries
880 - 887.7	Surgeries involving extremities - Open wounds with tendon involvement
941 - 949.5	Burns
950 - 957.9, 959 - 959.9	Traumatic injuries

☞ **Note**: The conditions above **must** be listed as the primary diagnosis on the claim.

-OR-

- The client no longer needs nursing services, but continues to require specialized outpatient physical therapy as part of a recently approved Acute PM&R program (within the previous 12 months) for the following conditions:

ICD-9-CM Diagnosis Codes	Condition
854	Traumatic brain injury
900.82, 344.0, 344.1	Spinal cord injury (paraplegia and/or quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for multiple sclerosis
335.20	Amyotrophic lateral sclerosis
343 - 343.9	Cerebral palsy
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive severe burns
344.0, 707.0	Skin flaps for sacral decubitus for quads only
890 - 897.7, 887.6 - 887.7	Open wound of lower limb, bilateral limb loss

CPT codes and descriptions are copyright 2003 American Medical Association

Physical Therapy Program Limitations

MAA does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
[WAC 338-545-500 (11)]

> ☞ **Note**: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes. If time is included in the CPT description, the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028).
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039).
- Therapeutic exercises (CPT codes 97110-97139).
- Manual therapy (CPT code 97140).
- Therapeutic procedures (CPT code 97150).
- Prosthetic training (CPT code 97520).
- Therapeutic activities (CPT code 97530).
- Self-care/home management training (CPT code 97535).
- Community/work reintegration training (CPT code 97537).
- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).
- Assistive technology assessment (CPT code 97755).

CPT codes and descriptions are copyright 2003 American Medical Association

<u>The following are not included in the physical therapy program 48-unit limitation:</u>

- Muscle testing (CPT codes 95831-95852). MAA covers one muscle testing procedure per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.

- Physical therapy evaluation (CPT code 97001). Use for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This procedure is not used for re-evaluating the client's condition and establishing the plan of care.

- Physical therapy re-evaluation (CPT code 97002). Allowed once per client, per calendar year. Use for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This procedure is for re-evaluating the client's condition and revising the plan of care under which the client is being treated.

- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). MAA covers two units per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Active wound care management involving selective and non-selective debridement (CPT codes 97601 and 97602). The following conditions apply:

  - ✓ MAA covers one unit of CPT code 97601 or 97602 per client, per day. Providers may not bill CPT codes 97601 and 97602 in conjunction with each other.

  - ✓ Providers must not bill CPT codes 97601 and 97602 in addition to CPT codes 11040-11044.

- Checkout for orthotic/prosthetic use (CPT code 97703). MAA covers two 15-minute units per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Wheelchair needs assessment (CPT code 97703). MAA covers one wheelchair needs assessment per client, per calendar year, limited to four 15-minute units per assessment. Indicate on the claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97703). MAA covers two DME needs assessments per client, per calendar year, limited to two 15-minute units per assessment. Indicate on the claim that this is a DME needs assessment.

- Splints (refer to Section K for those splints covered in a provider’s office).

CPT codes and descriptions are copyright 2003 American Medical Association

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy in addition to existing program unit limitations, the provider must request a Limitation Extension (LE). See Section I – Prior Authorization.

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See Important Contacts.)

What is not covered? [WAC 388-545-500(12)]

MAA does not reimburse separately for physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

CPT codes and descriptions are copyright 2003 American Medical Association

Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R): Inpatient PM&R is limited to MAA-contracted facilities.

DDD Physical: MAA covers one physical every 12 months for clients with disabilities. Providers must bill using HCPCS code T1023 with modifier HI.

HIV/AIDS Counseling: MAA covers two sessions of risk factor reduction counseling (CPT code 99401) for HIV/AIDS counseling per client, per lifetime. [Refer to WAC 388-531-0600] Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling.

Needle Electromyography (EMGs): MAA has adopted Medicare-established limits for billing needle EMGs (CPT codes 95860 – 95870) as follows:

CPT Code	Brief Description	Limits
95860 95861 95863 95864	Needle EMG; one extremity with or without related paraspinal areas two extremities… three extremities… four extremities…	• Extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95869	Needle EMG; thoracic paraspinal muscles	• Limited to one unit per day. • For this to pay with extremity codes 95860-95864, test must be for T3-T11 areas only; T1 or T2 alone are not separately payable.
95870	Needle EMG; other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	• Limited to one unit **per extremity**, and one unit for cervical or lumbar paraspinal muscle, regardless of number of levels tested (maximum of 5 units). • Not payable with extremity codes (CPT codes 95860-95864).

TB Treatment Services Performed by Non-Professional Providers: Health Departments billing for TB treatment services provided by **non-professional providers** in either the client's home or in the office must bill using HCPCS code T1020 (personal care services). Do not bill the initial visit with a modifier. Follow-up visits must be billed using T1020 with modifier TS (follow-up services modifier).

Cochlear Implant Services [Refer to WAC 388-531-0200(4)(c)]

- Cochlear implantation (CPT code 69930) requires prior authorization (refer to Section I – Prior Authorization). Providers must send in medical documentation to justify the need for cochlear implants. In particular, MAA requires information on how the client was counseled on the different options for dealing with hearing loss such as, but not limited to, manual language.

- MAA reimburses providers for replacement parts for cochlear implants given directly to the client using HCPCS code A9900. Prior authorization is required for the replacement parts. Pricing is determined by the authorization section.

- When reimbursing for battery packs, MAA covers the **least costly, equally effective** product.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

- Vagus nerve stimulation (CPT codes 61885, 64573, and 64585) requires prior authorization (refer to Section I - Prior Authorization).

  Exception: CPT codes 61885 and 61886 **do not** require prior authorization when billed in conjunction with CPT code 61862 **and** the ICD-9-CM diagnosis is 333.1 or 332.0.

- VNS procedures can be performed in an inpatient hospital or outpatient hospital setting.

- Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.

Osseointegrated Implants

- Insertion of osseointegrated implants (CPT codes 69714-69718) requires prior authorization (refer to Section I - Prior Authorization).

- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.

This page intentionally left blank.

Family Planning

What is Family Planning? [WAC 388-532-050]

Family planning is medical care, contraceptive supplies, and educational services that enable individuals to plan and space the number of children by using contraception to avoid unintended pregnancy.

Contraceptive Management

The following contraceptives may be administered in a provider's office:

Procedure Code	Brief Description
Cervical Cap/Diaphragm	
A4261	Cervical cap for contraceptive use
A4266	Diaphragm
57170	Fitting of diaphragm/cap
Implant	
~~A4260~~	~~Levonorgestrel (Norplant) implant system, including implant and supplies. (One allowed in a 5-year period.)~~ **No longer available.**
~~11975~~	~~Insert contraceptive capsule~~
11976	Removal of contraceptive capsule
~~11977~~	~~Removal/insert contra capsule~~
Injectables	
J1055	Medroxyprogesterone acetate inj (Depo Provera). (Allowed once every 67 days.)
~~J1056~~	~~Injection Medroxyprogesterone acetate/estradiol cypionate 5mg/25 mg (Lunelle). (Allowed once over 23 days.)~~ **No longer available.**
90782	Injection, subcutaneous/intramuscular. (Allowed when the contraceptive injection is the only service performed.)
Intrauterine Devices (IUD)	
J7300	Intrauterine copper device (Paragard)
J7302	Levonorgestrel-releasing IUD (Mirena)
~~S4989~~	~~Intrauterine device (non-copper) (Progestasert)~~ **No longer available.**
58300	Insertion of IUD
58301	Removal of IUD
J3490*	Unclassified Drugs Use for emergency contraceptive pills, including Preven and Plan B.

***Claims billed with unlisted drug code J3490 must include the NDC and the dose administered to the client in field 19 of the hard copy HCFA-1500 claim form or the *Comments* section of the electronic HCFA-1500 claim form.**

Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

> ☞ **Note:** MAA does not reimburse for hysterectomies performed solely for the purpose of sterilization. Refer to page H.16 for information on hysterectomies.

What are MAA's reimbursement requirements for sterilizations? [Refer to WAC 388-531-1550(2)]

MAA covers sterilization when all of the following apply:

- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual;
- The client has **voluntarily** given informed consent in accordance with all of the requirements explained under this section as required by 42 CFR 441.258; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

> ☞ **Note:** MAA reimburses providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system.

MAA reimburses providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for the sterilization procedure only when a completed, federally approved Sterilization Consent Form is attached to the claim. MAA reimburses after the procedure is completed.

MAA reimburses providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. MAA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before MAA reimburses the provider for the sterilization of a mentally incompetent or institutionalized client. MAA requires both of the following to be attached to the claim form:

- A court order that states the client is to be sterilized; and
- A Sterilization Consent Form signed by the legal guardian.

When does MAA waive the 30-day waiting period? [WAC 388-531-1550(3) (4)]

MAA waives the 30-day waiting period, **but requires** at least a 72-hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

MAA waives the 30-day waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a sterilization consent form when one of the following circumstances apply:

- The client became eligible for Medical Assistance during the last month of pregnancy *("NOT ELIGIBLE 30 DAYS BEFORE DELIVERY");* or
- The client did not obtain medical care until the last month of pregnancy *("NO MEDICAL CARE 30 DAYS BEFORE DELIVERY"*); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. *("NO SUBSTANCE ABUSE AT TIME OF DELIVERY.")*

The provider must note on the HCFA-1500 claim form in field 19 or on the backup documentation, which of the above waiver conditions has been met. Required language is shown in parenthesis. Electronic billers must indicate this information in the *Comments* section.

When does MAA not accept a signed Sterilization Consent Form?
[Refer to WAC 388-531-1550(5) (6)]

MAA does not accept a signed Sterilization Consent Form obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client's state of awareness.

Why do I need a DSHS-approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent Form is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent Form to attach to their claim. **No other form will be accepted**.

MAA denies claims for sterilization procedures received without a Sterilization Consent Form.

MAA denies claims with an incomplete or improperly completed Sterilization Consent Form. Claims and completed Sterilization Consent Forms must be submitted to:

DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248

Who completes the Sterilization Consent Form?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page H.3: "When does MAA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
- The bottom right portion (section IV) of the Sterilization Consent Form is completed on or after the surgery date by the physician who performed the surgery.

Download the Sterilization Consent Form and Client Statement form at:

http://www1.dshs.wa.gov/msa/forms/eforms.html

How to Complete the Sterilization Consent Form

- All information on the Sterilization Consent Form must be legible.
- All blanks on the Sterilization Consent Form must be completed *except* race, ethnicity, and interpreter's statement (unless needed).
- MAA does not accept "stamped" or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent Form:

Section I: Consent to Sterilization	
Item	**Instructions**
1. Physician or Clinic:	**Must be name of physician or clinic that gave client required information regarding sterilization.** This may be different than performing physician if another physician takes over.
2. Specify type of operation:	**Indicate type of sterilization procedure.**
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's name and match Items #7, #12, and #18 on Sterilization Consent Form.
5. Physician:	Must be name of physician who will perform sterilization. Physician who performs surgery must be same physician who signs on bottom right (see #22) of Sterilization Consent Form. If a different physician performs the surgery, he/she must complete Item #22 and attach a completed Client Statement Form (see page H.12).
6. Specify type of operation:	Indicate type of sterilization procedure.
7. Signature:	Client signature. Must be client's first and last name. Must match name on Items #4, #12, and #18 on Sterilization Consent Form. Must be original signature in ink.
8. Month/Day/Year:	Date of consent. Must be date that client signed Sterilization Consent Form. Must be more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page H.3: "When does MAA waive the 30 day waiting period?" and/or section IV of Sterilization Consent Form.

Section II: Interpreter's Statement	
Item	**Instructions**
9. Language:	**Must specify language into which sterilization information statement has been translated.**
10. Interpreter:	Must be interpreter's name. **Must be original signature in ink.**
11. Date:	Must be date of interpreter's statement.

Section III: Statement of Person Obtaining Consent	
Item	**Instructions**
12. Name of individual:	Must be client's first and last name. Must match client's name on Items #4, #7, and #18 on Sterilization Consent Form.
13. Specify type of operation:	Indicate type of sterilization procedure.
14. Signature of person obtaining consent:	Must be original signature in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. **Initials are not accepted.**
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	**Instructions**
18. Name of individual to be sterilized:	Must be client's first and last name. Must match client's name on Items #4, #7, and #12 on Sterilization Consent Form.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to page H.3: "When does MAA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
20. Specify type of operation:	Indicate type of sterilization procedure.
21. Expected date of delivery:	When premature delivery box is checked, this date must be *expected* date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's signature. Must be physician who actually performed sterilization procedure. Must be original signature in ink.
23. Date:	Date of physician's signature. Must be completed with either same date as listed in Item #19 or later. **NO EXCEPTIONS!**
24. Physician's printed name	Must be printed name of physician who signed in Item #22.

☞ **Note:** If the physician who performs the surgery is different from the physician identified in Item #5, then a Client Statement Form must be attached to the Sterilization Consent Form. See "How to Complete a Client Statement Form."

How to Complete a Client Statement Form

When do I need a Client Statement Form?

- The physician who performs the surgery is different from the physician identified in Item # 5; or
- There is a change in the sterilization method.

General Guidelines

- All information must be legible.
- The Client Statement Form **must** be attached to the Sterilization Consent Form and submitted with each claim.
- The physician who performs the surgery must fill out Items # 18-24 on the Sterilization Consent Form.
- All blanks must be completed.

The following numbers correspond to those listed on the Client Statement Form:

Client Statement Form	
Item	**Instructions**
1. Individual to be sterilized:	Must be client's first and last name.
2. Physician:	Must be name of physician who actually performed sterilization. Must be same physician who signs Item #22 on Sterilization Consent Form.
3. Specify type of operation:	Indicate type of sterilization procedure.
4. Signature:	Client signature. Must be client's first and last name. Must match name on Items #4, #12, and #18 on Sterilization Consent Form. Must be original signature in ink.
5. Month/Day/Year:	Must be date that client signed Client Statement Form.

How to Complete a Sterilization Consent Form For a Client Age 18-20

1. Use DSHS 13-364 Sterilization Consent Form.
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":

    a. Section I: Consent to Sterilization: **"I am at least 21…"**
    b. Section III: Statement of Person Obtaining Consent: **"To the best of my knowledge… is at least 21…"**
    c. Section IV: Physician's Statement: **"To the best of my knowledge… is at least 21…"**

STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) _____
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) _____ The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) _____
Month Day Year

I (4) _____ hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) _____
Physician

by a method called (6) _____ My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) _____ signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) _____ the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) _____
Signature of person obtaining consent *Date*

(16) _____
Facility

(17) _____
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) _____ (19) _____
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) _____ The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

☐ Premature delivery
Individual's expected date of delivery (21) _____
☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) _____
Physician's Signature *Date*

(24) _____
Physician's Printed Name

SAMPLE STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

CLIENT STATEMENT

I (1) _____ hereby consent of my own free will to be sterilized by (2) _____
Individual to be sterilized *Physician*

by a method called (3) _____ My consent expires 180 days from the date of my signature below. I
Specify type of operation

also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(4) _____ (5) _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

☐ American Indian or Alaska Native ☐ Black (not of Hispanic origin) ☐ White (not of Hispanic origin)

☐ Asian or Pacific Islander ☐ Hispanic

INTERPRETER'S STATEMENT (To be used if an interpreter is provided to assist the individual to be sterilized.)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to
Language

him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

SAMPLE STERILIZATION CONSENT FORM NEEDING CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2002**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2002**
Physician's Signature *Date*

(24) **Mary Williams**
Physician's Printed Name

SAMPLE CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

CLIENT STATEMENT

I (1) **Jane Doe** hereby consent of my own free will to be sterilized by (2) **Dr. Mary Williams**
Individual to be sterilized *Physician*

by a method called (3) **tubal ligation** My consent expires 180 days from the date of my signature below. I
Specify type of operation

also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(4) _____ (5) **October 1, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

☒ American Indian or Alaska Native ☐ Black (not of Hispanic origin) ☐ White (not of Hispanic origin)

☐ Asian or Pacific Islander ☐ Hispanic

INTERPRETER'S STATEMENT (To be used if an interpreter is provided to assist the individual to be sterilized.)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in **Spanish** language and explained its contents to
Language

him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ **October 1, 2001**
Interpreter *Date*

STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least ~~21~~ 18 years of age and was born on (3) **August 1, 1984**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☐ American Indian or Alaska Native
- ☒ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least ~~21~~ 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least ~~21~~ 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

Hysterectomies [Refer to WAC 388-531-1550(10)]

- Hysterectomies are reimbursed only for medical reasons unrelated to sterilization.

- **Prior authorization is not required** in either of the following circumstances:

  - ✓ The client has been diagnosed with cancer(s) of the female reproductive organs; and/or
  - ✓ The client is 46 years of age or older.

- Use MAA's expedited prior authorization (EPA) process for clients 45 years of age and younger who have not been diagnosed with cancer(s) of the female reproductive organs. See Section I – Prior Authorization.

- Federal regulations prohibit payment for hysterectomy procedures until a properly completed consent form is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons must obtain a copy of a completed DSHS-approved consent form to attach to their claim.

- **ALL** hysterectomy procedures require a properly completed DSHS-approved consent form, regardless of the client's age or the ICD-9-CM diagnosis.

- Submit the claim and completed DSHS-approved consent form to the:

DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248

Download the Hysterectomy Consent Form (DSHS 13-365) at:

http://www1.dshs.wa.gov/msa/forms/eforms.html

Prior Authorization

[Refer to WAC 388-531-0200]

Limitation Extensions and Expedited Prior Authorization numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services. For example: Therapies are not covered under the Family Planning Only Program.

MAA's prior authorization requirements are met through the following authorization processes:

- Written or fax authorization; and
- Expedited prior authorization (EPA).

These authorization procedures do not apply to out-of-state care. Out-of-state hospital admissions are not covered unless they are emergency admissions of clients who are on an eligible program that allows out-of-state care. **[Refer to WAC 388-502-0120]**

Limitation Extensions (LE)

What is a Limitation Extension?

Limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administrative Code (WAC).

How do I get LE authorization?

Some LE authorizations may be obtained by using the Expedited Prior Authorization process. Refer to the EPA section (page I.5) for criteria. If the EPA process is not applicable, limitation extensions may be obtained using the written/fax authorization process (see below).

Written/Fax Prior Authorization

What is written/fax prior authorization?

Written or fax prior authorization is a paper authorization process available to providers when expedited prior authorization has not been established or the expedited prior authorization criteria is not applicable.

Which services require written/fax prior authorization?

All services noted in WAC, MAA's billing instructions, and/or the fee schedule as needing prior authorization (PA), require written or fax prior authorization.

EXAMPLES of services that require written/fax prior authorizations are:

Code	Procedure
54416-54417	Repair of Penile Implant
55873	Cryosurgical Ablation of the Prostate
61885, 61886, 64573 and 64585	Vagus Nerve Stimulator Insertion, Removal, or Revision
66930 and A9900	Cochlear Implantation and External Replacement Parts
67909	Reduction of Overcorrection of Ptosis
69714-69718	Osseointegrated Implants
78810	Tumor imaging (PET)
88380	Microdissection
95965-95967	Magnetoencephalography (MEG)
99221-99223	Inpatient Acute PM&R
G0030-G0047	Myocardial perfusion imaging (PET)
J2020	Linezolid injection
J2940	Somatrem injection
J2941	Somatropin injection
J7340	Metobolic active D/E tissue
S0093	Morphine 500 mg
0009T-0013T	New technology CPT Category III codes

How do I obtain written/fax prior authorization?

Send or fax your request to:

MAA – Division of Medical Management
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

On the following pages are sample fax forms for your convenience. All the information on the form is required by MAA.

Fax/Written Request Basic Information

Provider Information

Name _____ Provider #: _____

Phone _____ Fax: _____

Client Information

Name _____ PIC# ____-____-____

i.e. (AB-122300-SMITH-A)

Service Request Information

Description of service being requested: _____

_____

Procedure Code _____ Number units requested _____ number units used this year _____

Medical Information

Dates of injury or illness _____

Diagnosis code _____ Diagnosis name _____

Place of service _____

How will approving this request change the course of treatment?

_____

_____

Goal of treatment? _____

_____

_____

What is the clinical justification for this request (if not addressed above?)

_____

_____

_____

Please send in any necessary additional documentation with your request to:

Fax: **360-586-1471** or mail to: Medical Request Coordinator
MAA\DMM
PO Box 45506
Olympia, WA 98504-5506

PET SCAN INFORMATION FORM

Medical Assistance Administration

Telephone: (360) 725-1584 FAX: (360) 586-1471

PATIENT NAME: _____

BIRTHDATE: _____ **PIC CODE:** _____

ICD 9 CODE (with DIAGNOSIS):

1)_____**(Diagnosis):**_____

2)_____**(Diagnosis):**_____

3)_____**(Diagnosis):**_____

DOES MEDICARE COVER PET SCAN FOR THIS DIAGNOSIS? _____

_____

INDICATIONS FOR PET SCAN: _____

_____

SENSITIVITY AND SPECIFICITY OF PET SCAN IN THIS SETTING: _____

_____

INDICATIONS WHY OTHER IMAGING WILL NOT WORK: _____

_____

OTHER STUDIES/TESTS ALREADY DONE and RESULTS: _____

_____

HOW WILL PET SCAN RESULTS CHANGE THE COURSE OF TREATMENT? _____

_____

PROVIDER'S MEDICAID NUMBER (7 DIGITS): _____

FACILITY NAME: _____

DOCTOR' NAME _____

CONTACT PERSON: _____

PHONE: _____ **FAX:** _____

ADDRESS: _____

Expedited Prior Authorization (EPA)

Expedited prior authorization does not apply to out-of-state care. Out-of-state hospital admissions are not covered unless they are emergency admissions of clients who are on an eligible program that allows out-of-state care.

What is the EPA process?

MAA's EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

How is an EPA number created?

The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* section when billing electronically.

Example: The 9-digit authorization number for a brain MRI in a client with suspected brain tumor and new onset of unexplained seizures would be **870000303** (**870000** = first six digits of all expedited prior authorization numbers, **303** = last three digits of an EPA number and specific diagnostic condition, procedure, or service, and which criteria the case meets).

☞ **Note:** Prior authorization is required when the client's situation does not meet published criteria and there is no option to create an EPA number that indicates medical necessity is documented in the client's medical record.

The service is not covered if there is an option to create an EPA number based on the medical necessity being documented in the medical record and medical necessity cannot be documented.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Expedited Prior Authorization Guidelines

- **Diagnoses**

  Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number is denied.

- **Documentation**

  The billing provider must have documentation of how expedited criteria was met, and have this information in the client's file available to MAA on request. When care is received in the hospital, the documentation of how the expedited prior authorization criteria were met must also be in the hospital record.

Which services require EPA?

EPA is required for services noted in WAC, MAA's billing instructions, and/or fee schedules as needing EPA.

Examples of services requiring EPA:

- **Hysterectomies** (CPT: 51925, 58150-58285, 58545, 58546, 58550, 59525)
  Note: CPT codes 58152 and 58267 must meet guidelines for both hysterectomies and bladder repair.

  Exceptions: MAA does not require EPA for clients 46 years of age and older; **or** clients that have been diagnosed with cancer(s) of the female reproductive organs (ICD-9-CM: 179-184.9, 198.6, 198.82, 233.1-233.3, 236.0-236.3, and 239.5).

- **Bladder Repairs** (CPT: 51840-51845, 57288-57289, 58152, and 58267)
  Note: Bladder repairs are only allowed for clients with a diagnosis of stress urinary incontinence (ICD-9-CM: 625.6, 788.30-788.39)

- **Reduction Mammoplasties** (CPT: 19318)
  Note: Reduction Mammoplasties are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.

- **Mastectomies for Gynecomastia** (CPT: 19140)
  Note: Mastectomies for Gynecomastia are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.

- **Visual Exams, Dispensing and Fitting Fees, Frames, Glasses, and Lenses**
  When in excess of MAA establish limitations.

CPT codes and descriptions only are copyright 2003 American Medical Association.

- **Blepharoplasties** (CPT 67901-67908, 67912) **and Strabismus Surgery** (CPT 67311-67340). Only for clients 18 years of age and older.

- **Physical and Occupational Therapy**
  When in excess of MAA establish limitations.

- **Outpatient PET Scans**

  Exception: CPT code 78810 and HCPCS codes G0030-G0047 require written/fax prior authorization.

- **Outpatient MRIs and MRAs**

- **Inpatient Medical Admits** (CPT: 99221-99223)
  MAA requires EPA for inpatient hospital admissions for the following diagnoses for clients seven years of age and older:

Description	ICD-9-CM Diagnosis Code(s)
Abdominal Pain	789-789.09
Back Pain	724-724.6, 724.8-724.9, 846-847.9
Cellulitis	681-681.9, 682, 682.2-682.9
Chronic pancreatitis	577-577.1
Constipation	560.3, 560.39, 564-564.9
Dehydration; Disorders of Electrolyte Imbalance	276-276.6, 276.8-276.9
Headache	784.0
Gastritis/Gastroenteritis	535-535.6, 558-558.9
Migraine Headache	346-346.9
Nausea/vomiting	536.2; 787-787.03
Malaise & Fatigue	780.7-780.79
Painful Respiration	786.52
Related general symptoms	780, 780.4, & 780.9
Respiratory abnormality	786.09

Short stay admissions (less than 24 hours) do not require prior authorization – use CPT codes 99218-99220 for admits, and 99217 for discharge; or 99234-99236 for admission/discharge on the same calendar date.

Clients six years of age and younger do not require prior authorization for inpatient medical admissions. However, these admissions must be medically appropriate in accordance with MAA's established criteria.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria

Abdominal Hysterectomy

CPT: 58150, 58180, 58200, 58210

101 Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with two or more of the following conditions:

1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months;
2) Documented hct of <30 or hgb <10; or
3) Documented failure of conservative care (i.e., d&c, laparoscopy, or hormone therapy for at least three months).

102 Diagnosis of **fibroids** for any one of the following indications in a client 30 years of age or older:

1) Myomata associated with uterus greater than 12 weeks or 10cm in size;
2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct <30 or hgb <10; or
3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.

103 Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following:

1) Significant findings per laproscope; and
2) Unresponsiveness to 3 months of hormone therapy or cauterization.

104 Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics

Vaginal Hysterectomy

CPT: 58270-58285, 58550-58554, 58260-58263, 58290, 58291-58293, 58294, 58545-58546

111 Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with two or more of the following conditions:

1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months;
2) Documented hct of < 30 or hgb < 10; or
3) Documentation of failure of conservative care (i.e., d&c, laparoscopy, or hormone therapy for at least three months).

112 Diagnosis of **fibroids** for any one of the following indications in a client 30 years of age or older:

1) Myomata associated with uterus greater than 12 weeks or 10cm in size;
2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct < 30 or hgb < 10; or
3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.

113 Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following:

1) Significant findings per laproscope; and
2) Unresponsiveness to 3 months of hormone therapy or cauterization.

114 Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria

115 Diagnosis of **symptomatic pelvic relaxation** (in a client 30 years of age or older) with a 3rd degree or greater uterine prolapse (at or to vaginal introitus).

Bladder Neck Suspension

CPT: 51840-51845, 57288-57289

201 Diagnosis of **stress urinary incontinence** with all of the following:

1) Documented urinary leakage severe enough to cause the client to be pad dependent; and
2) Surgically sterile or past child bearing years; and
3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; and
4) Urodynamics showing loss of ureterovescical angle or physical exam showing weak bladder neck; and
5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery.

Hysterectomy With Colopourethrocystopexy

CPT: 51925, 58152, 58267, and 58293

221 Diagnosis of **Abnormal uterine bleeding and Stress Urinary Incontinence**-meeting criteria 101 or 111 and 201.

222 Diagnosis of **Fibroids and Stress Urinary Incontinence**-meeting criteria 102 or 112 and 201.

223 Diagnosis of **Symptomatic Endometriosis and Stress Urinary Incontinence**-meeting criteria 103 or 113 and 201.

224 Diagnosis of **Chronic Pelvic Inflammatory Disease and Stress Urinary Incontinence** - meeting criteria 104 and 114.

225 Diagnosis of **Symptomatic Pelvic Relaxation and Stress Urinary Incontinence** - meeting criteria 115 and 201.

226 **Hysterectomy not requiring authorization** and **Stress Urinary Incontinence** meeting criteria 201.

Other Hysterectomies and/or Bladder Repairs With Diagnosis of 625.6 or 788.30-788.39

CPT: 51840-51845, 51925, 57288-57289, 58150, 58152, 58180, 58200, 58210, 58240, 58260-58263, 58267, 58270, 58275, 58280, 58285, 58290-58294. 58550-58554, and 59525

230 Hysterectomies and/or bladder repairs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Reduction Mammoplasties/ Mastectomy For Gynecomastia

CPT: 19318, 19140

241 Diagnosis for **hypertrophy of the breast** with:

1) Photographs in client's chart, and
2) Documented medical necessity including:
   a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, and
   b) Conservative treatment not effective; and
3) Abnormally large breasts in relation to body size with shoulder grooves, and
4) Within 20% of ideal body weight, and
5) Verification of minimum removal of 500 grams of tissue from each breast.

242 Diagnosis for **gynecomastia**:

1) Pictures in clients' chart, and
2) Persistent tenderness and pain, and
3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria

Other Reduction Mammoplasties/ Mastectomy For Gynecomastia With Diagnosis Of 611.1 Or 611.9

250 Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Brain MRI/MRA
CPT: 70544-70546, 70551-70559

301 Suspected diagnosis of **acoustic neuroma** if one of the following:

1) Unilateral sensorineural hearing loss per audiogram; or
2) Decreased discrimination score that is out of proportion to amount of hearing loss per ENT evaluation; or
3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above.

302 Suspected diagnosis of **pituitary tumor** with any two of the following:

1) Galactorrhea;
2) Pre menopausal amenorrhea;
3) Elevated prolactin level **(females must have negative pregnancy test)**; or
4) Positive or inconclusive computed tomography and one of the above with a need for clearer definition

303 Suspected diagnosis of **brain tumor** with any one of the following:

1) Unexplained new onset seizure;
2) Objective evidence of increased intracranial pressure; or
3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above.

304 **Follow up** of **brain tumor** if done at:

1) Three months from the date of last MRI/MRA and in the first two years of diagnosis in any of the following cases:
   a) Tumor is currently being treated;
   b) Post treatment;
   c) With documented changes in tumor size; or
2) Six months from the date of last MRI/MRA and in the second to fifth years of diagnosis; or
3) One year from the date of last MRI/MRA in the sixth to tenth year of diagnosis; or
4) Symptoms of recurrence in a client that would be treated aggressively.

305 Suspected diagnosis of **multiple sclerosis** with three or more of the following objective findings:

1) Progressive weakness or decreased sensation in extremities;
2) Difficulty word finding;
3) Diplopia;
4) Vertigo or vertigo nystagmus;
5) Optic neuritis;
6) Facial weakness; or
7) Positive Lhermitte's sign.

Note to 305: Only for initial diagnosis, not as a follow-up.

306 Suspected diagnosis of **toxoplasmosis versus lymphoma versus progressive multifocal leukoencephalopathy** in an HIV positive client with:

1) Central nervous system changes **in a client that would be aggressively treated**; and
2) Positive or inconclusive computed tomography with a need for clearer definition **in a client that would be aggressively treated.**

307 Diagnosis of **breast cancer** for staging as part of PSCT or BMT protocol.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria

308 Suspected diagnosis of **seizure disorder** with unexplained onset of seizures.

309 Diagnostic evidence of **refractory seizures**, as part of preoperative work up.

310 Suspected diagnosis of **residual tumor or residual vascular malformation**

Lumbar MRI/MRA
CPT: 72148, 72149, 72158

311 Suspected diagnosis of **Herniated Nucleus Pulposus or Tumor** in a surgical candidate with two or more of the following objective findings:

1) New onset of bowel or bladder incontinence not related to known diagnosis;
2) Asymetric or bilaterally absent tendon reflexes in the lower extremity (patella/achilles);
3) Visible atrophy of key muscle groups of lower extremities;
4) Decreased sensation in a dermatomal pattern not previously attributed to another diagnosis;
5) Significant weakness of key muscle groups of either or both lower extremity; or
6) Positive study indicating definitive nerve root compression.

312 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

Cervical MRI/MRA
CPT: 72141, 72142, 72156

321 Suspected **herniated nucleus pulposa or tumor** with two or more of the following objective findings:

1) Decreased tricep, bicep, or brachial radialis reflex;
2) Decreased sensation in upper extremities in a dermatomal distribution;
3) Decreased muscle strength of upper extremities and limitation of movement;
4) Upper extremity muscle atrophy;
5) Hyperreflexia;
6) Positive babinski in non-infant; or
7) Studies showing definitive nerve root compression, and ruling out carpal tunnel syndrome.

Note to 321: Carpal tunnel syndrome must be ruled out prior to cervical MRI when symptoms indicate possible carpal tunnel syndrome.

322 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

Thoracic MRI/MRA
CPT: 72146, 72147, 72157

331 Suspected diagnosis of **tumor or abscess**:

1) With a bone scan or x-ray suspicious for same, or
2) Evidence of myelopathy, such as hyperreflexia, positive babinski in a non-infant, ataxia, etc.

Pelvic MRI/MRA
CPT: 72195-72197

341 Suspected diagnosis of **avascular necrosis** with:

1) Pain in the hip radiating to the knee; and
2) A history of one of the following:
   a) Previous trauma;
   b) Intracapsular fractures;
   c) Alcoholism;
   d) High dose steroid use;
   e) Air embolism from diving, or
   f) Hemoglobinopathies

342 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria	Code	Criteria

Knee MRI/MRA
CPT: 73721-73723

351 Suspected **anterior cruciate ligament tear** when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least three of the following:

1) History of hyperextension injury with immediate swelling, and complaints of giving way or buckling; or
2) Four or more weeks of conservative care; or
3) Current exam with the following findings: hemarthrosis and\or positive Lockman's and\or positive pivot shift; or
4) MRI is necessary to choose treatment option(s).

352 Suspected **posterior cruciate ligament tear** when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least two of the following:

1) History of direct blow to anterior tibia or forced hyperflexion; or
2) Four or more weeks of conservative care; or
3) Current clinical with one or more positive findings: positive drawers, test positive tibial sag.

353 Suspected **meniscal tear** when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least two of the following:

1) History of twisting injury with subsequent catching, locking, and swelling; or
2) Four or more weeks of conservative care; or
3) One or more of the following exam findings: joint line tenderness, positive McMurrays.

Upper Extremity MRI/MRA
CPT: 73218-73223

361 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

Lower Extremity MRI/MRA
CPT: 73718-73723

371 Suspected diagnosis of **tumor or abscess** with a bone scan or x-ray suspicious for same.

Abdominal MRI/MRA
CPT: 74181-74183

381 Suspected diagnosis of **tumor or abscess** with both of the following:

1) Ultrasound positive for mass on the kidney, pancreas, or liver; and
2) Objective evidence of poor renal function.

Other MRI/MRA
All other covered MRI/MRA

390 MRIs/MRAs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Note: If billing for more than one MRI/MRA for the same reason, use criteria code 390.

Note: If billing for more than one MRI/MRA for different reasons, build two separate expedited prior authorization numbers.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria	Code	Criteria

PET Scan
HCPCS code: G0125
DX: 235.7, 793.1

382 PET imaging regional or whole body when the client has a pulmonary nodule.

PET Scans
HCPCS codes: G0210, G0213, G0216, G0220

383 PET Imaging whole body to diagnose; lung cancer (non small cell), colorectal cancer, melanoma, or lymphoma **when at least one of the following is true:**

1) The PET results may assist in avoiding an invasive diagnostic procedure; or
2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure.

PET Scans
HCPCS codes: G0211, G0214, G0217, G0221
DX: 162.0-162.9, 153.0-154.8, 172.0-172.9, 190.9, 200.00-202.28

384 PET Imaging whole body for initial staging of; lung cancer (non-small cell), colorectal cancer, melanoma, or lymphoma **when one of the following is true:**

1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or
2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and
3) The clinical management of the client would differ depending on the stage of the cancer identified.

PET Scans
HCPCS codes: G0212, G0215, G0218, G0222
DX: 162.0-162.9, 153.0-154.8, 172.0-172.9, 190.9, 200.00-202.28

385 PET Imaging whole body for re-staging of; lung cancer (non-small cell), colorectal cancer, melanoma, or lymphoma after completion of treatment for **one of the following reasons:**

1) To detect residual disease; or
2) To detect suspected recurrence; or
3) To determine the extent of known recurrence.

PET Scans
HCPCS codes: G0223, G0226

386 PET Imaging whole body or regional to diagnose; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer when **at least one of the following is true:**

1) The PET results may assist in avoiding an invasive diagnostic procedure; or
2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure.

PET Scans
HCPCS codes: G0224, G0227
DX: 160-161.9, 170, 170.1, 171.0

387 PET Imaging whole body or regional for initial staging of; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer when **at least one of the following is true:**

1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or
2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria	Code	Criteria

3) The clinical management of the client would differ depending on the stage of the cancer identified.

PET Scans
HCPCS codes: G0225, G0228
DX: 160-161.9, 170, 170.1, 171.0

388 PET Imaging whole body or regional for re-staging of; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer after the completion of treatment for **one of the following**:

1) To detect residual disease;
2) To detect suspected recurrence; or
3) To determine the extent of known recurrence.

PET Scans
HCPCS codes: G0229
DX: 345.11, 345.41, 345.54

389 PET Imaging; metabolic brain imaging for pre-surgical evaluation of refractory seizures.

PET Scans
HCPCS codes: G0230
DX: 410.00-414.9

391 PET Imaging; metabolic assessment for myocardial viability when a SPECT study is inconclusive.

PET Scans
HCPCS codes: G0231, G0232, G0233
DX: 153.0-154.8, 200.00-202.28, 202.80-202.88, 172.0-172.9

392 PET WhBD, gamma cameras only, for one of the following reasons:

1) Recurrence of colorectal or colorectal metastatic cancer;
2) Recurrence of melanoma or metastatic melanoma; or
3) Staging and characterization of lymphoma.

PET Scans
HCPCS codes: G0234
DX: 162.0-162.9

393 PET regional or whole body, gamma camera only, when the study is for **one of the following:**

1) A solitary pulmonary nodule following CT; or
2) Initial staging of pathologically diagnosed non-small cell lung cancer.

PET Scans
HCPCS codes: G0253, G0254
DX: 174.0, 175.9

394 PET imaging, for breast cancer, full and partial ring, when the study is for <u>one</u> of the following:

1) Staging/restaging of local regional recurrence or distant metastases, i.e., staging/restaging after, or prior to, course of treatment; or
2) Evaluation of response to treatment, performed during course of treatment.

PET Scans
HCPCS codes: G0296
DX: 193

395 PET imaging, full and partial ring, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria

Medical Admits

CPT: 99221-99223

401 Diagnosis of **Cellulitis** (681-681.9, 682, 682.2-682.9) in a client that received greater than 30 hours of IV antibiotics during the hospitalization and any one of the following:

1) Incision & drainage during admit; or
2) White Count greater than10 on admit; or
3) Persistence or progression of fever, lymphodenopathy, edema, or erythema after a minimum of 24 hours of outpatient antibiotic treatment.

402 Diagnosis of **Abdominal Pain** (789-789.09) in a client with a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours.

403 Diagnosis of **Dehydration or Electrolyte Imbalances** (276-276.6, 276.8-276.9) in a client with abnormal lab values requiring intravenous electrolyte supplementation, during the hospital stay, for greater than 30 hours.

404 Diagnosis of **Nausea/Vomiting** (536.2; 787-787.03) in a client:

1) With a nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours; or
2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.

405 Diagnosis of **Gastritis** (535-535.6, 558-558.9) in a client:

1) With a Nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; or
2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.

406 Diagnosis of **headaches** (784.0**,** 346-346.9) in a client receiving intravenous DHE, during the hospital stay, for greater than 30 hours.

407 Diagnosis of **chronic pancreatitis** (577, 577.1) in a client:

1) With a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; or
2) That is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.

408 Diagnosis of **back pain** (724-724.5, 724.8-724.9, 846-847.9) in a client:

1) Failed outpatient treatment; and
2) Continued use of intravenous pain medication, during the hospital stay, greater than 30 hours; or
3) Continued inability to ambulate after physical therapy intervention greater than 30 hours.

409 Diagnosis of **constipation** (560.3, 560.39, 564-564.9) in a client:

1) Failed outpatient treatment; or
2) Recent abdominal surgery; and
3) Extensive inpatient treatment, during the hospital stay, greater than 30 hours.

Other Inpatient Medical Admits

420 Inpatient medical admits requiring expedited prior authorization and not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria, for continued stay over 24 hours. Medical appropriateness must be clearly evident by the documentation in the client's medical record.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria	Code	Criteria

Visual Exams
CPT: 92014-92015

610 **Eye Exam** within two (2) years of last exam when no medical indication exists and **both** of the following are documented in the client's record:

1) Glasses or contacts are broken or lost; **and**
2) Last exam was 18 months ago or longer.

628 Diopter change of +/- one.

Dispensing/Fitting Fees For Glasses
CPT: 92340-92342

615 **Glasses (both frames and lenses)** within two (2) years of last dispense may be replaced when glasses are broken or lost and **all** of the following are documented in the client's record:

1) Copy of current prescription (must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) Both frames and lenses are broken or lost.

Dispensing/Fitting Fees For Frames Only
CPT: 92340

618 **Frames Only** within two (2) years of last dispense may be replaced when frames only are broken, and all of the following are documented in the client's record:

1) No longer covered under the manufacturer's one (1) year warranty; **and**
2) Copy of current prescription demonstrating the need for prescription eye wear; **and**
3) Documentation of frame damage.

619 **Durable Frames (American Athletic or Invincible)** when **one** of the following is documented in the client's record:

1) Client has a seizure disorder that results in frequent falls; **or**
2) Client has a history of two or more incidences of broken frames in the past 12 months as a result of a medical condition.

620 **Flexible Frame (Daryl or Scott)** when **one** of the following is documented in the client's record:

1) Client has a seizure disorder that results in frequent falls; **or**
2) Client has a history of two or more incidences of broken frames in the past 12 months as a result of a medical condition.

Dispensing/Fitting Fees For Lenses Only
CPT: 92341, 94342

623 **Lenses Only** within two (2) years of last dispense when the lenses only are lost or broken and **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) Documentation of lens damage or loss.

624 **Lenses Only** within two (2) years of last dispense, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lenses at no charge) when **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription must not be older than 17 months); **and**
2) Date of last dispense; **and**
3) The current exam shows a refractive change of .75 diopters or more; **and**

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria	Code	Criteria

4) The client has headaches, blurred vision, difficulty with school or work and it has been diagnosed by a physician as caused from the inability to see adequately; **and**
5) The client does not have a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy).

Note: In conditions other than pregnancy, if vision has been stable for 3 months and medical condition is stable, lenses are allowed when (1)-(4) previously listed are true.

625 **High Index Lenses** when **one** of the following is documented in the client's record:

1) Spherical correction is greater than, or equal to, +\- 8 diopters; **or**
2) Cylinder correction is greater than, or equal, to +\- 3 diopters.

626 **Executive bifocals and trifocals** for clients 11 years of age and older, with a diagnosis of accommodative esotropia or strabismus documented in the client's record.

628 Diopter change of +/- one.

Dispensing/Fitting Fees For Contacts
CPT: 92070, 92310-92313

627 **Contacts (client must meet criteria found in MAA's Vision Care Billing Instructions for contacts)** within one (1) year of last dispense may be replaced when contacts are broken or lost and **both** of the following are documented in the client's record:

1) Copy of current prescription (must not be older than 17 months) **and**
2) Date of last dispense documented.

628 Diopter change of +/- one.

Blepharoplasties
CPT: 67901-67908

630 Blepharoplasty for noncosmetic reasons when both of the following are true:

1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; and
2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

Strabismus Surgery
CPT: 67311-67340

631 Strabismus surgery for clients 18 years of age and older when both of the following are true:

1) The client has double vision; and
2) It is not done for cosmetic reasons.

Physical Therapy
CPT: 97010-97150, 97520-97537,97750

640 **An additional 48 Physical Therapy program units** when the client has already used the allowed program units for the current year and has **one** of the following surgeries or injuries:

1) Lower Extremity Joint Surgery;
2) CVA not requiring acute inpatient rehabilitation; or
3) Spine surgery.

641 **An additional 96 Physical Therapy program units** when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria	Code	Criteria

Occupational Therapy

CPT: 97110, 97112, 97520, 97530, 97532, 97533, 97535, 97537

644 **An additional 12 Occupational Therapy** visits when the client has used the allowed visits for the current year and has **one** of the following:

1) Hand\Upper Extremity Joint Surgery; or
2) CVA not requiring acute inpatient rehabilitation.

645 **An additional 24 Occupational Therapy** visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.

Orthotics

HCPCS: L3000

784 **Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each**

Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met:

1) Required to prevent or correct pronation;
2) Required to promote proper foot alignment due to pronation; or
3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc.

☞ **Note:**

1) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.
3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.

HCPCS: **L3030**

780 **Foot insert, removable, formed to patient foot.**

One (1) pair allowed in a 12-month period if one of the following criteria is met:

1) Severe arthritis with pain;
2) Flat feet or pes planus with pain;
3) Valgus or varus deformity with pain;
4) Plantar facitis with pain; or
5) Pronation.

☞ **NOTE:**

1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

HCPCS: **L3310 & L3320**

781 **Lift, elevation, heel & sole, per inch.**

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

HCPCS: **L3334**

782 **Lift, elevation, heel, per inch**

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

CPT codes and descriptions only are copyright 2003 American Medical Association.

Code	Criteria	Code	Criteria

☞ **NOTE:**

1) Lifts are not covered for less than one (1) inch.
2) Lifts are only allowed on one (1) pair of client shoes.
3) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

HCPCS: L3215 or L3219

785 Orthopedic footwear, woman's or man's shoes, oxford.

Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:

1) When one or both shoes are attached to a brace;
2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts;
3) To accommodate a partial foot prosthesis; or
4) To accommodate clubfoot.

☞ **NOTE:**

1) MAA does not allow orthopedic footwear for the following reasons:
   a) To accommodate L3030 orthotics;
   b) Bunions;
   c) Hammer toes;
   d) Size difference (mismatched shoes); or
   e) Abnormal sized foot.

CPT codes and descriptions only are copyright 2003 American Medical Association.

MAA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650 and WAC 388-531-0700]

The following services must be performed in an MAA-approved Center of Excellence (COE) and **do not require prior authorization**. See the next page for a list of COEs.

- Organ/bone marrow/peripheral stem cell transplants;
- Inpatient Chronic Pain Management; and
- Sleep studies (CPT codes 95805, 95807-95811), only allowed for ICD-9-CM diagnoses 780.51, 780.53, 780.57, or 347.

☞ **Note:** When billing on a paper HCFA-1500 claim form, note the COE in field 32. When billing electronically, note the COE in the *Comments* section.

CPT codes and descriptions only are copyright 2003 American Medical Association.

MAA-Approved Organ Transplant Centers of Excellence (COE)

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Children's Hospital & Medical Center/Seattle	• Bone Marrow (BMT) (autologous & allogenic) • Peripheral Stem Cell Transplant (PSC-T) • Heart • Liver • Kidney	• 38230, 38240-38242 • 38205-38206, 38240-38242 • 33945 • 47135-47136 • 50360, 50365, 50380
Dorenbacher Children's Hospital/Portland NW Marrow Transplant Program (PSC-T only)	• BMT • PSC-T	• 38230, 38240-38242 • 38205-38206, 38240-38242
Fred Hutchinson Cancer Research Center/Seattle	• BMT • PSC-T	• 38230, 38240-38242 • 38205-38206, 38240-38242
Good Samaritan Hospital Medical/Puyallup	• PSC-T	• 38205-38206, 38240-38242
Inland NW Blood Center	• PSC-T	• 38205-38206, 38240-38242
Legacy Good Samaritan Hospital/Portland (Northwest Marrow Transplant Program)	• BMT • PSC-T	• 38230, 38240-38242 • 38205-38206, 38240-38242
Mary Bridge Children's Hospital/Seattle	• PSC-T (autologous only)	• 38206, 38242
Oregon Health Sciences University (OHSU)/Portland	• Heart • Liver • Kidney • Pancreas	• 33945 • 47135-47136 • 50360, 50365, 50380 • 48160, 48554
Providence St. Peter Hospital/Olympia	• PSC-T	• 38206, 38240-38242
Sacred Heart Medical Center/Spokane	• Kidney • Heart • Heart/Lung(s) • Lung	• 50360, 50365, 50380 • 33945 • 33935 • 32851-32854
Seattle Cancer Care Alliance/Seattle	• BMT • PSC-T	• 38230, 38240-38242 • 38205-38206, 38240-38242
St. Joseph's Hospital/Tacoma	• BMT (autologous only) • PSC-T	• 38230, 38242 • 38205-38206, 38240-38242

MAA-Approved Organ Transplant Centers of Excellence (COE) (Cont.)

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Swedish Medical Center/Seattle	• Kidney • PSC-T	• 50360, 50365, 50380 • 38231, 38240-38241
University of Washington Medical Center/Seattle	• BMT • PSC-T • Heart • Heart/Lung(s) • Lung • Kidney • Liver • Pancreas	• 38230, 38240-38241 • 38231, 38240-38241 • 33945 • 33935 • 32851-32854 • 50360, 50365, 50380 • 47135-47136 • 48160, 48554
Virginia Mason Hospital/Seattle	• Kidney • Pancreas • BMT • PSC-T	• 50360, 50365, 50380 • 48160, 48554 • 38230, 38240-38241 • 38231, 38240-38241

MAA-Approved Sleep Centers

[Refer to WAC 388-531-1500]

MAA Approved Sleep Centers	Location
ARMC Sleep Apnea Laboratory	Auburn Regional Medical Center - Auburn, WA
Diagnostic Sleep Disorder Program Center	Children's Hospital and Medical - Seattle, WA
Eastside Sleep Disorder Clinic	Overlake Hospital Medical Center - Bellevue, WA
Highline Sleep Disorders Center	Highline Community Hospital - Seatttle, WA
Holy Family Sleep Disorder Center	Holy Family Hospital -Spokane, WA
Kathryn Severyns Dement Sleep Disorders Center	St. Mary's Medical Center - Walla Walla, WA
Multi Care Sleep Disorders Center	Tacoma General Hospital/ or Mary Bridge Children's Hospital - Tacoma, WA
Providence Everett Sleep Disorder Center	Providence Everett Medical Center - Everett, WA.
Sleep Center for Southwest Washington	Providence St. Peter - Olympia, WA
Sleep Disorders Center Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center - Portland, OR
Sleep Disorders Center of Harrison Hospital	Harrison Hospital - Bremerton, WA
Sleep Disorders Center Virginia Mason Medical Center	Virginia Mason Medical Center - Seattle, WA
Sleep Related Breathing Disorders Laboratory St Clare Hospital	St. Clare Hospital - Tacoma, WA
Sleep Studies Laboratory Mid Columbia Medical Center	Mid Columbia Medical Center - Dalles, OR
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center - Lewiston, ID
Swedish Sleep Medicine Institute	Providence Swedish or Swedish First Hill - Seattle, WA
The Sleep Institute of Spokane	Sacred Heart Medical Center or 104 W. 5th Suite 400 W - Spokane, WA
Harborview Medical Center	Harborview Medical Center - Seattle, WA
Vancouver Sleep Disorders Center	Vancouver Neurology - Vancouver, WA

Website Update Only

CPT codes and descriptions only are copyright 2003 American Medical Association.

Providers must:

- Use CPT codes 95805, 95807-95811 for sleep study services.
- Enter the location of the approved sleep center where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of MAA-approved sleep center.) Enter the information into the *Comments* section of the claim form.

> ☞ **Note**: All sleep studies are limited to Obstructive Sleep Apnea, ICD-9-CM diagnosis codes **780.51, 780.53, 780.57,** or Narcolepsy **347**.

MAA-Approved Inpatient Pain Clinics

MAA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma

CPT codes and descriptions only are copyright 2003 American Medical Association.

Site of Service (SOS) Payment Differential

How are fees established for professional services performed in facility and non-facility settings?

Based on the Resource Based Relative Value Scale (RBRVS) methodology, MAA's fee schedule amounts are established using three relative value unit (RVU) components: work, practice expense, and malpractice expense. MAA uses two levels of practice expense components to determine the fee schedule amounts for reimbursing professional services. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees (FS Fee) -** Paid when the provider performs the services in a facility setting (e.g., a hospital or ambulatory surgery center) and the cost of the resources are the responsibility of the facility; or

- **Non-facility setting maximum allowable fees (NFS Fee) -** Paid when the provider performs the service in a non-facility setting (e.g., office or clinic) and typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include:

- Evaluation and management (E&M) codes which specify the site of service within the description of the procedure codes (e.g., initial hospital care); and
- Major surgical procedures that are generally performed only in hospital settings.

How does the site of service payment policy affect provider reimbursements?

Providers billing professional services are reimbursed at one of two maximum allowable fees, depending on where the service is performed.

CPT codes and descriptions only are copyright 2003 American Medical Association

Does MAA reimburse providers differently for services performed in facility and non-facility settings?

When a provider performs a professional service in a facility setting, MAA makes two payments - one to the performing provider and another to the facility. The payment to the provider (FS Fee) includes the provider's professional services only. A separate payment is made directly to the facility where the service took place, which includes payment for necessary resources. The FS Fee excludes the allowance for resources that are included in the payment to the facility. Reimbursing the lower FS Fee to the performing provider when the facility is also reimbursed eliminates duplicate payment for resources.

When a provider performs a professional service in a non-facility setting, MAA makes only one payment to the performing provider. The payment to the provider (NFS Fee) includes the provider's professional services and payment for necessary resources.

When are professional services reimbursed at the facility setting maximum allowable fee?

Providers are reimbursed at the FS Fee when MAA also makes a payment to a facility. In most cases, MAA follows Medicare's determination for using the FS Fee. Professional services billed with the following place of service codes are reimbursed at the FS Fee:

FACILITY SETTING

Place of Service Code	Place of Service Description
06	Indian Health Service – provider based
08	Tribal 638 – provider based
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility

CPT codes and descriptions only are copyright 2003 American Medical Association

Due to Medicare consolidated billing requirements, MAA does not make a separate payment to providers who perform certain services in hospitals and skilled nursing facilities. The facilities are reimbursed at the NFS Fee. Some therapies, such as physical therapy services (CPT codes 97001-97799), are always paid at the NFS Fee.

When are professional services reimbursed at the nonfacility setting maximum allowable fee?

The NFS Fee is paid when MAA does not make a separate payment to a facility, such as when services are performed in a provider's office or a client's home. In most cases, MAA follows Medicare's determination for using the NFS Fee.

Professional services billed with the following place of service codes are reimbursed at the NFS Fee:

NON-FACILITY SETTING

Place of Service Code	Place of Service Description
04	Homeless Shelter
05	Indian Health – Free Standing
07	Tribal 638 – Free Standing
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
20	Urgent Care Facility
32	Nursing Facility
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
54	Intermediate Care Facility
55	Residential Substance Abuse Treatment Facility
57	Non-Resident Substance Abuse Treatment Facility
60	Mass Immunization Center
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

CPT codes and descriptions only are copyright 2003 American Medical Association

Which professional services have an SOS payment differential?

Most of the services with an SOS payment differential are from the surgery, medicine, and E&M ranges of CPT codes. However, some HCPCS, CPT radiology, pathology, and laboratory codes also have an SOS payment differential.

Fee Schedule

- Maximum allowable fees for all codes, including CPT codes and selected HCPCS codes, are **listed in the fee schedule** beginning on page J.5. This enables providers to use this section as a quick reference for MAA's maximum allowable fees.

- Beginning on page J.5, MAA identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in MAA's billing instructions and Washington Administrative Code (WAC) remain applicable.

- Selected HCPCS codes once listed on page J.129 have been integrated into other sections of these billing instructions. Page J.129 contains a list that directs providers to those sections where the policies and limitations for selected HCPCS codes are found.

- Section L contains rate setting methodology and unit rounding instructions for injectable drug codes.

- Many of MAA's fee schedules are available for download in Excel format at MAA's website at http://maa.dshs.wa.gov. Click on Provider Publications/Fee Schedules, accept the CPT agreement, and then click on Fee Schedules.

CPT codes and descriptions only are copyright 2003 American Medical Association

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
00104		4 Base	4 Base		000	N	00529		11 Base	11 Base		000	N
00120		5 Base	5 Base		000	N	00530		4 Base	4 Base		000	N
00124		4 Base	4 Base		000	N	00532		4 Base	4 Base		000	N
00126		4 Base	4 Base		000	N	00534		7 Base	7 Base		000	N
00140		5 Base	5 Base		000	N	00537		10 Base	10 Base		000	N
00142		4 Base	4 Base		000	N	00539		18 Base	18 Base		000	N
00144		6 Base	6 Base		000	N	00540		12 Base	12 Base		000	N
00145		6 Base	6 Base		000	N	00541		15 Base	15 Base		000	N
00147		4 Base	4 Base		000	N	00542		15 Base	15 Base		000	N
00148		4 Base	4 Base		000	N	00546		15 Base	15 Base		000	N
00160		5 Base	5 Base		000	N	00548		17 Base	17 Base		000	N
00162		7 Base	7 Base		000	N	00550		10 Base	10 Base		000	N
00164		4 Base	4 Base		000	N	00560		15 Base	15 Base		000	N
00170		5 Base	5 Base		000	N	00562		20 Base	20 Base		000	N
00172		6 Base	6 Base		000	N	00563		25 Base	25 Base		000	N
00174		6 Base	6 Base		000	N	00566		25 Base	25 Base		000	N
00176		7 Base	7 Base		000	N	00580		20 Base	20 Base		000	N
00190		5 Base	5 Base		000	N	00600		10 Base	10 Base		000	N
00192		7 Base	7 Base		000	N	00604		13 Base	13 Base		000	N
00210		11 Base	11 Base		000	N	00620		10 Base	10 Base		000	N
00212		5 Base	5 Base		000	N	00622		13 Base	13 Base		000	N
00214		9 Base	9 Base		000	N	00630		8 Base	8 Base		000	N
00215		9 Base	9 Base		000	N	00632		7 Base	7 Base		000	N
00216		15 Base	15 Base		000	N	00634		10 Base	10 Base		000	N
00218		13 Base	13 Base		000	N	00635		4 Base	4 Base		000	N
00220		10 Base	10 Base		000	N	00640		3 Base	3 Base		000	N
00222		6 Base	6 Base		000	N	00670		13 Base	13 Base		000	N
00300		5 Base	5 Base		000	N	00700		4 Base	4 Base		000	N
00320		6 Base	6 Base		000	N	00702		4 Base	4 Base		000	N
00322		3 Base	3 Base		000	N	00730		5 Base	5 Base		000	N
00326		8 Base	8 Base		000	N	00740		5 Base	5 Base		000	N
00350		10 Base	10 Base		000	N	00750		4 Base	4 Base		000	N
00352		5 Base	5 Base		000	N	00752		6 Base	6 Base		000	N
00400		3 Base	3 Base		000	N	00754		7 Base	7 Base		000	N
00402		5 Base	5 Base		000	N	00756		7 Base	7 Base		000	N
00404		5 Base	5 Base		000	N	00770		15 Base	15 Base		000	N
00406		13 Base	13 Base		000	N	00790		7 Base	7 Base		000	N
00410		4 Base	4 Base		000	N	00792		13 Base	13 Base		000	N
00450		5 Base	5 Base		000	N	00794		8 Base	8 Base		000	N
00452		6 Base	6 Base		000	N	00796		30 Base	30 Base		000	N
00454		3 Base	3 Base		000	N	00797		9 Base	9 Base		000	N
00470		6 Base	6 Base		000	N	00800		4 Base	4 Base		000	N
00472		10 Base	10 Base		000	N	00802		5 Base	5 Base		000	N
00474		13 Base	13 Base		000	N	00810		5 Base	5 Base		000	N
00500		15 Base	15 Base		000	N	00820		5 Base	5 Base		000	N
00520		6 Base	6 Base		000	N	00830		4 Base	4 Base		000	N
00522		4 Base	4 Base		000	N	00832		6 Base	6 Base		000	N
00524		4 Base	4 Base		000	N	00834		5 Base	5 Base		000	N
00528		8 Base	8 Base		000	N	00836		6 Base	6 Base		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
00840		6 Base	6 Base		000	N	01170		8 Base	8 Base		000	N
00842		4 Base	4 Base		000	N	01173		12 Base	12 Base		000	N
00844		7 Base	7 Base		000	N	01180		3 Base	3 Base		000	N
00846		8 Base	8 Base		000	N	01190		4 Base	4 Base		000	N
00848		8 Base	8 Base		000	N	01200		4 Base	4 Base		000	N
00851		6 Base	6 Base		000	N	01202		4 Base	4 Base		000	N
00860		6 Base	6 Base		000	N	01210		6 Base	6 Base		000	N
00862		7 Base	7 Base		000	N	01212		10 Base	10 Base		000	N
00864		8 Base	8 Base		000	N	01214		8 Base	8 Base		000	N
00865		7 Base	7 Base		000	N	01215		10 Base	10 Base		000	N
00866		10 Base	10 Base		000	N	01220		4 Base	4 Base		000	N
00868		10 Base	10 Base		000	N	01230		6 Base	6 Base		000	N
00870		5 Base	5 Base		000	N	01232		5 Base	5 Base		000	N
00872		7 Base	7 Base		000	N	01234		8 Base	8 Base		000	N
00873		5 Base	5 Base		000	N	01250		4 Base	4 Base		000	N
00880		15 Base	15 Base		000	N	01260		3 Base	3 Base		000	N
00882		10 Base	10 Base		000	N	01270		8 Base	8 Base		000	N
00902		5 Base	5 Base		000	N	01272		4 Base	4 Base		000	N
00904		7 Base	7 Base		000	N	01274		6 Base	6 Base		000	N
00906		4 Base	4 Base		000	N	01320		4 Base	4 Base		000	N
00908		6 Base	6 Base		000	N	01340		4 Base	4 Base		000	N
00910		3 Base	3 Base		000	N	01360		5 Base	5 Base		000	N
00912		5 Base	5 Base		000	N	01380		3 Base	3 Base		000	N
00914		5 Base	5 Base		000	N	01382		3 Base	3 Base		000	N
00916		5 Base	5 Base		000	N	01390		3 Base	3 Base		000	N
00918		5 Base	5 Base		000	N	01392		4 Base	4 Base		000	N
00920		3 Base	3 Base		000	N	01400		4 Base	4 Base		000	N
00921		3 Base	3 Base		000	N	01402		7 Base	7 Base		000	N
00922		6 Base	6 Base		000	N	01404		5 Base	5 Base		000	N
00924		4 Base	4 Base		000	N	01420		3 Base	3 Base		000	N
00926		4 Base	4 Base		000	N	01430		3 Base	3 Base		000	N
00928		6 Base	6 Base		000	N	01432		6 Base	6 Base		000	N
00930		4 Base	4 Base		000	N	01440		8 Base	8 Base		000	N
00932		4 Base	4 Base		000	N	01442		8 Base	8 Base		000	N
00934		6 Base	6 Base		000	N	01444		8 Base	8 Base		000	N
00936		8 Base	8 Base		000	N	01462		3 Base	3 Base		000	N
00938		4 Base	4 Base		000	N	01464		3 Base	3 Base		000	N
00940		3 Base	3 Base		000	N	01470		3 Base	3 Base		000	N
00942		4 Base	4 Base		000	N	01472		5 Base	5 Base		000	N
00944		6 Base	6 Base		000	N	01474		5 Base	5 Base		000	N
00948		4 Base	4 Base		000	N	01480		3 Base	3 Base		000	N
00950		5 Base	5 Base		000	N	01482		4 Base	4 Base		000	N
00952		4 Base	4 Base		000	N	01484		4 Base	4 Base		000	N
01112		5 Base	5 Base		000	N	01486		7 Base	7 Base		000	N
01120		6 Base	6 Base		000	N	01490		3 Base	3 Base		000	N
01130		3 Base	3 Base		000	N	01500		8 Base	8 Base		000	N
01140		15 Base	15 Base		000	N	01502		6 Base	6 Base		000	N
01150		10 Base	10 Base		000	N	01520		3 Base	3 Base		000	N
01160		4 Base	4 Base		000	N	01522		5 Base	5 Base		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
01610		5 Base	5 Base		000	N
01620		4 Base	4 Base		000	N
01622		4 Base	4 Base		000	N
01630		5 Base	5 Base		000	N
01632		6 Base	6 Base		000	N
01634		9 Base	9 Base		000	N
01636		15 Base	15 Base		000	N
01638		10 Base	10 Base		000	N
01650		6 Base	6 Base		000	N
01652		10 Base	10 Base		000	N
01654		8 Base	8 Base		000	N
01656		10 Base	10 Base		000	N
01670		4 Base	4 Base		000	N
01680		3 Base	3 Base		000	N
01682		4 Base	4 Base		000	N
01710		3 Base	3 Base		000	N
01712		5 Base	5 Base		000	N
01714		5 Base	5 Base		000	N
01716		5 Base	5 Base		000	N
01730		3 Base	3 Base		000	N
01732		3 Base	3 Base		000	N
01740		4 Base	4 Base		000	N
01742		5 Base	5 Base		000	N
01744		5 Base	5 Base		000	N
01756		6 Base	6 Base		000	N
01758		5 Base	5 Base		000	N
01760		7 Base	7 Base		000	N
01770		6 Base	6 Base		000	N
01772		6 Base	6 Base		000	N
01780		3 Base	3 Base		000	N
01782		4 Base	4 Base		000	N
01810		3 Base	3 Base		000	N
01820		3 Base	3 Base		000	N
01829		3 Base	3 Base		000	N
01830		3 Base	3 Base		000	N
01832		6 Base	6 Base		000	N
01840		6 Base	6 Base		000	N
01842		6 Base	6 Base		000	N
01844		6 Base	6 Base		000	N
01850		3 Base	3 Base		000	N
01852		4 Base	4 Base		000	N
01860		3 Base	3 Base		000	N
01905		5 Base	5 Base		000	N
01916		5 Base	5 Base		000	N
01920		7 Base	7 Base		000	N
01922		7 Base	7 Base		000	N
01924		6 Base	6 Base		000	N
01925		8 Base	8 Base		000	N
01926		10 Base	10 Base		000	N
01930		5 Base	5 Base		000	N
01931		7 Base	7 Base		000	N
01932		7 Base	7 Base		000	N
01933		8 Base	8 Base		000	N
01951		3 Base	3 Base		000	N
01952		5 Base	5 Base		000	N
01953		20.24	20.24		000	N
01958		5 Base	5 Base		000	N
01960		5 Base	5 Base		000	N
01961		9 Base	9 Base		000	N
01962		8 Base	8 Base		000	N
01963		10 Base	10 Base		000	N
01964		4 Base	4 Base		000	N
01967		6 Base	6 Base		000	N
01968		3 Base	3 Base		000	N
01969		5 Base	5 Base		000	N
01990		7 Base	7 Base		000	N
01991		3 Base	3 Base		000	N
01992		5 Base	5 Base		000	N
01995		5 Base	5 Base		000	N
01996		20.18	20.18		000	N
01999		B.R.	B.R.		000	N
02100		3 Base	3 Base		000	N
02101		5 Base	5 Base		000	N
10021		80.71	42.62		000	N
10022		89.77	39.67		000	N
10040		51.23	43.53		010	N
10060		55.99	49.87		010	N
10061		99.75	92.95		010	N
10080		100.43	54.63		010	N
10081		153.93	94.53		010	N
10120		63.25	39.22		010	N
10121		142.82	109.72		010	N
10140		72.54	58.94		010	N
10160		46.25	40.13		010	N
10180		131.03	104.28		010	N
11000		27.88	19.72		000	N
11001		12.47	9.75		000	N
11010		259.57	158.46		010	N
11011		307.86	178.19		000	N
11012		450.91	264.11		000	N
11040		24.03	17.23		000	N
11041		34.91	27.43		000	N
11042		49.65	37.86		000	N
11043		137.61	119.24		010	N
11044		180.00	163.45		010	N
11055		22.67	14.06		000	N
11056		29.02	20.18		000	N
11057		35.59	26.07		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
11100		48.29	27.88		000	N
11101		17.46	14.06		000	N
11200		42.62	36.05		010	N
11201		10.65	9.75		000	N
11300		35.14	17.46		000	N
11301		45.79	28.79		000	N
11302		54.86	35.59		000	N
11303		65.97	41.26		000	N
11305		35.37	22.22		000	N
11306		48.97	32.87		000	N
11307		56.45	38.31		000	N
11308		66.65	46.93		000	N
11310		43.07	25.16		000	N
11311		53.27	36.05		000	N
11312		61.44	41.03		000	N
11313		80.48	55.31		000	N
11400		66.42	41.03		010	N
11401		77.30	53.50		010	N
11402		88.41	62.12		010	N
11403		99.52	74.58		010	N
11404		113.35	83.20		010	N
11406		139.19	106.32		010	N
11420		64.61	45.57		010	N
11421		82.29	60.30		010	N
11422		92.04	70.73		010	N
11423		109.27	82.97		010	N
11424		124.46	96.57		010	N
11426		173.88	141.46		010	N
11440		78.21	56.45		010	N
11441		90.91	70.50		010	N
11442		101.56	78.44		010	N
11443		124.00	97.93		010	N
11444		158.01	126.95		010	N
11446		202.44	172.07		010	N
11450		184.76	114.26		090	N
11451		252.54	156.65		090	N
11462		181.36	108.36		090	N
11463		257.76	159.82		090	N
11470		198.14	132.39		090	N
11471		265.69	172.29		090	N
11600		92.49	54.18		010	N
11601		105.87	71.64		010	N
11602		112.67	76.40		010	N
11603		124.46	83.65		010	N
11604		136.70	90.68		010	N
11606		178.19	124.00		010	N
11620		89.09	51.01		010	N
11621		105.19	71.18		010	N
11622		119.47	82.52		010	N
11623		140.55	100.20		010	N
11624		161.86	115.84		010	N
11626		212.87	160.05		010	N
11640		94.53	58.49		010	N
11641		122.42	87.73		010	N
11642		141.69	102.47		010	N
11643		163.90	120.60		010	N
11644		207.20	155.29		010	N
11646		278.16	224.89		010	N
11719		9.75	5.67		000	N
11720		15.42	10.65		000	N
11721		23.12	17.91		000	N
11730		51.01	37.63		000	N
11732		23.80	19.04		000	N
11740		28.56	12.24		000	N
11750		94.53	85.24		010	N
11752		135.57	135.57		010	N
11755		56.22	43.30		000	N
11760		81.84	67.56		010	N
11762		124.69	114.71		010	N
11765		42.85	28.79		010	N
11770		145.31	99.07		010	N
11771		273.17	218.77		090	N
11772		337.56	261.84		090	N
11900		26.98	17.23		000	N
11901		34.01	27.20		000	N
11920		#	#		000	N
11921		#	#		000	N
11922		#	#		000	N
11950		#	#		000	N
11951		#	#		000	N
11952		#	#		000	N
11954		#	#		000	N
11960		466.55	466.55		090	N
11970		316.93	316.93		090	N
11971		215.59	162.09		090	N
11975		#	#		000	N
11976		119.95	119.95		000	N
11977		#	#		000	N
11980		60.98	48.29		000	N
11981		76.62	52.37		000	N
11982		89.32	63.48		000	N
11983		134.89	115.39		000	N
12001		87.28	52.82		010	N
12002		92.72	66.88		010	N
12004		108.82	78.66		010	N
12005		135.34	98.16		010	N
12006		168.44	125.14		010	N
12007		189.97	143.73		010	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
12011		92.49	54.63		010	N
12013		101.56	70.96		010	N
12014		119.70	84.79		010	N
12015		150.76	107.00		010	N
12016		178.64	131.94		010	N
12017		159.14	159.14		010	N
12018		187.48	187.48		010	Y
12020		125.59	104.96		010	N
12021		85.92	78.21		010	N
12031		104.96	70.73		010	N
12032		148.26	101.56		010	N
12034		143.50	103.15		010	N
12035		204.71	134.21		010	N
12036		223.53	155.29		010	N
12037		263.43	180.23		010	N
12041		114.26	77.53		010	N
12042		139.65	97.48		010	N
12044		149.85	112.44		010	N
12045		174.11	139.65		010	N
12046		255.72	168.21		010	N
12047		261.39	185.44		010	Y
12051		133.53	90.68		010	N
12052		139.42	97.48		010	N
12053		148.94	109.72		010	N
12054		165.04	120.60		010	N
12055		212.19	157.10		010	N
12056		283.15	198.59		010	N
12057		285.87	232.37		010	Y
13100		155.97	116.30		010	N
13101		179.77	144.63		010	N
13102		47.38	43.53		000	N
13120		162.77	121.74		010	N
13121		194.51	156.88		010	N
13122		55.09	49.65		000	N
13131		180.23	140.33		010	N
13132		249.37	214.68		010	N
13133		80.93	77.08		000	N
13150		218.77	152.57		010	N
13151		230.78	176.60		010	N
13152		291.31	242.12		010	N
13153		88.87	84.11		000	N
13160		427.56	427.56		090	N
14000		338.92	260.93		090	N
14001		434.13	357.51		090	N
14020		370.65	297.66		090	N
14021		482.64	420.53		090	N
14040		379.72	347.76		090	N
14041		520.05	475.16		090	N
14060		413.95	381.99		090	N
14061		562.44	513.02		090	N
14300		542.49	496.25		090	N
14350		405.11	405.11		090	N
15000		186.12	149.17		000	N
15001		56.22	34.46		000	Y
15050		244.38	216.05		090	N
15100		515.29	404.66		090	N
15101		130.81	81.16		000	N
15120		489.90	420.98		090	N
15121		171.61	109.50		000	N
15200		443.65	335.74		090	N
15201		56.90	47.38		000	N
15220		436.17	340.73		090	N
15221		50.33	42.39		000	N
15240		455.21	397.86		090	N
15241		79.34	67.10		000	N
15260		468.36	438.89		090	N
15261		116.75	87.05		000	N
15342		66.65	37.41		010	N
15343		12.24	8.39		000	N
15350		288.36	210.60		090	N
15351		46.70	34.01		000	N
15400		195.19	193.38		090	N
15401		53.05	35.14		000	N
15570		440.25	383.12		090	N
15572		422.80	374.06		090	N
15574		445.92	403.75		090	N
15576		428.24	360.23		090	N
15600		209.02	109.50		090	N
15610		145.99	129.90		090	N
15620		243.93	157.10		090	N
15630		237.13	170.48		090	N
15650		251.41	189.97		090	N
15732		851.26	717.51		090	Y
15734		854.21	728.16		090	Y
15736		824.51	665.36		090	N
15738		860.10	718.19		090	Y
15740		470.86	426.65		090	N
15750		491.49	491.49		090	Y
15756		1,341.61	1,341.61		090	Y
15757		1,371.08	1,371.08		090	Y
15758		1,371.31	1,371.31		090	Y
15760		436.62	374.96		090	N
15770		340.96	340.96		090	Y
15775		#	#		000	N
15776		#	#		000	N
15780		336.42	336.42		090	N
15781		238.49	238.49		090	N
15782		201.08	201.08		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
15783		215.59	198.36		090	N
15786		85.92	77.53		010	N
15787		15.19	11.56		000	N
15788		126.50	101.79		090	N
15789		264.11	230.10		090	N
15792		116.75	107.68		090	N
15793		183.40	183.40		090	N
15810		205.39	205.39		090	N
15811		278.39	260.25		090	N
15819		#	#		090	N
15820		#	#		090	N
15821		#	#		090	N
15822		#	#		090	N
15823		#	#		090	N
15824		#	#		000	N
15825		#	#		000	N
15826		#	#		000	N
15828		#	#		000	N
15829		#	#		000	N
15831		#	#		090	Y
15832		#	#		090	Y
15833		#	#		090	N
15834		#	#		090	N
15835		#	#		090	N
15836		#	#		090	N
15837		#	#		090	N
15838		#	#		090	N
15839		#	#		090	N
15840		556.32	556.32		090	N
15841		931.51	931.51		090	Y
15842		1,475.82	1,475.82		090	Y
15845		517.10	517.10		090	Y
15850		Bundled	Bundled		000	N
15851		60.08	28.34		000	N
15852		63.93	29.24		000	N
15860		76.62	65.29		000	N
15876		#	#		000	N
15877		#	#		000	N
15878		#	#		000	N
15879		#	#		000	N
15920		327.13	327.13		090	N
15922		415.54	415.54		090	Y
15931		362.49	362.49		090	N
15933		452.95	452.95		090	N
15934		504.18	504.18		090	N
15935		603.02	603.02		090	Y
15936		501.23	501.23		090	N
15937		583.75	583.75		090	Y
15940		376.10	376.10		090	N
15941		505.77	505.77		090	N
15944		485.82	485.82		090	N
15945		541.36	541.36		090	N
15946		870.53	870.53		090	Y
15950		313.98	313.98		090	N
15951		450.23	450.23		090	N
15952		464.05	464.05		090	Y
15953		524.58	524.58		090	N
15956		636.80	636.80		090	N
15958		642.69	642.69		090	Y
15999		B.R.	B.R.		090	N
16000		41.26	27.66		000	N
16010		36.27	35.59		000	N
16015		84.56	84.56		000	N
16020		49.42	33.32		000	N
16025		86.60	67.78		000	N
16030		101.79	76.85		000	N
16035		126.50	126.50		090	N
16036		50.10	50.10		000	N
17000		36.73	21.76		010	N
17003		6.12	5.21		000	N
17004		119.02	95.44		010	N
17106		221.94	186.80		090	N
17107		391.74	344.36		090	N
17108		540.68	494.89		090	N
17110		53.05	26.98		010	N
17111		60.30	35.37		010	N
17250		40.35	20.40		000	N
17260		51.01	31.74		010	N
17261		64.84	41.26		010	N
17262		80.71	55.31		010	N
17263		90.00	62.12		010	N
17264		97.03	66.20		010	N
17266		113.58	78.21		010	N
17270		70.50	46.02		010	N
17271		76.17	52.14		010	N
17272		87.51	61.89		010	N
17273		99.29	71.18		010	N
17274		120.38	88.64		010	N
17276		143.95	109.04		010	N
17280		64.84	40.81		010	N
17281		84.33	60.30		010	N
17282		98.16	71.41		010	N
17283		121.06	90.91		010	N
17284		143.50	110.86		010	N
17286		190.65	155.74		010	N
17304		364.53	260.93		000	N
17305		154.61	97.93		000	N
17306		155.06	98.16		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
17307		153.93	98.61		000	N
17310		60.53	33.32		000	N
17340		26.75	25.39		010	N
17360		#	#		010	N
17380		#	#		000	N
17999		B.R.	B.R.		000	N
19000		67.10	28.79		000	N
19001		28.34	13.38		000	N
19020		226.02	151.89		090	N
19030		113.35	47.61		000	N
19100		80.25	40.58		000	N
19101		184.08	115.16		010	N
19102		139.65	63.48		000	N
19103		363.85	115.39		000	N
19110		240.53	177.28		090	N
19112		224.43	153.02		090	N
19120		243.48	209.02		090	N
19125		261.61	226.47		090	N
19126		96.35	96.35		000	N
19140		295.16	206.30	EX	090	N
19160		228.29	228.29		090	N
19162		483.32	483.32		090	Y
19180		334.84	334.84		090	Y
19182		302.87	302.87		090	Y
19200		568.79	568.79		090	Y
19220		581.03	581.03		090	Y
19240		588.29	588.29		090	Y
19260		645.41	645.41		090	Y
19271		896.37	896.37		090	Y
19272		984.10	984.10		090	Y
19290		99.07	39.45		000	N
19291		55.09	19.95		000	N
19295		63.70	63.70		000	N
19316		441.61	441.61		090	Y
19318		648.14	648.14	EX	090	Y
19324		#	#		090	N
19325		#	#		090	N
19328		258.44	258.44		090	N
19330		329.17	329.17		090	N
19340		230.10	230.10		000	N
19342		486.04	486.04		090	N
19350		548.84	386.30		090	N
19355		482.64	303.78		090	N
19357		772.14	772.14		090	Y
19361		752.42	752.42		090	Y
19364		1,557.66	1,557.66		090	Y
19366		790.05	790.05		090	Y
19367		1,024.23	1,024.23		090	Y
19368		1,276.55	1,276.55		090	Y
19369		1,201.28	1,201.28		090	Y
19370		360.91	360.91		090	N
19371		414.63	414.63		090	N
19380		406.70	406.70		090	N
19396		186.80	77.08		000	N
19499		B.R.	B.R.		090	N
20000		106.10	88.87		010	N
20005		161.41	133.53		010	N
20100		382.90	350.48		010	Y
20101		146.22	115.39		010	N
20102		177.28	138.06		010	Y
20103		227.61	206.75		010	N
20150		496.93	496.93		090	Y
20200		110.18	54.86		000	N
20205		153.48	86.15		000	N
20206		96.35	31.74		000	N
20220		138.51	91.81		000	N
20225		157.56	112.67		000	N
20240		140.33	140.33		010	N
20245		331.89	331.89		010	N
20250		228.97	228.97		010	N
20251		261.84	261.84		010	Y
20500		164.81	119.24		010	N
20501		87.51	23.80		000	N
20520		97.48	87.28		010	N
20525		166.62	148.94		010	N
20526		44.89	34.23		000	N
20550		34.69	23.80		000	N
20551		34.01	26.07		000	N
20552		33.10	21.08		000	N
20553		37.63	23.58		000	N
20600		30.83	24.48		000	N
20605		34.01	25.16		000	N
20610		41.26	29.24		000	N
20612		33.55	24.94		000	N
20615		114.26	97.93		010	N
20650		112.22	101.33		010	N
20660		137.83	106.55		000	N
20661		244.61	244.61		090	N
20662		279.97	279.97		090	N
20663		249.14	249.14		090	N
20664		376.78	376.78		090	N
20665		80.48	63.48		010	N
20670		197.91	134.66		010	N
20680		159.60	159.60		090	N
20690		146.67	146.67		090	N
20692		243.93	243.93		090	Y
20693		278.61	278.61		090	N
20694		264.11	209.70		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
20802		1,551.53	1,551.53		090	Y
20805		2,024.43	2,024.43		090	Y
20808		2,536.32	2,536.32		090	Y
20816		1,665.56	1,665.56		090	Y
20822		1,470.60	1,470.60		090	Y
20824		1,651.74	1,651.74		090	Y
20827		1,539.29	1,539.29		090	Y
20838		1,588.03	1,588.03		090	Y
20900		311.03	276.12		090	Y
20902		351.84	351.84		090	Y
20910		294.94	256.62		090	N
20912		295.62	295.62		090	N
20920		232.37	232.37		090	N
20922		323.50	285.19		090	Y
20924		300.60	300.60		090	Y
20926		254.36	254.36		090	N
20930		Bundled	Bundled		000	N
20931		69.82	69.82		000	N
20936		Bundled	Bundled		000	N
20937		106.32	106.32		000	Y
20938		115.84	115.84		000	Y
20950		63.25	55.31		000	N
20955		1,558.11	1,558.11		090	Y
20956		1,587.13	1,587.13		090	Y
20957		1,485.34	1,485.34		090	Y
20962		1,610.02	1,610.02		090	Y
20969		1,721.11	1,721.11		090	Y
20970		1,671.01	1,671.01		090	Y
20972		1,607.76	1,570.12		090	Y
20973		1,719.52	1,719.52		090	Y
20974		30.38	28.79		000	N
20975		107.91	107.91		000	Y
20979		#	#		000	N
20982		2,592.31	246.20	PA	000	Y
20999		B.R.	B.R.		090	N
21010		407.83	407.83		090	N
21015		258.21	258.21		090	N
21025		479.24	433.45		090	N
21026		277.71	245.52		090	N
21029		388.11	334.84		090	N
21030		271.81	213.78		090	N
21031		184.76	151.66		090	N
21032		185.67	154.16		090	N
21034		707.76	656.30		090	Y
21040		263.65	201.08		090	N
21044		486.95	486.95		090	Y
21045		655.16	655.16		090	Y
21046		608.01	608.01		090	Y
21047		766.93	766.93		090	Y
21048		625.69	625.69		090	Y
21049		729.07	729.07		090	Y
21050		497.83	497.83		090	N
21060		481.96	481.96		090	Y
21070		361.81	361.81		090	N
21076		625.47	567.43		010	N
21077		1,578.97	1,441.36		090	N
21079		1,050.75	942.62		090	N
21080		1,203.32	1,078.41		090	N
21081		1,086.12	968.01		090	N
21082		960.98	871.89		090	N
21083		924.26	818.39		090	N
21084		1,065.49	950.33		090	N
21085		413.73	376.10		010	N
21086		1,162.97	1,055.06		090	N
21087		1,161.38	1,058.92		090	N
21088		B.R.	B.R.		090	N
21089		B.R.	B.R.		090	N
21100		228.51	205.62		090	N
21110		285.19	254.13		090	N
21116		187.25	27.20		000	N
21120		320.55	239.62	PA	090	N
21121		424.84	338.01		090	Y
21122		368.61	368.61		090	Y
21123		467.91	467.91		090	Y
21125		527.53	446.37		090	Y
21127		601.66	477.66		090	Y
21137		405.11	405.11		090	Y
21138		522.09	522.09		090	Y
21139		577.86	577.86		090	Y
21141		764.43	764.43		090	Y
21142		751.96	751.96		090	Y
21143		786.88	786.88		090	Y
21145		822.47	822.47		090	Y
21146		873.93	873.93		090	Y
21147		877.56	877.56		090	Y
21150		919.95	919.95		090	Y
21151		1,096.09	1,096.09		090	Y
21154		1,261.36	1,261.36		090	Y
21155		1,412.79	1,412.79		090	Y
21159		1,670.10	1,670.10		090	Y
21160		1,709.09	1,709.09		090	Y
21172		994.99	994.99		090	Y
21175		1,285.16	1,285.16		090	Y
21179		899.77	899.77		090	Y
21180		986.83	986.83		090	Y
21181		425.06	425.06		090	N
21182		1,236.20	1,236.20		090	Y
21183		1,350.91	1,350.91		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
21184		1,474.68	1,474.68		090	Y
21188		897.96	897.96		090	Y
21193		719.77	719.77		090	Y
21194		802.74	802.74		090	Y
21195		721.13	721.13	PA	090	Y
21196		782.57	782.57	PA	090	Y
21198		594.18	594.18		090	Y
21199		601.21	601.21		090	Y
21206		589.87	589.87		090	Y
21208		584.21	464.74		090	N
21209		437.98	331.21		090	Y
21210		564.94	467.00		090	N
21215		575.82	487.18		090	N
21230		461.79	461.79		090	N
21235		424.38	326.67		090	N
21240		634.99	634.99		090	Y
21242		604.38	604.38		090	Y
21243		921.76	921.76		090	Y
21244		520.50	520.50		090	Y
21245		657.20	511.21		090	Y
21246		642.92	535.24		090	Y
21247		973.00	973.00		090	Y
21248		581.03	495.79		090	N
21249		807.96	717.96		090	N
21255		696.88	696.88		090	Y
21256		668.99	668.99		090	Y
21260		607.56	607.56		090	Y
21261		1,202.64	1,202.64		090	Y
21263		986.83	986.83		090	Y
21267		761.26	761.26		090	Y
21268		923.58	923.58		090	Y
21270		520.73	433.68		090	Y
21275		477.66	477.66		090	Y
21280		281.79	281.79		090	N
21282		190.88	190.88		090	N
21295		102.24	102.24		090	N
21296		204.48	204.48		090	N
21299		B.R.	B.R.		090	N
21300		73.00	24.26		000	N
21310		68.01	17.68		000	N
21315		106.32	65.97		010	N
21320		142.59	87.51		010	N
21325		178.19	178.19		090	N
21330		253.45	253.45		090	N
21335		365.44	365.44		090	N
21336		278.61	278.61		090	N
21337		183.40	150.76		090	N
21338		295.39	295.39		090	N
21339		355.01	355.01		090	Y
21340		462.24	462.24		090	N
21343		549.52	549.52		090	Y
21344		799.12	799.12		090	Y
21345		462.69	379.27		090	N
21346		561.31	466.32		090	N
21347		536.60	536.60		090	Y
21348		670.58	670.58		090	Y
21355		199.50	145.99		010	N
21356		369.29	175.69		010	N
21360		476.30	299.92		090	Y
21365		637.48	637.48		090	Y
21366		700.73	700.73		090	Y
21385		383.80	383.80		090	Y
21386		396.04	396.04		090	Y
21387		410.10	410.10		090	Y
21390		428.46	428.46		090	Y
21395		525.04	525.04		090	Y
21400		119.70	82.52		090	N
21401		197.23	170.25		090	Y
21406		317.38	317.38		090	Y
21407		373.83	373.83		090	Y
21408		519.14	519.14		090	Y
21421		353.20	267.05		090	N
21422		462.47	366.57		090	Y
21423		451.36	451.36		090	Y
21431		416.90	329.40		090	Y
21432		349.34	349.34		090	Y
21433		1,014.71	1,014.71		090	Y
21435		724.53	724.53		090	Y
21436		1,109.24	1,109.24		090	Y
21440		250.73	160.50		090	N
21445		373.60	277.93		090	Y
21450		316.70	158.69		090	N
21451		319.87	250.96		090	N
21452		228.06	129.67		090	N
21453		377.00	292.90		090	N
21454		308.31	308.31		090	N
21461		486.50	389.70		090	Y
21462		561.99	446.37		090	Y
21465		518.92	518.92		090	Y
21470		658.34	658.34		090	Y
21480		59.62	19.27		000	N
21485		233.27	207.20		090	N
21490		524.58	524.58		090	Y
21493		96.12	96.12		090	N
21494		282.69	282.69		090	Y
21495		275.21	275.21		090	Y
21497		244.16	209.02		090	N
21499		B.R.	B.R.		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
21501		201.76	184.76		090	N
21502		309.45	309.45		090	Y
21510		275.89	275.89		090	N
21550		133.07	89.55		010	N
21555		223.53	180.23		090	N
21556		231.69	231.69		090	N
21557		344.81	344.81		090	Y
21600		306.95	306.95		090	Y
21610		579.22	579.22		090	Y
21615		404.66	404.66		090	Y
21616		486.27	486.27		090	Y
21620		310.13	310.13		090	Y
21627		320.55	320.55		090	Y
21630		711.61	711.61		090	Y
21632		715.24	715.24		090	Y
21685		553.83	553.83	PA	090	Y
21700		286.55	258.44		090	Y
21705		367.03	367.03		090	Y
21720		271.59	252.54		090	Y
21725		304.91	304.91		090	Y
21740		615.94	615.94		090	Y
21742		B.R.	B.R.		090	Y
21743		B.R.	B.R.		090	Y
21750		414.63	414.63		090	Y
21800		71.86	55.99		090	N
21805		145.54	145.54		090	N
21810		284.06	284.06		090	Y
21820		92.72	74.36		090	N
21825		339.82	339.82		090	Y
21899		B.R.	B.R.		090	N
21920		124.46	83.43		010	N
21925		263.43	188.16		090	N
21930		249.60	203.35		090	N
21935		682.14	682.14		090	N
22100		429.60	429.60		090	Y
22101		436.17	436.17		090	Y
22102		439.80	439.80		090	Y
22103		89.09	89.09		000	Y
22110		549.75	549.75		090	Y
22112		547.25	547.25		090	Y
22114		547.48	547.48		090	Y
22116		88.19	88.19		000	Y
22210		988.41	988.41		090	Y
22212		805.47	805.47		090	Y
22214		817.93	817.93		090	Y
22216		230.33	230.33		000	Y
22220		880.96	880.96		090	Y
22222		821.79	821.79		090	Y
22224		884.81	884.81		090	Y
22226		230.55	230.55		000	Y
22305		126.05	107.68		090	N
22310		179.32	161.64		090	N
22315		538.19	403.30		090	N
22318		891.16	891.16		090	Y
22319		990.23	990.23		090	Y
22325		750.83	750.83		090	Y
22326		816.12	816.12		090	Y
22327		780.98	780.98		090	Y
22328		171.39	171.39		000	Y
22505		70.05	70.05		010	N
22520		#	#		010	N
22521		#	#		010	N
22522		#	#		000	N
22532		966.88	966.88		090	Y
22533		903.40	903.40		090	Y
22534		227.15	227.15		000	Y
22548		1,057.78	1,057.78		090	Y
22554		781.66	781.66		090	Y
22556		951.46	951.46		090	Y
22558		878.69	878.69		090	Y
22585		211.06	211.06		000	Y
22590		853.53	853.53		090	Y
22595		812.72	812.72		090	Y
22600		685.09	685.09		090	Y
22610		681.23	681.23		090	Y
22612		871.43	871.43		090	Y
22614		245.74	245.74		000	Y
22630		866.45	866.45		090	Y
22632		199.72	199.72		000	Y
22800		763.07	763.07		090	Y
22802		1,243.90	1,243.90		090	Y
22804		1,455.19	1,455.19		090	Y
22808		1,063.90	1,063.90		090	Y
22810		1,204.23	1,204.23		090	Y
22812		1,301.48	1,301.48		090	Y
22818		1,264.08	1,264.08		090	Y
22819		1,399.87	1,399.87		090	Y
22830		464.96	464.96		090	Y
22840		478.11	478.11		000	Y
22841		Bundled	Bundled		000	N
22842		479.70	479.70		000	Y
22843		503.27	503.27		000	Y
22844		627.28	627.28		000	Y
22845		459.97	459.97		000	Y
22846		477.20	477.20		000	Y
22847		526.62	526.62		000	Y
22848		228.74	228.74		000	Y
22849		752.19	752.19		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
22850		409.65	409.65		090	Y	23350		111.99	31.28		000	N
22851		253.90	253.90		000	Y	23395		724.31	724.31		090	Y
22852		390.83	390.83		090	Y	23397		676.47	676.47		090	Y
22855		626.15	626.15		090	Y	23400		581.94	581.94		090	Y
22899		B.R.	B.R.		090	Y	23405		375.19	375.19		090	Y
22900		219.45	219.45		090	Y	23406		469.95	469.95		090	Y
22999		B.R.	B.R.		090	N	23410		535.47	535.47		090	Y
23000		228.51	205.16		090	Y	23412		569.47	569.47		090	Y
23020		403.30	403.30		090	Y	23415		439.57	439.57		090	N
23030		155.97	154.16		010	N	23420		589.42	589.42		090	Y
23031		131.26	131.26		010	N	23430		443.20	443.20		090	Y
23035		416.67	416.67		090	Y	23440		459.75	459.75		090	Y
23040		416.67	416.67		090	Y	23450		570.83	570.83		090	Y
23044		331.89	331.89		090	N	23455		609.60	609.60		090	Y
23065		119.02	90.00		010	N	23460		656.98	656.98		090	Y
23066		222.17	198.36		090	N	23462		641.56	641.56		090	Y
23075		111.08	101.56		010	N	23465		653.80	653.80		090	Y
23076		324.63	324.63		090	N	23466		624.79	624.79		090	Y
23077		651.31	651.31		090	Y	23470		719.55	719.55		090	Y
23100		284.96	284.96		090	Y	23472		857.83	857.83		090	Y
23101		267.05	267.05		090	N	23480		488.77	488.77		090	N
23105		375.87	375.87		090	Y	23485		572.19	572.19		090	Y
23106		285.42	285.42		090	N	23490		495.34	495.34		090	Y
23107		391.06	391.06		090	Y	23491		611.41	611.41		090	Y
23120		331.44	331.44		090	Y	23500		136.70	111.76		090	N
23125		415.77	415.77		090	Y	23505		216.73	180.68		090	N
23130		357.28	357.28		090	N	23515		340.05	340.05		090	Y
23140		298.34	298.34		090	N	23520		138.29	116.75		090	N
23145		407.38	407.38		090	Y	23525		211.96	180.23		090	N
23146		365.44	365.44		090	N	23530		322.82	322.82		090	Y
23150		377.00	377.00		090	Y	23532		364.99	364.99		090	Y
23155		454.99	454.99		090	Y	23540		153.48	112.22		090	N
23156		391.96	391.96		090	Y	23545		185.44	159.82		090	N
23170		319.65	319.65		090	N	23550		330.98	330.98		090	Y
23172		324.41	324.41		090	Y	23552		384.03	384.03		090	Y
23174		436.17	436.17		090	Y	23570		141.23	122.87		090	N
23180		430.50	430.50		090	N	23575		235.77	200.86		090	N
23182		412.37	412.37		090	Y	23585		404.89	404.89		090	Y
23184		458.84	458.84		090	Y	23600		206.52	162.77		090	N
23190		328.26	328.26		090	Y	23605		276.12	238.72		090	N
23195		430.73	430.73		090	Y	23615		440.02	440.02		090	Y
23200		512.12	512.12		090	Y	23616		871.66	871.66		090	Y
23210		531.84	531.84		090	Y	23620		180.91	135.57		090	N
23220		624.11	624.11		090	Y	23625		245.74	205.16		090	N
23221		728.84	728.84		090	Y	23630		340.28	340.28		090	Y
23222		979.57	979.57		090	Y	23650		191.11	149.62		090	N
23330		91.36	89.77		010	N	23655		210.38	210.38		090	N
23331		345.49	345.49		090	N	23660		337.78	337.78		090	Y
23332		512.34	512.34		090	Y	23665		265.24	227.38		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
23670		359.77	359.77		090	Y	24301		447.28	447.28		090	Y
23675		328.72	294.26		090	N	24305		343.68	343.68		090	N
23680		444.11	444.11		090	Y	24310		282.92	282.92		090	N
23700		117.66	117.66		010	N	24320		438.89	438.89		090	Y
23800		604.16	604.16		090	Y	24330		424.61	424.61		090	Y
23802		662.42	662.42		090	Y	24331		469.50	469.50		090	Y
23900		774.41	774.41		090	Y	24332		336.65	336.65		090	N
23920		604.84	604.84		090	Y	24340		361.13	361.13		090	Y
23921		259.80	259.80		090	N	24341		380.40	380.40		090	Y
23929		B.R.	B.R.		090	Y	24342		467.23	467.23		090	Y
23930		136.02	127.63		010	N	24343		402.85	402.85		090	Y
23931		100.88	95.44		010	N	24344		617.08	617.08		090	Y
23935		296.98	296.98		090	N	24345		400.58	400.58		090	Y
24000		271.81	271.81		090	N	24346		613.90	613.90		090	Y
24006		415.31	415.31		090	Y	24350		261.39	261.39		090	N
24065		98.39	91.13		010	N	24351		286.32	286.32		090	N
24066		263.65	229.42		090	N	24352		306.05	306.05		090	Y
24075		214.00	182.49		090	N	24354		305.59	305.59		090	N
24076		274.76	274.76		090	N	24356		314.89	314.89		090	N
24077		493.98	493.98		090	Y	24360		531.38	531.38		090	Y
24100		228.29	228.29		090	Y	24361		601.44	601.44		090	Y
24101		291.76	291.76		090	Y	24362		610.73	610.73		090	Y
24102		362.49	362.49		090	Y	24363		784.84	784.84		090	Y
24105		192.24	192.24		090	N	24365		377.23	377.23		090	Y
24110		343.00	343.00		090	N	24366		405.57	405.57		090	Y
24115		412.37	412.37		090	Y	24400		488.77	488.77		090	Y
24116		513.02	513.02		090	Y	24410		616.85	616.85		090	Y
24120		304.68	304.68		090	N	24420		589.19	589.19		090	Y
24125		339.82	339.82		090	Y	24430		553.60	553.60		090	Y
24126		368.16	368.16		090	Y	24435		587.38	587.38		090	Y
24130		297.20	297.20		090	N	24470		399.90	399.90		090	Y
24134		459.97	459.97		090	Y	24495		411.91	411.91		090	N
24136		369.75	369.75		090	N	24498		519.60	519.60		090	Y
24138		382.90	382.90		090	Y	24500		205.62	164.58		090	N
24140		452.72	452.72		090	Y	24505		300.15	254.13		090	N
24145		380.86	380.86		090	N	24515		514.16	514.16		090	Y
24147		391.74	391.74		090	N	24516		508.94	508.94		090	Y
24149		625.24	625.24		090	Y	24530		213.10	180.00		090	N
24150		572.19	572.19		090	Y	24535		369.29	323.73		090	N
24151		668.99	668.99		090	Y	24538		440.70	440.70		090	N
24152		434.13	434.13		090	Y	24545		462.24	462.24		090	Y
24153		409.42	409.42		090	N	24546		663.10	663.10		090	Y
24155		489.90	489.90		090	Y	24560		187.48	144.86		090	N
24160		356.37	356.37		090	N	24565		309.22	266.15		090	N
24164		289.50	289.50		090	N	24566		386.75	386.75		090	N
24200		88.41	81.61		010	N	24575		463.60	463.60		090	Y
24201		245.97	215.14		090	N	24576		186.57	155.52		090	N
24220		267.73	41.26		000	N	24577		322.37	279.52		090	N
24300		221.26	221.26		090	N	24579		501.01	501.01		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
24582		426.88	426.88		090	N
24586		646.32	646.32		090	Y
24587		640.88	640.88		090	Y
24600		234.18	187.25		090	N
24605		259.12	259.12		090	N
24615		419.62	419.62		090	Y
24620		318.29	318.29		090	N
24635		665.36	665.36		090	Y
24640		73.90	49.65		010	N
24650		159.60	117.88		090	N
24655		267.51	219.90		090	N
24665		380.86	380.86		090	Y
24666		428.69	428.69		090	Y
24670		166.85	133.98		090	N
24675		275.21	231.69		090	N
24685		398.99	398.99		090	Y
24800		484.46	484.46		090	Y
24802		588.51	588.51		090	Y
24900		412.14	412.14		090	Y
24920		415.54	415.54		090	Y
24925		325.09	325.09		090	Y
24930		431.64	431.64		090	Y
24931		462.69	462.69		090	Y
24935		580.81	580.81		090	N
24940		389.36	389.36		090	Y
24999		B.R.	B.R.		090	N
25000		245.74	245.74		090	N
25001		180.23	180.23		090	N
25020		378.82	378.82		090	N
25023		681.46	681.46		090	N
25024		415.31	415.31		090	N
25025		652.22	652.22		090	N
25028		326.90	326.90		090	N
25031		293.80	293.80		090	N
25035		510.08	510.08		090	N
25040		352.29	352.29		090	N
25065		111.76	111.76		010	N
25066		270.23	270.23		090	N
25075		233.95	233.95		090	N
25076		353.20	353.20		090	N
25077		536.37	536.37		090	N
25085		307.63	307.63		090	Y
25100		223.30	223.30		090	N
25101		255.94	255.94		090	N
25105		321.01	321.01		090	N
25107		356.60	356.60		090	Y
25110		265.69	265.69		090	N
25111		196.78	196.78		090	N
25112		238.94	238.94		090	N
25115		555.42	555.42		090	N
25116		491.26	491.26		090	N
25118		245.74	245.74		090	N
25119		332.57	332.57		090	Y
25120		441.38	441.38		090	N
25125		494.89	494.89		090	N
25126		498.29	498.29		090	Y
25130		282.92	282.92		090	N
25135		348.44	348.44		090	Y
25136		301.28	301.28		090	Y
25145		448.19	448.19		090	Y
25150		374.74	374.74		090	N
25151		487.86	487.86		090	Y
25170		639.07	639.07		090	Y
25210		308.99	308.99		090	N
25215		405.11	405.11		090	Y
25230		275.67	275.67		090	N
25240		294.71	294.71		090	N
25246		264.79	45.34		000	N
25248		328.94	328.94		090	N
25250		305.59	305.59		090	Y
25251		421.66	421.66		090	Y
25259		221.49	221.49		090	N
25260		516.88	516.88		090	N
25263		514.38	514.38		090	Y
25265		587.38	587.38		090	Y
25270		441.61	441.61		090	N
25272		484.00	484.00		090	N
25274		544.76	544.76		090	N
25275		388.79	388.79		090	N
25280		482.42	482.42		090	N
25290		490.35	490.35		090	N
25295		456.12	456.12		090	N
25300		418.49	418.49		090	Y
25301		401.26	401.26		090	Y
25310		514.84	514.84		090	Y
25312		572.19	572.19		090	Y
25315		600.07	600.07		090	Y
25316		699.60	699.60		090	Y
25320		530.02	530.02		090	Y
25332		498.51	498.51		090	Y
25335		597.13	597.13		090	Y
25337		513.02	513.02		090	N
25350		552.24	552.24		090	Y
25355		603.70	603.70		090	Y
25360		541.59	541.59		090	Y
25365		682.82	682.82		090	Y
25370		717.96	717.96		090	Y
25375		719.32	719.32		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
25390		607.78	607.78		090	Y	25645		340.50	340.50		090	Y
25391		734.28	734.28		090	Y	25650		188.16	151.21		090	N
25392		726.57	726.57		090	Y	25651		260.93	260.93		090	N
25393		810.91	810.91		090	Y	25652		351.84	351.84		090	N
25394		455.21	455.21		090	Y	25660		227.61	227.61		090	N
25400		635.67	635.67		090	Y	25670		365.44	365.44		090	Y
25405		771.91	771.91		090	Y	25671		290.86	290.86		090	N
25415		729.29	729.29		090	Y	25675		267.05	223.98		090	N
25420		844.00	844.00		090	Y	25676		374.28	374.28		090	Y
25425		841.06	841.06		090	Y	25680		258.21	258.21		090	N
25426		804.10	804.10		090	Y	25685		429.82	429.82		090	Y
25430		400.13	400.13		090	N	25690		265.47	265.47		090	N
25431		437.76	437.76		090	Y	25695		377.46	377.46		090	Y
25440		483.32	483.32		090	Y	25800		458.61	458.61		090	Y
25441		559.27	559.27		090	Y	25805		523.68	523.68		090	Y
25442		474.26	474.26		090	Y	25810		496.02	496.02		090	Y
25443		462.47	462.47		090	Y	25820		370.65	370.65		090	Y
25444		491.94	491.94		090	Y	25825		447.96	447.96		090	Y
25445		428.01	428.01		090	N	25830		592.59	592.59		090	Y
25446		694.38	694.38		090	Y	25900		523.45	523.45		090	N
25447		460.43	460.43		090	Y	25905		524.13	524.13		090	Y
25449		609.82	609.82		090	Y	25907		479.02	479.02		090	Y
25450		436.40	436.40		090	N	25909		519.14	519.14		090	Y
25455		498.51	498.51		090	N	25915		887.53	887.53		090	Y
25490		564.26	564.26		090	Y	25920		403.53	403.53		090	N
25491		595.99	595.99		090	Y	25922		354.79	354.79		090	Y
25492		672.17	672.17		090	Y	25924		403.75	403.75		090	Y
25500		153.25	124.00		090	N	25927		500.55	500.55		090	N
25505		298.79	253.45		090	N	25929		330.53	330.53		090	Y
25515		406.25	406.25		090	Y	25931		472.90	472.90		090	N
25520		331.21	295.16		090	N	25999		B.R.	B.R.		090	N
25525		542.27	542.27		090	Y	26010		167.98	76.17		010	N
25526		645.41	645.41		090	Y	26011		263.43	108.14		010	N
25530		148.26	117.66		090	N	26020		246.42	246.42		090	N
25535		288.36	250.05		090	N	26025		245.29	245.29		090	N
25545		404.21	404.21		090	Y	26030		287.91	287.91		090	N
25560		153.93	121.96		090	N	26034		302.19	302.19		090	N
25565		312.85	266.37		090	N	26035		425.97	425.97		090	N
25574		343.45	343.45		090	Y	26037		334.84	334.84		090	N
25575		484.23	484.23		090	Y	26040		176.83	176.83		090	N
25600		169.57	134.66		090	N	26045		269.77	269.77		090	N
25605		333.70	287.23		090	N	26055		402.17	157.10		090	N
25611		402.62	402.62		090	N	26060		150.53	150.53		090	N
25620		386.52	386.52		090	Y	26070		168.21	168.21		090	N
25622		172.97	138.06		090	N	26075		180.68	180.68		090	N
25624		276.12	228.51		090	N	26080		217.18	217.18		090	N
25628		395.14	395.14		090	Y	26100		187.03	187.03		090	N
25630		178.41	141.01		090	N	26105		189.52	189.52		090	N
25635		262.75	197.23		090	N	26110		180.91	180.91		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
26115		403.53	204.94		090	N
26116		276.12	276.12		090	N
26117		377.23	377.23		090	N
26121		349.80	349.80		090	N
26123		436.85	436.85		090	N
26125		173.43	173.43		000	N
26130		258.66	258.66		090	N
26135		323.50	323.50		090	N
26140		293.58	293.58		090	N
26145		297.43	297.43		090	N
26160		370.88	172.75		090	N
26170		233.05	233.05		090	N
26180		254.13	254.13		090	N
26185		269.32	269.32		090	Y
26200		261.84	261.84		090	N
26205		352.29	352.29		090	N
26210		253.68	253.68		090	N
26215		321.46	321.46		090	N
26230		296.07	296.07		090	N
26235		289.27	289.27		090	N
26236		256.17	256.17		090	N
26250		337.78	337.78		090	N
26255		519.37	519.37		090	Y
26260		318.29	318.29		090	Y
26261		367.48	367.48		090	Y
26262		265.01	265.01		090	Y
26320		198.36	198.36		090	N
26340		172.07	172.07		090	N
26350		506.90	506.90		090	N
26352		563.12	563.12		090	Y
26356		638.16	638.16		090	N
26357		595.99	595.99		090	Y
26358		630.45	630.45		090	Y
26370		546.57	546.57		090	N
26372		619.12	619.12		090	Y
26373		593.27	593.27		090	Y
26390		551.33	551.33		090	Y
26392		665.14	665.14		090	Y
26410		406.02	406.02		090	N
26412		479.70	479.70		090	N
26415		487.63	487.63		090	N
26416		587.61	587.61		090	N
26418		403.98	403.98		090	N
26420		498.51	498.51		090	Y
26426		472.22	472.22		090	N
26428		516.20	516.20		090	N
26432		346.62	346.62		090	N
26433		376.32	376.32		090	N
26434		430.28	430.28		090	Y
26437		422.80	422.80		090	N
26440		452.49	452.49		090	N
26442		586.47	586.47		090	N
26445		428.69	428.69		090	N
26449		552.92	552.92		090	N
26450		266.83	266.83		090	N
26455		264.79	264.79		090	N
26460		255.72	255.72		090	N
26471		413.05	413.05		090	N
26474		407.15	407.15		090	Y
26476		391.74	391.74		090	N
26477		394.46	394.46		090	N
26478		428.92	428.92		090	N
26479		423.70	423.70		090	Y
26480		529.57	529.57		090	N
26483		580.13	580.13		090	Y
26485		562.22	562.22		090	Y
26489		525.49	525.49		090	N
26490		515.52	515.52		090	N
26492		564.71	564.71		090	Y
26494		528.89	528.89		090	Y
26496		555.19	555.19		090	N
26497		562.67	562.67		090	Y
26498		735.19	735.19		090	Y
26499		533.65	533.65		090	Y
26500		427.56	427.56		090	N
26502		469.50	469.50		090	Y
26504		486.04	486.04		090	Y
26508		430.50	430.50		090	N
26510		408.97	408.97		090	N
26516		471.99	471.99		090	N
26517		541.36	541.36		090	Y
26518		544.99	544.99		090	Y
26520		469.72	469.72		090	N
26525		473.35	473.35		090	N
26530		308.54	308.54		090	Y
26531		361.81	361.81		090	Y
26535		217.86	217.86		090	N
26536		385.16	385.16		090	N
26540		446.83	446.83		090	N
26541		537.05	537.05		090	Y
26542		456.80	456.80		090	N
26545		467.46	467.46		090	N
26546		575.82	575.82		090	Y
26548		510.53	510.53		090	N
26550		937.40	937.40		090	Y
26551		1,973.20	1,973.20		090	Y
26553		1,625.44	1,625.44		090	Y
26554		2,288.08	2,288.08		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
26555		851.94	851.94		090	Y
26556		2,009.02	2,009.02		090	Y
26560		370.65	370.65		090	Y
26561		559.04	559.04		090	Y
26562		764.89	764.89		090	Y
26565		456.80	456.80		090	Y
26567		457.03	457.03		090	N
26568		598.94	598.94		090	Y
26580		764.66	764.66		090	Y
26587		550.65	550.65		090	Y
26590		766.25	766.25		090	Y
26591		321.23	321.23		090	N
26593		398.31	398.31		090	N
26596		428.69	428.69		090	Y
26600		143.50	110.40		090	N
26605		193.38	155.06		090	N
26607		282.47	282.47		090	N
26608		283.15	283.15		090	N
26615		262.97	262.97		090	N
26641		222.39	180.68		090	N
26645		251.64	207.43		090	N
26650		301.51	301.51		090	N
26665		349.57	349.57		090	N
26670		203.58	160.96		090	N
26675		260.25	218.54		090	N
26676		297.43	297.43		090	N
26685		322.82	322.82		090	N
26686		364.31	364.31		090	Y
26700		197.91	159.14		090	N
26705		244.16	203.12		090	N
26706		246.65	246.65		090	N
26715		277.48	277.48		090	N
26720		131.26	101.56		090	N
26725		224.66	177.73		090	N
26727		280.43	280.43		090	N
26735		286.78	286.78		090	N
26740		131.03	111.08		090	N
26742		231.23	186.12		090	N
26746		283.38	283.38		090	N
26750		114.71	90.45		090	N
26755		188.84	148.49		090	N
26756		250.28	250.28		090	N
26765		215.37	215.37		090	N
26770		175.47	133.07		090	N
26775		227.61	181.13		090	N
26776		265.01	265.01		090	N
26785		217.41	217.41		090	N
26820		524.13	524.13		090	Y
26841		493.07	493.07		090	N

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
26842		525.49	525.49		090	Y
26843		484.91	484.91		090	Y
26844		536.15	536.15		090	Y
26850		465.42	465.42		090	N
26852		518.69	518.69		090	Y
26860		384.03	384.03		090	N
26861		65.74	65.74		000	N
26862		479.70	479.70		090	Y
26863		148.26	148.26		000	Y
26910		460.43	460.43		090	N
26951		359.77	359.77		090	N
26952		439.57	439.57		090	N
26989		B.R.	B.R.		090	N
26990		364.76	364.76		090	N
26991		341.41	306.50		090	N
26992		582.62	582.62		090	N
27000		265.47	265.47		090	N
27001		319.19	319.19		090	Y
27003		337.10	337.10		090	Y
27005		428.92	428.92		090	Y
27006		431.86	431.86		090	Y
27025		480.38	480.38		090	N
27030		556.10	556.10		090	Y
27033		572.42	572.42		090	Y
27035		698.46	698.46		090	Y
27036		561.54	561.54		090	Y
27040		129.90	116.75		010	N
27041		400.81	400.81		090	N
27047		336.42	300.60		090	N
27048		273.17	273.17		090	Y
27049		546.80	546.80		090	Y
27050		213.10	213.10		090	N
27052		294.94	294.94		090	Y
27054		388.11	388.11		090	Y
27060		247.10	247.10		090	N
27062		257.53	257.53		090	N
27065		277.48	277.48		090	Y
27066		460.43	460.43		090	Y
27067		600.98	600.98		090	Y
27070		497.15	497.15		090	Y
27071		539.32	539.32		090	Y
27075		1,293.78	1,293.78		090	Y
27076		903.63	903.63		090	Y
27077		1,506.65	1,506.65		090	Y
27078		580.58	580.58		090	Y
27079		583.98	583.98		090	Y
27080		278.84	278.84		090	Y
27086		92.27	89.09		010	N
27087		371.33	371.33		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
27090		485.14	485.14		090	Y
27091		888.21	888.21		090	Y
27093		311.49	42.62		000	N
27095		282.92	48.29		000	N
27096		248.01	41.26		000	N
27097		374.74	374.74		090	Y
27098		390.38	390.38		090	Y
27100		485.82	485.82		090	Y
27105		514.16	514.16		090	Y
27110		544.76	544.76		090	Y
27111		518.46	518.46		090	Y
27120		731.11	731.11		090	Y
27122		635.67	635.67		090	Y
27125		618.66	618.66		090	Y
27130		821.11	821.11		090	Y
27132		954.86	954.86		090	Y
27134		1,139.62	1,139.62		090	Y
27137		862.14	862.14		090	Y
27138		898.41	898.41		090	Y
27140		529.80	529.80		090	Y
27146		726.35	726.35		090	Y
27147		829.95	829.95		090	Y
27151		767.15	767.15		090	Y
27156		1,004.05	1,004.05		090	Y
27158		762.39	762.39		090	Y
27161		706.85	706.85		090	Y
27165		755.82	755.82		090	Y
27170		671.71	671.71		090	Y
27175		369.07	369.07		090	N
27176		515.97	515.97		090	Y
27177		636.57	636.57		090	Y
27178		501.46	501.46		090	Y
27179		562.22	562.22		090	Y
27181		603.93	603.93		090	Y
27185		410.33	410.33		090	N
27187		585.34	585.34		090	Y
27193		305.82	274.53		090	N
27194		448.41	419.85		090	N
27200		116.30	96.35		090	N
27202		579.22	579.22		090	Y
27215		422.12	422.12		090	Y
27216		614.58	614.58		090	Y
27217		595.54	595.54		090	Y
27218		783.25	783.25		090	Y
27220		320.78	285.19		090	N
27222		553.15	553.15		090	N
27226		565.16	565.16		090	Y
27227		954.86	954.86		090	Y
27228		1,101.54	1,101.54		090	Y
27230		289.95	256.17		090	N
27232		438.66	438.66		090	N
27235		528.44	528.44		090	N
27236		652.22	652.22		090	Y
27238		258.66	258.66		090	N
27240		535.47	535.47		090	N
27244		668.77	668.77		090	Y
27245		837.20	837.20		090	Y
27246		250.96	222.39		090	N
27248		456.57	456.57		090	Y
27250		281.79	281.79		090	N
27252		435.04	435.04		090	N
27253		555.42	555.42		090	Y
27254		745.16	745.16		090	Y
27256		182.72	151.89		010	N
27257		196.78	196.78		010	N
27258		645.19	645.19		090	Y
27259		879.14	879.14		090	Y
27265		237.81	237.81		090	N
27266		336.42	336.42		090	N
27275		107.23	107.23		010	N
27280		583.30	583.30		090	Y
27282		470.63	470.63		090	Y
27284		923.58	923.58		090	Y
27286		946.25	946.25		090	Y
27290		917.23	917.23		090	Y
27295		739.04	739.04		090	Y
27299		B.R.	B.R.		090	Y
27301		332.80	299.47		090	N
27303		378.82	378.82		090	Y
27305		274.08	274.08		090	Y
27306		228.29	228.29		090	Y
27307		275.21	275.21		090	N
27310		411.46	411.46		090	Y
27315		286.10	286.10		090	Y
27320		277.25	277.25		090	Y
27323		105.87	99.52		010	N
27324		223.75	223.75		090	N
27327		234.63	201.76		090	N
27328		245.52	245.52		090	N
27329		575.59	575.59		090	Y
27330		232.82	232.82		090	N
27331		277.48	277.48		090	Y
27332		375.19	375.19		090	Y
27333		339.37	339.37		090	Y
27334		393.10	393.10		090	Y
27335		445.47	445.47		090	Y
27340		211.28	211.28		090	N
27345		280.65	280.65		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
27347		272.04	272.04		090	Y	27455		556.10	556.10		090	Y
27350		375.42	375.42		090	Y	27457		573.55	573.55		090	Y
27355		353.20	353.20		090	Y	27465		592.37	592.37		090	Y
27356		424.16	424.16		090	Y	27466		684.86	684.86		090	Y
27357		470.63	470.63		090	Y	27468		774.41	774.41		090	Y
27358		180.45	180.45		000	Y	27470		684.86	684.86		090	Y
27360		497.15	497.15		090	Y	27472		747.88	747.88		090	Y
27365		686.22	686.22		090	Y	27475		386.30	386.30		090	N
27370		298.34	30.38		000	N	27477		429.37	429.37		090	N
27372		266.15	235.99		090	N	27479		555.87	555.87		090	Y
27380		350.70	350.70		090	Y	27485		396.95	396.95		090	N
27381		473.58	473.58		090	Y	27486		802.06	802.06		090	Y
27385		373.83	373.83		090	Y	27487		1,026.95	1,026.95		090	Y
27386		488.99	488.99		090	Y	27488		670.13	670.13		090	Y
27390		256.40	256.40		090	Y	27495		663.55	663.55		090	Y
27391		336.88	336.88		090	N	27496		286.55	286.55		090	N
27392		412.59	412.59		090	Y	27497		310.81	310.81		090	N
27393		298.79	298.79		090	Y	27498		342.54	342.54		090	Y
27394		385.39	385.39		090	Y	27499		390.38	390.38		090	Y
27395		516.88	516.88		090	Y	27500		312.39	266.15		090	N
27396		364.76	364.76		090	Y	27501		325.99	282.24		090	N
27397		497.61	497.61		090	Y	27502		458.39	458.39		090	N
27400		398.77	398.77		090	Y	27503		462.01	462.01		090	N
27403		378.14	378.14		090	Y	27506		737.91	737.91		090	Y
27405		393.78	393.78		090	Y	27507		586.47	586.47		090	Y
27407		453.40	453.40		090	Y	27508		309.45	271.59		090	N
27409		558.14	558.14		090	Y	27509		379.72	379.72		090	N
27418		481.96	481.96		090	Y	27510		399.22	399.22		090	N
27420		437.76	437.76		090	Y	27511		607.78	607.78		090	Y
27422		436.85	436.85		090	Y	27513		778.49	778.49		090	Y
27424		437.08	437.08		090	Y	27514		749.92	749.92		090	Y
27425		260.25	260.25		090	N	27516		304.68	261.16		090	N
27427		418.26	418.26		090	Y	27517		429.82	394.46		090	N
27428		614.81	614.81		090	Y	27519		652.67	652.67		090	Y
27429		682.82	682.82		090	Y	27520		192.92	151.44		090	N
27430		431.64	431.64		090	Y	27524		444.33	444.33		090	Y
27435		436.17	436.17		090	Y	27530		231.69	194.51		090	N
27437		380.86	380.86		090	N	27532		367.25	331.44		090	N
27438		481.96	481.96		090	Y	27535		527.30	527.30		090	Y
27440		404.43	404.43		090	Y	27536		666.27	666.27		090	Y
27441		430.50	430.50		090	Y	27538		287.23	241.66		090	N
27442		508.26	508.26		090	Y	27540		553.37	553.37		090	Y
27443		478.11	478.11		090	Y	27550		296.07	258.21		090	N
27445		735.87	735.87		090	Y	27552		360.68	360.68		090	N
27446		663.78	663.78		090	Y	27556		638.16	638.16		090	Y
27447		884.58	884.58		090	Y	27557		732.92	732.92		090	Y
27448		482.19	482.19		090	Y	27558		756.72	756.72		090	Y
27450		602.80	602.80		090	Y	27560		223.07	170.71		090	N
27454		738.82	738.82		090	Y	27562		256.17	256.17		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
27566		527.53	527.53		090	Y
27570		86.37	86.37		010	N
27580		836.75	836.75		090	Y
27590		465.19	465.19		090	Y
27591		526.62	526.62		090	Y
27592		403.75	403.75		090	Y
27594		299.92	299.92		090	N
27596		433.22	433.22		090	N
27598		433.90	433.90		090	Y
27599		B.R.	B.R.		090	Y
27600		251.86	251.86		090	N
27601		258.44	258.44		090	N
27602		307.63	307.63		090	Y
27603		368.16	235.54		090	N
27604		309.90	216.95		090	N
27605		275.21	127.18		010	N
27606		336.20	184.31		010	N
27607		355.24	355.24		090	N
27610		376.32	376.32		090	N
27612		328.72	328.72		090	Y
27613		139.19	93.17		010	N
27614		343.22	248.01		090	N
27615		557.46	557.46		090	N
27618		335.74	223.75		090	N
27619		456.12	354.11		090	N
27620		279.97	279.97		090	Y
27625		363.63	363.63		090	Y
27626		389.47	389.47		090	Y
27630		328.03	224.21		090	N
27635		356.60	356.60		090	N
27637		445.01	445.01		090	Y
27638		464.05	464.05		090	Y
27640		539.55	539.55		090	N
27641		438.89	438.89		090	N
27645		647.68	647.68		090	Y
27646		581.03	581.03		090	Y
27647		493.53	493.53		090	Y
27648		239.40	30.38		000	N
27650		421.66	421.66		090	Y
27652		449.55	449.55		090	N
27654		423.70	423.70		090	Y
27656		341.64	206.07		090	Y
27658		338.24	237.13		090	Y
27659		434.58	308.54		090	Y
27664		375.87	226.47		090	N
27665		392.19	257.53		090	Y
27675		317.83	317.83		090	Y
27676		371.56	371.56		090	Y
27680		266.60	266.60		090	N
27681		311.49	311.49		090	N
27685		353.43	293.80		090	Y
27686		480.38	343.45		090	N
27687		284.96	284.96		090	Y
27690		372.24	372.24		090	Y
27691		435.72	435.72		090	Y
27692		69.37	69.37		000	Y
27695		303.10	303.10		090	N
27696		362.04	362.04		090	N
27698		401.03	401.03		090	Y
27700		366.80	366.80		090	Y
27702		588.74	588.74		090	Y
27703		663.32	663.32		090	Y
27704		312.85	312.85		090	N
27705		455.67	455.67		090	Y
27707		226.93	226.93		090	N
27709		443.43	443.43		090	Y
27712		612.77	612.77		090	Y
27715		618.66	618.66		090	Y
27720		520.28	520.28		090	Y
27722		515.29	515.29		090	Y
27724		744.03	744.03		090	Y
27725		674.21	674.21		090	Y
27727		596.90	596.90		090	Y
27730		591.01	332.34		090	N
27732		400.35	249.14		090	N
27734		358.19	358.19		090	N
27740		712.06	421.44		090	Y
27742		554.05	433.90		090	Y
27745		446.60	446.60		090	Y
27750		204.94	168.44		090	N
27752		319.65	276.35		090	N
27756		323.73	323.73		090	Y
27758		508.49	508.49		090	Y
27759		591.01	591.01		090	Y
27760		197.23	157.78		090	N
27762		297.88	253.00		090	N
27766		379.50	379.50		090	N
27780		180.23	141.01		090	N
27781		257.76	215.14		090	N
27784		330.53	330.53		090	N
27786		189.29	148.94		090	N
27788		262.29	217.41		090	N
27792		355.47	355.47		090	N
27808		202.90	155.06		090	N
27810		291.31	246.42		090	N
27814		471.08	471.08		090	Y
27816		188.16	151.66		090	N
27818		302.64	256.40		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
27822		521.41	521.41		090	Y	28070		267.05	219.67		090	N
27823		594.41	594.41		090	Y	28072		265.24	216.73		090	N
27824		201.54	159.82		090	N	28080		227.83	176.83		090	N
27825		346.85	293.35		090	N	28086		340.73	230.33		090	Y
27826		423.25	423.25		090	Y	28088		260.25	190.65		090	N
27827		653.12	653.12		090	Y	28090		250.50	193.83		090	N
27828		735.41	735.41		090	Y	28092		237.58	175.24		090	N
27829		296.52	296.52		090	Y	28100		356.15	255.26		090	Y
27830		212.87	183.40		090	N	28102		335.29	335.29		090	Y
27831		218.31	218.31		090	N	28103		359.55	275.89		090	Y
27832		308.31	308.31		090	Y	28104		276.80	223.98		090	Y
27840		203.35	203.35		090	N	28106		289.72	289.72		090	Y
27842		274.08	274.08		090	N	28107		308.31	241.21		090	Y
27846		433.22	433.22		090	Y	28108		230.33	182.72		090	N
27848		510.53	510.53		090	Y	28110		241.44	187.48		090	N
27860		105.87	105.87		010	N	28111		291.99	223.30		090	N
27870		598.94	598.94		090	Y	28112		268.19	207.88		090	N
27871		411.01	411.01		090	Y	28113		278.39	229.19		090	N
27880		469.95	469.95		090	Y	28114		525.49	447.28		090	Y
27881		521.41	521.41		090	Y	28116		363.40	318.06		090	N
27882		384.26	384.26		090	N	28118		315.79	256.17		090	Y
27884		347.08	347.08		090	N	28119		280.65	227.15		090	N
27886		392.64	392.64		090	N	28120		336.20	253.68		090	N
27888		421.21	421.21		090	Y	28122		367.25	316.93		090	Y
27889		407.15	407.15		090	N	28124		262.52	216.27		090	N
27892		320.55	320.55		090	N	28126		212.87	170.93		090	N
27893		318.06	318.06		090	N	28130		362.04	362.04		090	Y
27894		447.05	447.05		090	Y	28140		364.53	289.72		090	N
27899		B.R.	B.R.		090	N	28150		241.21	190.88		090	N
28001		202.22	149.17		010	N	28153		217.41	164.13		090	N
28002		282.47	223.53		010	N	28160		226.25	183.85		090	N
28003		389.47	351.84		090	N	28171		372.92	372.92		090	Y
28005		367.71	367.71		090	N	28173		411.69	351.61		090	N
28008		243.48	194.51		090	N	28175		306.73	247.56		090	Y
28010		199.72	139.87		090	N	28190		197.23	127.41		010	N
28011		276.57	203.80		090	N	28192		264.11	201.99		090	N
28020		289.72	223.75		090	N	28193		289.27	238.04		090	N
28022		259.12	209.47		090	N	28200		253.22	202.22		090	N
28024		252.32	201.54		090	N	28202		361.13	280.20		090	Y
28030		240.30	240.30		090	N	28208		243.02	191.33		090	N
28035		257.98	223.53		090	N	28210		324.18	257.08		090	Y
28043		222.62	165.26		090	N	28220		243.93	198.14		090	N
28045		260.93	205.62		090	N	28222		280.65	241.21		090	N
28046		471.54	423.70		090	N	28225		214.46	164.13		090	N
28050		240.76	192.24		090	N	28226		244.84	204.48		090	N
28052		237.35	182.04		090	N	28230		237.81	196.32		090	N
28054		221.26	165.04		090	N	28232		216.95	166.17		090	N
28060		280.20	226.02		090	N	28234		219.45	165.94		090	N
28062		330.08	262.75		090	N	28238		381.76	315.34		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
28240		240.30	195.42		090	N	28450		141.91	106.32		090	N
28250		301.74	249.60		090	Y	28455		170.71	157.78		090	N
28260		366.80	322.14		090	Y	28456		165.26	165.26		090	N
28261		506.67	470.63		090	N	28465		324.18	324.18		090	N
28262		736.09	670.13		090	Y	28470		139.65	107.68		090	N
28264		461.79	445.92		090	Y	28475		169.12	149.40		090	N
28270		257.76	218.77		090	N	28476		200.86	200.86		090	N
28272		215.37	167.30		090	N	28485		274.08	274.08		090	N
28280		299.70	237.13		090	N	28490		78.21	67.33		090	N
28285		254.58	206.30		090	N	28495		97.48	87.28		090	N
28286		248.92	201.54		090	N	28496		282.69	143.27		090	N
28288		274.99	243.02		090	N	28505		319.87	204.94		090	N
28289		386.30	323.05		090	Y	28510		73.00	66.42		090	N
28290		306.50	266.60		090	N	28515		90.45	82.52		090	N
28292		360.00	312.85		090	Y	28525		298.11	182.49		090	N
28293		484.00	373.37		090	Y	28530		74.58	60.53		090	N
28294		394.91	336.20		090	Y	28531		266.37	118.11		090	N
28296		422.80	369.29		090	Y	28540		117.43	112.90		090	N
28297		445.92	391.51		090	Y	28545		128.54	128.54		090	N
28298		372.24	328.49		090	Y	28546		263.43	193.60		090	N
28299		466.78	414.18		090	Y	28555		425.52	312.17		090	Y
28300		545.44	407.38		090	Y	28570		108.82	95.21		090	N
28302		542.49	401.26		090	Y	28575		185.21	177.28		090	N
28304		416.90	362.72		090	Y	28576		339.60	233.05		090	N
28305		499.87	406.02		090	Y	28585		392.64	355.69		090	Y
28306		315.57	248.24		090	Y	28600		123.55	109.27		090	N
28307		424.84	281.33		090	N	28605		154.84	151.89		090	N
28308		275.21	222.39		090	Y	28606		493.07	263.65		090	N
28309		510.30	510.30		090	N	28615		383.12	383.12		090	Y
28310		282.92	230.55		090	N	28630		70.50	68.01		010	N
28312		253.90	211.06		090	N	28635		86.60	82.75		010	N
28313		275.89	253.45		090	N	28636		212.19	141.91		010	N
28315		258.21	208.79		090	N	28645		238.04	188.61		090	N
28320		391.06	391.06		090	Y	28660		67.10	56.90		010	N
28322		447.05	360.00		090	Y	28665		86.60	86.15		010	N
28340		341.64	280.88		090	N	28666		204.71	120.15		010	N
28341		382.44	330.08		090	N	28675		277.25	161.64		090	N
28344		265.01	194.28		090	N	28705		758.08	758.08		090	Y
28345		312.85	262.52		090	N	28715		560.86	560.86		090	Y
28360		584.43	584.43		090	Y	28725		489.45	489.45		090	Y
28400		153.48	123.78		090	N	28730		471.31	471.31		090	Y
28405		243.70	221.26		090	N	28735		459.29	459.29		090	Y
28406		318.06	318.06		090	N	28737		406.02	406.02		090	Y
28415		715.01	715.01		090	Y	28740		472.44	354.11		090	Y
28420		724.99	724.99		090	Y	28750		485.36	339.14		090	N
28430		146.67	113.35		090	N	28755		278.61	210.38		090	N
28435		190.20	170.48		090	N	28760		383.58	328.03		090	Y
28436		256.62	256.62		090	N	28800		346.17	346.17		090	Y
28445		635.44	635.44		090	Y	28805		346.85	346.85		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
28810		265.24	265.24		090	N
28820		306.05	205.16		090	N
28825		272.04	177.73		090	N
28899		B.R.	B.R.		090	N
29000		128.54	97.03		000	N
29010		128.54	92.49		000	N
29015		128.31	95.44		000	N
29020		126.95	83.65		000	N
29025		133.98	102.02		000	N
29035		124.46	80.71		000	N
29040		116.98	92.72		000	N
29044		141.69	97.03		000	N
29046		137.15	108.59		000	N
29049		51.23	35.14		000	N
29055		110.18	78.44		000	N
29058		67.33	49.65		000	N
29065		51.23	39.22		000	N
29075		47.38	35.14		000	N
29085		50.33	36.50		000	N
29086		36.73	26.98		000	N
29105		49.19	34.01		000	N
29125		37.41	23.80		000	N
29126		46.02	29.24		000	N
29130		22.67	16.32		000	N
29131		29.92	18.82		000	N
29200		32.87	24.03		000	N
29220		32.42	24.94		000	N
29240		36.95	25.62		000	N
29260		30.60	21.08		000	N
29280		31.06	20.18		000	N
29305		125.59	91.59		000	N
29325		136.70	102.70		000	N
29345		74.81	59.85		000	N
29355		76.85	64.38		000	N
29358		81.61	61.21		000	N
29365		66.88	51.91		000	N
29405		48.97	38.09		000	N
29425		53.05	42.62		000	N
29435		64.84	51.46		000	N
29440		29.70	20.86		000	N
29445		85.92	67.78		000	N
29450		83.43	75.26		000	N
29505		43.30	27.43		000	N
29515		37.63	28.79		000	N
29520		32.64	22.90		000	N
29530		32.19	21.99		000	N
29540		21.99	19.72		000	N
29550		21.08	18.14		000	N
29580		29.02	22.22		000	N
29590		29.92	25.39		000	N
29700		34.69	20.86		000	N
29705		37.63	28.11		000	N
29710		68.46	50.33		000	N
29715		49.19	32.42		000	N
29720		42.85	26.30		000	N
29730		37.18	27.43		000	N
29740		54.41	39.90		000	N
29750		55.99	45.34		000	N
29799		B.R.	B.R.		000	N
29800		327.35	327.35		090	N
29804		391.96	391.96		090	Y
29805		281.33	281.33		090	N
29806		620.48	620.48		090	N
29807		605.06	605.06		090	N
29819		348.89	348.89		090	N
29820		322.37	322.37		090	Y
29821		351.84	351.84		090	Y
29822		341.64	341.64		090	Y
29823		373.15	373.15		090	Y
29824		380.40	380.40		090	Y
29825		348.44	348.44		090	Y
29826		401.49	401.49		090	Y
29827		648.59	648.59		090	Y
29830		268.19	268.19		090	N
29834		292.44	292.44		090	Y
29835		298.56	298.56		090	Y
29836		347.30	347.30		090	Y
29837		314.89	314.89		090	Y
29838		353.43	353.43		090	N
29840		260.93	260.93		090	N
29843		281.33	281.33		090	Y
29844		294.26	294.26		090	Y
29845		335.29	335.29		090	Y
29846		308.99	308.99		090	N
29847		320.33	320.33		090	Y
29848		265.01	265.01		090	N
29850		317.61	317.61		090	N
29851		558.14	558.14		090	Y
29855		470.86	470.86		090	Y
29856		605.52	605.52		090	Y
29860		363.85	363.85		090	Y
29861		401.49	401.49		090	Y
29862		447.51	447.51		090	Y
29863		446.60	446.60		090	Y
29870		239.62	239.62		090	N
29871		299.92	299.92		090	N
29873		298.11	298.11		090	N
29874		315.79	315.79		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
29875		294.03	294.03		090	N
29876		361.81	361.81		090	N
29877		340.28	340.28		090	Y
29879		366.80	366.80		090	N
29880		384.26	384.26		090	N
29881		356.15	356.15		090	Y
29882		382.90	382.90		090	N
29883		483.55	483.55		090	N
29884		338.92	338.92		090	Y
29885		413.05	413.05		090	Y
29886		347.98	347.98		090	N
29887		411.23	411.23		090	Y
29888		589.42	589.42		090	Y
29889		689.62	689.62		090	Y
29891		384.71	384.71		090	Y
29892		405.79	405.79		090	Y
29893		275.21	224.43		090	Y
29894		309.22	309.22		090	Y
29895		303.32	303.32		090	Y
29897		317.61	317.61		090	Y
29898		353.65	353.65		090	Y
29899		583.75	583.75		090	Y
29900		269.77	269.77		090	N
29901		297.43	297.43		090	N
29902		318.29	318.29		090	N
29999		B.R.	B.R.		090	N
30000		130.81	66.88		010	N
30020		111.08	68.24		010	N
30100		69.60	41.49		000	N
30110		116.52	75.72		010	N
30115		197.46	197.46		090	N
30117		177.05	151.89		090	N
30118		401.03	401.03		090	Y
30120		255.04	253.90		090	N
30124		144.18	144.18		090	N
30125		309.90	309.90		090	Y
30130		161.86	161.86		090	N
30140		173.88	173.88		090	N
30150		399.67	399.67		090	N
30160		409.87	409.87		090	Y
30200		58.04	36.73		000	N
30210		76.17	56.68		010	N
30220		140.55	72.54		010	N
30300		136.02	70.05		010	N
30310		121.06	121.06		010	N
30320		213.10	213.10		090	N
30400		#	#		090	N
30410		#	#		090	Y
30420		#	#		090	N
30430		#	#		090	Y
30435		#	#		090	Y
30450		#	#		090	Y
30460		422.34	422.34		090	Y
30462		799.34	799.34		090	Y
30465		461.11	461.11		090	N
30520		256.17	256.17		090	N
30540		316.25	316.25		090	Y
30545		473.58	473.58		090	Y
30560		143.27	80.03		010	N
30580		326.90	302.87		090	N
30600		296.75	278.39		090	N
30620		277.71	277.71		090	N
30630		314.43	314.43		090	N
30801		76.40	74.13		010	N
30802		111.54	108.59		010	N
30901		60.76	36.95		000	N
30903		101.79	48.97		000	N
30905		129.90	65.52		000	N
30906		150.30	87.05		000	N
30915		307.63	307.63		090	N
30920		409.87	409.87		090	N
30930		68.46	68.46		010	N
30999		B.R.	B.R.		090	N
31000		94.53	60.30		010	N
31002		121.96	121.96		010	N
31020		165.49	151.66		090	N
31030		272.72	253.68		090	N
31032		287.68	287.68		090	N
31040		373.15	373.15		090	N
31050		231.46	231.46		090	N
31051		307.63	307.63		090	N
31070		199.72	199.72		090	N
31075		387.20	387.20		090	Y
31080		469.50	469.50		090	Y
31081		546.35	546.35		090	Y
31084		557.68	557.68		090	Y
31085		586.47	586.47		090	Y
31086		537.51	537.51		090	Y
31087		546.80	546.80		090	Y
31090		427.78	427.78		090	N
31200		233.27	233.27		090	N
31201		358.87	358.87		090	N
31205		419.85	419.85		090	Y
31225		781.21	781.21		090	Y
31230		878.69	878.69		090	Y
31231		108.14	47.83		000	N
31233		155.97	87.51		000	N
31235		180.91	104.28		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
31237		196.10	116.07		000	N	31540		159.37	159.37		000	N
31238		204.03	127.63		000	N	31541		174.11	174.11		000	N
31239		397.18	397.18		010	N	31560		204.94	204.94		000	N
31240		103.60	103.60		000	N	31561		222.85	222.85		000	N
31254		178.64	178.64		000	N	31570		224.43	148.49		000	N
31255		263.65	263.65		000	N	31571		163.68	163.68		000	N
31256		128.77	128.77		000	N	31575		69.82	47.61		000	N
31267		208.79	208.79		000	N	31576		130.58	77.76		000	N
31276		333.02	333.02		000	N	31577		145.54	95.89		000	N
31287		151.89	151.89		000	N	31578		166.40	104.74		000	N
31288		176.15	176.15		000	N	31579		141.91	89.55		000	N
31290		695.74	695.74		010	N	31580		554.73	554.73		090	Y
31291		738.14	738.14		010	N	31582		922.90	922.90		090	N
31292		601.89	601.89		010	N	31584		810.68	810.68		090	Y
31293		653.12	653.12		010	N	31585		239.85	239.85		090	N
31294		752.87	752.87		010	N	31586		386.07	386.07		090	N
31299		B.R.	B.R.		090	N	31587		521.64	521.64		090	Y
31300		621.61	621.61		090	Y	31588		617.76	617.76		090	Y
31320		294.03	294.03		090	N	31590		370.88	370.88		090	Y
31360		733.37	733.37		090	Y	31595		378.14	378.14		090	Y
31365		989.55	989.55		090	Y	31599		B.R.	B.R.		090	N
31367		929.24	929.24		090	Y	31600		243.70	243.70		000	N
31368		1,137.35	1,137.35		090	Y	31601		164.58	164.58		000	Y
31370		908.84	908.84		090	Y	31603		141.01	141.01		000	N
31375		841.51	841.51		090	Y	31605		115.62	115.62		000	N
31380		840.15	840.15		090	Y	31610		384.71	384.71		090	N
31382		876.65	876.65		090	Y	31611		272.95	272.95		090	Y
31390		1,154.13	1,154.13		090	Y	31612		47.61	30.15		000	N
31395		1,330.96	1,330.96		090	Y	31613		236.45	236.45		090	N
31400		478.79	478.79		090	Y	31614		351.84	351.84		090	N
31420		471.99	471.99		090	Y	31615		110.86	77.98		000	N
31500		68.92	68.92		000	N	31622		161.86	86.60		000	N
31502		49.87	21.54		000	N	31623		184.31	88.87		000	N
31505		50.78	29.47		000	N	31624		166.40	88.87		000	N
31510		125.37	76.17		000	N	31625		202.90	108.59		000	N
31511		126.95	77.98		000	N	31628		216.05	120.15		000	N
31512		126.95	82.29		000	N	31629		389.02	128.99		000	N
31513		85.24	85.24		000	N	31630		138.97	138.97		000	N
31515		128.54	68.69		000	N	31631		152.12	152.12		000	N
31520		98.61	98.61		000	N	31632		43.98	33.78		000	N
31525		152.12	102.70		000	N	31633		53.95	42.17		000	N
31526		102.47	102.47		000	N	31635		126.27	126.27		000	N
31527		122.42	122.42		000	N	31640		174.11	174.11		000	N
31528		90.45	90.45		000	N	31641		169.12	169.12		000	N
31529		104.28	104.28		000	N	31643		112.67	112.67		000	N
31530		127.41	127.41		000	N	31645		102.24	102.24		000	N
31531		139.65	139.65		000	N	31646		89.09	89.09		000	N
31535		123.10	123.10		000	N	31656		72.77	72.77		000	N
31536		138.51	138.51		000	N	31700		78.89	47.61		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
31708		46.70	46.70		000	N	32420		70.96	70.96		000	N
31710		47.15	47.15		000	N	32440		920.18	920.18		090	Y
31715		39.90	39.90		000	N	32442		1,003.15	1,003.15		090	Y
31717		118.11	70.05		000	N	32445		961.21	961.21		090	Y
31720		58.49	32.87		000	N	32480		865.54	865.54		090	Y
31725		89.55	60.08		000	N	32482		915.87	915.87		090	Y
31730		118.79	92.95		000	N	32484		787.10	787.10		090	Y
31750		582.85	582.85		090	Y	32486		913.15	913.15		090	Y
31755		712.06	712.06		090	Y	32488		970.28	970.28		090	Y
31760		787.56	787.56		090	Y	32491		831.08	831.08		090	Y
31766		1,074.78	1,074.78		090	Y	32500		822.01	822.01		090	Y
31770		797.53	797.53		090	Y	32501		153.93	153.93		000	Y
31775		870.30	870.30		090	Y	32520		811.59	811.59		090	Y
31780		691.21	691.21		090	Y	32522		890.25	890.25		090	Y
31781		858.51	858.51		090	Y	32525		967.10	967.10		090	Y
31785		655.62	655.62		090	Y	32540		594.41	594.41		090	Y
31786		894.56	894.56		090	Y	32601		193.15	193.15		000	N
31800		295.16	295.16		090	N	32602		209.47	209.47		000	N
31805		496.70	496.70		090	Y	32603		264.79	264.79		000	N
31820		235.99	222.39		090	N	32604		301.51	301.51		000	N
31825		339.82	327.13		090	N	32605		244.16	244.16		000	N
31830		240.08	231.23		090	N	32606		289.95	289.95		000	N
31899		B.R.	B.R.		090	N	32650		427.10	427.10		090	Y
32000		108.14	47.38		000	N	32651		492.17	492.17		090	Y
32002		128.31	71.41		000	N	32652		707.08	707.08		090	Y
32005		204.48	69.60		000	N	32653		486.50	486.50		090	Y
32020		131.26	131.26		000	N	32654		488.77	488.77		090	Y
32035		354.56	354.56		090	Y	32655		497.38	497.38		090	Y
32036		394.91	394.91		090	Y	32656		510.76	510.76		090	Y
32095		335.52	335.52		090	Y	32657		522.54	522.54		090	Y
32100		558.14	558.14		090	Y	32658		465.19	465.19		090	Y
32110		805.47	805.47		090	Y	32659		464.96	464.96		090	Y
32120		456.12	456.12		090	Y	32660		659.24	659.24		090	Y
32124		488.31	488.31		090	Y	32661		516.42	516.42		090	Y
32140		530.48	530.48		090	Y	32662		619.80	619.80		090	Y
32141		529.80	529.80		090	Y	32663		716.60	716.60		090	Y
32150		532.06	532.06		090	Y	32664		535.24	535.24		090	Y
32151		540.00	540.00		090	Y	32665		579.22	579.22		090	Y
32160		355.24	355.24		090	Y	32800		515.29	515.29		090	Y
32200		577.40	577.40		090	Y	32810		503.95	503.95		090	Y
32201		124.46	124.46		000	Y	32815		840.60	840.60		090	Y
32215		445.92	445.92		090	Y	32820		819.75	819.75		090	Y
32220		895.01	895.01		090	Y	32850		B.R.	B.R.		000	N
32225		530.93	530.93		090	Y	32851		1,624.76	1,624.76		090	Y
32310		512.12	512.12		090	Y	32852		1,826.07	1,826.07		090	Y
32320		879.37	879.37		090	Y	32853		1,951.43	1,951.43		090	Y
32400		80.48	53.95		000	N	32854		2,098.34	2,098.34		090	Y
32402		310.13	310.13		090	Y	32900		740.86	740.86		090	Y
32405		94.99	60.30		000	N	32905		759.90	759.90		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
32906		957.81	957.81		090	Y
32940		713.42	713.42		090	Y
32960		84.79	57.36		000	N
32997		191.79	191.79		000	N
32999		B.R.	B.R.		090	Y
33010		75.72	75.72		000	N
33011		76.62	76.62		000	N
33015		282.47	282.47		090	N
33020		475.62	475.62		090	Y
33025		453.63	453.63		090	Y
33030		696.65	696.65		090	Y
33031		786.65	786.65		090	Y
33050		544.76	544.76		090	Y
33120		891.84	891.84		090	Y
33130		773.73	773.73		090	Y
33140		#	#		090	Y
33141		#	#		000	Y
33200		468.59	468.59		090	N
33201		411.69	411.69		090	N
33206		267.05	267.05		090	N
33207		304.00	304.00		090	N
33208		307.63	307.63		090	N
33210		107.46	107.46		000	N
33211		111.08	111.08		000	N
33212		213.10	213.10		090	N
33213		241.21	241.21		090	N
33214		301.74	301.74		090	N
33215		188.61	188.61		090	N
33216		237.35	237.35		090	N
33217		237.35	237.35		090	N
33218		232.14	232.14		090	N
33220		233.27	233.27		090	N
33222		221.03	221.03		090	N
33223		262.52	262.52		090	N
33224		305.36	305.36		000	N
33225		271.13	271.13		000	N
33226		294.03	294.03		000	N
33233		155.52	155.52		090	N
33234		303.32	303.32		090	N
33235		385.39	385.39		090	N
33236		489.90	489.90		090	N
33237		525.04	525.04		090	N
33238		568.79	568.79		090	N
33240		290.86	290.86		090	N
33241		146.67	146.67		090	N
33243		832.67	832.67		090	Y
33244		540.68	540.68		090	N
33245		536.37	536.37		090	Y
33246		757.18	757.18		090	Y
33249		534.79	534.79		090	N
33250		773.05	773.05		090	Y
33251		886.40	886.40		090	Y
33253		1,104.03	1,104.03		090	Y
33261		897.73	897.73		090	Y
33282		197.23	197.23		090	N
33284		143.95	143.95		090	N
33300		661.74	661.74		090	Y
33305		790.28	790.28		090	Y
33310		690.75	690.75		090	Y
33315		822.24	822.24		090	Y
33320		607.33	607.33		090	Y
33321		743.58	743.58		090	Y
33322		762.17	762.17		090	Y
33330		778.03	778.03		090	Y
33332		839.70	839.70		090	Y
33335		1,071.38	1,071.38		090	Y
33400		1,075.01	1,075.01		090	Y
33401		912.69	912.69		090	Y
33403		948.29	948.29		090	Y
33404		1,054.16	1,054.16		090	Y
33405		1,299.44	1,299.44		090	Y
33406		1,379.92	1,379.92		090	Y
33410		1,208.31	1,208.31		090	Y
33411		1,345.24	1,345.24		090	Y
33412		1,524.78	1,524.78		090	Y
33413		1,559.24	1,559.24		090	Y
33414		1,097.68	1,097.68		090	Y
33415		964.84	964.84		090	Y
33416		1,084.31	1,084.31		090	Y
33417		1,040.10	1,040.10		090	Y
33420		768.97	768.97		090	N
33422		975.04	975.04		090	Y
33425		978.44	978.44		090	Y
33426		1,228.03	1,228.03		090	Y
33427		1,447.25	1,447.25		090	Y
33430		1,244.58	1,244.58		090	Y
33460		862.37	862.37		090	Y
33463		948.29	948.29		090	Y
33464		1,007.91	1,007.91		090	Y
33465		1,031.26	1,031.26		090	Y
33468		1,086.12	1,086.12		090	Y
33470		780.75	780.75		090	Y
33471		795.72	795.72		090	Y
33472		843.10	843.10		090	Y
33474		836.07	836.07		090	Y
33475		1,161.16	1,161.16		090	Y
33476		912.69	912.69		090	Y
33478		985.46	985.46		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
33496		987.73	987.73		090	Y	33692		1,101.54	1,101.54		090	Y
33500		905.44	905.44		090	Y	33694		1,193.12	1,193.12		090	Y
33501		639.29	639.29		090	Y	33697		1,259.09	1,259.09		090	Y
33502		788.01	788.01		090	Y	33702		967.56	967.56		090	Y
33503		750.38	750.38		090	N	33710		1,081.13	1,081.13		090	Y
33504		899.09	899.09		090	Y	33720		956.22	956.22		090	Y
33505		940.58	940.58		090	Y	33722		1,047.35	1,047.35		090	Y
33506		1,211.26	1,211.26		090	Y	33730		1,165.69	1,165.69		090	Y
33508		9.97	9.97		000	Y	33732		1,009.04	1,009.04		090	Y
33510		1,102.67	1,102.67		090	Y	33735		740.86	740.86		090	Y
33511		1,146.88	1,146.88		090	Y	33736		866.67	866.67		090	Y
33512		1,207.63	1,207.63		090	Y	33737		810.45	810.45		090	Y
33513		1,222.59	1,222.59		090	Y	33750		760.13	760.13		090	Y
33514		1,254.56	1,254.56		090	Y	33755		761.71	761.71		090	Y
33516		1,328.01	1,328.01		090	Y	33762		763.98	763.98		090	Y
33517		84.79	84.79		000	Y	33764		773.05	773.05		090	Y
33518		159.82	159.82		000	Y	33766		851.94	851.94		090	Y
33519		234.41	234.41		000	Y	33767		895.24	895.24		090	Y
33521		309.67	309.67		000	Y	33770		1,276.32	1,276.32		090	Y
33522		384.71	384.71		000	Y	33771		1,174.53	1,174.53		090	Y
33523		459.75	459.75		000	Y	33774		1,120.58	1,120.58		090	Y
33530		192.70	192.70		000	Y	33775		1,152.77	1,152.77		090	Y
33533		1,130.78	1,130.78		090	Y	33776		1,236.65	1,236.65		090	Y
33534		1,217.83	1,217.83		090	Y	33777		1,200.60	1,200.60		090	Y
33535		1,287.43	1,287.43		090	Y	33778		1,402.59	1,402.59		090	Y
33536		1,343.88	1,343.88		090	Y	33779		1,228.94	1,228.94		090	Y
33542		1,033.30	1,033.30		090	Y	33780		1,499.85	1,499.85		090	Y
33545		1,291.28	1,291.28		090	Y	33781		1,245.49	1,245.49		090	Y
33572		146.22	146.22		000	Y	33786		1,372.44	1,372.44		090	Y
33600		1,009.04	1,009.04		090	Y	33788		952.37	952.37		090	Y
33602		998.61	998.61		090	Y	33800		581.03	581.03		090	Y
33606		1,091.11	1,091.11		090	Y	33802		647.91	647.91		090	Y
33608		1,121.94	1,121.94		090	Y	33803		727.71	727.71		090	Y
33610		1,107.88	1,107.88		090	Y	33813		781.21	781.21		090	Y
33611		1,169.32	1,169.32		090	Y	33814		931.51	931.51		090	Y
33612		1,240.96	1,240.96		090	Y	33820		608.01	608.01		090	Y
33615		1,187.45	1,187.45		090	Y	33822		650.86	650.86		090	Y
33617		1,298.08	1,298.08		090	Y	33824		730.65	730.65		090	Y
33619		1,603.90	1,603.90		090	Y	33840		757.18	757.18		090	Y
33641		764.66	764.66		090	Y	33845		827.23	827.23		090	Y
33645		905.89	905.89		090	Y	33851		792.32	792.32		090	Y
33647		1,043.27	1,043.27		090	Y	33852		870.07	870.07		090	Y
33660		1,053.70	1,053.70		090	Y	33853		1,154.13	1,154.13		090	Y
33665		1,051.21	1,051.21		090	Y	33860		1,335.72	1,335.72		090	Y
33670		1,148.69	1,148.69		090	Y	33861		1,453.83	1,453.83		090	Y
33681		1,110.15	1,110.15		090	Y	33863		1,552.44	1,552.44		090	Y
33684		1,069.57	1,069.57		090	Y	33870		1,533.40	1,533.40		090	Y
33688		1,022.19	1,022.19		090	Y	33875		1,164.33	1,164.33		090	Y
33690		736.09	736.09		090	Y	33877		1,454.05	1,454.05		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
33910		888.89	888.89		090	Y
33915		724.99	724.99		090	Y
33916		914.51	914.51		090	Y
33917		906.35	906.35		090	Y
33918		954.41	954.41		090	Y
33919		1,387.63	1,387.63		090	Y
33920		1,122.85	1,122.85		090	Y
33922		835.39	835.39		090	Y
33924		183.40	183.40		000	Y
33930		B.R.	B.R.		000	N
33935		2,228.01	2,228.01		090	Y
33940		B.R.	B.R.		000	N
33945		1,570.35	1,570.35		090	Y
33960		598.94	598.94		000	Y
33961		363.17	363.17		000	Y
33967		158.46	158.46		000	N
33968		21.31	21.31		000	N
33970		220.81	220.81		000	Y
33971		380.40	380.40		090	N
33973		319.87	319.87		000	Y
33974		541.59	541.59		090	N
33975		658.56	658.56		000	Y
33976		757.40	757.40		000	Y
33977		746.07	746.07		090	Y
33978		821.79	821.79		090	Y
33979		1,473.78	1,473.78		000	Y
33980		1,961.86	1,961.86		090	Y
33999		B.R.	B.R.		090	Y
34001		479.47	479.47		090	Y
34051		566.07	566.07		090	Y
34101		374.74	374.74		090	Y
34111		369.07	369.07		090	Y
34151		846.95	846.95		090	Y
34201		374.74	374.74		090	Y
34203		589.87	589.87		090	Y
34401		839.02	839.02		090	Y
34421		438.21	438.21		090	Y
34451		910.65	910.65		090	Y
34471		373.15	373.15		090	N
34490		364.99	364.99		090	N
34501		588.97	588.97		090	Y
34502		959.85	959.85		090	Y
34510		682.14	682.14		090	Y
34520		637.93	637.93		090	Y
34530		620.93	620.93		090	Y
34800		714.56	714.56		090	Y
34802		783.25	783.25		090	Y
34804		783.48	783.48		090	Y
34805		749.47	749.47		090	Y

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
34808		131.49	131.49		000	Y
34812		215.14	215.14		000	Y
34813		152.57	152.57		000	Y
34820		311.03	311.03		000	Y
34825		432.54	432.54		090	Y
34826		131.49	131.49		000	Y
34830		1,105.84	1,105.84		090	N
34831		1,127.61	1,127.61		090	N
34832		1,193.58	1,193.58		090	N
34833		390.83	390.83		000	Y
34834		183.17	183.17		000	Y
34900		583.53	583.53		090	Y
35001		718.87	718.87		090	Y
35002		739.72	739.72		090	Y
35005		644.28	644.28		090	Y
35011		620.48	620.48		090	Y
35013		763.98	763.98		090	Y
35021		705.72	705.72		090	Y
35022		800.93	800.93		090	Y
35045		599.62	599.62		090	Y
35081		969.37	969.37		090	Y
35082		1,314.41	1,314.41		090	Y
35091		1,205.14	1,205.14		090	Y
35092		1,520.93	1,520.93		090	Y
35102		1,057.56	1,057.56		090	Y
35103		1,366.77	1,366.77		090	Y
35111		847.63	847.63		090	Y
35112		998.61	998.61		090	Y
35121		1,029.44	1,029.44		090	Y
35122		1,189.27	1,189.27		090	Y
35131		860.78	860.78		090	Y
35132		1,019.70	1,019.70		090	Y
35141		695.06	695.06		090	Y
35142		805.47	805.47		090	Y
35151		786.20	786.20		090	Y
35152		885.49	885.49		090	Y
35161		684.63	684.63		090	Y
35162		717.51	717.51		090	Y
35180		500.55	500.55		090	Y
35182		1,016.30	1,016.30		090	Y
35184		628.87	628.87		090	Y
35188		533.43	533.43		090	Y
35189		956.67	956.67		090	Y
35190		467.23	467.23		090	Y
35201		575.59	575.59		090	Y
35206		474.71	474.71		090	Y
35207		427.56	427.56		090	N
35211		809.09	809.09		090	Y
35216		680.10	680.10		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
35221		821.11	821.11		090	Y	35491		259.12	259.12		000	Y
35226		519.60	519.60		090	Y	35492		233.50	233.50		000	Y
35231		707.30	707.30		090	Y	35493		281.56	281.56		000	N
35236		596.45	596.45		090	Y	35494		347.98	347.98		000	N
35241		844.91	844.91		090	Y	35495		327.35	327.35		000	N
35246		912.47	912.47		090	Y	35500		206.75	206.75		000	Y
35251		997.48	997.48		090	Y	35501		681.46	681.46		090	Y
35256		638.61	638.61		090	Y	35506		715.24	715.24		090	Y
35261		617.53	617.53		090	Y	35507		712.74	712.74		090	Y
35266		525.49	525.49		090	Y	35508		691.66	691.66		090	Y
35271		805.24	805.24		090	Y	35509		658.11	658.11		090	Y
35276		860.55	860.55		090	Y	35510		793.00	793.00		090	Y
35281		944.43	944.43		090	Y	35511		734.28	734.28		090	Y
35286		582.62	582.62		090	Y	35512		777.81	777.81		090	Y
35301		667.86	667.86		090	Y	35515		686.45	686.45		090	Y
35311		943.07	943.07		090	Y	35516		568.34	568.34		090	Y
35321		562.67	562.67		090	Y	35518		726.80	726.80		090	Y
35331		912.24	912.24		090	Y	35521		769.87	769.87		090	Y
35341		882.54	882.54		090	Y	35522		755.14	755.14		090	Y
35351		793.00	793.00		090	Y	35525		720.45	720.45		090	Y
35355		645.19	645.19		090	Y	35526		1,015.16	1,015.16		090	Y
35361		967.33	967.33		090	Y	35531		1,218.29	1,218.29		090	Y
35363		1,035.11	1,035.11		090	Y	35533		956.45	956.45		090	Y
35371		523.00	523.00		090	Y	35536		1,074.33	1,074.33		090	Y
35372		627.05	627.05		090	Y	35541		903.17	903.17		090	Y
35381		578.09	578.09		090	Y	35546		891.84	891.84		090	Y
35390		105.42	105.42		000	Y	35548		759.90	759.90		090	Y
35400		101.33	101.33		000	N	35549		829.04	829.04		090	Y
35450		339.37	339.37		000	Y	35551		939.90	939.90		090	Y
35452		246.20	246.20		000	Y	35556		771.91	771.91		090	Y
35454		216.73	216.73		000	Y	35558		735.41	735.41		090	Y
35456		260.25	260.25		000	Y	35560		1,092.01	1,092.01		090	Y
35458		331.21	331.21		000	Y	35563		827.91	827.91		090	Y
35459		300.38	300.38		000	Y	35565		796.85	796.85		090	Y
35460		212.87	212.87		000	N	35566		939.22	939.22		090	Y
35470		294.94	294.94		000	N	35571		842.64	842.64		090	Y
35471		341.18	341.18		000	N	35572		222.17	222.17		000	Y
35472		239.62	239.62		000	N	35582		949.87	949.87		090	Y
35473		211.28	211.28		000	N	35583		797.08	797.08		090	Y
35474		241.66	241.66		000	N	35585		996.80	996.80		090	Y
35475		318.74	318.74		000	N	35587		873.48	873.48		090	Y
35476		208.34	208.34		000	N	35600		162.77	162.77		000	Y
35480		379.27	379.27		000	Y	35601		641.11	641.11		090	Y
35481		270.68	270.68		000	Y	35606		679.65	679.65		090	Y
35482		238.04	238.04		000	Y	35612		576.72	576.72		090	Y
35483		282.69	282.69		000	Y	35616		583.07	583.07		090	Y
35484		358.41	358.41		000	Y	35621		690.30	690.30		090	Y
35485		331.66	331.66		000	Y	35623		827.68	827.68		090	Y
35490		371.11	371.11		000	Y	35626		968.69	968.69		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
35631		1,151.41	1,151.41		090	Y	36012		109.95	109.95		000	N
35636		1,004.28	1,004.28		090	Y	36013		76.17	76.17		000	N
35641		873.93	873.93		090	Y	36014		94.31	94.31		000	N
35642		647.91	647.91		090	Y	36015		109.50	109.50		000	N
35645		628.41	628.41		090	Y	36100		97.71	97.71		000	N
35646		1,084.08	1,084.08		090	Y	36120		63.02	63.02		000	N
35647		978.21	978.21		090	Y	36140		62.80	62.80		000	N
35650		659.47	659.47		090	Y	36145		63.02	63.02		000	N
35651		873.02	873.02		090	Y	36160		81.16	81.16		000	N
35654		858.29	858.29		090	Y	36200		95.21	95.21		000	N
35656		689.62	689.62		090	Y	36215		147.13	147.13		000	N
35661		669.22	669.22		090	Y	36216		165.26	165.26		000	N
35663		762.85	762.85		090	Y	36217		199.04	199.04		000	N
35665		732.24	732.24		090	Y	36218		31.96	31.96		000	N
35666		797.08	797.08		090	Y	36245		148.94	148.94		000	N
35671		691.44	691.44		090	Y	36246		166.40	166.40		000	N
35681		52.59	52.59		000	Y	36247		198.14	198.14		000	N
35682		236.45	236.45		000	N	36248		32.19	32.19		000	N
35683		279.29	279.29		000	N	36260		354.56	354.56		090	N
35685		128.09	128.09		000	Y	36261		218.31	218.31		090	Y
35686		106.32	106.32		000	Y	36262		164.13	164.13		090	N
35691		648.14	648.14		090	Y	36299		B.R.	B.R.		000	N
35693		565.84	565.84		090	Y	36400		15.42	10.88		000	N
35694		679.42	679.42		090	Y	36405		13.38	9.07		000	N
35695		679.65	679.65		090	Y	36406		11.11	5.44		000	N
35697		99.29	99.29		000	Y	36410		11.11	5.44		000	N
35700		101.33	101.33		000	Y	36415		2.45	2.45		000	N
35701		325.54	325.54		090	Y	36416		2.45	2.45		000	N
35721		278.39	278.39		090	Y	36420		94.99	31.28		000	N
35741		302.64	302.64		090	Y	36425		23.35	23.35		000	N
35761		228.06	228.06		090	Y	36430		24.26	24.26		000	N
35800		283.83	283.83		090	Y	36440		32.19	32.19		000	N
35820		492.39	492.39		090	Y	36450		70.28	70.28		000	N
35840		366.80	366.80		090	Y	36455		80.71	80.71		000	N
35860		232.82	232.82		090	Y	36460		213.32	213.32		000	Y
35870		782.12	782.12		090	Y	36468		B.R.	B.R.		000	N
35875		371.11	371.11		090	N	36469		B.R.	B.R.		000	N
35876		600.76	600.76		090	Y	36470		89.32	36.95		010	N
35879		570.38	570.38		090	Y	36471		109.27	52.59		010	N
35881		640.43	640.43		090	Y	36481		339.37	229.87		000	N
35901		328.49	328.49		090	Y	36500		114.26	114.26		000	N
35903		373.37	373.37		090	Y	36510		111.76	40.13		000	N
35905		1,059.82	1,059.82		090	Y	36511		57.13	57.13		000	N
35907		1,165.01	1,165.01		090	Y	36512		57.13	57.13		000	N
36000		17.91	5.44		000	N	36513		57.13	57.13		000	N
36002		113.35	69.37		000	N	36514		57.13	57.13		000	N
36005		216.73	29.92		000	N	36515		57.58	57.58		000	N
36010		76.85	76.85		000	N	36516		40.58	40.58		000	N
36011		98.84	98.84		000	N	36522		734.51	65.29		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
36540		2.45	2.45		000	N
36550		15.64	15.64		000	N
36555		202.22	83.43		000	N
36556		192.70	75.49		000	N
36557		437.08	185.44		010	N
36558		427.78	176.15		010	N
36560		821.56	220.35		010	N
36561		814.08	212.64		010	N
36563		1,026.04	221.26		010	N
36565		654.48	212.64		010	N
36566		684.18	227.83		010	N
36568		235.09	60.98		000	N
36569		213.55	57.36		000	N
36570		1,054.38	191.79		010	N
36571		947.83	191.11		010	N
36575		102.70	31.96		000	N
36576		259.80	123.55		010	N
36578		331.66	140.33		010	N
36580		187.71	42.17		000	N
36581		392.87	130.81		010	N
36582		739.04	191.79		010	N
36583		430.73	193.15		010	N
36584		195.87	42.62		000	N
36585		932.19	179.55		010	N
36589		106.55	88.41		010	N
36590		229.42	119.92		010	N
36595		538.41	120.15		000	N
36596		118.56	29.24		000	N
36597		101.56	38.54		000	N
36600		18.59	9.75		000	N
36620		32.87	32.87		000	N
36625		63.25	63.25		000	N
36640		75.72	75.72		000	N
36660		43.75	43.75		000	N
36680		40.35	40.35		000	N
36800		100.43	100.43		000	N
36810		137.38	137.38		000	N
36815		92.04	92.04		000	N
36819		498.51	498.51		090	Y
36820		498.51	498.51		090	Y
36821		331.89	331.89		090	Y
36822		239.62	239.62		090	N
36823		741.54	741.54		090	N
36825		364.99	364.99		090	Y
36830		422.57	422.57		090	Y
36831		289.72	289.72		090	Y
36832		372.69	372.69		090	Y
36833		419.62	419.62		090	Y
36834		358.87	358.87		090	Y
36835		280.20	280.20		090	N
36838		737.00	737.00		090	Y
36860		104.96	78.89		000	N
36861		94.31	94.31		000	N
36870		1,198.79	194.06		090	N
37140		802.29	802.29		090	N
37145		863.05	863.05		090	Y
37160		750.60	750.60		090	Y
37180		853.07	853.07		090	Y
37181		917.23	917.23		090	Y
37182		561.99	561.99		000	Y
37183		261.61	261.61		000	Y
37195		193.60	193.60		000	N
37200		141.91	141.91		000	N
37201		176.37	176.37		000	N
37202		206.52	206.52		000	N
37203		177.05	177.05		000	N
37204		567.20	567.20		000	N
37205		283.15	283.15		000	N
37206		131.49	131.49		000	N
37207		279.97	279.97		000	Y
37208		135.11	135.11		000	Y
37209		71.18	71.18		000	N
37250		68.69	68.69		000	N
37251		52.14	52.14		000	N
37500		421.44	421.44		090	N
37501		B.R.	B.R.		090	N
37565		386.07	386.07		090	N
37600		416.67	416.67		090	Y
37605		473.35	473.35		090	Y
37606		265.01	265.01		090	Y
37607		236.67	236.67		090	N
37609		180.45	118.11		010	N
37615		236.90	236.90		090	Y
37616		603.25	603.25		090	Y
37617		748.79	748.79		090	Y
37618		203.80	203.80		090	Y
37620		386.98	386.98		090	N
37650		297.43	297.43		090	N
37660		710.48	710.48		090	Y
37700		157.56	157.56		090	N
37720		227.38	227.38		090	N
37730		281.33	281.33		090	N
37735		391.28	391.28		090	Y
37760		385.16	385.16		090	Y
37765		#	#		090	N
37766		#	#		090	N
37780		161.86	161.86		090	N
37785		213.78	156.42		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
37788		741.99	741.99		090	Y
37790		306.95	306.95		090	N
37799		B.R.	B.R.		090	N
38100		500.33	500.33		090	Y
38101		528.44	528.44		090	Y
38102		157.33	157.33		000	Y
38115		543.17	543.17		090	Y
38120		593.73	593.73		090	Y
38129		B.R.	B.R.		090	Y
38200		82.97	82.97		000	N
38204		Bundled	Bundled		000	N
38205		50.55	50.55		000	N
38206		50.55	50.55		000	N
38207		B.R.	B.R.		000	N
38208		B.R.	B.R.		000	N
38209		B.R.	B.R.		000	N
38210		B.R.	B.R.		000	N
38211		B.R.	B.R.		000	N
38212		B.R.	B.R.		000	N
38213		B.R.	B.R.		000	N
38214		B.R.	B.R.		000	N
38215		B.R.	B.R.		000	N
38220		116.52	37.18		000	N
38221		128.09	46.93		000	N
38230		178.87	178.87		010	N
38240		76.40	76.40		000	N
38241		76.62	76.62		000	N
38242		57.58	57.58		000	N
38300		149.85	95.89		010	N
38305		280.88	244.38		090	N
38308		288.36	243.48		090	Y
38380		315.11	315.11		090	Y
38381		486.04	486.04		090	Y
38382		385.84	385.84		090	Y
38500		177.73	139.19		010	N
38505		76.62	45.79		000	N
38510		283.60	234.63		010	N
38520		256.85	256.85		090	N
38525		225.11	225.11		090	N
38530		297.20	297.20		090	Y
38542		248.24	248.24		090	Y
38550		263.43	263.43		090	N
38555		550.43	550.43		090	Y
38562		392.64	392.64		090	Y
38564		390.38	390.38		090	Y
38570		319.65	319.65		010	Y
38571		478.79	478.79		010	Y
38572		566.75	566.75		010	Y
38589		B.R.	B.R.		090	Y

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
38700		385.39	385.39		090	Y
38720		584.89	584.89		090	Y
38724		619.12	619.12		090	Y
38740		357.28	357.28		090	Y
38745		458.84	458.84		090	Y
38746		160.05	160.05		000	Y
38747		160.28	160.28		000	Y
38760		455.21	455.21		090	Y
38765		690.53	690.53		090	Y
38770		454.99	454.99		090	Y
38780		600.98	600.98		090	Y
38790		288.82	49.42		000	N
38792		22.90	22.90		000	N
38794		182.49	182.49		090	N
38999		B.R.	B.R.		090	Y
39000		262.07	262.07		090	Y
39010		452.27	452.27		090	Y
39200		501.46	501.46		090	Y
39220		637.03	637.03		090	Y
39400		253.90	253.90		010	N
39499		B.R.	B.R.		090	Y
39501		478.79	478.79		090	Y
39502		572.42	572.42		090	Y
39503		3,001.28	3,001.28		090	Y
39520		591.46	591.46		090	Y
39530		551.11	551.11		090	Y
39531		583.53	583.53		090	Y
39540		476.52	476.52		090	Y
39541		512.57	512.57		090	Y
39545		511.89	511.89		090	Y
39560		447.28	447.28		090	Y
39561		655.62	655.62		090	Y
39599		B.R.	B.R.		090	Y
40490		71.41	43.07		000	N
40500		243.02	216.05		090	N
40510		271.13	224.66		090	N
40520		283.15	230.33		090	N
40525		344.36	344.36		090	N
40527		405.11	405.11		090	N
40530		283.38	251.86		090	N
40650		216.50	176.37		090	N
40652		254.13	224.89		090	N
40654		295.16	267.51		090	N
40700		528.44	528.44		090	N
40701		659.70	659.70		090	Y
40702		512.12	512.12		090	Y
40720		576.72	576.72		090	N
40761		612.77	612.77		090	N
40799		B.R.	B.R.		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
40800		79.12	54.63		010	N
40801		134.21	107.91		010	N
40804		88.64	55.77		010	N
40805		142.59	110.40		010	N
40806		38.77	29.24		000	N
40808		75.72	48.06		010	N
40810		86.37	59.40		010	N
40812		130.58	97.03		010	N
40814		191.79	158.46		090	N
40816		201.76	166.85		090	N
40818		176.15	138.74		090	N
40819		158.92	125.59		090	N
40820		92.49	84.79		010	N
40830		113.35	100.65		010	N
40831		143.27	131.03		010	N
40840		411.91	384.03		090	Y
40842		411.23	374.96		090	N
40843		541.81	490.13		090	Y
40844		715.92	668.31		090	Y
40845		816.12	764.21		090	N
40899		B.R.	B.R.		010	N
41000		88.19	63.70		010	N
41005		91.81	67.78		010	N
41006		179.55	158.01		090	N
41007		170.71	151.21		090	N
41008		185.44	161.64		090	N
41009		198.14	175.01		090	N
41010		104.74	104.74		010	N
41015		218.99	189.07		090	N
41016		223.30	191.79		090	N
41017		222.17	194.28		090	N
41018		256.17	220.58		090	N
41100		98.16	72.09		010	N
41105		90.91	64.38		010	N
41108		76.17	51.23		010	N
41110		94.53	67.10		010	N
41112		163.68	128.54		090	N
41113		182.95	145.77		090	N
41114		406.70	350.70		090	N
41115		121.06	101.33		010	N
41116		155.97	122.64		090	N
41120		410.78	410.78		090	Y
41130		462.24	462.24		090	Y
41135		900.23	900.23		090	Y
41140		987.05	987.05		090	Y
41145		1,167.51	1,167.51		090	Y
41150		914.28	914.28		090	Y
41153		942.39	942.39		090	Y
41155		1,085.44	1,085.44		090	Y
41250		116.98	83.88		010	N
41251		137.61	99.75		010	N
41252		167.98	124.91		010	N
41500		172.97	172.97		090	N
41510		153.70	153.70		090	N
41520		159.37	140.10		090	N
41599		B.R.	B.R.		090	N
41800		89.55	61.66		010	N
41805		92.72	83.65		010	N
41806		148.94	138.06		010	N
41820		B.R.	B.R.		000	N
41821		B.R.	B.R.		000	N
41822		151.44	88.19		010	N
41823		214.68	175.24		090	N
41825		106.78	85.69		010	N
41826		144.63	122.64		010	N
41827		211.51	170.93		090	N
41828		175.47	151.89		010	N
41830		193.60	162.77		010	N
41850		B.R.	B.R.		000	N
41870		B.R.	B.R.		000	N
41872		168.89	143.73		090	N
41874		182.49	150.76		090	N
41899		B.R.	B.R.		090	N
42000		92.49	58.72		010	N
42100		83.88	63.02		010	N
42104		103.15	75.26		010	N
42106		136.47	115.62		010	N
42107		246.88	203.58		090	N
42120		277.03	277.03		090	Y
42140		96.12	93.63		090	N
42145		346.40	346.40		090	N
42160		126.05	104.51		010	N
42180		138.51	109.50		010	N
42182		189.75	163.00		010	N
42200		499.87	499.87		090	Y
42205		533.65	533.65		090	Y
42210		597.35	597.35		090	Y
42215		394.23	394.23		090	Y
42220		297.43	297.43		090	Y
42225		408.51	408.51		090	Y
42226		423.48	423.48		090	Y
42227		399.45	399.45		090	Y
42235		311.94	311.94		090	Y
42260		452.72	411.69		090	Y
42280		83.43	57.81		010	N
42281		113.80	90.00		010	N
42299		B.R.	B.R.		090	Y
42300		114.71	89.09		010	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
42305		261.16	261.16		090	N
42310		91.36	73.00		010	N
42320		137.83	105.64		010	N
42325		147.36	117.43		090	Y
42326		197.23	164.13		090	Y
42330		129.22	96.35		010	N
42335		169.57	157.33		090	N
42340		229.42	209.70		090	N
42400		59.17	35.59		000	N
42405		175.69	136.93		010	N
42408		226.02	203.35		090	N
42409		149.62	138.97		090	Y
42410		381.08	381.08		090	Y
42415		668.77	668.77		090	Y
42420		768.74	768.74		090	Y
42425		524.58	524.58		090	Y
42426		824.51	824.51		090	Y
42440		285.42	285.42		090	Y
42450		241.89	209.47		090	N
42500		229.19	199.72		090	N
42505		307.86	272.72		090	N
42507		272.27	272.27		090	Y
42508		381.31	381.31		090	Y
42509		481.96	481.96		090	N
42510		337.56	337.56		090	Y
42550		328.72	38.99		000	N
42600		250.28	220.35		090	N
42650		45.57	35.14		000	N
42660		60.98	46.47		000	N
42665		142.82	129.22		090	N
42699		B.R.	B.R.		090	Y
42700		102.24	78.89		010	N
42720		246.88	218.99		010	N
42725		443.88	443.88		090	Y
42800		84.79	65.74		010	N
42802		137.83	81.84		010	N
42804		121.06	71.18		010	N
42806		132.62	82.52		010	N
42808		128.77	100.20		010	N
42809		98.16	75.26		010	N
42810		190.20	156.42		090	Y
42815		296.30	296.30		090	Y
42820		174.33	174.33		090	N
42821		188.16	188.16		090	N
42825		158.92	158.92		090	N
42826		155.29	155.29		090	N
42830		122.42	122.42		090	N
42831		131.26	131.26		090	N
42835		116.07	116.07		090	N
42836		149.17	149.17		090	N
42842		366.80	366.80		090	N
42844		577.18	577.18		090	Y
42845		958.71	958.71		090	Y
42860		113.12	113.12		090	N
42870		240.53	240.53		090	N
42890		527.53	527.53		090	Y
42892		633.63	633.63		090	Y
42894		900.45	900.45		090	Y
42900		212.42	212.42		010	N
42950		347.76	347.76		090	Y
42953		391.96	391.96		090	Y
42955		309.45	309.45		090	Y
42960		102.70	102.70		010	N
42961		246.65	246.65		090	Y
42962		304.68	304.68		090	Y
42970		214.00	214.00		090	N
42971		264.56	264.56		090	Y
42972		300.60	300.60		090	Y
42999		B.R.	B.R.		090	N
43020		329.40	329.40		090	Y
43030		321.01	321.01		090	Y
43045		750.15	750.15		090	Y
43100		369.52	369.52		090	Y
43101		590.10	590.10		090	Y
43107		1,372.44	1,372.44		090	Y
43108		1,186.32	1,186.32		090	Y
43112		1,485.11	1,485.11		090	Y
43113		1,243.45	1,243.45		090	Y
43116		1,150.73	1,150.73		090	Y
43117		1,359.75	1,359.75		090	Y
43118		1,148.92	1,148.92		090	Y
43121		1,029.90	1,029.90		090	Y
43122		1,357.03	1,357.03		090	Y
43123		1,165.01	1,165.01		090	Y
43124		986.15	986.15		090	Y
43130		464.51	464.51		090	Y
43135		592.82	592.82		090	Y
43200		130.35	63.70		000	N
43201		157.78	79.12		000	N
43202		168.89	67.56		000	N
43204		124.69	124.69		000	N
43205		125.14	125.14		000	N
43215		90.91	90.91		000	N
43216		84.79	84.79		000	N
43217		225.34	97.48		000	N
43219		98.39	98.39		000	N
43220		73.00	73.00		000	N
43226		80.03	80.03		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
43227		119.24	119.24		000	N	43330		678.51	678.51		090	Y
43228		127.18	127.18		000	N	43331		724.31	724.31		090	Y
43231		107.23	107.23		000	N	43340		685.31	685.31		090	Y
43232		149.40	149.40		000	N	43341		750.38	750.38		090	Y
43234		167.98	69.14		000	N	43350		578.09	578.09		090	Y
43235		172.75	81.84		000	N	43351		675.11	675.11		090	Y
43236		214.23	98.39		000	N	43352		567.88	567.88		090	Y
43237		132.17	132.17		000	N	43360		1,222.82	1,222.82		090	Y
43238		164.13	164.13		000	N	43361		1,385.14	1,385.14		090	Y
43239		196.10	96.57		000	N	43400		718.64	718.64		090	Y
43240		224.21	224.21		000	N	43401		758.31	758.31		090	Y
43241		87.96	87.96		000	N	43405		710.25	710.25		090	Y
43242		235.99	235.99		000	N	43410		507.13	507.13		090	Y
43243		150.30	150.30		000	N	43415		879.60	879.60		090	Y
43244		165.04	165.04		000	N	43420		515.97	515.97		090	N
43245		107.00	107.00		000	N	43425		751.51	751.51		090	Y
43246		143.27	143.27		000	N	43450		90.45	49.65		000	N
43247		113.12	113.12		000	N	43453		172.52	53.95		000	N
43248		105.87	105.87		000	N	43456		376.55	87.73		000	N
43249		97.71	97.71		000	N	43458		223.53	103.83		000	N
43250		107.46	107.46		000	N	43460		124.69	124.69		000	N
43251		123.10	123.10		000	N	43496		B.R.	B.R.		090	Y
43255		157.56	157.56		000	N	43499		B.R.	B.R.		090	Y
43256		144.18	144.18		000	N	43500		383.58	383.58		090	Y
43258		150.30	150.30		000	N	43501		680.10	680.10		090	Y
43259		169.57	169.57		000	N	43502		783.02	783.02		090	Y
43260		194.06	194.06		000	N	43510		467.46	467.46		090	Y
43261		204.03	204.03		000	N	43520		366.57	366.57		090	Y
43262		239.40	239.40		000	N	43600		69.37	69.37		000	N
43263		235.31	235.31		000	N	43605		413.95	413.95		090	Y
43264		287.68	287.68		000	N	43610		498.29	498.29		090	Y
43265		321.91	321.91		000	N	43611		609.14	609.14		090	Y
43267		239.17	239.17		000	N	43620		1,003.60	1,003.60		090	Y
43268		241.66	241.66		000	N	43621		1,025.14	1,025.14		090	Y
43269		263.43	263.43		000	N	43622		1,082.49	1,082.49		090	Y
43271		239.17	239.17		000	N	43631		767.15	767.15		090	Y
43272		239.40	239.40		000	N	43632		767.38	767.38		090	Y
43280		597.81	597.81		090	Y	43633		783.70	783.70		090	Y
43289		B.R.	B.R.		090	Y	43634		849.90	849.90		090	Y
43300		375.42	375.42		090	Y	43635		67.33	67.33		000	Y
43305		671.26	671.26		090	Y	43638		980.70	980.70		090	Y
43310		901.36	901.36		090	Y	43639		992.49	992.49		090	Y
43312		993.85	993.85		090	Y	43640		586.47	586.47		090	Y
43313		1,607.98	1,607.98		090	Y	43641		595.09	595.09		090	Y
43314		1,766.90	1,766.90		090	Y	43651		362.72	362.72		090	Y
43320		699.37	699.37		090	Y	43652		426.88	426.88		090	Y
43324		706.40	706.40		090	Y	43653		289.27	289.27		090	Y
43325		693.93	693.93		090	Y	43659		B.R.	B.R.		090	Y
43326		702.09	702.09		090	Y	43750		171.39	171.39		010	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
43752		Bundled	Bundled		000	N
43760		64.16	36.73		000	N
43761		65.97	65.97		000	N
43800		470.18	470.18		090	Y
43810		499.42	499.42		090	Y
43820		522.32	522.32		090	Y
43825		653.58	653.58		090	Y
43830		343.22	343.22		090	Y
43831		299.70	299.70		090	Y
43832		536.83	536.83		090	Y
43840		535.47	535.47		090	Y
43842		#	#		090	Y
43843		#	#		090	Y
43846		#	#		090	Y
43847		#	#		090	Y
43848		#	#		090	Y
43850		830.18	830.18		090	Y
43855		875.29	875.29		090	Y
43860		841.51	841.51		090	Y
43865		890.70	890.70		090	Y
43870		339.82	339.82		090	Y
43880		830.18	830.18		090	Y
43999		B.R.	B.R.		090	N
44005		554.05	554.05		090	Y
44010		433.22	433.22		090	Y
44015		85.47	85.47		000	Y
44020		480.83	480.83		090	Y
44021		483.10	483.10		090	Y
44025		489.67	489.67		090	Y
44050		481.06	481.06		090	Y
44055		729.29	729.29		090	Y
44100		73.45	73.45		000	N
44110		410.55	410.55		090	Y
44111		492.39	492.39		090	Y
44120		580.81	580.81		090	Y
44121		145.99	145.99		000	Y
44125		598.03	598.03		090	Y
44126		1,137.58	1,137.58		090	Y
44127		1,300.80	1,300.80		090	Y
44128		145.99	145.99		000	Y
44130		499.19	499.19		090	Y
44132		#	#		000	N
44133		#	#		000	N
44135		#	#		000	N
44136		#	#		000	N
44139		72.54	72.54		000	Y
44140		722.49	722.49		090	Y
44141		717.96	717.96		090	Y
44143		813.40	813.40		090	Y
44144		751.96	751.96		090	Y
44145		897.05	897.05		090	Y
44146		970.50	970.50		090	Y
44147		708.21	708.21		090	Y
44150		866.67	866.67		090	Y
44151		963.25	963.25		090	Y
44152		950.78	950.78		090	Y
44153		1,078.64	1,078.64		090	Y
44155		989.77	989.77		090	Y
44156		1,094.73	1,094.73		090	Y
44160		641.79	641.79		090	Y
44200		502.37	502.37		090	Y
44201		350.93	350.93		090	Y
44202		753.32	753.32		090	Y
44203		145.31	145.31		000	Y
44204		853.98	853.98		090	Y
44205		756.72	756.72		090	Y
44206		917.45	917.45		090	Y
44207		994.99	994.99		090	Y
44208		1,078.19	1,078.19		090	Y
44210		955.77	955.77		090	Y
44211		1,182.92	1,182.92		090	Y
44212		1,104.94	1,104.94		090	Y
44238		B.R.	B.R.		090	Y
44239		B.R.	B.R.		090	Y
44300		420.76	420.76		090	Y
44310		540.91	540.91		090	Y
44312		286.10	286.10		090	N
44314		514.38	514.38		090	Y
44316		706.40	706.40		090	Y
44320		604.84	604.84		090	Y
44322		496.93	496.93		090	Y
44340		286.32	286.32		090	N
44345		533.20	533.20		090	Y
44346		581.94	581.94		090	Y
44360		87.51	87.51		000	N
44361		96.12	96.12		000	N
44363		115.62	115.62		000	N
44364		124.00	124.00		000	N
44365		110.86	110.86		000	N
44366		145.09	145.09		000	N
44369		147.81	147.81		000	N
44370		158.92	158.92		000	N
44372		145.99	145.99		000	N
44373		116.75	116.75		000	N
44376		172.29	172.29		000	N
44377		180.91	180.91		000	N
44378		232.14	232.14		000	N
44379		245.06	245.06		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
44380		38.54	38.54		000	N
44382		45.79	45.79		000	N
44383		99.07	99.07		000	N
44385		158.01	65.97		000	N
44386		200.63	77.08		000	N
44388		185.89	94.76		000	N
44389		223.75	104.51		000	N
44390		246.65	126.27		000	N
44391		300.38	142.37		000	N
44392		241.21	126.50		000	N
44393		273.85	158.92		000	N
44394		283.60	146.22		000	N
44397		160.28	160.28		000	N
44500		19.72	19.72		000	N
44602		534.33	534.33		090	Y
44603		621.38	621.38		090	Y
44604		543.63	543.63		090	Y
44605		670.81	670.81		090	Y
44615		545.89	545.89		090	Y
44620		422.57	422.57		090	Y
44625		515.52	515.52		090	Y
44626		856.93	856.93		090	Y
44640		720.68	720.68		090	Y
44650		749.47	749.47		090	Y
44660		702.09	702.09		090	Y
44661		816.35	816.35		090	Y
44680		527.98	527.98		090	Y
44700		545.44	545.44		090	Y
44701		99.29	99.29		000	Y
44799		B.R.	B.R.		090	Y
44800		403.53	403.53		090	Y
44820		423.48	423.48		090	Y
44850		380.63	380.63		090	Y
44899		B.R.	B.R.		090	Y
44900		356.83	356.83		090	Y
44901		106.10	106.10		000	Y
44950		345.94	345.94		090	Y
44955		50.33	50.33		000	Y
44960		427.10	427.10		090	Y
44970		313.75	313.75		090	Y
44979		B.R.	B.R.		090	Y
45000		178.87	178.87		090	N
45005		160.05	87.96		010	N
45020		191.79	191.79		090	N
45100		145.31	145.31		090	N
45108		184.53	184.53		090	N
45110		971.41	971.41		090	Y
45111		574.23	574.23		090	Y
45112		1,014.94	1,014.94		090	Y
45113		1,031.03	1,031.03		090	Y
45114		921.99	921.99		090	Y
45116		832.44	832.44		090	Y
45119		1,033.53	1,033.53		090	Y
45120		841.51	841.51		090	Y
45121		927.88	927.88		090	Y
45123		559.72	559.72		090	Y
45126		1,539.52	1,539.52		090	Y
45130		553.37	553.37		090	Y
45135		664.91	664.91		090	Y
45136		965.97	965.97		090	Y
45150		206.98	206.98		090	N
45160		524.13	524.13		090	Y
45170		400.81	400.81		090	Y
45190		345.04	345.04		090	Y
45300		43.53	16.78		000	N
45303		447.73	19.27		000	N
45305		84.11	36.95		000	N
45307		93.40	36.05		000	N
45308		66.20	32.42		000	N
45309		112.90	69.14		000	N
45315		100.43	51.01		000	N
45317		92.95	53.95		000	N
45320		105.42	56.90		000	N
45321		43.75	43.75		000	N
45327		55.77	55.77		000	N
45330		73.22	34.91		000	N
45331		94.31	41.94		000	N
45332		154.38	62.57		000	N
45333		151.44	62.80		000	N
45334		92.49	92.49		000	N
45335		113.35	50.10		000	N
45337		80.93	80.93		000	N
45338		171.61	80.48		000	N
45339		151.66	105.42		000	N
45340		198.36	63.48		000	N
45341		89.09	89.09		000	N
45342		133.75	133.75		000	N
45345		97.03	97.03		000	N
45355		117.43	117.43		000	N
45378	53	73.22	34.91		000	N
45378		226.70	124.46		000	N
45379		284.96	154.38		000	N
45380		267.28	145.99		000	N
45381		286.32	138.51		000	N
45382		357.73	186.12		000	N
45383		320.10	192.24		000	N
45384		265.24	154.61		000	N
45385		302.87	174.33		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
45386		421.21	150.30		000	N
45387		195.19	195.19		000	N
45500		260.02	260.02		090	N
45505		271.59	271.59		090	N
45520		32.87	17.68		000	N
45540		552.01	552.01		090	Y
45541		460.65	460.65		090	Y
45550		769.42	769.42		090	Y
45560		373.15	373.15		090	Y
45562		535.69	535.69		090	Y
45563		815.89	815.89		090	Y
45800		599.85	599.85		090	Y
45805		723.63	723.63		090	Y
45820		621.16	621.16		090	Y
45825		730.43	730.43		090	Y
45900		97.93	97.93		010	N
45905		88.19	88.19		010	N
45910		104.74	104.74		010	N
45915		183.63	102.02		010	N
45999		B.R.	B.R.		090	N
46020		123.10	113.35		010	N
46030		61.21	46.47		010	N
46040		244.38	195.64		090	N
46045		173.65	173.65		090	N
46050		88.41	49.19		010	N
46060		216.05	216.05		090	N
46070		110.63	110.63		090	N
46080		116.52	87.51		010	N
46083		91.59	56.22		010	N
46200		167.53	139.65		090	N
46210		176.60	115.39		090	N
46211		221.03	172.07		090	N
46220		90.45	60.08		010	N
46221		85.92	74.58		010	N
46230		133.07	92.72		010	N
46250		209.02	153.93		090	N
46255		239.40	176.83		090	N
46257		201.99	201.99		090	N
46258		219.90	219.90		090	N
46260		234.18	234.18		090	N
46261		259.80	259.80		090	N
46262		273.85	273.85		090	N
46270		198.82	146.67		090	N
46275		211.96	170.93		090	N
46280		222.39	222.39		090	N
46285		182.49	153.93		090	N
46288		260.02	260.02		090	N
46320		88.19	59.17		010	N
46500		103.15	53.27		010	N
46600		48.51	21.08		000	N
46604		244.84	46.47		000	N
46606		107.68	29.92		000	N
46608		138.51	52.82		000	N
46610		126.05	46.93		000	N
46611		121.28	62.80		000	N
46612		176.15	80.03		000	N
46614		101.11	68.69		000	N
46615		123.78	91.13		000	N
46700		316.70	316.70		090	N
46705		258.44	258.44		090	Y
46706		86.60	86.60		010	N
46715		263.43	263.43		090	Y
46716		553.37	553.37		090	Y
46730		927.20	927.20		090	Y
46735		1,098.81	1,098.81		090	Y
46740		1,026.95	1,026.95		090	Y
46742		1,271.79	1,271.79		090	Y
46744		1,728.81	1,728.81		090	Y
46746		1,953.25	1,953.25		090	Y
46748		2,062.74	2,062.74		090	Y
46750		364.31	364.31		090	Y
46751		342.32	342.32		090	Y
46753		289.72	289.72		090	N
46754		134.89	91.59		010	N
46760		509.17	509.17		090	Y
46761		471.31	471.31		090	Y
46762		431.41	431.41		090	Y
46900		127.41	64.38		010	N
46910		106.78	70.50		010	N
46916		115.84	76.40		010	N
46917		255.94	71.41		010	N
46922		122.19	70.96		010	N
46924		266.15	98.16		010	N
46934		199.95	147.13		090	N
46935		138.06	86.83		010	N
46936		192.24	141.91		090	N
46937		126.27	91.59		010	N
46938		211.06	176.15		090	N
46940		102.24	81.61		010	N
46942		91.59	72.77		010	N
46945		126.73	88.64		090	N
46946		159.14	105.87		090	N
46999		B.R.	B.R.		090	N
47000		119.92	59.62		000	N
47001		62.12	62.12		000	N
47010		573.32	573.32		090	Y
47011		115.39	115.39		000	Y
47015		535.01	535.01		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
47100		420.76	420.76		090	Y
47120		1,205.82	1,205.82		090	Y
47122		1,824.94	1,824.94		090	Y
47125		1,636.55	1,636.55		090	Y
47130		1,770.75	1,770.75		090	Y
47133		B.R.	B.R.		000	N
47135		2,762.57	2,762.57		090	Y
47136		2,338.41	2,338.41		090	Y
47140		1,855.99	1,855.99		090	Y
47141		2,246.14	2,246.14		090	Y
47142		2,475.34	2,475.34		090	Y
47300		530.48	530.48		090	Y
47350		675.79	675.79		090	Y
47360		915.64	915.64		090	Y
47361		1,564.23	1,564.23		090	Y
47362		648.14	648.14		090	Y
47370		652.90	652.90		090	Y
47371		653.12	653.12		090	Y
47379		B.R.	B.R.		090	Y
47380		755.82	755.82		090	Y
47381		767.83	767.83		090	Y
47382		509.39	509.39		010	Y
47399		B.R.	B.R.		090	Y
47400		1,087.48	1,087.48		090	Y
47420		690.30	690.30		090	Y
47425		688.26	688.26		090	Y
47460		629.32	629.32		090	Y
47480		400.81	400.81		090	Y
47490		304.91	304.91		090	N
47500		61.21	61.21		000	N
47505		77.53	23.80		000	N
47510		300.38	300.38		090	N
47511		364.99	364.99		090	N
47525		205.84	205.84		010	N
47530		238.04	238.04		090	N
47550		98.84	98.84		000	Y
47552		201.31	201.31		000	N
47553		210.15	210.15		000	N
47554		299.24	299.24		000	N
47555		248.24	248.24		000	N
47556		278.84	278.84		000	N
47560		163.45	163.45		000	N
47561		177.05	177.05		000	N
47562		390.83	390.83		090	Y
47563		419.17	419.17		090	Y
47564		491.26	491.26		090	Y
47570		436.85	436.85		090	Y
47579		B.R.	B.R.		090	Y
47600		475.62	475.62		090	Y

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
47605		510.76	510.76		090	Y
47610		645.19	645.19		090	Y
47612		642.92	642.92		090	Y
47620		703.90	703.90		090	Y
47630		326.67	326.67		090	N
47700		556.55	556.55		090	Y
47701		962.11	962.11		090	N
47711		795.49	795.49		090	Y
47712		1,030.80	1,030.80		090	Y
47715		655.84	655.84		090	Y
47716		584.43	584.43		090	Y
47720		563.80	563.80		090	Y
47721		667.40	667.40		090	Y
47740		647.68	647.68		090	Y
47741		738.36	738.36		090	Y
47760		885.26	885.26		090	Y
47765		861.69	861.69		090	Y
47780		909.52	909.52		090	Y
47785		1,064.36	1,064.36		090	Y
47800		803.65	803.65		090	Y
47801		550.20	550.20		090	Y
47802		752.87	752.87		090	Y
47900		692.34	692.34		090	Y
47999		B.R.	B.R.		090	Y
48000		931.06	931.06		090	Y
48001		1,165.46	1,165.46		090	Y
48005		1,387.40	1,387.40		090	Y
48020		554.51	554.51		090	Y
48100		430.50	430.50		090	Y
48102		317.61	166.62		010	N
48120		547.48	547.48		090	Y
48140		787.10	787.10		090	Y
48145		821.11	821.11		090	Y
48146		929.24	929.24		090	Y
48148		604.61	604.61		090	Y
48150		1,636.32	1,636.32		090	Y
48152		1,502.11	1,502.11		090	Y
48153		1,635.41	1,635.41		090	Y
48154		1,511.64	1,511.64		090	Y
48155		880.05	880.05		090	Y
48160		B.R.	B.R.		000	N
48180		844.00	844.00		090	Y
48400		61.21	61.21		000	N
48500		545.89	545.89		090	Y
48510		520.96	520.96		090	Y
48511		124.46	124.46		000	Y
48520		539.32	539.32		090	Y
48540		674.43	674.43		090	Y
48545		632.04	632.04		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
48547		878.01	878.01		090	Y
48550		B.R.	B.R.		000	N
48554		1,244.36	1,244.36		090	Y
48556		579.67	579.67		090	Y
48999		B.R.	B.R.		090	Y
49000		414.86	414.86		090	Y
49002		377.23	377.23		090	Y
49010		441.61	441.61		090	Y
49020		781.66	781.66		090	Y
49021		105.64	105.64		000	N
49040		473.35	473.35		090	Y
49041		124.69	124.69		000	Y
49060		548.16	548.16		090	N
49061		115.39	115.39		000	Y
49062		407.38	407.38		090	Y
49080		128.31	42.39		000	N
49081		90.00	43.07		000	N
49085		422.12	422.12		090	N
49180		117.20	53.95		000	N
49200		369.07	369.07		090	Y
49201		531.61	531.61		090	Y
49215		1,137.13	1,137.13		090	Y
49220		523.90	523.90		090	Y
49250		307.18	307.18		090	N
49255		406.93	406.93		090	Y
49320		187.03	187.03		010	Y
49321		194.74	194.74		010	Y
49322		210.38	210.38		010	Y
49323		338.01	338.01		090	Y
49329		B.R.	B.R.		090	Y
49400		63.25	63.25		000	N
49419		244.38	244.38		090	N
49420		79.12	79.12		000	N
49421		211.06	211.06		090	N
49422		222.17	222.17		010	N
49423		49.87	49.87		000	N
49424		28.11	28.11		000	N
49425		413.95	413.95		090	Y
49426		349.34	349.34		090	N
49427		32.42	32.42		000	N
49428		219.67	219.67		010	N
49429		264.56	264.56		010	N
49491		392.87	392.87		090	Y
49492		491.26	491.26		090	Y
49495		215.14	215.14		090	Y
49496		319.87	319.87		090	Y
49500		206.52	206.52		090	Y
49501		315.34	315.34		090	Y
49505		280.65	275.21		090	Y

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
49507		339.37	339.37		090	Y
49520		339.82	339.82		090	Y
49521		415.31	415.31		090	Y
49525		305.36	305.36		090	Y
49540		365.67	365.67		090	Y
49550		307.63	307.63		090	Y
49553		334.61	334.61		090	Y
49555		321.23	321.23		090	Y
49557		389.47	389.47		090	Y
49560		403.75	403.75		090	Y
49561		490.13	490.13		090	Y
49565		405.34	405.34		090	Y
49566		495.57	495.57		090	Y
49568		160.28	160.28		000	Y
49570		213.32	213.32		090	Y
49572		245.52	245.52		090	Y
49580		161.18	161.18		090	Y
49582		244.38	244.38		090	Y
49585		229.65	229.65		090	Y
49587		272.27	272.27		090	Y
49590		304.68	304.68		090	Y
49600		396.73	396.73		090	Y
49605		2,437.03	2,437.03		090	Y
49606		648.59	648.59		090	Y
49610		375.64	375.64		090	Y
49611		382.67	382.67		090	Y
49650		230.33	230.33		090	Y
49651		299.02	299.02		090	Y
49659		B.R.	B.R.		090	Y
49900		449.32	449.32		090	Y
49904		851.26	851.26		090	N
49905		214.68	214.68		000	Y
49906		B.R.	B.R.		090	N
49999		B.R.	B.R.		090	Y
50010		390.38	390.38		090	Y
50020		552.01	552.01		090	N
50021		105.19	105.19		000	Y
50040		549.97	549.97		090	N
50045		529.80	529.80		090	Y
50060		646.78	646.78		090	Y
50065		639.29	639.29		090	Y
50070		680.33	680.33		090	Y
50075		841.28	841.28		090	Y
50080		532.52	532.52		090	N
50081		760.35	760.35		090	Y
50100		584.21	584.21		090	Y
50120		543.40	543.40		090	Y
50125		561.54	561.54		090	Y
50130		583.98	583.98		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
50135		643.83	643.83		090	Y
50200		82.97	82.97		000	N
50205		397.18	397.18		090	Y
50220		584.89	584.89		090	Y
50225		678.06	678.06		090	Y
50230		732.69	732.69		090	Y
50234		745.39	745.39		090	Y
50236		858.29	858.29		090	Y
50240		769.65	769.65		090	Y
50280		535.01	535.01		090	Y
50290		510.98	510.98		090	Y
50300		B.R.	B.R.		000	N
50320		771.23	771.23		090	Y
50340		459.75	459.75		090	Y
50360		1,141.43	1,141.43		090	Y
50365		1,336.85	1,336.85		090	Y
50370		511.21	511.21		090	Y
50380		814.31	814.31		090	Y
50390		61.21	61.21		000	N
50392		105.19	105.19		000	N
50393		129.22	129.22		000	N
50394		76.40	23.80		000	N
50395		105.19	105.19		000	N
50396		69.37	69.37		000	N
50398		61.89	45.34		000	N
50400		645.87	645.87		090	Y
50405		813.17	813.17		090	Y
50500		676.70	676.70		090	Y
50520		618.89	618.89		090	Y
50525		771.23	771.23		090	Y
50526		829.50	829.50		090	Y
50540		676.02	676.02		090	Y
50541		531.61	531.61		090	Y
50542		669.90	669.90		090	Y
50543		843.55	843.55		090	Y
50544		733.15	733.15		090	Y
50545		786.88	786.88		090	Y
50546		684.86	684.86		090	Y
50547		862.37	862.37		090	Y
50548		794.81	794.81		090	Y
50549		B.R.	B.R.		090	Y
50551		247.10	175.47		000	N
50553		569.47	188.16		000	N
50555		595.77	204.94		000	N
50557		617.98	207.20		000	N
50559		209.92	209.92		000	N
50561		587.38	237.81		000	N
50562		354.11	354.11		090	Y
50570		299.02	299.02		000	N

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
50572		325.09	325.09		000	N
50574		345.94	345.94		000	N
50575		438.21	438.21		000	N
50576		344.13	344.13		000	N
50578		355.47	355.47		000	N
50580		371.33	371.33		000	N
50590		464.96	333.48		090	N
50600		541.13	541.13		090	Y
50605		535.92	535.92		090	Y
50610		550.88	550.88		090	Y
50620		515.74	515.74		090	Y
50630		509.17	509.17		090	Y
50650		590.10	590.10		090	Y
50660		658.56	658.56		090	Y
50684		370.65	23.80		000	N
50686		140.78	51.23		000	N
50688		68.01	68.01		010	N
50690		390.60	36.05		000	N
50700		531.38	531.38		090	Y
50715		672.62	672.62		090	Y
50722		586.02	586.02		090	Y
50725		641.56	641.56		090	Y
50727		316.02	316.02		090	Y
50728		445.92	445.92		090	Y
50740		632.95	632.95		090	Y
50750		659.24	659.24		090	Y
50760		627.51	627.51		090	Y
50770		659.02	659.02		090	Y
50780		622.97	622.97		090	Y
50782		693.25	693.25		090	Y
50783		710.02	710.02		090	Y
50785		690.75	690.75		090	Y
50800		509.85	509.85		090	Y
50810		713.20	713.20		090	Y
50815		685.54	685.54		090	Y
50820		736.32	736.32		090	Y
50825		945.79	945.79		090	Y
50830		1,047.81	1,047.81		090	Y
50840		685.99	685.99		090	Y
50845		704.81	704.81		090	Y
50860		528.66	528.66		090	Y
50900		476.07	476.07		090	Y
50920		498.97	498.97		090	Y
50930		646.78	646.78		090	Y
50940		503.95	503.95		090	Y
50945		570.38	570.38		090	Y
50947		820.65	820.65		090	Y
50948		748.11	748.11		090	Y
50949		B.R.	B.R.		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
50951		262.52	182.95		000	N	51720		88.19	63.25		000	N
50953		576.27	195.64		000	N	51725	26	47.61	47.61		000	N
50955		631.59	212.42		000	N	51725	TC	121.74	121.74		000	N
50957		581.26	212.64		000	N	51725		169.34	169.34		000	N
50959		135.11	135.11		000	N	51726	26	53.95	53.95		000	N
50961		728.61	189.29		000	N	51726	TC	167.76	167.76		000	N
50970		224.21	224.21		000	N	51726		221.71	221.71		000	N
50972		216.95	216.95		000	N	51736	TC	8.84	8.84		000	N
50974		286.78	286.78		000	N	51736	26	19.27	19.27		000	N
50976		283.38	283.38		000	N	51736		28.34	28.34		000	N
50978		160.50	160.50		000	N	51741	TC	10.20	10.20		000	N
50980		214.68	214.68		000	N	51741	26	35.82	35.82		000	N
51000		64.16	24.26		000	N	51741		46.02	46.02		000	N
51005		135.11	32.87		000	N	51772	26	51.69	51.69		000	N
51010		216.73	128.31		010	N	51772	TC	120.83	120.83		000	N
51020		252.77	252.77		090	Y	51772		172.52	172.52		000	N
51030		256.62	256.62		090	N	51784	26	48.29	48.29		000	N
51040		171.61	171.61		090	Y	51784	TC	83.43	83.43		000	N
51045		257.08	257.08		090	Y	51784		131.94	131.94		000	N
51050		252.09	252.09		090	Y	51785	26	48.29	48.29		000	N
51060		318.51	318.51		090	Y	51785	TC	95.21	95.21		000	N
51065		314.89	314.89		090	N	51785		143.27	143.27		000	N
51080		226.70	226.70		090	Y	51792	26	36.50	36.50		000	N
51500		365.67	365.67		090	Y	51792	TC	130.13	130.13		000	N
51520		333.25	333.25		090	Y	51792		166.40	166.40		000	N
51525		478.79	478.79		090	Y	51795	26	48.29	48.29		000	N
51530		433.22	433.22		090	Y	51795	TC	165.04	165.04		000	N
51535		447.73	447.73		090	Y	51795		213.32	213.32		000	N
51550		535.69	535.69		090	Y	51797	26	50.55	50.55		000	N
51555		713.42	713.42		090	Y	51797	TC	125.37	125.37		000	N
51565		730.20	730.20		090	Y	51797		175.92	175.92		000	N
51570		812.49	812.49		090	Y	51798		9.75	9.75		000	N
51575		1,012.90	1,012.90		090	Y	51800		596.90	596.90		090	Y
51580		1,039.19	1,039.19		090	Y	51820		631.36	631.36		090	Y
51585		1,166.37	1,166.37		090	Y	51840		389.70	389.70	EX	090	Y
51590		1,079.09	1,079.09		090	Y	51841		464.28	464.28	EX	090	Y
51595		1,220.33	1,220.33		090	Y	51845		346.17	346.17	EX	090	Y
51596		1,303.30	1,303.30		090	Y	51860		427.33	427.33		090	Y
51597		1,269.75	1,269.75		090	Y	51865		519.82	519.82		090	Y
51600		155.06	27.66		000	N	51880		278.84	278.84		090	Y
51605		262.97	23.58		000	N	51900		455.89	455.89		090	Y
51610		64.38	38.77		000	N	51920		418.49	418.49		090	Y
51700		58.94	27.43		000	N	51925		583.53	583.53	EX	090	Y
51701		49.65	16.55		000	N	51940		971.41	971.41		090	Y
51702		65.74	18.14		000	N	51960		779.17	779.17		090	Y
51703		105.19	48.51		000	N	51980		399.67	399.67		090	Y
51705		77.98	38.31		010	N	51990		447.51	447.51		090	Y
51710		114.48	53.50		010	N	51992		481.28	481.28		090	Y
51715		181.81	121.06		000	N	52000		125.59	65.52		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
52001		249.37	173.43		000	N	52500		293.80	293.80		090	N
52005		194.28	77.76		000	N	52510		233.05	233.05		090	N
52007		99.07	99.07		000	N	52601		414.86	414.86		090	N
52010		98.61	98.61		000	N	52606		277.25	277.25		090	N
52204		140.33	77.98		000	N	52612		277.93	277.93		090	N
52214		119.47	119.47		000	N	52614		241.44	241.44		090	N
52224		101.79	101.79		000	N	52620		227.38	227.38		090	N
52234		148.26	148.26		000	N	52630		248.01	248.01		090	N
52235		174.11	174.11		000	N	52640		226.93	226.93		090	N
52240		308.99	308.99		000	N	52647		2,006.52	353.20		090	N
52250		145.99	145.99		000	N	52648		379.72	379.72		090	N
52260		126.73	126.73		000	N	52700		236.67	236.67		090	N
52265		156.65	96.35		000	N	53000		90.68	90.68		010	N
52270		109.27	109.27		000	N	53010		155.97	155.97		090	N
52275		150.98	150.98		000	N	53020		113.58	58.04		000	N
52276		160.96	160.96		000	N	53025		115.84	38.77		000	N
52277		200.18	200.18		000	N	53040		412.59	299.24		090	N
52281		237.81	92.27		000	N	53060		98.16	98.16		010	N
52282		204.94	204.94		000	N	53080		293.35	293.35		090	N
52283		182.04	121.51		000	N	53085		422.34	422.34		090	Y
52285		180.68	117.43		000	N	53200		160.96	85.01		000	N
52290		148.04	148.04		000	N	53210		440.02	440.02		090	Y
52300		171.16	171.16		000	N	53215		528.89	528.89		090	Y
52301		179.32	179.32		000	N	53220		256.40	256.40		090	N
52305		169.80	169.80		000	N	53230		341.41	341.41		090	Y
52310		148.49	91.59		000	N	53235		357.96	357.96		090	Y
52315		167.08	167.08		000	N	53240		238.94	238.94		090	N
52317		213.32	213.32		000	N	53250		218.77	218.77		090	N
52318		291.31	291.31		000	N	53260		148.04	114.03		010	N
52320		150.30	150.30		000	N	53265		117.43	117.43		010	N
52325		196.32	196.32		000	N	53270		117.66	117.66		010	N
52327		166.62	166.62		000	N	53275		161.18	161.18		010	N
52330		161.18	161.18		000	N	53400		448.19	448.19		090	Y
52332		92.49	92.49		000	N	53405		496.25	496.25		090	Y
52334		155.97	155.97		000	N	53410		559.72	559.72		090	Y
52341		195.19	195.19		000	N	53415		637.03	637.03		090	Y
52342		209.92	209.92		000	N	53420		486.95	486.95		090	N
52343		232.37	232.37		000	N	53425		545.44	545.44		090	Y
52344		249.14	249.14		000	N	53430		556.32	556.32		090	Y
52345		264.79	264.79		000	N	53431		666.95	666.95		090	Y
52346		297.43	297.43		000	N	53440		463.37	463.37		090	Y
52347		166.17	166.17		000	N	53442		400.58	400.58		090	Y
52351		189.75	189.75		000	N	53444		458.61	458.61		090	Y
52352		222.85	222.85		000	N	53445		503.73	503.73		090	Y
52353		257.08	257.08		000	N	53446		367.48	367.48		090	Y
52354		237.58	237.58		000	N	53447		471.76	471.76		090	Y
52355		284.28	284.28		000	N	53448		719.55	719.55		090	Y
52400		319.42	319.42		090	N	53449		343.90	343.90		090	Y
52450		268.41	268.41		090	N	53450		225.34	225.34		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
53460		258.44	258.44		090	N
53500		853.19	853.19		090	Y
53502		278.16	278.16		090	N
53505		274.53	274.53		090	Y
53510		363.63	363.63		090	Y
53515		458.84	458.84		090	Y
53520		313.98	313.98		090	N
53600		55.77	38.77		000	N
53601		53.27	32.19		000	N
53605		40.35	40.35		000	N
53620		85.69	52.82		000	N
53621		81.39	43.98		000	N
53660		47.83	24.71		000	N
53661		48.06	24.03		000	N
53665		24.26	24.26		000	N
53850		2,469.22	325.31		090	N
53852		2,369.47	344.36		090	N
53853		1,451.33	197.68		090	N
53899		B.R.	B.R.		090	N
54000		67.56	67.56		010	N
54001		151.44	87.51		010	N
54015		187.25	187.25		010	N
54050		68.46	53.73		010	N
54055		65.74	47.61		010	N
54056		86.37	60.30		010	N
54057		49.87	49.87		010	N
54060		135.34	79.57		010	N
54065		97.25	97.25		010	N
54100		111.08	64.16		000	N
54105		128.77	128.77		010	N
54110		372.01	372.01		090	Y
54111		478.34	478.34		090	Y
54112		556.55	556.55		090	Y
54115		343.45	250.50		090	Y
54120		367.71	367.71		090	Y
54125		479.47	479.47		090	Y
54130		691.66	691.66		090	Y
54135		887.08	887.08		090	Y
54150		67.10	67.10		010	N
54152		83.43	83.43		010	N
54160		85.24	85.24		010	N
54161		114.71	114.71		010	N
54162		118.34	118.34		010	N
54163		118.56	118.56		010	N
54164		102.70	102.70		010	N
54200		67.78	48.06		010	N
54205		301.06	301.06		090	Y
54220		148.49	80.25		000	N
54230		58.04	46.47		000	N
54231		81.61	69.37		000	N
54235		51.01	41.71		000	N
54240	TC	14.51	14.51		000	N
54240	26	41.26	41.26		000	N
54240		55.77	55.77		000	N
54250		#	#		000	N
54250	26	#	#		000	N
54250	TC	#	#		000	N
54300		381.76	381.76		090	Y
54304		449.32	449.32		090	Y
54308		425.06	425.06		090	Y
54312		490.58	490.58		090	Y
54316		590.10	590.10		090	Y
54318		417.81	417.81		090	Y
54322		464.05	464.05		090	Y
54324		581.03	581.03		090	Y
54326		560.40	560.40		090	Y
54328		545.89	545.89		090	Y
54332		591.23	591.23		090	Y
54336		741.76	741.76		090	Y
54340		338.24	338.24		090	Y
54344		568.56	568.56		090	Y
54348		608.46	608.46		090	Y
54352		860.10	860.10		090	Y
54360		428.24	428.24		090	Y
54380		481.06	481.06		090	Y
54385		559.27	559.27		090	Y
54390		738.59	738.59		090	Y
54400		318.06	318.06		090	N
54401		#	#		090	N
54405		#	#		090	Y
54406		415.99	415.99		090	Y
54408		#	#		090	Y
54410		#	#		090	Y
54411		#	#		090	Y
54415		294.48	294.48		090	Y
54416		382.44	382.44	PA	090	Y
54417		476.30	476.30	PA	090	Y
54420		405.57	405.57		090	Y
54430		363.63	363.63		090	Y
54435		232.14	232.14		090	N
54440		B.R.	B.R.		090	Y
54450		52.37	37.63		000	N
54500		45.57	44.43		000	N
54505		127.18	127.18		010	N
54512		302.19	302.19		090	Y
54520		191.11	191.11		090	N
54522		341.86	341.86		090	Y
54530		305.14	305.14		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
54535		423.70	423.70		090	Y
54550		276.57	276.57		090	Y
54560		390.60	390.60		090	Y
54600		251.64	251.64		090	N
54620		174.33	174.33		010	N
54640		254.36	254.36		090	N
54650		403.98	403.98		090	Y
54660		#	#		090	N
54670		237.13	237.13		090	N
54680		451.59	451.59		090	Y
54690		386.07	386.07		090	Y
54692		436.17	436.17		090	N
54699		B.R.	B.R.		090	Y
54700		127.41	127.41		010	N
54800		77.76	76.62		000	N
54820		192.47	192.47		090	N
54830		199.95	199.95		090	N
54840		189.75	189.75		090	N
54860		228.97	228.97		090	N
54861		313.75	313.75		090	N
54900		463.15	463.15		090	N
54901		620.25	620.25		090	N
55000		82.97	49.65		000	N
55040		197.00	197.00		090	N
55041		279.07	279.07		090	N
55060		205.16	205.16		090	N
55100		138.06	88.19		010	N
55110		209.92	209.92		090	N
55120		254.58	190.88		090	N
55150		265.01	265.01		090	Y
55175		196.32	196.32		090	N
55180		384.03	384.03		090	N
55200		228.29	156.88		090	N
55250		287.23	143.05		090	N
55300		113.80	113.80		000	N
55400		#	#		090	Y
55450		263.88	141.46		010	N
55500		208.34	208.34		090	N
55520		224.89	224.89		090	Y
55530		206.52	206.52		090	N
55535		237.13	237.13		090	Y
55540		278.61	278.61		090	Y
55550		235.54	235.54		090	Y
55559		B.R.	B.R.		090	Y
55600		230.78	230.78		090	N
55605		292.44	292.44		090	N
55650		406.02	406.02		090	Y
55680		193.83	193.83		090	N
55700		137.15	54.18		000	N
55705		162.32	162.32		010	N
55720		273.40	273.40		090	Y
55725		314.21	314.21		090	Y
55801		596.45	596.45		090	Y
55810		741.54	741.54		090	Y
55812		916.55	916.55		090	Y
55815		1,007.91	1,007.91		090	Y
55821		486.95	486.95		090	Y
55831		530.02	530.02		090	Y
55840		761.03	761.03		090	Y
55842		814.99	814.99		090	Y
55845		939.67	939.67		090	Y
55859		435.49	435.49		090	N
55860		493.30	493.30		090	N
55862		624.33	624.33		090	Y
55865		763.75	763.75		090	Y
55866		997.93	997.93		090	Y
55870		#	#		000	N
55873		670.81	670.81	PA	090	N
55899		B.R.	B.R.		090	N
55970		#	#		000	N
55980		#	#		000	N
56405		66.20	62.12		010	N
56420		87.05	59.40		010	N
56440		109.95	109.95		010	N
56441		90.45	81.16		010	N
56501		79.12	66.65		010	N
56515		125.14	108.14		010	N
56605		52.37	37.86		000	N
56606		24.94	18.82		000	N
56620		297.20	297.20		090	Y
56625		332.57	332.57		090	Y
56630		466.78	466.78		090	Y
56631		608.69	608.69		090	Y
56632		725.21	725.21		090	Y
56633		609.37	609.37		090	Y
56634		664.46	664.46		090	Y
56637		803.65	803.65		090	Y
56640		800.25	800.25		090	Y
56700		102.24	102.24		010	Y
56720		25.84	25.84		000	N
56740		168.44	168.44		010	N
56800		146.45	146.45		010	Y
56805		683.95	683.95		090	Y
56810		155.29	155.29		010	Y
56820		66.88	50.78		000	N
56821		90.23	70.05		000	N
57000		113.35	113.35		010	N
57010		237.58	237.58		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
57020		59.17	50.78		000	N
57022		97.71	97.71		010	N
57023		172.29	172.29		010	N
57061		69.37	56.90		010	N
57065		117.66	103.38		010	N
57100		54.63	40.35		000	N
57105		86.37	72.54		010	N
57106		253.22	253.22		090	Y
57107		810.23	810.23		090	Y
57109		915.64	915.64		090	Y
57110		523.00	523.00		090	Y
57111		961.66	961.66		090	Y
57112		985.24	985.24		090	Y
57120		290.86	290.86		090	Y
57130		109.95	95.89		010	Y
57135		118.34	104.28		010	N
57150		39.22	18.82		000	N
57155		250.73	250.73		090	N
57160		47.15	30.83		000	N
57170		56.90	30.38		000	N
57180		89.32	68.92		010	N
57200		164.36	164.36		090	Y
57210		206.98	206.98		090	Y
57220		178.41	178.41		090	Y
57230		217.18	217.18		090	Y
57240		237.35	237.35		090	Y
57250		219.45	219.45		090	Y
57260		317.15	317.15		090	Y
57265		420.98	420.98		090	Y
57268		264.33	264.33		090	Y
57270		444.33	444.33		090	Y
57280		542.27	542.27		090	Y
57282		341.86	341.86		090	Y
57284		478.11	478.11		090	Y
57287		385.62	385.62		090	Y
57288		450.68	450.68	EX	090	Y
57289		422.57	422.57	EX	090	Y
57291		#	#		090	Y
57292		#	#		090	Y
57300		286.55	286.55		090	Y
57305		485.82	485.82		090	Y
57307		558.36	558.36		090	Y
57308		363.63	363.63		090	Y
57310		253.00	253.00		090	Y
57311		288.14	288.14		090	Y
57320		296.30	296.30		090	Y
57330		431.41	431.41		090	Y
57335		669.67	669.67		090	Y
57400		82.29	82.29		000	N
57410		89.09	63.25		000	N
57415		86.15	86.15		010	N
57420		70.05	53.95		000	N
57421		95.67	74.81		000	N
57425		1,063.48	1,063.48		090	Y
57452		68.24	50.78		000	N
57454		96.12	78.66		000	N
57455		88.19	68.01		000	N
57456		83.43	63.70		000	N
57460		208.79	98.39		000	N
57461		228.51	116.52		000	N
57500		85.24	34.91		000	N
57505		62.12	53.73		010	N
57510		83.20	71.18		010	N
57511		89.32	78.89		010	N
57513		90.23	79.57		010	N
57520		212.42	163.90		090	N
57522		183.17	144.86		090	N
57530		197.68	197.68		090	Y
57531		992.49	992.49		090	Y
57540		447.51	447.51		090	Y
57545		477.66	477.66		090	Y
57550		225.79	225.79		090	Y
57555		340.28	340.28		090	Y
57556		319.19	319.19		090	Y
57700		158.69	158.69		090	N
57720		174.79	174.79		090	Y
57800		36.73	30.15		000	N
57820		75.94	67.78		010	N
58100		66.65	52.82		000	N
58120		134.43	124.46		010	N
58140		526.62	526.62		090	Y
58145		310.81	310.81		090	Y
58146		664.46	664.46		090	Y
58150		552.47	552.47	EX	090	Y
58152		727.25	727.25	EX	090	Y
58180		552.47	552.47	EX	090	Y
58200		767.15	767.15	EX	090	Y
58210		1,022.42	1,022.42	EX	090	Y
58240		1,359.29	1,359.29	EX	090	Y
58260		475.39	475.39	EX	090	Y
58262		535.69	535.69	EX	090	Y
58263		579.45	579.45	EX	090	Y
58267		612.54	612.54	EX	090	Y
58270		516.20	516.20	EX	090	Y
58275		569.47	569.47	EX	090	Y
58280		609.37	609.37	EX	090	Y
58285		775.99	775.99	EX	090	Y
58290		662.19	662.19	EX	090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
58291		729.29	729.29	EX	090	Y
58292		773.27	773.27	EX	090	Y
58293		806.37	806.37	EX	090	Y
58294		711.84	711.84	EX	090	Y
58300		57.58	33.78		000	N
58301		62.34	42.85		000	N
58321		#	#		000	N
58322		#	#		000	N
58323		#	#		000	N
58340		161.18	36.73		000	N
58345		#	#		010	Y
58346		257.30	257.30		090	N
58350		#	#		010	N
58353		919.95	135.79		010	Y
58400		248.92	248.92		090	Y
58410		461.11	461.11		090	Y
58520		435.04	435.04		090	Y
58540		520.05	520.05		090	Y
58545		527.76	527.76		090	Y
58546		668.54	668.54		090	Y
58550		521.18	521.18	EX	090	Y
58552		578.54	578.54	EX	090	Y
58553		663.55	663.55	EX	090	Y
58554		765.79	765.79	EX	090	Y
58555		131.26	116.52		000	N
58558		165.72	165.72		000	N
58559		213.55	213.55		000	N
58560		242.57	242.57		000	Y
58561		345.04	345.04		000	N
58562		180.23	180.23		000	N
58563		213.78	213.78		000	N
58578		B.R.	B.R.		090	Y
58579		B.R.	B.R.		090	Y
58600		212.64	212.64		090	Y
58605		192.92	192.92		090	Y
58611		92.92	92.92		000	Y
58615		159.37	159.37		010	Y
58660		401.94	401.94		090	Y
58661		392.87	392.87		010	Y
58662		426.20	426.20		090	Y
58670		214.23	214.23		090	N
58671		214.91	214.91		090	N
58672		#	#		090	Y
58673		494.43	494.43		090	Y
58679		B.R.	B.R.		090	Y
58700		425.06	425.06		090	Y
58720		415.77	415.77		090	Y
58740		494.66	494.66		090	Y
58750		#	#		090	Y
58752		#	#		090	Y
58760		#	#		090	Y
58770		507.35	507.35		090	Y
58800		204.48	170.25		090	N
58805		227.15	227.15		090	Y
58820		178.64	178.64		090	Y
58822		369.97	369.97		090	Y
58823		106.32	106.32		000	Y
58825		396.04	396.04		090	Y
58900		231.01	231.01		090	Y
58920		401.26	401.26		090	Y
58925		413.50	413.50		090	Y
58940		276.12	276.12		090	Y
58943		659.24	659.24		090	Y
58950		612.77	612.77		090	Y
58951		797.76	797.76		090	Y
58952		895.24	895.24		090	Y
58953		1,133.05	1,133.05		090	Y
58954		1,233.47	1,233.47		090	Y
58960		535.24	535.24		090	Y
58970		#	#		000	N
58974		#	#		000	Y
58976		#	#		000	Y
58999		B.R.	B.R.		090	Y
59000		162.28	99.15		000	N
59001		105.64	105.64		000	N
59012		127.63	127.63		000	N
59015		94.76	82.97		000	N
59020	TC	13.83	13.83		000	N
59020	26	23.80	23.80		000	N
59020		37.41	37.41		000	N
59025	TC	11.56	11.56		000	N
59025	26	37.35	37.35		000	N
59025		48.91	48.91		000	N
59030		77.08	77.08		000	N
59050		31.96	31.96		000	N
59051		26.75	26.75		000	N
59070		473.50	351.68		000	Y
59072		565.53	565.53		000	N
59074		450.82	351.68		000	Y
59076		565.53	565.53		000	Y
59100		477.20	477.20		090	Y
59120		449.32	449.32		090	Y
59121		456.12	456.12		090	Y
59130		492.62	492.62		090	N
59135		535.69	535.69		090	N
59136		503.05	503.05		090	Y
59140		264.56	227.61		090	Y
59150		430.28	430.28		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
59151		431.18	431.18		090	Y
59160		147.36	120.60		010	N
59200		Bundled	Bundled		000	N
59300		113.80	86.15		000	N
59320		94.99	94.99		000	N
59325		152.34	152.34		000	N
59350		176.15	176.15		000	Y
59400		1,899.78	1,899.78		045	N
59409		943.89	943.89		000	N
59410		1,056.37	1,056.37		045	N
59412		64.16	64.16		000	N
59414		57.36	57.36		045	N
59425		442.38	335.23		000	N
59426		776.72	577.98		000	N
59430		167.17	153.39		000	N
59510		1,899.78	1,899.78		045	N
59514		943.89	943.89		000	Y
59515		1,056.37	1,056.37		045	N
59525		595.32	595.32	EX	000	Y
59610		2,005.59	2,005.59		045	N
59612		1059.03	1059.03		045	N
59614		1165.74	1165.74		045	N
59618		2,278.57	2,278.57		045	Y
59620		1,219.98	1,219.98		045	Y
59622		1,377.82	1,377.82		045	Y
59812		162.32	162.32		090	N
59820		187.48	187.48		090	N
59821		197.91	197.91		090	N
59830		254.58	254.58		090	N
59840		196.20	196.20		010	N
59841		263.64	263.64		010	N
59850		232.37	232.37		090	N
59851		243.48	243.48		090	N
59852		335.52	335.52		090	N
59855		244.61	244.61		090	N
59856		292.44	292.44		090	N
59857		352.52	352.52		090	N
59866		#	#		000	Y
59870		254.81	254.81		090	Y
59871		97.03	82.75		000	N
59897		B.R.	B.R.		000	N
59898		B.R.	B.R.		090	Y
59899		B.R.	B.R.		045	Y
60000		92.49	89.77		010	N
60001		57.36	31.06		000	N
60100		69.14	48.74		000	N
60200		375.87	375.87		090	Y
60210		401.26	401.26		090	Y
60212		576.04	576.04		090	Y
60220		435.49	435.49		090	Y
60225		523.68	523.68		090	Y
60240		574.91	574.91		090	Y
60252		738.36	738.36		090	Y
60254		984.78	984.78		090	Y
60260		629.55	629.55		090	Y
60270		743.12	743.12		090	Y
60271		612.54	612.54		090	Y
60280		253.68	253.68		090	Y
60281		345.49	345.49		090	Y
60500		576.04	576.04		090	Y
60502		722.95	722.95		090	Y
60505		789.37	789.37		090	Y
60512		147.81	147.81		000	Y
60520		613.68	613.68		090	Y
60521		700.05	700.05		090	Y
60522		846.04	846.04		090	Y
60540		592.59	592.59		090	Y
60545		686.67	686.67		090	Y
60600		697.56	697.56		090	Y
60605		802.29	802.29		090	Y
60650		680.33	680.33		090	Y
60659		B.R.	B.R.		090	Y
60699		B.R.	B.R.		090	Y
61000		60.76	60.76		000	N
61001		61.44	61.44		000	N
61020		70.96	70.96		000	N
61026		75.26	75.26		000	N
61050		66.20	66.20		000	N
61055		83.20	83.20		000	N
61070		45.79	45.79		000	N
61105		230.10	230.10		090	N
61107		211.74	211.74		000	N
61108		439.34	439.34		090	N
61120		375.87	375.87		090	N
61140		656.98	656.98		090	Y
61150		714.33	714.33		090	N
61151		515.29	515.29		090	N
61154		624.79	624.79		090	Y
61156		671.26	671.26		090	Y
61210		243.02	243.02		000	N
61215		224.66	224.66		090	N
61250		438.21	438.21		090	Y
61253		507.35	507.35		090	Y
61304		888.44	888.44		090	Y
61305		1,071.16	1,071.16		090	Y
61312		1,012.44	1,012.44		090	Y
61313		1,016.98	1,016.98		090	Y
61314		936.95	936.95		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
61315		1,119.67	1,119.67		090	Y
61316		54.18	54.18		000	N
61320		1,034.43	1,034.43		090	Y
61321		1,134.63	1,134.63		090	Y
61322		1,109.92	1,109.92		090	Y
61323		1,148.24	1,148.24		090	N
61330		902.04	902.04		090	Y
61332		1,068.89	1,068.89		090	Y
61333		1,042.14	1,042.14		090	Y
61334		725.89	725.89		090	Y
61340		759.22	759.22		090	Y
61343		1,194.71	1,194.71		090	Y
61345		1,086.35	1,086.35		090	Y
61440		1,053.70	1,053.70		090	Y
61450		1,029.67	1,029.67		090	Y
61458		1,092.01	1,092.01		090	Y
61460		1,134.63	1,134.63		090	Y
61470		1,011.99	1,011.99		090	Y
61480		1,074.10	1,074.10		090	Y
61490		1,029.67	1,029.67		090	Y
61500		726.57	726.57		090	Y
61501		606.42	606.42		090	Y
61510		1,156.17	1,156.17		090	Y
61512		1,405.54	1,405.54		090	Y
61514		1,017.66	1,017.66		090	Y
61516		994.99	994.99		090	Y
61517		46.25	46.25		000	N
61518		1,497.58	1,497.58		090	Y
61519		1,639.27	1,639.27		090	Y
61520		2,163.85	2,163.85		090	Y
61521		1,760.55	1,760.55		090	Y
61522		1,162.29	1,162.29		090	Y
61524		1,102.67	1,102.67		090	Y
61526		2,009.47	2,009.47		090	N
61530		1,707.50	1,707.50		090	N
61531		604.38	604.38		090	Y
61533		795.94	795.94		090	Y
61534		845.36	845.36		090	Y
61535		484.91	484.91		090	Y
61536		1,407.81	1,407.81		090	Y
61537		1,016.30	1,016.30		090	Y
61538		1,078.64	1,078.64		090	Y
61539		1,281.99	1,281.99		090	Y
61540		1,226.45	1,226.45		090	Y
61541		1,148.24	1,148.24		090	Y
61542		1,256.60	1,256.60		090	Y
61543		1,174.31	1,174.31		090	Y
61544		1,004.73	1,004.73		090	Y
61545		1,746.04	1,746.04		090	Y
61546		1,245.94	1,245.94		090	Y
61548		862.59	862.59		090	Y
61550		518.01	518.01		090	Y
61552		673.75	673.75		090	Y
61556		845.14	845.14		090	Y
61557		923.80	923.80		090	Y
61558		964.16	964.16		090	Y
61559		1,338.66	1,338.66		090	Y
61563		1,057.78	1,057.78		090	Y
61564		1,343.88	1,343.88		090	Y
61566		1,220.33	1,220.33		090	Y
61567		1,398.51	1,398.51		090	Y
61570		979.12	979.12		090	Y
61571		1,062.09	1,062.09		090	Y
61575		1,341.84	1,341.84		090	Y
61576		1,972.06	1,972.06		090	Y
61580		1,333.00	1,333.00		090	Y
61581		1,386.95	1,386.95		090	N
61582		1,474.91	1,474.91		090	Y
61583		1,547.00	1,547.00		090	Y
61584		1,488.97	1,488.97		090	Y
61585		1,618.18	1,618.18		090	Y
61586		1,158.89	1,158.89		090	Y
61590		1,701.84	1,701.84		090	Y
61591		1,787.08	1,787.08		090	Y
61592		1,674.63	1,674.63		090	Y
61595		1,253.65	1,253.65		090	Y
61596		1,465.16	1,465.16		090	Y
61597		1,535.21	1,535.21		090	Y
61598		1,393.98	1,393.98		090	Y
61600		1,110.38	1,110.38		090	Y
61601		1,219.87	1,219.87		090	Y
61605		1,228.49	1,228.49		090	Y
61606		1,608.44	1,608.44		090	Y
61607		1,494.86	1,494.86		090	Y
61608		1,748.54	1,748.54		090	Y
61609		381.54	381.54		000	Y
61610		1,052.79	1,052.79		000	Y
61611		290.40	290.40		000	Y
61612		1,016.52	1,016.52		000	Y
61613		1,713.17	1,713.17		090	Y
61615		1,352.27	1,352.27		090	Y
61616		1,796.37	1,796.37		090	Y
61618		690.30	690.30		090	Y
61619		827.00	827.00		090	Y
61623		333.93	333.93		000	N
61624		641.11	641.11		000	N
61626		522.54	522.54		000	N
61680		1,230.53	1,230.53		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
61682		2,417.08	2,417.08		090	Y
61684		1,582.14	1,582.14		090	Y
61686		2,551.96	2,551.96		090	Y
61690		1,170.91	1,170.91		090	Y
61692		2,032.59	2,032.59		090	Y
61697		2,016.72	2,016.72		090	Y
61698		1,931.71	1,931.71		090	Y
61700		2,009.47	2,009.47		090	Y
61702		1,911.53	1,911.53		090	Y
61703		716.83	716.83		090	Y
61705		1,410.75	1,410.75		090	Y
61708		1,196.98	1,196.98		090	Y
61710		1,039.19	1,039.19		090	N
61711		1,442.49	1,442.49		090	Y
61720		687.13	687.13		090	N
61735		834.94	834.94		090	N
61750		738.59	738.59		090	N
61751		727.03	727.03		090	N
61760		807.05	807.05		090	N
61770		858.29	858.29		090	N
61790		422.57	422.57		090	N
61791		603.25	603.25		090	N
61793		700.73	700.73		090	N
61795		156.20	156.20		000	N
61850		506.67	506.67		090	Y
61860		840.15	840.15		090	Y
61863		788.46	788.46	PA	090	Y
61864		175.01	175.01	PA	000	Y
61867		1,212.39	1,212.39	PA	090	Y
61868		294.03	294.03	PA	000	Y
61870		601.21	601.21		090	Y
61875		592.14	592.14		090	Y
61880		276.80	276.80		090	Y
61885		281.33	281.33	PA	090	N
61886		363.40	363.40	PA	090	N
61888		226.70	226.70		010	N
62000		430.50	430.50		090	N
62005		620.48	620.48		090	Y
62010		807.51	807.51		090	Y
62100		883.68	883.68		090	Y
62115		858.74	858.74		090	Y
62116		948.97	948.97		090	Y
62117		1,079.32	1,079.32		090	Y
62120		925.39	925.39		090	Y
62121		836.07	836.07		090	Y
62140		555.19	555.19		090	Y
62141		609.37	609.37		090	Y
62142		451.81	451.81		090	Y
62143		537.28	537.28		090	Y
62145		761.49	761.49		090	Y
62146		652.22	652.22		090	Y
62147		779.39	779.39		090	Y
62148		73.68	73.68		000	N
62160		105.64	105.64		000	N
62161		754.00	754.00		090	Y
62162		967.33	967.33		090	Y
62163		612.77	612.77		090	Y
62164		1,046.22	1,046.22		090	Y
62165		819.75	819.75		090	Y
62180		855.34	855.34		090	Y
62190		461.79	461.79		090	N
62192		507.35	507.35		090	Y
62194		188.84	188.84		010	N
62200		746.30	746.30		090	Y
62201		610.05	610.05		090	N
62220		534.11	534.11		090	Y
62223		538.19	538.19		090	Y
62225		240.76	240.76		090	N
62230		434.13	434.13		090	Y
62252	TC	25.84	25.84		000	N
62252	26	28.79	28.79		000	N
62252		54.63	54.63		000	N
62256		287.46	287.46		090	Y
62258		593.95	593.95		090	Y
62263		420.53	203.35		010	N
62264		282.47	138.97		010	N
62268		356.37	163.68		000	N
62269		413.50	166.17		000	N
62270		97.48	38.09		000	N
62272		117.88	48.29		000	N
62273		114.48	65.06		000	N
62280		214.68	83.65		010	N
62281		195.87	81.61		010	N
62282		243.93	74.13		010	N
62284		148.94	51.01		000	N
62287		324.41	324.41		090	N
62290		228.51	101.79		000	N
62291		200.40	95.89		000	N
62292		295.62	295.62		090	N
62294		415.77	415.77		090	N
62310		163.00	63.70		000	N
62311		155.06	52.82		000	N
62318		182.27	67.56		000	N
62319		161.64	61.89		000	N
62350		261.39	261.39		090	N
62351		428.92	428.92		090	Y
62355		207.20	207.20		090	N
62360		126.27	126.27		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
62361		223.53	223.53		090	N	63172		724.99	724.99		090	Y
62362		279.07	279.07		090	N	63173		888.21	888.21		090	Y
62365		218.09	218.09		090	N	63180		755.36	755.36		090	Y
62367	26	14.51	14.51		000	N	63182		797.76	797.76		090	Y
62367	TC	17.23	17.23		000	N	63185		576.04	576.04		090	Y
62367		31.74	31.74		000	N	63190		695.06	695.06		090	Y
62368	26	22.44	22.44		000	N	63191		719.32	719.32		090	Y
62368	TC	26.52	26.52		000	N	63194		795.94	795.94		090	Y
62368		48.97	48.97		000	N	63195		760.35	760.35		090	Y
63001		643.60	643.60		090	Y	63196		919.50	919.50		090	Y
63003		653.12	653.12		090	Y	63197		859.87	859.87		090	Y
63005		623.65	623.65		090	Y	63198		889.80	889.80		090	Y
63011		549.97	549.97		090	Y	63199		1,082.72	1,082.72		090	Y
63012		640.20	640.20		090	Y	63200		777.35	777.35		090	Y
63015		795.72	795.72		090	Y	63250		1,551.53	1,551.53		090	Y
63016		785.29	785.29		090	Y	63251		1,629.75	1,629.75		090	Y
63017		662.87	662.87		090	Y	63252		1,616.37	1,616.37		090	Y
63020		621.16	621.16		090	Y	63265		876.88	876.88		090	Y
63030		513.02	513.02		090	Y	63266		907.03	907.03		090	Y
63035		120.60	120.60		000	Y	63267		738.14	738.14		090	Y
63040		763.98	763.98		090	Y	63268		728.84	728.84		090	Y
63042		723.40	723.40		090	Y	63270		1,082.49	1,082.49		090	Y
63043		381.99	381.99		000	Y	63271		1,090.88	1,090.88		090	Y
63044		361.70	361.70		000	Y	63272		1,023.10	1,023.10		090	Y
63045		681.69	681.69		090	Y	63273		992.27	992.27		090	Y
63046		654.94	654.94		090	Y	63275		956.67	956.67		090	Y
63047		614.58	614.58		090	Y	63276		947.83	947.83		090	Y
63048		125.14	125.14		000	Y	63277		848.31	848.31		090	Y
63055		889.80	889.80		090	Y	63278		838.56	838.56		090	Y
63056		822.47	822.47		090	Y	63280		1,145.74	1,145.74		090	Y
63057		197.68	197.68		000	Y	63281		1,132.59	1,132.59		090	Y
63064		992.95	992.95		090	Y	63282		1,068.21	1,068.21		090	Y
63066		126.27	126.27		000	Y	63283		1,016.52	1,016.52		090	Y
63075		799.12	799.12		090	Y	63285		1,435.69	1,435.69		090	Y
63076		156.20	156.20		000	Y	63286		1,421.18	1,421.18		090	Y
63077		854.43	854.43		090	Y	63287		1,466.98	1,466.98		090	Y
63078		123.10	123.10		000	Y	63290		1,489.19	1,489.19		090	Y
63081		964.61	964.61		090	Y	63300		987.73	987.73		090	Y
63082		168.21	168.21		000	Y	63301		1,093.60	1,093.60		090	Y
63085		1,068.44	1,068.44		090	Y	63302		1,109.92	1,109.92		090	Y
63086		121.06	121.06		000	Y	63303		1,193.80	1,193.80		090	Y
63087		1,381.51	1,381.51		090	Y	63304		1,188.81	1,188.81		090	Y
63088		165.04	165.04		000	Y	63305		1,258.64	1,258.64		090	Y
63090		1,099.50	1,099.50		090	Y	63306		1,191.99	1,191.99		090	Y
63091		112.22	112.22		000	Y	63307		1,195.62	1,195.62		090	Y
63101		1,272.69	1,272.69		090	Y	63308		201.31	201.31		000	Y
63102		1,272.69	1,272.69		090	Y	63600		469.50	469.50		090	N
63103		148.26	148.26		000	Y	63610		1,483.30	260.25		000	N
63170		811.59	811.59		090	Y	63615		647.68	647.68		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
63650		237.13	237.13		090	N
63655		432.09	432.09		090	Y
63660		237.13	237.13		090	N
63685		276.12	276.12		090	Y
63688		219.22	219.22		090	N
63700		669.45	669.45		090	Y
63702		697.33	697.33		090	Y
63704		860.10	860.10		090	Y
63706		962.34	962.34		090	Y
63707		474.26	474.26		090	Y
63709		593.95	593.95		090	Y
63710		583.98	583.98		090	Y
63740		473.80	473.80		090	Y
63741		319.87	319.87		090	Y
63744		338.01	338.01		090	Y
63746		258.21	258.21		090	N
64400		72.54	34.91		000	N
64402		69.82	41.94		000	N
64405		66.65	40.81		000	N
64408		70.28	49.19		000	N
64410		92.95	43.30		000	N
64412		90.68	37.18		000	N
64413		76.85	43.75		000	N
64415		100.43	44.43		000	N
64416		97.71	97.71		010	N
64417		105.64	44.43		000	N
64418		92.27	39.90		000	N
64420		109.27	36.50		000	N
64421		163.90	50.55		000	N
64425		81.16	52.82		000	N
64430		94.99	46.70		000	N
64435		95.44	50.55		000	N
64445		97.03	43.98		000	N
64446		102.70	102.70		010	N
64447		47.61	47.61		000	N
64448		93.63	93.63		010	N
64449		92.27	92.27		010	N
64450		59.62	40.13		000	N
64470		155.97	57.36		000	N
64472		75.72	38.31		000	N
64475		138.51	44.89		000	N
64476		65.29	29.24		000	N
64479		214.68	69.60		000	N
64480		92.27	47.61		000	N
64483		218.31	60.76		000	N
64484		96.12	40.58		000	N
64505		60.76	43.53		000	N
64508		94.53	38.31		000	N
64510		102.47	37.63		000	N
64517		114.26	72.32		000	N
64520		136.93	41.94		000	N
64530		128.09	48.74		000	N
64550		11.11	5.44		000	N
64553		118.11	98.84		010	N
64555		124.69	81.39		010	N
64560		117.88	87.28		010	N
64561		227.61	227.61		010	N
64565		118.56	70.73		010	N
64573		322.59	322.59	PA	090	N
64575		168.66	168.66		090	N
64577		191.79	191.79		090	N
64580		179.32	179.32		090	Y
64581		438.44	438.44		090	N
64585		318.29	92.27	PA	010	Y
64590		229.65	106.78		010	Y
64595		289.27	78.44		010	N
64600		277.93	120.38		010	N
64605		335.74	185.89		010	N
64610		367.93	269.09		010	N
64612		106.55	71.18		010	N
64613		114.71	69.37		010	N
64614		126.27	77.76		010	N
64620		173.65	95.44		010	N
64622		246.65	100.20		010	N
64623		79.12	29.02		000	N
64626		232.37	121.74		010	N
64627		87.96	34.46		000	N
64630		134.21	100.88		010	N
64640		162.32	103.38		010	N
64680		199.72	92.04		010	N
64681		283.38	131.71		010	N
64702		194.74	194.74		090	N
64704		191.79	191.79		090	Y
64708		267.51	267.51		090	Y
64712		301.96	301.96		090	Y
64713		406.93	406.93		090	Y
64714		345.49	345.49		090	Y
64716		276.57	276.57		090	Y
64718		289.50	289.50		090	N
64719		226.02	226.02		090	N
64721		223.53	223.53		090	N
64722		183.85	183.85		090	Y
64726		170.48	170.48		090	N
64727		113.80	113.80		000	N
64732		197.68	197.68		090	Y
64734		222.85	222.85		090	N
64736		212.19	212.19		090	Y
64738		254.13	254.13		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
64740		236.90	236.90		090	Y	64870		586.93	586.93		090	Y
64742		264.79	264.79		090	Y	64872		75.49	75.49		000	Y
64744		227.15	227.15		090	N	64874		110.40	110.40		000	Y
64746		254.58	254.58		090	Y	64876		114.48	114.48		000	Y
64752		277.03	277.03		090	Y	64885		680.78	680.78		090	Y
64755		462.24	462.24		090	Y	64886		800.93	800.93		090	Y
64760		249.82	249.82		090	Y	64890		610.96	610.96		090	Y
64761		232.59	232.59		090	Y	64891		571.28	571.28		090	Y
64763		294.26	294.26		090	Y	64892		571.51	571.51		090	Y
64766		338.92	338.92		090	Y	64893		619.34	619.34		090	Y
64771		323.50	323.50		090	Y	64895		703.00	703.00		090	Y
64772		302.87	302.87		090	Y	64896		757.63	757.63		090	Y
64774		217.63	217.63		090	N	64897		717.28	717.28		090	Y
64776		214.00	214.00		090	N	64898		772.37	772.37		090	Y
64778		113.35	113.35		000	N	64901		374.51	374.51		000	Y
64782		244.61	244.61		090	N	64902		429.82	429.82		000	Y
64783		137.15	137.15		000	N	64905		547.48	547.48		090	Y
64784		398.99	398.99		090	N	64907		752.87	752.87		090	Y
64786		625.01	625.01		090	Y	64999		B.R.	B.R.		090	N
64787		158.69	158.69		000	N	65091		375.19	375.19		090	N
64788		195.87	195.87		090	N	65093		393.32	393.32		090	N
64790		458.16	458.16		090	N	65101		410.33	410.33		090	N
64792		582.39	582.39		090	Y	65103		427.33	427.33		090	N
64795		113.58	113.58		000	N	65105		464.05	464.05		090	Y
64802		345.26	345.26		090	Y	65110		666.27	666.27		090	Y
64804		536.37	536.37		090	Y	65112		779.62	779.62		090	Y
64809		464.05	464.05		090	Y	65114		810.00	810.00		090	Y
64818		379.27	379.27		090	Y	65125		285.64	141.91		090	N
64820		423.70	423.70		090	N	65130		403.07	403.07		090	N
64821		388.56	388.56		090	N	65135		411.46	411.46		090	N
64822		386.75	386.75		090	N	65140		437.76	437.76		090	N
64823		448.19	448.19		090	N	65150		360.45	360.45		090	N
64831		400.81	400.81		090	N	65155		470.86	470.86		090	N
64832		210.83	210.83		000	N	65175		369.29	369.29		090	N
64834		420.30	420.30		090	N	65205		30.60	21.31		000	N
64835		453.63	453.63		090	Y	65210		36.73	26.75		000	N
64836		452.27	452.27		090	Y	65220		31.06	21.31		000	N
64837		233.95	233.95		000	Y	65222		39.45	28.11		000	N
64840		503.95	503.95		090	Y	65235		344.58	344.58		090	N
64856		560.63	560.63		090	N	65260		520.05	520.05		090	Y
64857		587.83	587.83		090	Y	65265		586.93	586.93		090	Y
64858		681.23	681.23		090	Y	65270		132.85	96.35		010	N
64859		157.78	157.78		000	Y	65272		222.39	209.47		090	N
64861		761.26	761.26		090	Y	65273		231.69	231.69		090	N
64862		769.19	769.19		090	Y	65275		256.85	256.85		090	N
64864		495.11	495.11		090	Y	65280		367.48	367.48		090	N
64865		601.89	601.89		090	Y	65285		587.61	587.61		090	Y
64866		603.02	603.02		090	Y	65286		322.37	301.74		090	N
64868		552.47	552.47		090	Y	65290		276.57	276.57		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
65400		340.50	313.98		090	N
65410		74.13	49.65		000	N
65420		270.91	252.77		090	N
65426		295.16	273.40		090	N
65430		148.04	49.87		000	N
65435		52.14	30.83		000	N
65436		232.82	218.31		090	N
65450		242.57	222.17		090	N
65600		209.24	151.44		090	N
65710		573.32	573.32		090	Y
65730		607.33	607.33		090	Y
65750		659.24	659.24		090	Y
65755		654.48	654.48		090	Y
65760		#	#		000	N
65765		#	#		000	N
65767		#	#		000	N
65770		741.31	741.31		090	Y
65771		#	#		000	N
65772		265.01	249.14		090	N
65775		304.68	304.68		090	N
65780		466.55	466.55	PA	090	Y
65781		712.06	712.06	PA	090	Y
65782		613.90	613.90	PA	090	Y
65800		97.25	72.09		000	N
65805		97.25	72.32		000	N
65810		299.02	299.02		090	N
65815		310.58	290.63		090	N
65820		435.72	435.72		090	N
65850		462.47	462.47		090	N
65855		210.15	183.85		010	N
65860		172.97	158.24		090	N
65865		280.43	280.43		090	N
65870		311.03	311.03		090	N
65875		324.41	324.41		090	N
65880		343.22	343.22		090	N
65900		521.64	521.64		090	Y
65920		397.18	397.18		090	N
65930		352.52	352.52		090	N
66020		91.81	73.68		010	N
66030		80.03	62.12		010	N
66130		352.52	339.82		090	N
66150		421.66	421.66		090	N
66155		419.85	419.85		090	N
66160		483.55	483.55		090	N
66165		410.55	410.55		090	Y
66170		571.74	571.74		090	Y
66172		700.73	700.73		090	Y
66180		607.56	607.56		090	Y
66185		379.50	379.50		090	Y
66220		383.35	383.35		090	Y
66225		473.80	473.80		090	Y
66250		316.47	289.72		090	N
66500		204.26	204.26		090	N
66505		219.67	219.67		090	N
66600		408.51	408.51		090	N
66605		561.54	561.54		090	N
66625		281.56	265.01		090	N
66630		315.11	315.11		090	N
66635		299.24	299.24		090	N
66680		266.37	266.37		090	N
66682		316.47	316.47		090	N
66700		234.86	205.39		090	N
66710		231.91	200.63		090	N
66720		242.80	217.86		090	N
66740		235.77	208.79		090	N
66761		222.85	192.70		090	N
66762		236.67	204.48		090	N
66770		260.48	230.33		090	N
66820		254.36	254.36		090	N
66821		146.67	144.41		090	N
66825		424.84	424.84		090	N
66830		355.47	355.47		090	N
66840		346.40	346.40		090	N
66850		392.19	392.19		090	N
66852		422.80	422.80		090	N
66920		379.04	379.04		090	N
66930		436.17	436.17	PA	090	N
66940		393.78	393.78		090	N
66982		545.89	545.89		090	N
66983		354.33	354.33		090	N
66984		415.77	415.77		090	N
66985		368.84	368.84		090	N
66986		500.55	500.55		090	N
66990		51.46	51.46		000	N
66999		B.R.	B.R.		090	N
67005		234.63	234.63		090	N
67010		274.76	274.76		090	Y
67015		340.05	340.05		090	N
67025		487.41	333.25		090	N
67027		548.84	457.48		090	Y
67028		208.56	85.47		000	N
67030		270.00	270.00		090	Y
67031		194.96	180.23		090	N
67036		494.21	494.21		090	Y
67038		863.05	863.05		090	Y
67039		629.32	629.32		090	Y
67040		727.03	727.03		090	Y
67101		402.85	363.17		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
67105		357.51	317.15		090	N
67107		643.15	643.15		090	Y
67108		880.28	880.28		090	Y
67110		559.72	419.17		090	N
67112		731.33	731.33		090	Y
67115		279.75	279.75		090	N
67120		422.57	299.47		090	N
67121		507.13	507.13		090	Y
67141		288.14	270.91		090	N
67145		258.21	239.62		090	N
67208		294.03	280.88		090	N
67210		350.93	340.50		090	N
67218		755.82	755.82		090	N
67220		534.56	511.44		090	N
67221		201.76	135.79		000	N
67225		16.78	15.87		000	N
67227		301.06	278.39		090	N
67228		548.16	492.85		090	N
67250		442.07	442.07		090	N
67255		460.65	460.65		090	Y
67299		B.R.	B.R.		090	N
67311		304.00	304.00	EX*	090	N
67312		374.51	374.51	EX*	090	N
67314		343.45	343.45	EX*	090	N
67316		416.45	416.45	EX*	090	N
67318		360.00	360.00	EX*	090	N
67320		146.90	146.90	EX*	000	N
67331		139.65	139.65	EX*	000	N
67332		152.34	152.34	EX*	000	Y
67334		135.11	135.11	EX*	000	N
67335		84.33	84.33	EX*	000	N
67340		167.08	167.08	EX*	000	Y
67343		341.41	341.41		090	Y
67345		170.03	101.56		010	N
67350		110.86	110.86		000	N
67399		B.R.	B.R.		090	Y
67400		517.56	517.56		090	Y
67405		441.84	441.84		090	Y
67412		522.32	522.32		090	Y
67413		514.61	514.61		090	Y
67414		583.98	583.98		090	Y
67415		59.62	59.62		000	N
67420		903.63	903.63		090	Y
67430		687.81	687.81		090	Y
67440		664.23	664.23		090	Y
67445		700.73	700.73		090	Y
67450		681.46	681.46		090	Y
67500		37.63	23.12		000	N
67505		40.58	24.26		000	N
67515		33.10	20.63		000	N
67550		523.45	523.45		090	N
67560		533.20	533.20		090	N
67570		674.43	674.43		090	Y
67599		B.R.	B.R.		090	Y
67700		142.82	46.25		010	N
67710		138.51	36.27		010	N
67715		133.75	43.07		010	N
67800		90.00	48.51		010	N
67801		166.85	65.52		010	N
67805		178.19	77.08		010	N
67808		209.70	209.70		090	N
67810		118.56	50.55		000	N
67820		46.47	29.70		000	N
67825		68.92	57.36		010	N
67830		211.51	84.79		010	N
67835		245.52	245.52		090	N
67840		170.03	71.18		010	N
67850		178.64	83.20		010	N
67875		193.60	46.25		000	N
67880		311.03	187.93		090	N
67882		371.79	245.52		090	N
67900		387.20	290.63		090	N
67901		312.17	312.17	LE	090	N
67902		315.11	315.11	LE	090	N
67903		411.46	306.50	LE	090	N
67904		433.90	311.94	LE	090	N
67906		372.01	301.06	LE	090	N
67908		323.05	250.96	LE	090	N
67909		342.32	267.51	PA	090	N
67911		262.97	262.97		090	N
67912		600.98	254.58	PA	090	N
67914		299.92	177.28		090	N
67915		256.17	134.21		090	N
67916		395.36	255.72		090	N
67917		364.53	282.92		090	N
67921		288.82	165.94		090	N
67922		252.54	152.34		090	N
67923		398.77	273.85		090	N
67924		345.04	265.92		090	N
67930		278.61	153.25		010	N
67935		407.83	283.83		090	N
67938		164.58	44.43		010	N
67950		327.58	289.04		090	N
67961		368.39	265.24		090	N
67966		347.30	286.10		090	N
67971		398.09	398.09		090	Y
67973		516.65	516.65		090	Y
67974		513.02	513.02		090	Y

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
67975		374.74	374.74		090	N
67999		B.R.	B.R.		090	N
68020		162.77	48.06		010	N
68040		130.58	28.56		000	N
68100		146.67	46.02		000	N
68110		180.45	73.68		010	N
68115		183.17	81.61		010	N
68130		302.42	214.00		090	N
68135		165.26	63.93		010	N
68200		27.88	16.78		000	N
68320		276.57	250.28		090	N
68325		319.87	319.87		090	N
68326		312.62	312.62		090	N
68328		355.47	355.47		090	N
68330		279.52	252.32		090	N
68335		325.09	325.09		090	N
68340		345.94	207.66		090	N
68360		254.13	230.78		090	N
68362		349.80	349.80		090	N
68371		220.81	220.81	PA	010	N
68399		B.R.	B.R.		090	N
68400		214.23	86.60		010	N
68420		235.99	107.91		010	N
68440		135.34	33.55		010	N
68500		495.79	495.79		090	N
68505		516.65	516.65		090	N
68510		301.74	156.88		000	N
68520		355.92	355.92		090	N
68525		150.76	150.76		000	N
68530		302.87	151.66		010	N
68540		474.48	474.48		090	N
68550		584.66	584.66		090	N
68700		322.82	322.82		090	N
68705		173.43	71.86		010	N
68720		401.03	401.03		090	Y
68745		392.64	392.64		090	Y
68750		403.75	403.75		090	Y
68760		132.17	68.92		010	N
68761		110.63	54.63		010	N
68770		457.71	320.78		090	N
68801		43.75	36.05		010	N
68810		98.16	65.97		010	N
68811		109.72	109.72		010	N
68815		262.75	137.15		010	N
68840		67.10	51.46		010	N
68850		392.87	25.84		000	N
68899		B.R.	B.R.		090	N
69000		102.70	66.88		010	N
69005		119.24	93.85		010	N

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
69020		125.82	82.52		010	N
69090		#	#		000	N
69100		59.17	28.34		000	N
69105		73.45	38.31		000	N
69110		176.37	152.57		090	N
69120		189.29	189.29		090	N
69140		346.62	346.62		090	N
69145		145.31	123.10		090	N
69150		554.96	554.96		090	N
69155		836.52	836.52		090	Y
69200		72.09	31.96		000	N
69205		60.30	60.30		010	N
69210		29.24	20.18		000	N
69220		73.00	37.18		000	N
69222		120.60	80.25		010	N
69300		#	#		010	N
69310		453.40	453.40		090	N
69320		687.35	687.35		090	Y
69399		B.R.	B.R.		090	N
69400		73.45	35.59		000	N
69401		45.11	30.15		000	N
69405		143.50	116.30		010	N
69410		54.86	18.82		000	N
69420		102.92	68.69		010	N
69421		90.00	90.00		010	N
69424		69.60	36.27		000	N
69433		107.68	75.04		010	N
69436		98.39	98.39		010	N
69440		327.35	327.35		090	N
69450		249.82	249.82		090	N
69501		381.76	381.76		090	N
69502		511.89	511.89		090	N
69505		532.75	532.75		090	N
69511		553.60	553.60		090	N
69530		762.39	762.39		090	Y
69535		1,388.99	1,388.99		090	N
69540		113.58	73.45		010	N
69550		457.03	457.03		090	Y
69552		767.38	767.38		090	Y
69554		1,281.54	1,281.54		090	Y
69601		549.97	549.97		090	N
69602		556.55	556.55		090	N
69603		572.87	572.87		090	N
69604		571.96	571.96		090	N
69605		741.08	741.08		090	Y
69610		230.78	182.04		010	N
69620		282.69	245.74		090	N
69631		418.71	418.71		090	N
69632		531.38	531.38		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
69633		507.81	507.81		090	N	70010		140.78	140.78		000	N
69635		536.37	536.37		090	N	70015	TC	32.64	32.64		000	N
69636		624.33	624.33		090	N	70015	26	36.95	36.95		000	N
69637		620.25	620.25		090	N	70015		69.60	69.60		000	N
69641		524.81	524.81		090	N	70030	26	5.44	5.44		000	N
69642		685.31	685.31		090	N	70030	TC	9.75	9.75		000	N
69643		626.83	626.83		090	N	70030		15.19	15.19		000	N
69644		687.35	687.35		090	N	70100	26	5.67	5.67		000	N
69645		665.36	665.36		090	N	70100	TC	12.24	12.24		000	N
69646		725.21	725.21		090	N	70100		17.91	17.91		000	N
69650		403.75	403.75		090	N	70110	26	7.71	7.71		000	N
69660		485.36	485.36		090	N	70110	TC	14.96	14.96		000	N
69661		634.99	634.99		090	N	70110		22.67	22.67		000	N
69662		621.16	621.16		090	N	70120	26	5.67	5.67		000	N
69666		407.61	407.61		090	N	70120	TC	14.96	14.96		000	N
69667		408.29	408.29		090	N	70120		20.63	20.63		000	N
69670		475.84	475.84		090	Y	70130	26	10.43	10.43		000	N
69676		405.34	405.34		090	N	70130	TC	19.04	19.04		000	N
69700		333.25	333.25		090	N	70130		29.47	29.47		000	N
69710		#	#		000	N	70134	26	10.43	10.43		000	N
69711		#	#		090	Y	70134	TC	17.91	17.91		000	N
69714		566.52	566.52	PA	090	N	70134		28.34	28.34		000	N
69715		726.35	726.35	PA	090	N	70140	26	5.89	5.89		000	N
69717		582.39	582.39	PA	090	N	70140	TC	14.96	14.96		000	N
69718		730.20	730.20	PA	090	N	70140		20.86	20.86		000	N
69720		594.86	594.86		090	N	70150	26	8.16	8.16		000	N
69725		1,000.43	1,000.43		090	Y	70150	TC	19.04	19.04		000	N
69740		624.11	624.11		090	Y	70150		27.20	27.20		000	N
69745		660.38	660.38		090	Y	70160	26	5.44	5.44		000	N
69799		B.R.	B.R.		090	N	70160	TC	12.24	12.24		000	N
69801		363.40	363.40		090	N	70160		17.68	17.68		000	N
69802		536.83	536.83		090	Y	70170	26	9.29	9.29		000	N
69805		564.94	564.94		090	Y	70170	TC	22.90	22.90		000	N
69806		509.17	509.17		090	N	70170		32.19	32.19		000	N
69820		428.46	428.46		090	Y	70190	26	6.57	6.57		000	N
69840		404.89	404.89		090	Y	70190	TC	14.96	14.96		000	N
69905		458.84	458.84		090	N	70190		21.54	21.54		000	N
69910		552.01	552.01		090	N	70200	26	8.61	8.61		000	N
69915		839.70	839.70		090	Y	70200	TC	19.04	19.04		000	N
69930		678.06	678.06		090	N	70200		27.66	27.66		000	N
69949		B.R.	B.R.		090	N	70210	26	5.44	5.44		000	N
69950		1,012.90	1,012.90		090	Y	70210	TC	14.96	14.96		000	N
69955		1,057.56	1,057.56		090	Y	70210		20.40	20.40		000	N
69960		1,057.10	1,057.10		090	Y	70220	26	7.71	7.71		000	N
69970		1,152.54	1,152.54		090	Y	70220	TC	19.04	19.04		000	N
69979		B.R.	B.R.		090	N	70220		26.75	26.75		000	N
69990		132.17	132.17		000	Y	70240	26	5.89	5.89		000	N
70010	26	37.18	37.18		000	N	70240	TC	9.75	9.75		000	N
70010	TC	103.38	103.38		000	N	70240		15.64	15.64		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
70250	26	7.48	7.48		000	N
70250	TC	14.96	14.96		000	N
70250		22.44	22.44		000	N
70260	26	10.43	10.43		000	N
70260	TC	21.54	21.54		000	N
70260		31.96	31.96		000	N
70300	26	3.63	3.63		000	N
70300	TC	6.57	6.57		000	N
70300		10.20	10.20		000	N
70310	26	5.67	5.67		000	N
70310	TC	9.75	9.75		000	N
70310		15.42	15.42		000	N
70320	26	7.03	7.03		000	N
70320	TC	19.04	19.04		000	N
70320		26.07	26.07		000	N
70328	26	5.67	5.67		000	N
70328	TC	11.56	11.56		000	N
70328		17.23	17.23		000	N
70330	26	7.48	7.48		000	N
70330	TC	20.40	20.40		000	N
70330		27.88	27.88		000	N
70332	26	17.23	17.23		000	N
70332	TC	50.33	50.33		000	N
70332		67.56	67.56		000	N
70336	26	46.02	46.02		000	N
70336	TC	268.41	268.41		000	N
70336		314.43	314.43		000	N
70350	26	5.67	5.67		000	N
70350	TC	8.84	8.84		000	N
70350		14.51	14.51		000	N
70355	26	6.57	6.57		000	N
70355	TC	13.83	13.83		000	N
70355		20.40	20.40		000	N
70360	26	5.44	5.44		000	N
70360	TC	9.75	9.75		000	N
70360		15.19	15.19		000	N
70370	26	9.97	9.97		000	N
70370	TC	31.28	31.28		000	N
70370		41.26	41.26		000	N
70371	26	26.30	26.30		000	N
70371	TC	50.33	50.33		000	N
70371		76.62	76.62		000	N
70373	26	13.83	13.83		000	N
70373	TC	43.07	43.07		000	N
70373		56.90	56.90		000	N
70380	26	5.44	5.44		000	N
70380	TC	16.10	16.10		000	N
70380		21.54	21.54		000	N
70390	26	12.02	12.02		000	N
70390	TC	43.07	43.07		000	N
70390		55.09	55.09		000	N
70450	26	26.52	26.52		000	N
70450	TC	113.12	113.12		000	N
70450		139.87	139.87		000	N
70460	26	35.14	35.14		000	N
70460	TC	135.34	135.34		000	N
70460		170.71	170.71		000	N
70470	26	39.45	39.45		000	N
70470	TC	169.57	169.57		000	N
70470		209.02	209.02		000	N
70480	26	39.90	39.90		000	N
70480	TC	113.12	113.12		000	N
70480		153.25	153.25		000	N
70481	26	42.85	42.85		000	N
70481	TC	135.34	135.34		000	N
70481		178.41	178.41		000	N
70482	26	44.89	44.89		000	N
70482	TC	169.57	169.57		000	N
70482		214.46	214.46		000	N
70486	26	35.37	35.37		000	N
70486	TC	113.12	113.12		000	N
70486		148.72	148.72		000	N
70487	26	40.35	40.35		000	N
70487	TC	135.34	135.34		000	N
70487		175.92	175.92		000	N
70488	26	43.98	43.98		000	N
70488	TC	169.57	169.57		000	N
70488		213.55	213.55		000	N
70490	26	39.90	39.90		000	N
70490	TC	113.12	113.12		000	N
70490		153.25	153.25		000	N
70491	26	42.85	42.85		000	N
70491	TC	135.34	135.34		000	N
70491		178.41	178.41		000	N
70492	26	44.89	44.89		000	N
70492	TC	169.57	169.57		000	N
70492		214.46	214.46		000	N
70496	26	54.63	54.63		000	N
70496	TC	254.58	254.58		000	N
70496		309.22	309.22		000	N
70498	26	54.63	54.63		000	N
70498	TC	254.58	254.58		000	N
70498		309.22	309.22		000	N
70540	26	41.71	41.71		000	N
70540	TC	264.79	264.79		000	N
70540		306.27	306.27		000	N
70542	26	50.10	50.10		000	N
70542	TC	317.83	317.83		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
70542		367.71	367.71		000	N	71021	26	8.39	8.39		000	N
70543	26	66.65	66.65		000	N	71021	TC	17.91	17.91		000	N
70543	TC	587.83	587.83		000	N	71021		26.30	26.30		000	N
70543		654.48	654.48		000	N	71022	26	9.75	9.75		000	N
70544	26	37.18	37.18	EX	000	N	71022	TC	17.91	17.91		000	N
70544	TC	268.41	268.41	EX	000	N	71022		27.66	27.66		000	N
70544		305.59	305.59	EX	000	N	71023	26	12.02	12.02		000	N
70545	26	37.18	37.18	EX	000	N	71023	TC	19.04	19.04		000	N
70545	TC	268.41	268.41	EX	000	N	71023		31.06	31.06		000	N
70545		305.59	305.59	EX	000	N	71030	26	9.52	9.52		000	N
70546	26	56.22	56.22	EX	000	N	71030	TC	19.04	19.04		000	N
70546	TC	526.17	526.17	EX	000	N	71030		28.56	28.56		000	N
70546		582.39	582.39	EX	000	N	71034	26	14.51	14.51		000	N
70547	26	37.18	37.18		000	N	71034	TC	34.46	34.46		000	N
70547	TC	268.41	268.41		000	N	71034		48.97	48.97		000	N
70547		305.59	305.59		000	N	71035	26	5.67	5.67		000	N
70548	26	37.18	37.18		000	N	71035	TC	12.24	12.24		000	N
70548	TC	268.41	268.41		000	N	71035		17.91	17.91		000	N
70548		305.59	305.59		000	N	71040	26	18.36	18.36		000	N
70549	26	56.22	56.22		000	N	71040	TC	34.91	34.91		000	N
70549	TC	526.17	526.17		000	N	71040		53.27	53.27		000	N
70549		582.39	582.39		000	N	71060	26	23.35	23.35		000	N
70551	26	46.25	46.25	EX	000	N	71060	TC	53.05	53.05		000	N
70551	TC	268.41	268.41	EX	000	N	71060		76.40	76.40		000	N
70551		314.66	314.66	EX	000	N	71090	26	17.46	17.46		000	N
70552	26	55.77	55.77	EX	000	N	71090	TC	40.81	40.81		000	N
70552	TC	321.91	321.91	EX	000	N	71090		58.26	58.26		000	N
70552		377.68	377.68	EX	000	N	71100	26	6.80	6.80		000	N
70553	26	73.68	73.68	EX	000	N	71100	TC	13.83	13.83		000	N
70553	TC	596.45	596.45	EX	000	N	71100		20.63	20.63		000	N
70553		670.13	670.13	EX	000	N	71101	26	8.39	8.39		000	N
70557	26	89.77	89.77	EX	000	N	71101	TC	16.10	16.10		000	N
70557		B.R.	B.R.	EX	000	N	71101		24.48	24.48		000	N
70557	TC	B.R.	B.R.	EX	000	N	71110	26	8.39	8.39		000	N
70558	26	99.29	99.29	EX	000	N	71110	TC	19.04	19.04		000	N
70558		B.R.	B.R.	EX	000	N	71110		27.43	27.43		000	N
70558	TC	B.R.	B.R.	EX	000	N	71111	26	9.97	9.97		000	N
70559	26	99.52	99.52	EX	000	N	71111	TC	21.54	21.54		000	N
70559		B.R.	B.R.	EX	000	N	71111		31.51	31.51		000	N
70559	TC	B.R.	B.R.	EX	000	N	71120	26	6.35	6.35		000	N
71010	26	5.67	5.67		000	N	71120	TC	15.64	15.64		000	N
71010	TC	11.11	11.11		000	N	71120		21.99	21.99		000	N
71010		16.78	16.78		000	N	71130	26	6.80	6.80		000	N
71015	26	6.57	6.57		000	N	71130	TC	17.00	17.00		000	N
71015	TC	12.24	12.24		000	N	71130		23.80	23.80		000	N
71015		18.82	18.82		000	N	71250	26	36.05	36.05		000	N
71020	26	6.80	6.80		000	N	71250	TC	141.46	141.46		000	N
71020	TC	14.96	14.96		000	N	71250		177.73	177.73		000	N
71020		21.76	21.76		000	N	71260	26	38.54	38.54		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
71260	TC	169.57	169.57		000	N
71260		207.88	207.88		000	N
71270	26	42.85	42.85		000	N
71270	TC	211.96	211.96		000	N
71270		254.81	254.81		000	N
71275	26	59.40	59.40		000	N
71275	TC	291.76	291.76		000	N
71275		351.16	351.16		000	N
71550	26	45.11	45.11		000	N
71550	TC	265.69	265.69		000	N
71550		310.81	310.81		000	N
71551	26	53.73	53.73		000	N
71551	TC	318.74	318.74		000	N
71551		372.24	372.24		000	N
71552	26	70.05	70.05		000	N
71552	TC	584.89	584.89		000	N
71552		654.94	654.94		000	N
71555	26	56.68	56.68		000	N
71555	TC	268.41	268.41		000	N
71555		325.09	325.09		000	N
72010	26	14.28	14.28		000	N
72010	TC	24.71	24.71		000	N
72010		38.99	38.99		000	N
72020	26	4.76	4.76		000	N
72020	TC	9.75	9.75		000	N
72020		14.51	14.51		000	N
72040	26	6.80	6.80		000	N
72040	TC	14.51	14.51		000	N
72040		21.31	21.31		000	N
72050	26	9.75	9.75		000	N
72050	TC	21.54	21.54		000	N
72050		31.28	31.28		000	N
72052	26	11.34	11.34		000	N
72052	TC	26.98	26.98		000	N
72052		38.31	38.31		000	N
72069	26	7.25	7.25		000	N
72069	TC	11.56	11.56		000	N
72069		18.82	18.82		000	N
72070	26	6.80	6.80		000	N
72070	TC	15.64	15.64		000	N
72070		22.44	22.44		000	N
72072	26	6.80	6.80		000	N
72072	TC	17.91	17.91		000	N
72072		24.71	24.71		000	N
72074	26	6.80	6.80		000	N
72074	TC	21.99	21.99		000	N
72074		28.79	28.79		000	N
72080	26	7.03	7.03		000	N
72080	TC	16.10	16.10		000	N
72080		23.12	23.12		000	N
72090	26	8.84	8.84		000	N
72090	TC	16.10	16.10		000	N
72090		24.94	24.94		000	N
72100	26	7.03	7.03		000	N
72100	TC	16.10	16.10		000	N
72100		23.12	23.12		000	N
72110	26	9.75	9.75		000	N
72110	TC	21.99	21.99		000	N
72110		31.74	31.74		000	N
72114	26	11.56	11.56		000	N
72114	TC	28.34	28.34		000	N
72114		40.13	40.13		000	N
72120	26	7.03	7.03		000	N
72120	TC	21.54	21.54		000	N
72120		28.56	28.56		000	N
72125	26	36.05	36.05		000	N
72125	TC	141.46	141.46		000	N
72125		177.73	177.73		000	N
72126	26	37.63	37.63		000	N
72126	TC	169.57	169.57		000	N
72126		207.20	207.20		000	N
72127	26	39.45	39.45		000	N
72127	TC	211.96	211.96		000	N
72127		251.41	251.41		000	N
72128	26	36.05	36.05		000	N
72128	TC	141.46	141.46		000	N
72128		177.73	177.73		000	N
72129	26	37.63	37.63		000	N
72129	TC	169.57	169.57		000	N
72129		207.20	207.20		000	N
72130	26	39.45	39.45		000	N
72130	TC	211.96	211.96		000	N
72130		251.41	251.41		000	N
72131	26	36.05	36.05		000	N
72131	TC	141.46	141.46		000	N
72131		177.73	177.73		000	N
72132	26	38.09	38.09		000	N
72132	TC	169.57	169.57		000	N
72132		207.66	207.66		000	N
72133	26	39.67	39.67		000	N
72133	TC	211.96	211.96		000	N
72133		251.64	251.64		000	N
72141	26	49.87	49.87		000	N
72141	TC	268.41	268.41		000	N
72141		318.29	318.29		000	N
72142	26	60.53	60.53		000	N
72142	TC	321.91	321.91		000	N
72142		382.44	382.44		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
72146	26	49.65	49.65		000	N
72146	TC	297.66	297.66		000	N
72146		347.30	347.30		000	N
72147	26	60.30	60.30		000	N
72147	TC	321.91	321.91		000	N
72147		382.22	382.22		000	N
72148	26	46.25	46.25	EX	000	N
72148	TC	297.66	297.66	EX	000	N
72148		343.90	343.90	EX	000	N
72149	26	56.22	56.22	EX	000	N
72149	TC	321.91	321.91	EX	000	N
72149		378.14	378.14	EX	000	N
72156	26	80.25	80.25		000	N
72156	TC	596.45	596.45		000	N
72156		676.70	676.70		000	N
72157	26	80.25	80.25	EX	000	N
72157	TC	596.45	596.45	EX	000	N
72157		676.70	676.70	EX	000	N
72158	26	73.90	73.90		000	N
72158	TC	596.45	596.45		000	N
72158		670.13	670.13		000	N
72159	26	58.49	58.49		000	N
72159	TC	291.99	291.99		000	N
72159		350.48	350.48		000	N
72170	26	5.44	5.44		000	N
72170	TC	12.24	12.24		000	N
72170		17.68	17.68		000	N
72190	26	6.57	6.57		000	N
72190	TC	16.10	16.10		000	N
72190		22.67	22.67		000	N
72191	26	56.22	56.22		000	N
72191	TC	283.83	283.83		000	N
72191		339.82	339.82		000	N
72192	26	34.01	34.01		000	N
72192	TC	141.46	141.46		000	N
72192		175.69	175.69		000	N
72193	26	36.05	36.05		000	N
72193	TC	163.90	163.90		000	N
72193		200.18	200.18		000	N
72194	26	38.09	38.09		000	N
72194	TC	203.12	203.12		000	N
72194		240.98	240.98		000	N
72195	26	45.34	45.34	EX	000	N
72195	TC	265.69	265.69	EX	000	N
72195		311.03	311.03	EX	000	N
72196	26	53.50	53.50	EX	000	N
72196	TC	318.74	318.74	EX	000	N
72196		372.01	372.01	EX	000	N
72197	26	70.05	70.05	EX	000	N
72197	TC	589.19	589.19	EX	000	N
72197		659.47	659.47	EX	000	N
72198	26	58.26	58.26		000	N
72198	TC	268.41	268.41		000	N
72198		326.67	326.67		000	N
72200	26	5.44	5.44		000	N
72200	TC	12.24	12.24		000	N
72200		17.68	17.68		000	N
72202	26	5.89	5.89		000	N
72202	TC	14.96	14.96		000	N
72202		20.86	20.86		000	N
72220	26	5.44	5.44		000	N
72220	TC	13.83	13.83		000	N
72220		19.27	19.27		000	N
72240	26	28.34	28.34		000	N
72240	TC	113.80	113.80		000	N
72240		142.14	142.14		000	N
72255	26	28.11	28.11		000	N
72255	TC	103.38	103.38		000	N
72255		131.49	131.49		000	N
72265	26	25.62	25.62		000	N
72265	TC	97.71	97.71		000	N
72265		123.55	123.55		000	N
72270	26	41.03	41.03		000	N
72270	TC	146.22	146.22		000	N
72270		187.25	187.25		000	N
72275	26	22.67	22.67		000	N
72275	TC	52.14	52.14		000	N
72275		74.81	74.81		000	N
72285	26	35.82	35.82		000	N
72285	TC	200.63	200.63		000	N
72285		236.45	236.45		000	N
72295	26	25.84	25.84		000	N
72295	TC	187.93	187.93		000	N
72295		213.78	213.78		000	N
73000	26	4.99	4.99		000	N
73000	TC	12.24	12.24		000	N
73000		17.23	17.23		000	N
73010	26	5.44	5.44		000	N
73010	TC	12.24	12.24		000	N
73010		17.68	17.68		000	N
73020	26	4.76	4.76		000	N
73020	TC	11.11	11.11		000	N
73020		15.87	15.87		000	N
73030	26	5.67	5.67		000	N
73030	TC	13.83	13.83		000	N
73030		19.50	19.50		000	N
73040	26	17.23	17.23		000	N
73040	TC	50.33	50.33		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
73040		67.33	67.33		000	N
73050	26	6.57	6.57		000	N
73050	TC	16.10	16.10		000	N
73050		22.67	22.67		000	N
73060	26	5.44	5.44		000	N
73060	TC	13.83	13.83		000	N
73060		19.27	19.27		000	N
73070	26	4.76	4.76		000	N
73070	TC	12.24	12.24		000	N
73070		17.00	17.00		000	N
73080	26	5.44	5.44		000	N
73080	TC	13.83	13.83		000	N
73080		19.27	19.27		000	N
73085	26	17.46	17.46		000	N
73085	TC	50.33	50.33		000	N
73085		67.56	67.56		000	N
73090	26	4.99	4.99		000	N
73090	TC	12.24	12.24		000	N
73090		17.23	17.23		000	N
73092	26	4.99	4.99		000	N
73092	TC	11.56	11.56		000	N
73092		16.55	16.55		000	N
73100	26	5.44	5.44		000	N
73100	TC	11.56	11.56		000	N
73100		17.00	17.00		000	N
73110	26	5.44	5.44		000	N
73110	TC	12.47	12.47		000	N
73110		17.91	17.91		000	N
73115	26	17.46	17.46		000	N
73115	TC	38.09	38.09		000	N
73115		55.31	55.31		000	N
73120	26	4.99	4.99		000	N
73120	TC	11.56	11.56		000	N
73120		16.55	16.55		000	N
73130	26	5.44	5.44		000	N
73130	TC	12.47	12.47		000	N
73130		17.91	17.91		000	N
73140	26	4.08	4.08		000	N
73140	TC	9.75	9.75		000	N
73140		13.83	13.83		000	N
73200	26	34.01	34.01		000	N
73200	TC	118.56	118.56		000	N
73200		152.57	152.57		000	N
73201	26	36.05	36.05		000	N
73201	TC	141.46	141.46		000	N
73201		177.73	177.73		000	N
73202	26	38.09	38.09		000	N
73202	TC	177.96	177.96		000	N
73202		216.05	216.05		000	N
73206	26	55.99	55.99		000	N
73206	TC	259.12	259.12		000	N
73206		315.11	315.11		000	N
73218	26	41.71	41.71	EX	000	N
73218	TC	264.79	264.79	EX	000	N
73218		306.27	306.27	EX	000	N
73219	26	50.10	50.10	EX	000	N
73219	TC	317.83	317.83	EX	000	N
73219		367.71	367.71	EX	000	N
73220	26	66.88	66.88	EX	000	N
73220	TC	587.83	587.83	EX	000	N
73220		654.71	654.71	EX	000	N
73221	26	41.71	41.71	EX	000	N
73221	TC	264.79	264.79	EX	000	N
73221		306.27	306.27	EX	000	N
73222	26	50.10	50.10	EX	000	N
73222	TC	317.83	317.83	EX	000	N
73222		367.71	367.71	EX	000	N
73223	26	66.65	66.65	EX	000	N
73223	TC	587.83	587.83	EX	000	N
73223		654.48	654.48	EX	000	N
73225	26	56.45	56.45		000	N
73225	TC	262.97	262.97		000	N
73225		319.65	319.65		000	N
73500	26	5.44	5.44		000	N
73500	TC	11.11	11.11		000	N
73500		16.55	16.55		000	N
73510	26	6.80	6.80		000	N
73510	TC	13.83	13.83		000	N
73510		20.63	20.63		000	N
73520	26	8.39	8.39		000	N
73520	TC	16.10	16.10		000	N
73520		24.48	24.48		000	N
73525	26	17.23	17.23		000	N
73525	TC	50.33	50.33		000	N
73525		67.33	67.33		000	N
73530	26	9.07	9.07		000	N
73530	TC	12.24	12.24		000	N
73530		21.31	21.31		000	N
73540	26	6.57	6.57		000	N
73540	TC	13.83	13.83		000	N
73540		20.40	20.40		000	N
73542	26	17.91	17.91		000	N
73542	TC	50.33	50.33		000	N
73542		68.01	68.01		000	N
73550	26	5.44	5.44		000	N
73550	TC	13.83	13.83		000	N
73550		19.27	19.27		000	N
73560	26	5.67	5.67		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
73560	TC	12.24	12.24		000	N
73560		17.91	17.91		000	N
73562	26	5.89	5.89		000	N
73562	TC	13.83	13.83		000	N
73562		19.72	19.72		000	N
73564	26	7.25	7.25		000	N
73564	TC	14.96	14.96		000	N
73564		22.22	22.22		000	N
73565	26	5.67	5.67		000	N
73565	TC	11.56	11.56		000	N
73565		17.23	17.23		000	N
73580	26	17.23	17.23		000	N
73580	TC	62.57	62.57		000	N
73580		79.80	79.80		000	N
73590	26	5.44	5.44		000	N
73590	TC	12.24	12.24		000	N
73590		17.68	17.68		000	N
73592	26	5.21	5.21		000	N
73592	TC	11.56	11.56		000	N
73592		16.78	16.78		000	N
73600	26	4.99	4.99		000	N
73600	TC	11.56	11.56		000	N
73600		16.55	16.55		000	N
73610	26	5.44	5.44		000	N
73610	TC	12.47	12.47		000	N
73610		17.91	17.91		000	N
73615	26	17.46	17.46		000	N
73615	TC	50.33	50.33		000	N
73615		67.56	67.56		000	N
73620	26	4.99	4.99		000	N
73620	TC	11.56	11.56		000	N
73620		16.55	16.55		000	N
73630	26	5.44	5.44		000	N
73630	TC	12.47	12.47		000	N
73630		17.91	17.91		000	N
73650	26	4.99	4.99		000	N
73650	TC	11.11	11.11		000	N
73650		16.10	16.10		000	N
73660	26	4.08	4.08		000	N
73660	TC	9.75	9.75		000	N
73660		13.83	13.83		000	N
73700	26	34.01	34.01		000	N
73700	TC	118.56	118.56		000	N
73700		152.57	152.57		000	N
73701	26	36.05	36.05		000	N
73701	TC	141.46	141.46		000	N
73701		177.73	177.73		000	N
73702	26	38.09	38.09		000	N
73702	TC	177.96	177.96		000	N
73702		215.82	215.82		000	N
73706	26	58.72	58.72		000	N
73706	TC	259.12	259.12		000	N
73706		317.83	317.83		000	N
73718	26	41.71	41.71	EX	000	N
73718	TC	264.79	264.79	EX	000	N
73718		306.27	306.27	EX	000	N
73719	26	50.10	50.10	EX	000	N
73719	TC	317.83	317.83	EX	000	N
73719		367.71	367.71	EX	000	N
73720	26	66.88	66.88	EX	000	N
73720	TC	587.83	587.83	EX	000	N
73720		654.71	654.71	EX	000	N
73721	26	41.71	41.71	EX	000	N
73721	TC	264.79	264.79	EX	000	N
73721		306.27	306.27	EX	000	N
73722	26	50.33	50.33	EX	000	N
73722	TC	317.83	317.83	EX	000	N
73722		367.93	367.93	EX	000	N
73723	26	66.65	66.65	EX	000	N
73723	TC	587.83	587.83	EX	000	N
73723		654.48	654.48	EX	000	N
73725	26	56.90	56.90		000	N
73725	TC	268.41	268.41		000	N
73725		325.31	325.31		000	N
74000	26	5.67	5.67		000	N
74000	TC	12.24	12.24		000	N
74000		17.91	17.91		000	N
74010	26	7.25	7.25		000	N
74010	TC	13.83	13.83		000	N
74010		21.08	21.08		000	N
74020	26	8.39	8.39		000	N
74020	TC	14.96	14.96		000	N
74020		23.35	23.35		000	N
74022	26	9.97	9.97		000	N
74022	TC	17.91	17.91		000	N
74022		27.88	27.88		000	N
74150	26	36.95	36.95		000	N
74150	TC	135.34	135.34		000	N
74150		172.52	172.52		000	N
74160	26	39.45	39.45		000	N
74160	TC	163.90	163.90		000	N
74160		203.58	203.58		000	N
74170	26	43.30	43.30		000	N
74170	TC	203.12	203.12		000	N
74170		246.42	246.42		000	N
74175	26	58.72	58.72		000	N
74175	TC	283.83	283.83		000	N
74175		342.32	342.32		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
74181	26	45.34	45.34	EX	000	N
74181	TC	265.69	265.69	XE	000	N
74181		311.26	311.26	EX	000	N
74182	26	53.50	53.50	EX	000	N
74182	TC	318.74	318.74	EX	000	N
74182		372.01	372.01	EX	000	N
74183	26	70.05	70.05	EX	000	N
74183	TC	589.19	589.19	EX	000	N
74183		659.47	659.47	EX	000	N
74185	26	56.22	56.22		000	N
74185	TC	268.41	268.41		000	N
74185		324.63	324.63		000	N
74190	26	14.96	14.96		000	N
74190	TC	31.28	31.28		000	N
74190		46.25	46.25		000	N
74210	26	11.34	11.34		000	N
74210	TC	28.34	28.34		000	N
74210		39.67	39.67		000	N
74220	26	14.28	14.28		000	N
74220	TC	28.34	28.34		000	N
74220		42.62	42.62		000	N
74230	26	16.55	16.55		000	N
74230	TC	31.28	31.28		000	N
74230		47.83	47.83		000	N
74235	26	36.95	36.95		000	N
74235	TC	62.57	62.57		000	N
74235		99.75	99.75		000	N
74240	26	21.76	21.76		000	N
74240	TC	34.91	34.91		000	N
74240		56.68	56.68		000	N
74241	26	21.76	21.76		000	N
74241	TC	35.59	35.59		000	N
74241		57.36	57.36		000	N
74245	26	28.56	28.56		000	N
74245	TC	57.13	57.13		000	N
74245		85.69	85.69		000	N
74246	26	21.76	21.76		000	N
74246	TC	39.67	39.67		000	N
74246		61.21	61.21		000	N
74247	26	21.76	21.76		000	N
74247	TC	40.81	40.81		000	N
74247		62.34	62.34		000	N
74249	26	28.56	28.56		000	N
74249	TC	61.89	61.89		000	N
74249		90.45	90.45		000	N
74250	26	14.74	14.74		000	N
74250	TC	31.28	31.28		000	N
74250		46.02	46.02		000	N
74251	26	21.76	21.76		000	N
74251	TC	31.28	31.28		000	N
74251		53.05	53.05		000	N
74260	26	15.64	15.64		000	N
74260	TC	35.59	35.59		000	N
74260		51.23	51.23		000	N
74270	26	21.76	21.76		000	N
74270	TC	41.26	41.26		000	N
74270		62.80	62.80		000	N
74280	26	31.06	31.06		000	N
74280	TC	53.73	53.73		000	N
74280		84.56	84.56		000	N
74283	TC	61.66	61.66		000	N
74283	26	63.02	63.02		000	N
74283		124.69	124.69		000	N
74290	26	9.97	9.97		000	N
74290	TC	17.91	17.91		000	N
74290		27.88	27.88		000	N
74291	26	6.35	6.35		000	N
74291	TC	9.75	9.75		000	N
74291		16.10	16.10		000	N
74300	26	11.34	11.34		000	N
74300	TC	13.60	13.60		000	N
74300		24.94	24.94		000	N
74301	26	6.57	6.57		000	N
74301	TC	7.93	7.93		000	N
74301		14.28	14.28		000	N
74305	26	13.15	13.15		000	N
74305	TC	19.04	19.04		000	N
74305		32.19	32.19		000	N
74320	26	16.78	16.78		000	N
74320	TC	75.72	75.72		000	N
74320		92.49	92.49		000	N
74327	26	21.99	21.99		000	N
74327	TC	42.62	42.62		000	N
74327		64.38	64.38		000	N
74328	26	21.99	21.99		000	N
74328	TC	75.72	75.72		000	N
74328		97.71	97.71		000	N
74329	26	21.99	21.99		000	N
74329	TC	75.72	75.72		000	N
74329		97.71	97.71		000	N
74330	26	28.34	28.34		000	N
74330	TC	75.72	75.72		000	N
74330		104.06	104.06		000	N
74340	26	16.78	16.78		000	N
74340	TC	62.57	62.57		000	N
74340		79.34	79.34		000	N
74350	26	23.80	23.80		000	N
74350	TC	75.72	75.72		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
74350		99.52	99.52		000	N	74485	26	17.23	17.23		000	N
74355	26	23.80	23.80		000	N	74485	TC	75.72	75.72		000	N
74355	TC	62.57	62.57		000	N	74485		92.95	92.95		000	N
74355		86.37	86.37		000	N	74710	26	10.65	10.65		000	N
74360	26	17.00	17.00		000	N	74710	TC	25.39	25.39		000	N
74360	TC	75.72	75.72		000	N	74710		36.05	36.05		000	N
74360		92.72	92.72		000	N	74740	26	12.02	12.02		000	N
74363	26	27.66	27.66		000	N	74740	TC	31.28	31.28		000	N
74363	TC	146.22	146.22		000	N	74740		43.30	43.30		000	N
74363		173.88	173.88		000	N	74742	26	18.82	18.82		000	N
74400	26	15.19	15.19		000	N	74742	TC	75.72	75.72		000	N
74400	TC	40.81	40.81		000	N	74742		94.53	94.53		000	N
74400		55.99	55.99		000	N	74775	26	19.72	19.72		000	N
74410	26	15.19	15.19		000	N	74775	TC	34.91	34.91		000	N
74410	TC	46.93	46.93		000	N	74775		54.63	54.63		000	N
74410		62.12	62.12		000	N	75552	26	49.87	49.87		000	N
74415	26	15.19	15.19		000	N	75552	TC	268.41	268.41		000	N
74415	TC	50.78	50.78		000	N	75552		318.29	318.29		000	N
74415		65.97	65.97		000	N	75553	26	62.34	62.34		000	N
74420	26	11.34	11.34		000	N	75553	TC	268.41	268.41		000	N
74420	TC	62.57	62.57		000	N	75553		330.76	330.76		000	N
74420		73.90	73.90		000	N	75554	26	57.58	57.58		000	N
74425	26	11.34	11.34		000	N	75554	TC	268.41	268.41		000	N
74425	TC	31.28	31.28		000	N	75554		325.99	325.99		000	N
74425		42.62	42.62		000	N	75555	26	55.54	55.54		000	N
74430	26	10.20	10.20		000	N	75555	TC	268.41	268.41		000	N
74430	TC	25.39	25.39		000	N	75555		323.95	323.95		000	N
74430		35.59	35.59		000	N	75556		B.R.	B.R.		000	N
74440	26	11.79	11.79		000	N	75600	26	15.87	15.87		000	N
74440	TC	26.98	26.98		000	N	75600	TC	301.51	301.51		000	N
74440		38.77	38.77		000	N	75600		317.38	317.38		000	N
74445	TC	26.98	26.98		000	N	75605	26	35.82	35.82		000	N
74445	26	35.37	35.37		000	N	75605	TC	301.51	301.51		000	N
74445		62.57	62.57		000	N	75605		337.56	337.56		000	N
74450	26	10.43	10.43		000	N	75625	26	35.59	35.59		000	N
74450	TC	34.91	34.91		000	N	75625	TC	301.51	301.51		000	N
74450		45.34	45.34		000	N	75625		337.33	337.33		000	N
74455	26	10.43	10.43		000	N	75630	26	56.45	56.45		000	N
74455	TC	38.09	38.09		000	N	75630	TC	314.43	314.43		000	N
74455		48.51	48.51		000	N	75630		370.88	370.88		000	N
74470	26	16.78	16.78		000	N	75635	26	74.81	74.81		000	N
74470	TC	29.92	29.92		000	N	75635	TC	373.15	373.15		000	N
74470		46.70	46.70		000	N	75635		447.96	447.96		000	N
74475	26	16.78	16.78		000	N	75650	26	46.47	46.47		000	N
74475	TC	97.71	97.71		000	N	75650	TC	301.51	301.51		000	N
74475		114.48	114.48		000	N	75650		347.98	347.98		000	N
74480	26	16.78	16.78		000	N	75658	26	41.71	41.71		000	N
74480	TC	97.71	97.71		000	N	75658	TC	301.51	301.51		000	N
74480		114.48	114.48		000	N	75658		343.22	343.22		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
75660	26	41.03	41.03		000	N
75660	TC	301.51	301.51		000	N
75660		342.54	342.54		000	N
75662	26	53.05	53.05		000	N
75662	TC	301.51	301.51		000	N
75662		354.56	354.56		000	N
75665	26	41.03	41.03		000	N
75665	TC	301.51	301.51		000	N
75665		342.54	342.54		000	N
75671	26	52.14	52.14		000	N
75671	TC	301.51	301.51		000	N
75671		353.65	353.65		000	N
75676	26	41.26	41.26		000	N
75676	TC	301.51	301.51		000	N
75676		342.77	342.77		000	N
75680	26	52.14	52.14		000	N
75680	TC	301.51	301.51		000	N
75680		353.65	353.65		000	N
75685	26	40.81	40.81		000	N
75685	TC	301.51	301.51		000	N
75685		342.32	342.32		000	N
75705	26	68.69	68.69		000	N
75705	TC	301.51	301.51		000	N
75705		370.20	370.20		000	N
75710	26	35.82	35.82		000	N
75710	TC	301.51	301.51		000	N
75710		337.33	337.33		000	N
75716	26	40.81	40.81		000	N
75716	TC	301.51	301.51		000	N
75716		342.32	342.32		000	N
75722	26	36.05	36.05		000	N
75722	TC	301.51	301.51		000	N
75722		337.78	337.78		000	N
75724	26	47.83	47.83		000	N
75724	TC	301.51	301.51		000	N
75724		349.34	349.34		000	N
75726	26	35.37	35.37		000	N
75726	TC	301.51	301.51		000	N
75726		337.10	337.10		000	N
75731	26	35.37	35.37		000	N
75731	TC	301.51	301.51		000	N
75731		337.10	337.10		000	N
75733	26	40.81	40.81		000	N
75733	TC	301.51	301.51		000	N
75733		342.32	342.32		000	N
75736	26	35.37	35.37		000	N
75736	TC	301.51	301.51		000	N
75736		337.10	337.10		000	N
75741	26	40.81	40.81		000	N
75741	TC	301.51	301.51		000	N
75741		342.32	342.32		000	N
75743	26	51.46	51.46		000	N
75743	TC	301.51	301.51		000	N
75743		352.97	352.97		000	N
75746	26	35.37	35.37		000	N
75746	TC	301.51	301.51		000	N
75746		337.10	337.10		000	N
75756	26	36.95	36.95		000	N
75756	TC	301.51	301.51		000	N
75756		338.46	338.46		000	N
75774	26	11.56	11.56		000	N
75774	TC	301.51	301.51		000	N
75774		313.07	313.07		000	N
75790	TC	32.64	32.64		000	N
75790	26	57.58	57.58		000	N
75790		90.23	90.23		000	N
75801	26	25.62	25.62		000	N
75801	TC	129.90	129.90		000	N
75801		155.74	155.74		000	N
75803	26	36.27	36.27		000	N
75803	TC	129.90	129.90		000	N
75803		166.40	166.40		000	N
75805	26	25.39	25.39		000	N
75805	TC	146.22	146.22		000	N
75805		171.84	171.84		000	N
75807	26	36.27	36.27		000	N
75807	TC	146.22	146.22		000	N
75807		182.72	182.72		000	N
75809	26	14.74	14.74		000	N
75809	TC	19.04	19.04		000	N
75809		33.78	33.78		000	N
75810	26	35.59	35.59		000	N
75810	TC	301.51	301.51		000	N
75810		337.10	337.10		000	N
75820	26	21.99	21.99		000	N
75820	TC	22.90	22.90		000	N
75820		44.66	44.66		000	N
75822	26	33.10	33.10		000	N
75822	TC	35.37	35.37		000	N
75822		68.46	68.46		000	N
75825	26	35.59	35.59		000	N
75825	TC	301.51	301.51		000	N
75825		337.10	337.10		000	N
75827	26	35.37	35.37		000	N
75827	TC	301.51	301.51		000	N
75827		337.10	337.10		000	N
75831	26	35.37	35.37		000	N
75831	TC	301.51	301.51		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
75831		337.10	337.10		000	N
75833	26	46.47	46.47		000	N
75833	TC	301.51	301.51		000	N
75833		347.98	347.98		000	N
75840	26	35.82	35.82		000	N
75840	TC	301.51	301.51		000	N
75840		337.33	337.33		000	N
75842	26	46.25	46.25		000	N
75842	TC	301.51	301.51		000	N
75842		347.76	347.76		000	N
75860	26	36.05	36.05		000	N
75860	TC	301.51	301.51		000	N
75860		337.56	337.56		000	N
75870	26	36.05	36.05		000	N
75870	TC	301.51	301.51		000	N
75870		337.56	337.56		000	N
75872	26	35.37	35.37		000	N
75872	TC	301.51	301.51		000	N
75872		337.10	337.10		000	N
75880	26	21.99	21.99		000	N
75880	TC	22.90	22.90		000	N
75880		44.66	44.66		000	N
75885	26	44.66	44.66		000	N
75885	TC	301.51	301.51		000	N
75885		346.40	346.40		000	N
75887	26	44.66	44.66		000	N
75887	TC	301.51	301.51		000	N
75887		346.40	346.40		000	N
75889	26	35.37	35.37		000	N
75889	TC	301.51	301.51		000	N
75889		337.10	337.10		000	N
75891	26	35.37	35.37		000	N
75891	TC	301.51	301.51		000	N
75891		337.10	337.10		000	N
75893	26	16.78	16.78		000	N
75893	TC	301.51	301.51		000	N
75893		318.29	318.29		000	N
75894	26	41.03	41.03		000	N
75894	TC	578.31	578.31		000	N
75894		619.34	619.34		000	N
75896	26	41.26	41.26		000	N
75896	TC	502.59	502.59		000	N
75896		544.08	544.08		000	N
75898	TC	25.39	25.39		000	N
75898	26	51.46	51.46		000	N
75898		76.85	76.85		000	N
75900	26	15.19	15.19		000	N
75900	TC	502.37	502.37		000	N
75900		517.56	517.56		000	N
75901	26	15.19	15.19		000	N
75901	TC	45.11	45.11		000	N
75901		60.30	60.30		000	N
75902	26	12.24	12.24		000	N
75902	TC	45.11	45.11		000	N
75902		57.36	57.36		000	N
75940	26	17.23	17.23		000	N
75940	TC	301.51	301.51		000	N
75940		318.74	318.74		000	N
75945	26	12.92	12.92		000	N
75945	TC	109.27	109.27		000	N
75945		122.42	122.42		000	N
75946	26	12.92	12.92		000	N
75946	TC	55.09	55.09		000	N
75946		68.01	68.01		000	N
75952	26	151.21	151.21		000	N
75952		B.R.	B.R.		000	N
75952	TC	B.R.	B.R.		000	N
75953	26	56.22	56.22		000	N
75953		B.R.	B.R.		000	N
75953	TC	B.R.	B.R.		000	N
75954	26	76.85	76.85		000	N
75954		B.R.	B.R.		000	N
75954	TC	B.R.	B.R.		000	N
75960	26	26.07	26.07		000	N
75960	TC	356.60	356.60		000	N
75960		382.90	382.90		000	N
75961	26	132.39	132.39		000	N
75961	TC	251.64	251.64		000	N
75961		384.03	384.03		000	N
75962	26	17.46	17.46		000	N
75962	TC	377.23	377.23		000	N
75962		394.68	394.68		000	N
75964	26	11.34	11.34		000	N
75964	TC	200.86	200.86		000	N
75964		212.19	212.19		000	N
75966	26	41.49	41.49		000	N
75966	TC	377.23	377.23		000	N
75966		418.71	418.71		000	N
75968	26	11.34	11.34		000	N
75968	TC	200.86	200.86		000	N
75968		212.19	212.19		000	N
75970	26	26.30	26.30		000	N
75970	TC	276.57	276.57		000	N
75970		302.87	302.87		000	N
75978	26	16.78	16.78		000	N
75978	TC	377.23	377.23		000	N
75978		394.00	394.00		000	N
75980	26	44.66	44.66		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
75980	TC	129.90	129.90		000	N
75980		174.79	174.79		000	N
75982	26	44.43	44.43		000	N
75982	TC	146.22	146.22		000	N
75982		190.88	190.88		000	N
75984	26	22.67	22.67		000	N
75984	TC	46.93	46.93		000	N
75984		69.60	69.60		000	N
75989	26	36.73	36.73		000	N
75989	TC	75.72	75.72		000	N
75989		112.67	112.67		000	N
75992	26	17.00	17.00		000	N
75992	TC	377.23	377.23		000	N
75992		394.23	394.23		000	N
75993	26	11.56	11.56		000	N
75993	TC	200.86	200.86		000	N
75993		212.42	212.42		000	N
75994	26	41.49	41.49		000	N
75994	TC	377.23	377.23		000	N
75994		418.71	418.71		000	N
75995	26	41.71	41.71		000	N
75995	TC	377.23	377.23		000	N
75995		418.94	418.94		000	N
75996	26	11.11	11.11		000	N
75996	TC	200.86	200.86		000	N
75996		211.96	211.96		000	N
75998	26	12.47	12.47		000	N
75998	TC	31.74	31.74		000	N
75998		44.43	44.43		000	N
76000	26	5.21	5.21		000	N
76000	TC	31.28	31.28		000	N
76000		36.50	36.50		000	N
76001	26	21.08	21.08		000	N
76001	TC	62.57	62.57		000	N
76001		83.65	83.65		000	N
76003	26	17.00	17.00		000	N
76003	TC	31.28	31.28		000	N
76003		48.29	48.29		000	N
76005	26	18.14	18.14		000	N
76005	TC	31.28	31.28		000	N
76005		49.42	49.42		000	N
76006		14.51	14.51		000	N
76010	26	5.67	5.67		000	N
76010	TC	12.24	12.24		000	N
76010		17.91	17.91		000	N
76012		#	#		000	N
76012	26	#	#		000	N
76012	TC	#	#		000	N
76013		#	#		000	N
76013	26	#	#		000	N
76013	TC	#	#		000	N
76020	26	5.89	5.89		000	N
76020	TC	12.24	12.24		000	N
76020		18.14	18.14		000	N
76040	26	8.84	8.84		000	N
76040	TC	19.04	19.04		000	N
76040		27.88	27.88		000	N
76061	26	14.06	14.06		000	N
76061	TC	24.03	24.03		000	N
76061		38.09	38.09		000	N
76062	26	16.78	16.78		000	N
76062	TC	34.46	34.46		000	N
76062		51.23	51.23		000	N
76065	TC	17.91	17.91		000	N
76065	26	21.54	21.54		000	N
76065		39.45	39.45		000	N
76066	26	9.97	9.97		000	N
76066	TC	26.75	26.75		000	N
76066		36.73	36.73		000	N
76070	26	7.71	7.71		000	N
76070	TC	70.73	70.73		000	N
76070		78.44	78.44		000	N
76071	26	6.80	6.80		000	N
76071	TC	68.69	68.69		000	N
76071		75.49	75.49		000	N
76075	26	9.29	9.29		000	N
76075	TC	74.36	74.36		000	N
76075		83.65	83.65		000	N
76076	26	7.03	7.03		000	N
76076	TC	18.36	18.36		000	N
76076		25.39	25.39		000	N
76078	26	6.35	6.35		000	N
76078	TC	18.36	18.36		000	N
76078		24.71	24.71		000	N
76080	26	16.78	16.78		000	N
76080	TC	25.39	25.39		000	N
76080		42.17	42.17		000	N
76082	26	2.04	2.04		000	N
76082	TC	9.52	9.52		000	N
76082		11.56	11.56		000	N
76083	26	2.04	2.04		000	N
76083	TC	9.52	9.52		000	N
76083		11.56	11.56		000	N
76086	26	11.34	11.34		000	N
76086	TC	62.57	62.57		000	N
76086		73.90	73.90		000	N
76088	26	14.06	14.06		000	N
76088	TC	87.73	87.73		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
76088		101.79	101.79		000	N
76090	26	21.99	21.99		000	N
76090	TC	25.39	25.39		000	N
76090		47.38	47.38		000	N
76091	26	27.20	27.20		000	N
76091	TC	31.28	31.28		000	N
76091		58.49	58.49		000	N
76092	26	21.99	21.99		000	N
76092	TC	29.47	29.47		000	N
76092		51.46	51.46		000	N
76093	26	50.55	50.55		000	N
76093	TC	421.89	421.89		000	N
76093		472.67	472.67		000	N
76094	26	50.55	50.55		000	N
76094	TC	572.42	572.42		000	N
76094		622.97	622.97		000	N
76095	26	50.10	50.10		000	N
76095	TC	171.61	171.61		000	N
76095		221.49	221.49		000	N
76096	26	17.91	17.91		000	N
76096	TC	31.28	31.28		000	N
76096		49.19	49.19		000	N
76098	26	4.99	4.99		000	N
76098	TC	9.75	9.75		000	N
76098		14.74	14.74		000	N
76100	26	18.36	18.36		000	N
76100	TC	29.92	29.92		000	N
76100		48.29	48.29		000	N
76101	26	18.36	18.36		000	N
76101	TC	34.23	34.23		000	N
76101		52.59	52.59		000	N
76102	26	18.59	18.59		000	N
76102	TC	41.94	41.94		000	N
76102		60.30	60.30		000	N
76120	26	12.02	12.02		000	N
76120	TC	25.39	25.39		000	N
76120		37.41	37.41		000	N
76125	26	8.39	8.39		000	N
76125	TC	19.04	19.04		000	N
76125		27.43	27.43		000	N
76140		#	#		000	N
76150		9.75	9.75		000	N
76350		B.R.	B.R.		000	N
76355	26	37.86	37.86		000	N
76355	TC	197.68	197.68		000	N
76355		235.54	235.54		000	N
76360	26	35.82	35.82		000	N
76360	TC	197.68	197.68		000	N
76360		233.50	233.50		000	N
76362	26	124.46	124.46		000	N
76362	TC	216.50	216.50		000	N
76362		340.96	340.96		000	N
76370	26	26.52	26.52		000	N
76370	TC	70.73	70.73		000	N
76370		97.48	97.48		000	N
76375	26	4.99	4.99		000	N
76375	TC	84.56	84.56		000	N
76375		89.55	89.55		000	N
76380	26	30.83	30.83		000	N
76380	TC	83.65	83.65		000	N
76380		114.48	114.48		000	N
76390	26	43.75	43.75		000	N
76390	TC	262.97	262.97		000	N
76390		306.95	306.95		000	N
76393	26	46.93	46.93		000	N
76393	TC	267.73	267.73		000	N
76393		314.66	314.66		000	N
76394	26	132.39	132.39	EX	000	N
76394	TC	286.10	286.10	EX	000	N
76394		418.26	418.26	EX	000	N
76400	26	49.65	49.65		000	N
76400	TC	268.41	268.41		000	N
76400		318.06	318.06		000	N
76496		B.R.	B.R.		000	N
76496	26	B.R.	B.R.		000	N
76496	TC	B.R.	B.R.		000	N
76497		B.R.	B.R.		000	N
76497	26	B.R.	B.R.		000	N
76497	TC	B.R.	B.R.		000	N
76498		B.R.	B.R.	EX	000	N
76498	26	B.R.	B.R.	EX	000	N
76498	TC	B.R.	B.R.	EX	000	N
76499		B.R.	B.R.		000	N
76499	26	B.R.	B.R.		000	N
76499	TC	B.R.	B.R.		000	N
76506	26	20.86	20.86		000	N
76506	TC	34.23	34.23		000	N
76506		55.09	55.09		000	N
76511	26	30.83	30.83		000	N
76511	TC	34.01	34.01		000	N
76511		64.84	64.84		000	N
76512	26	21.99	21.99		000	N
76512	TC	35.14	35.14		000	N
76512		57.13	57.13		000	N
76513	26	21.99	21.99		000	N
76513	TC	37.18	37.18		000	N
76513		59.17	59.17		000	N
76514	TC	1.59	1.59		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
76514	26	5.89	5.89		000	N
76514		7.48	7.48		000	N
76516	26	18.14	18.14		000	N
76516	TC	28.79	28.79		000	N
76516		46.93	46.93		000	N
76519	26	18.14	18.14		000	N
76519	TC	30.83	30.83		000	N
76519		48.97	48.97		000	N
76529	26	18.82	18.82		000	N
76529	TC	27.88	27.88		000	N
76529		46.70	46.70		000	N
76536	26	17.46	17.46		000	N
76536	TC	34.23	34.23		000	N
76536		51.69	51.69		000	N
76604	26	17.00	17.00		000	N
76604	TC	31.28	31.28		000	N
76604		48.29	48.29		000	N
76645	26	17.23	17.23		000	N
76645	TC	25.39	25.39		000	N
76645		42.62	42.62		000	N
76700	26	25.39	25.39		000	N
76700	TC	47.38	47.38		000	N
76700		72.77	72.77		000	N
76705	26	18.82	18.82		000	N
76705	TC	34.23	34.23		000	N
76705		53.05	53.05		000	N
76770	26	23.35	23.35		000	N
76770	TC	47.38	47.38		000	N
76770		70.73	70.73		000	N
76775	26	18.36	18.36		000	N
76775	TC	34.23	34.23		000	N
76775		52.59	52.59		000	N
76778	26	23.35	23.35		000	N
76778	TC	47.38	47.38		000	N
76778		70.73	70.73		000	N
76800	TC	34.23	34.23		000	N
76800	26	34.69	34.69		000	N
76800		68.92	68.92		000	N
76801	26	31.51	31.51		000	N
76801	TC	50.33	50.33		000	N
76801		81.84	81.84		000	N
76802	26	26.30	26.30		000	N
76802	TC	26.52	26.52		000	N
76802		52.82	52.82		000	N
76805	26	31.51	31.51		000	N
76805	TC	50.33	50.33		000	N
76805		81.84	81.84		000	N
76810	TC	28.34	28.34		000	N
76810	26	31.74	31.74		000	N
76810		60.08	60.08		000	N
76811	26	61.66	61.66		000	N
76811	TC	88.87	88.87		000	N
76811		150.53	150.53		000	N
76812	TC	31.74	31.74		000	N
76812	26	57.36	57.36		000	N
76812		89.09	89.09		000	N
76815	26	20.40	20.40		000	N
76815	TC	34.23	34.23		000	N
76815		54.63	54.63		000	N
76816	TC	26.75	26.75		000	N
76816	26	26.98	26.98		000	N
76816		53.73	53.73		000	N
76817	26	23.80	23.80		000	N
76817	TC	35.82	35.82		000	N
76817		59.85	59.85		000	N
76818	26	33.55	33.55		000	N
76818	TC	38.99	38.99		000	N
76818		72.32	72.32		000	N
76819	26	24.26	24.26		000	N
76819	TC	38.99	38.99		000	N
76819		63.25	63.25		000	N
76825	TC	47.38	47.38		000	N
76825	26	53.05	53.05		000	N
76825		100.43	100.43		000	N
76826	TC	17.23	17.23		000	N
76826	26	26.30	26.30		000	N
76826		43.30	43.30		000	N
76827	26	18.59	18.59		000	N
76827	TC	41.94	41.94		000	N
76827		60.53	60.53		000	N
76828	26	18.14	18.14		000	N
76828	TC	27.20	27.20		000	N
76828		45.34	45.34		000	N
76830	26	21.76	21.76		000	N
76830	TC	36.73	36.73		000	N
76830		58.26	58.26		000	N
76831	26	22.67	22.67		000	N
76831	TC	36.73	36.73		000	N
76831		59.40	59.40		000	N
76856	26	21.76	21.76		000	N
76856	TC	36.73	36.73		000	N
76856		58.26	58.26		000	N
76857	26	12.02	12.02		000	N
76857	TC	37.18	37.18		000	N
76857		48.97	48.97		000	N
76870	26	20.18	20.18		000	N
76870	TC	36.73	36.73		000	N
76870		56.68	56.68		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
76872	26	21.76	21.76		000	N	76965	TC	133.30	133.30		000	N
76872	TC	44.43	44.43		000	N	76965		175.01	175.01		000	N
76872		66.20	66.20		000	N	76970	26	12.47	12.47		000	N
76873	26	48.29	48.29		000	N	76970	TC	25.39	25.39		000	N
76873	TC	51.01	51.01		000	N	76970		37.86	37.86		000	N
76873		99.29	99.29		000	N	76975	26	25.62	25.62		000	N
76880	26	18.82	18.82		000	N	76975	TC	36.73	36.73		000	N
76880	TC	34.23	34.23		000	N	76975		62.12	62.12		000	N
76880		53.05	53.05		000	N	76977	26	1.81	1.81		000	N
76885	26	23.35	23.35		000	N	76977	TC	19.95	19.95		000	N
76885	TC	36.73	36.73		000	N	76977		21.76	21.76		000	N
76885		59.85	59.85		000	N	76986	26	37.86	37.86		000	N
76886	26	19.72	19.72		000	N	76986	TC	62.57	62.57		000	N
76886	TC	34.23	34.23		000	N	76986		100.43	100.43		000	N
76886		53.95	53.95		000	N	76999		B.R.	B.R.		000	N
76930	26	21.54	21.54		000	N	76999	26	B.R.	B.R.		000	N
76930	TC	36.73	36.73		000	N	76999	TC	B.R.	B.R.		000	N
76930		58.26	58.26		000	N	77261		44.43	44.43		000	N
76932	26	21.54	21.54		000	N	77262		67.10	67.10		000	N
76932	TC	36.73	36.73		000	N	77263		99.97	99.97		000	N
76932		58.26	58.26		000	N	77280	26	21.76	21.76		000	N
76936	26	62.80	62.80		000	N	77280	TC	82.97	82.97		000	N
76936	TC	150.98	150.98		000	N	77280		104.74	104.74		000	N
76936		213.78	213.78		000	N	77285	26	32.64	32.64		000	N
76937	26	9.97	9.97		000	N	77285	TC	133.53	133.53		000	N
76937	TC	10.20	10.20		000	N	77285		166.17	166.17		000	N
76937		20.40	20.40		000	N	77290	26	47.83	47.83		000	N
76940	TC	40.13	40.13		000	N	77290	TC	155.97	155.97		000	N
76940	26	62.80	62.80		000	N	77290		204.03	204.03		000	N
76940		102.92	102.92		000	N	77295	26	140.78	140.78		000	N
76941	TC	36.50	36.50		000	N	77295	TC	669.45	669.45		000	N
76941	26	42.39	42.39		000	N	77295		810.23	810.23		000	N
76941		79.12	79.12		000	N	77299		B.R.	B.R.		000	N
76942	26	21.08	21.08		000	N	77299	26	B.R.	B.R.		000	N
76942	TC	60.08	60.08		000	N	77299	TC	B.R.	B.R.		000	N
76942		81.16	81.16		000	N	77300	26	19.50	19.50		000	N
76945	26	21.31	21.31		000	N	77300	TC	32.19	32.19		000	N
76945	TC	36.50	36.50		000	N	77300		51.69	51.69		000	N
76945		57.81	57.81		000	N	77301	26	243.70	243.70		000	N
76946	26	12.02	12.02		000	N	77301	TC	669.45	669.45		000	N
76946	TC	36.73	36.73		000	N	77301		913.15	913.15		000	N
76946		48.74	48.74		000	N	77305	26	21.99	21.99		000	N
76948	26	12.02	12.02		000	N	77305	TC	44.89	44.89		000	N
76948	TC	36.73	36.73		000	N	77305		66.65	66.65		000	N
76948		48.74	48.74		000	N	77310	26	32.64	32.64		000	N
76950	26	18.36	18.36		000	N	77310	TC	55.99	55.99		000	N
76950	TC	31.28	31.28		000	N	77310		88.64	88.64		000	N
76950		49.65	49.65		000	N	77315	26	47.83	47.83		000	N
76965	26	41.49	41.49		000	N	77315	TC	63.48	63.48		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
77315		111.54	111.54		000	N	77470	TC	267.28	267.28		000	N
77321	26	29.70	29.70		000	N	77470		331.89	331.89		000	N
77321	TC	96.80	96.80		000	N	77499		B.R.	B.R.		000	N
77321		126.50	126.50		000	N	77499	26	B.R.	B.R.		000	N
77326	26	29.02	29.02		000	N	77499	TC	B.R.	B.R.		000	N
77326	TC	56.68	56.68		000	N	77520		B.R.	B.R.		000	N
77326		85.69	85.69		000	N	77522		B.R.	B.R.		000	N
77327	26	42.85	42.85		000	N	77523		B.R.	B.R.		000	N
77327	TC	82.97	82.97		000	N	77525		B.R.	B.R.		000	N
77327		126.05	126.05		000	N	77600	26	48.51	48.51		000	N
77328	26	64.61	64.61		000	N	77600	TC	73.00	73.00		000	N
77328	TC	118.56	118.56		000	N	77600		121.51	121.51		000	N
77328		183.17	183.17		000	N	77605	26	65.52	65.52		000	N
77331	TC	11.79	11.79		000	N	77605	TC	97.48	97.48		000	N
77331	26	26.98	26.98		000	N	77605		163.00	163.00		000	N
77331		38.99	38.99		000	N	77610	26	48.29	48.29		000	N
77332	26	16.55	16.55		000	N	77610	TC	73.00	73.00		000	N
77332	TC	32.19	32.19		000	N	77610		121.51	121.51		000	N
77332		48.74	48.74		000	N	77615	26	64.61	64.61		000	N
77333	26	26.07	26.07		000	N	77615	TC	97.48	97.48		000	N
77333	TC	45.57	45.57		000	N	77615		162.09	162.09		000	N
77333		71.64	71.64		000	N	77620	26	48.29	48.29		000	N
77334	26	38.09	38.09		000	N	77620	TC	73.00	73.00		000	N
77334	TC	77.76	77.76		000	N	77620		121.51	121.51		000	N
77334		116.07	116.07		000	N	77750	TC	31.96	31.96		090	N
77336		71.41	71.41		000	N	77750	26	151.21	151.21		090	N
77370		83.43	83.43		000	N	77750		183.17	183.17		090	N
77399		B.R.	B.R.		000	N	77761	TC	60.30	60.30		090	N
77399	26	B.R.	B.R.		000	N	77761	26	114.94	114.94		090	N
77399	TC	B.R.	B.R.		000	N	77761		175.24	175.24		090	N
77401		42.85	42.85		000	N	77762	TC	86.37	86.37		090	N
77402		42.85	42.85		000	N	77762	26	176.60	176.60		090	N
77403		42.85	42.85		000	N	77762		262.97	262.97		090	N
77404		42.85	42.85		000	N	77763	TC	107.23	107.23		090	N
77406		42.85	42.85		000	N	77763	26	264.33	264.33		090	N
77407		50.10	50.10		000	N	77763		371.56	371.56		090	N
77408		50.10	50.10		000	N	77776	TC	52.37	52.37		090	N
77409		50.10	50.10		000	N	77776	26	132.85	132.85		090	N
77411		50.10	50.10		000	N	77776		185.21	185.21		090	N
77412		55.99	55.99		000	N	77777	TC	101.33	101.33		090	N
77413		55.99	55.99		000	N	77777	26	230.78	230.78		090	N
77414		55.99	55.99		000	N	77777		332.34	332.34		090	N
77416		55.99	55.99		000	N	77778	TC	122.87	122.87		090	N
77417		14.28	14.28		000	N	77778	26	345.26	345.26		090	N
77418		415.99	415.99		000	N	77778		468.14	468.14		090	N
77427		102.24	102.24		000	N	77781	26	51.23	51.23		090	N
77431		58.26	58.26		000	N	77781	TC	486.50	486.50		090	N
77432		253.90	253.90		000	N	77781		537.73	537.73		090	N
77470	26	64.61	64.61		000	N	77782	26	77.08	77.08		090	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
77782	TC	486.50	486.50		090	N
77782		563.58	563.58		090	N
77783	26	114.71	114.71		090	N
77783	TC	486.50	486.50		090	N
77783		601.21	601.21		090	N
77784	26	172.97	172.97		090	N
77784	TC	486.50	486.50		090	N
77784		659.24	659.24		090	N
77789	TC	10.65	10.65		000	N
77789	26	34.69	34.69		000	N
77789		45.34	45.34		000	N
77790	TC	11.79	11.79		000	N
77790	26	32.64	32.64		000	N
77790		44.43	44.43		000	N
77799		B.R.	B.R.		000	N
77799	26	B.R.	B.R.		000	N
77799	TC	B.R.	B.R.		000	N
78000	26	6.12	6.12		000	N
78000	TC	23.35	23.35		000	N
78000		29.47	29.47		000	N
78001	26	8.16	8.16		000	N
78001	TC	31.28	31.28		000	N
78001		39.45	39.45		000	N
78003	26	10.20	10.20		000	N
78003	TC	23.35	23.35		000	N
78003		33.55	33.55		000	N
78006	26	15.42	15.42		000	N
78006	TC	57.13	57.13		000	N
78006		72.54	72.54		000	N
78007	26	15.64	15.64		000	N
78007	TC	61.89	61.89		000	N
78007		77.53	77.53		000	N
78010	26	12.24	12.24		000	N
78010	TC	43.98	43.98		000	N
78010		56.22	56.22		000	N
78011	26	14.06	14.06		000	N
78011	TC	57.81	57.81		000	N
78011		71.86	71.86		000	N
78015	26	21.31	21.31		000	N
78015	TC	61.89	61.89		000	N
78015		83.20	83.20		000	N
78016	26	26.07	26.07		000	N
78016	TC	83.20	83.20		000	N
78016		109.27	109.27		000	N
78018	26	27.20	27.20		000	N
78018	TC	130.13	130.13		000	N
78018		157.33	157.33		000	N
78020	26	18.82	18.82		000	N
78020	TC	32.64	32.64		000	N
78020		51.46	51.46		000	N
78070	26	25.84	25.84		000	N
78070	TC	43.98	43.98		000	N
78070		69.82	69.82		000	N
78075	26	23.80	23.80		000	N
78075	TC	130.13	130.13		000	N
78075		153.93	153.93		000	N
78099		B.R.	B.R.		000	N
78099	26	B.R.	B.R.		000	N
78099	TC	B.R.	B.R.		000	N
78102	26	17.46	17.46		000	N
78102	TC	48.97	48.97		000	N
78102		66.42	66.42		000	N
78103	26	23.80	23.80		000	N
78103	TC	75.94	75.94		000	N
78103		99.75	99.75		000	N
78104	26	25.16	25.16		000	N
78104	TC	97.71	97.71		000	N
78104		122.87	122.87		000	N
78110	26	6.12	6.12		000	N
78110	TC	22.90	22.90		000	N
78110		29.02	29.02		000	N
78111	26	7.03	7.03		000	N
78111	TC	61.89	61.89		000	N
78111		68.92	68.92		000	N
78120	26	7.25	7.25		000	N
78120	TC	41.94	41.94		000	N
78120		49.19	49.19		000	N
78121	26	9.97	9.97		000	N
78121	TC	69.37	69.37		000	N
78121		79.34	79.34		000	N
78122	26	14.28	14.28		000	N
78122	TC	110.18	110.18		000	N
78122		124.46	124.46		000	N
78130	26	19.50	19.50		000	N
78130	TC	68.01	68.01		000	N
78130		87.51	87.51		000	N
78135	26	20.40	20.40		000	N
78135	TC	116.52	116.52		000	N
78135		136.93	136.93		000	N
78140	26	19.27	19.27		000	N
78140	TC	94.31	94.31		000	N
78140		113.58	113.58		000	N
78160	26	10.88	10.88		000	N
78160	TC	87.73	87.73		000	N
78160		98.84	98.84		000	N
78162	26	14.74	14.74		000	N
78162	TC	76.62	76.62		000	N
78162		91.36	91.36		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
78170	26	13.38	13.38		000	N
78170	TC	127.18	127.18		000	N
78170		140.78	140.78		000	N
78172	26	16.55	16.55		000	N
78172	TC	19.95	19.95		000	N
78172		36.50	36.50		000	N
78185	26	12.70	12.70		000	N
78185	TC	56.68	56.68		000	N
78185		69.37	69.37		000	N
78190	26	34.91	34.91		000	N
78190	TC	136.70	136.70		000	N
78190		171.84	171.84		000	N
78191	26	19.27	19.27		000	N
78191	TC	175.47	175.47		000	N
78191		194.51	194.51		000	N
78195	26	37.86	37.86		000	N
78195	TC	97.71	97.71		000	N
78195		135.57	135.57		000	N
78199		B.R.	B.R.		000	N
78199	26	B.R.	B.R.		000	N
78199	TC	B.R.	B.R.		000	N
78201	26	13.83	13.83		000	N
78201	TC	56.68	56.68		000	N
78201		70.50	70.50		000	N
78202	26	16.10	16.10		000	N
78202	TC	68.69	68.69		000	N
78202		84.79	84.79		000	N
78205	26	22.67	22.67		000	N
78205	TC	141.46	141.46		000	N
78205		164.13	164.13		000	N
78206	26	30.60	30.60		000	N
78206	TC	137.83	137.83		000	N
78206		168.44	168.44		000	N
78215	26	15.42	15.42		000	N
78215	TC	70.05	70.05		000	N
78215		85.47	85.47		000	N
78216	26	17.91	17.91		000	N
78216	TC	83.20	83.20		000	N
78216		101.11	101.11		000	N
78220	26	15.42	15.42		000	N
78220	TC	89.09	89.09		000	N
78220		104.51	104.51		000	N
78223	26	26.30	26.30		000	N
78223	TC	87.73	87.73		000	N
78223		114.26	114.26		000	N
78230	26	14.06	14.06		000	N
78230	TC	52.37	52.37		000	N
78230		66.42	66.42		000	N
78231	26	16.55	16.55		000	N
78231	TC	75.94	75.94		000	N
78231		92.49	92.49		000	N
78232	26	14.74	14.74		000	N
78232	TC	84.56	84.56		000	N
78232		99.29	99.29		000	N
78258	26	23.35	23.35		000	N
78258	TC	68.69	68.69		000	N
78258		92.04	92.04		000	N
78261	26	22.22	22.22		000	N
78261	TC	98.16	98.16		000	N
78261		120.38	120.38		000	N
78262	26	21.76	21.76		000	N
78262	TC	101.79	101.79		000	N
78262		123.55	123.55		000	N
78264	26	24.71	24.71		000	N
78264	TC	98.84	98.84		000	N
78264		123.55	123.55		000	N
78267		8.75	8.75		000	N
78268		75.01	75.01		000	N
78270	26	6.35	6.35		000	N
78270	TC	37.41	37.41		000	N
78270		43.75	43.75		000	N
78271	26	6.35	6.35		000	N
78271	TC	39.67	39.67		000	N
78271		46.02	46.02		000	N
78272	26	8.61	8.61		000	N
78272	TC	55.77	55.77		000	N
78272		64.38	64.38		000	N
78278	26	31.28	31.28		000	N
78278	TC	116.52	116.52		000	N
78278		147.81	147.81		000	N
78282	26	12.02	12.02		000	N
78282	TC	14.51	14.51		000	N
78282		26.52	26.52		000	N
78290	26	21.54	21.54		000	N
78290	TC	73.00	73.00		000	N
78290		94.53	94.53		000	N
78291	26	27.88	27.88		000	N
78291	TC	73.45	73.45		000	N
78291		101.33	101.33		000	N
78299		B.R.	B.R.		000	N
78299	26	B.R.	B.R.		000	N
78299	TC	B.R.	B.R.		000	N
78300	26	19.72	19.72		000	N
78300	TC	59.85	59.85		000	N
78300		79.57	79.57		000	N
78305	26	26.07	26.07		000	N
78305	TC	87.73	87.73		000	N
78305		113.80	113.80		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
78306	26	27.20	27.20		000	N
78306	TC	102.24	102.24		000	N
78306		129.45	129.45		000	N
78315	26	32.19	32.19		000	N
78315	TC	114.48	114.48		000	N
78315		146.67	146.67		000	N
78320	26	33.10	33.10		000	N
78320	TC	141.46	141.46		000	N
78320		174.56	174.56		000	N
78350	26	6.80	6.80		000	N
78350	TC	18.36	18.36		000	N
78350		25.16	25.16		000	N
78351		46.47	9.75		000	N
78399		B.R.	B.R.		000	N
78399	26	B.R.	B.R.		000	N
78399	TC	B.R.	B.R.		000	N
78414	26	14.28	14.28		000	N
78414	TC	17.23	17.23		000	N
78414		31.51	31.51		000	N
78428	26	25.39	25.39		000	N
78428	TC	54.18	54.18		000	N
78428		79.57	79.57		000	N
78445	26	15.42	15.42		000	N
78445	TC	44.89	44.89		000	N
78445		60.30	60.30		000	N
78455	26	23.12	23.12		000	N
78455	TC	95.44	95.44		000	N
78455		118.56	118.56		000	N
78456	26	31.74	31.74		000	N
78456	TC	97.03	97.03		000	N
78456		128.54	128.54		000	N
78457	26	24.26	24.26		000	N
78457	TC	63.48	63.48		000	N
78457		87.73	87.73		000	N
78458	26	28.79	28.79		000	N
78458	TC	96.35	96.35		000	N
78458		125.14	125.14		000	N
78459		#	#		000	N
78459	26	#	#		000	N
78459	TC	#	#		000	N
78460	26	27.20	27.20		000	N
78460	TC	56.68	56.68		000	N
78460		83.88	83.88		000	N
78461	26	38.99	38.99		000	N
78461	TC	113.12	113.12		000	N
78461		152.12	152.12		000	N
78464	26	34.46	34.46		000	N
78464	TC	169.57	169.57		000	N
78464		203.80	203.80		000	N
78465	26	46.25	46.25		000	N
78465	TC	282.47	282.47		000	N
78465		328.49	328.49		000	N
78466	26	22.22	22.22		000	N
78466	TC	62.57	62.57		000	N
78466		84.79	84.79		000	N
78468	26	25.39	25.39		000	N
78468	TC	87.73	87.73		000	N
78468		113.12	113.12		000	N
78469	26	29.02	29.02		000	N
78469	TC	125.14	125.14		000	N
78469		154.16	154.16		000	N
78472	26	31.28	31.28		000	N
78472	TC	132.17	132.17		000	N
78472		163.45	163.45		000	N
78473	26	46.25	46.25		000	N
78473	TC	197.68	197.68		000	N
78473		243.93	243.93		000	N
78478	26	19.72	19.72		000	N
78478	TC	37.63	37.63		000	N
78478		57.36	57.36		000	N
78480	26	19.72	19.72		000	N
78480	TC	37.63	37.63		000	N
78480		57.36	57.36		000	N
78481	26	31.51	31.51		000	N
78481	TC	125.14	125.14		000	N
78481		156.65	156.65		000	N
78483	26	46.93	46.93		000	N
78483	TC	188.39	188.39		000	N
78483		235.09	235.09		000	N
78491		#	#		000	N
78491	26	#	#		000	N
78491	TC	#	#		000	N
78492		#	#		000	N
78492	26	#	#		000	N
78492	TC	#	#		000	N
78494	26	37.41	37.41		000	N
78494	TC	168.21	168.21		000	N
78494		205.62	205.62		000	N
78496	26	15.87	15.87		000	N
78496	TC	168.21	168.21		000	N
78496		184.08	184.08		000	N
78499		B.R.	B.R.		000	N
78499	26	B.R.	B.R.		000	N
78499	TC	B.R.	B.R.		000	N
78580	26	23.35	23.35		000	N
78580	TC	82.07	82.07		000	N
78580		105.42	105.42		000	N
78584	26	31.06	31.06		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
78584	TC	76.62	76.62		000	N
78584		107.68	107.68		000	N
78585	26	34.23	34.23		000	N
78585	TC	134.89	134.89		000	N
78585		169.34	169.34		000	N
78586	26	12.47	12.47		000	N
78586	TC	62.12	62.12		000	N
78586		74.58	74.58		000	N
78587	26	15.42	15.42		000	N
78587	TC	66.88	66.88		000	N
78587		82.29	82.29		000	N
78588	26	34.23	34.23		000	N
78588	TC	76.85	76.85		000	N
78588		111.08	111.08		000	N
78591	26	12.70	12.70		000	N
78591	TC	68.01	68.01		000	N
78591		80.71	80.71		000	N
78593	26	15.42	15.42		000	N
78593	TC	82.52	82.52		000	N
78593		97.93	97.93		000	N
78594	26	16.55	16.55		000	N
78594	TC	119.02	119.02		000	N
78594		135.34	135.34		000	N
78596	26	39.67	39.67		000	N
78596	TC	169.57	169.57		000	N
78596		209.02	209.02		000	N
78599		B.R.	B.R.		000	N
78599	26	B.R.	B.R.		000	N
78599	TC	B.R.	B.R.		000	N
78600	26	13.83	13.83		000	N
78600	TC	68.69	68.69		000	N
78600		82.52	82.52		000	N
78601	26	15.87	15.87		000	N
78601	TC	81.39	81.39		000	N
78601		97.25	97.25		000	N
78605	26	16.78	16.78		000	N
78605	TC	81.39	81.39		000	N
78605		98.16	98.16		000	N
78606	26	20.40	20.40		000	N
78606	TC	92.72	92.72		000	N
78606		113.12	113.12		000	N
78607	26	38.99	38.99		000	N
78607	TC	157.10	157.10		000	N
78607		196.10	196.10		000	N
78608		#	#		000	N
78609		#	#		000	N
78610	26	9.52	9.52		000	N
78610	TC	38.09	38.09		000	N
78610		47.61	47.61		000	N

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
78615	26	13.60	13.60		000	N
78615	TC	92.27	92.27		000	N
78615		105.87	105.87		000	N
78630	26	21.54	21.54		000	N
78630	TC	120.60	120.60		000	N
78630		142.14	142.14		000	N
78635	26	19.72	19.72		000	N
78635	TC	61.21	61.21		000	N
78635		80.93	80.93		000	N
78645	26	17.91	17.91		000	N
78645	TC	82.07	82.07		000	N
78645		99.97	99.97		000	N
78647	26	28.56	28.56		000	N
78647	TC	141.46	141.46		000	N
78647		170.03	170.03		000	N
78650	26	19.04	19.04		000	N
78650	TC	111.08	111.08		000	N
78650		130.13	130.13		000	N
78660	26	16.55	16.55		000	N
78660	TC	50.78	50.78		000	N
78660		67.33	67.33		000	N
78699		B.R.	B.R.		000	N
78699	26	B.R.	B.R.		000	N
78699	TC	B.R.	B.R.		000	N
78700	26	14.06	14.06		000	N
78700	TC	73.00	73.00		000	N
78700		87.05	87.05		000	N
78701	26	15.42	15.42		000	N
78701	TC	85.01	85.01		000	N
78701		100.43	100.43		000	N
78704	26	23.35	23.35		000	N
78704	TC	94.76	94.76		000	N
78704		118.11	118.11		000	N
78707	26	30.38	30.38		000	N
78707	TC	106.78	106.78		000	N
78707		137.15	137.15		000	N
78708	26	38.09	38.09		000	N
78708	TC	106.78	106.78		000	N
78708		144.86	144.86		000	N
78709	26	43.98	43.98		000	N
78709	TC	106.78	106.78		000	N
78709		150.98	150.98		000	N
78710	26	20.86	20.86		000	N
78710	TC	141.46	141.46		000	N
78710		162.32	162.32		000	N
78715	26	9.52	9.52		000	N
78715	TC	38.09	38.09		000	N
78715		47.61	47.61		000	N
78725	26	11.79	11.79		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
78725	TC	43.07	43.07		000	N
78725		54.86	54.86		000	N
78730	26	11.56	11.56		000	N
78730	TC	34.91	34.91		000	N
78730		46.47	46.47		000	N
78740	26	17.68	17.68		000	N
78740	TC	50.78	50.78		000	N
78740		68.46	68.46		000	N
78760	26	20.86	20.86		000	N
78760	TC	63.93	63.93		000	N
78760		84.79	84.79		000	N
78761	26	22.44	22.44		000	N
78761	TC	76.62	76.62		000	N
78761		99.07	99.07		000	N
78799		B.R.	B.R.		000	N
78799	26	B.R.	B.R.		000	N
78799	TC	B.R.	B.R.		000	N
78800	26	20.86	20.86		000	N
78800	TC	81.39	81.39		000	N
78800		102.24	102.24		000	N
78801	26	24.94	24.94		000	N
78801	TC	101.11	101.11		000	N
78801		126.05	126.05		000	N
78802	26	27.20	27.20		000	N
78802	TC	132.62	132.62		000	N
78802		159.82	159.82		000	N
78803	26	34.46	34.46		000	N
78803	TC	157.10	157.10		000	N
78803		191.56	191.56		000	N
78804	26	33.55	33.55		000	N
78804	TC	259.80	259.80		000	N
78804		293.35	293.35		000	N
78805	26	23.12	23.12		000	N
78805	TC	81.39	81.39		000	N
78805		104.51	104.51		000	N
78806	26	27.20	27.20		000	N
78806	TC	154.16	154.16		000	N
78806		181.36	181.36		000	N
78807	26	34.69	34.69		000	N
78807	TC	157.10	157.10		000	N
78807		191.79	191.79		000	N
78810	TC	1,584.20	1,584.20	PA	000	N
78810		1,646.54	1,646.54	PA	000	N
78810	26	#	#	PA	000	N
78890		Bundled	Bundled		000	N
78890	26	Bundled	Bundled		000	N
78890	TC	Bundled	Bundled		000	N
78891		Bundled	Bundled		000	N
78891	26	Bundled	Bundled		000	N
78891	TC	Bundled	Bundled		000	N
78990		#	#		000	N
78999		B.R.	B.R.		000	N
78999	26	B.R.	B.R.		000	N
78999	TC	B.R.	B.R.		000	N
79000	26	55.99	55.99		000	N
79000	TC	62.57	62.57		000	N
79000		118.79	118.79		000	N
79001	TC	31.28	31.28		000	N
79001	26	33.10	33.10		000	N
79001		64.38	64.38		000	N
79020	26	56.22	56.22		000	N
79020	TC	62.57	62.57		000	N
79020		119.02	119.02		000	N
79030	TC	62.57	62.57		000	N
79030	26	65.74	65.74		000	N
79030		128.31	128.31		000	N
79035	TC	62.57	62.57		000	N
79035	26	79.34	79.34		000	N
79035		141.91	141.91		000	N
79100	26	41.71	41.71		000	N
79100	TC	62.57	62.57		000	N
79100		104.28	104.28		000	N
79200	26	62.57	62.57		000	N
79200	TC	62.57	62.57		000	N
79200		125.14	125.14		000	N
79300	26	50.55	50.55		000	N
79300	TC	61.21	61.21		000	N
79300		111.76	111.76		000	N
79400	26	61.66	61.66		000	N
79400	TC	62.57	62.57		000	N
79400		124.23	124.23		000	N
79403	26	73.45	73.45	PA	000	N
79403	TC	100.88	100.88	PA	000	N
79403		174.33	174.33	PA	000	N
79420	26	46.70	46.70		000	N
79420	TC	56.45	56.45		000	N
79420		103.38	103.38		000	N
79440	TC	62.57	62.57		000	N
79440	26	63.48	63.48		000	N
79440		126.05	126.05		000	N
79900		#	#		000	N
79999		B.R.	B.R.		000	N
79999	26	B.R.	B.R.		000	N
79999	TC	B.R.	B.R.		000	N
80048		7.12	7.12		000	N
80050		36.80	36.80		000	N
80051		7.12	7.12		000	N
80053		9.50	9.50		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
80055		53.94	53.94		000	N	80416		146.95	146.95		000	N
80061		14.92	14.92		000	N	80417		48.98	48.98		000	N
80069		7.12	7.12		000	N	80418		624.21	624.21		000	N
80074		53.03	53.03		000	N	80420		80.21	80.21		000	N
80076		7.12	7.12		000	N	80422		51.31	51.31		000	N
80100		16.20	16.20		000	N	80424		38.75	38.75		000	N
80101		15.33	15.33		000	N	80426		153.76	153.76		000	N
80102		14.75	14.75		000	N	80428		73.67	73.67		000	N
80103		B.R.	B.R.		000	N	80430		86.78	86.78		000	N
80150		16.78	16.78		000	N	80432		150.42	150.42		000	N
80152		19.93	19.93		000	N	80434		112.62	112.62		000	N
80154		20.59	20.59		000	N	80435		113.93	113.93		000	N
80156		16.21	16.21		000	N	80436		81.68	81.68		000	N
80157		14.76	14.76		000	N	80438		55.93	55.93		000	N
80158		20.11	20.11		000	N	80439		74.57	74.57		000	N
80160		19.17	19.17		000	N	80440		64.75	64.75		000	N
80162		14.78	14.78		000	N	80500		13.60	12.24		000	N
80164		15.09	15.09		000	N	80502		45.57	44.66		000	N
80166		17.26	17.26		000	N	81000		3.53	3.53		000	N
80168		18.20	18.20		000	N	81001		3.53	3.53		000	N
80170		18.25	18.25		000	N	81002		2.85	2.85		000	N
80172		18.14	18.14		000	N	81003		2.50	2.50		000	N
80173		16.21	16.21		000	N	81005		2.41	2.41		000	N
80174		19.17	19.17		000	N	81007		2.86	2.86		000	N
80176		16.35	16.35		000	N	81015		3.38	3.38		000	N
80178		7.36	7.36		000	N	81020		4.10	4.10		000	N
80182		15.09	15.09		000	N	81025		4.18	4.18		000	N
80184		12.76	12.76		000	N	81050		3.34	3.34		000	N
80185		14.76	14.76		000	N	81099		B.R.	B.R.		000	N
80186		15.33	15.33		000	N	82000		13.80	13.80		000	N
80188		18.47	18.47		000	N	82003		20.10	20.10		000	N
80190		18.66	18.66		000	N	82009		5.03	5.03		000	N
80192		18.66	18.66		000	N	82010		9.10	9.10		000	N
80194		16.25	16.25		000	N	82013		12.44	12.44		000	N
80196		7.91	7.91		000	N	82016		15.44	15.44		000	N
80197		15.28	15.28		000	N	82017		6.11	6.11		000	N
80198		15.76	15.76		000	N	82024		40.81	40.81		000	N
80200		17.95	17.95		000	N	82030		28.73	28.73		000	N
80201		13.28	13.28		000	N	82040		5.52	5.52		000	N
80202		15.09	15.09		000	N	82042		5.76	5.76		000	N
80299		15.25	15.25		000	N	82043		6.45	6.45		000	N
80400		36.31	36.31		000	N	82044		5.09	5.09		000	N
80402		96.80	96.80		000	N	82055		12.03	12.03		000	N
80406		87.14	87.14		000	N	82075		13.42	13.42		000	N
80408		139.75	139.75		000	N	82085		10.81	10.81		000	N
80410		89.45	89.45		000	N	82088		45.38	45.38		000	N
80412		353.82	353.82		000	N	82101		33.43	33.43		000	N
80414		57.51	57.51		000	N	82103		14.96	14.96		000	N
80415		62.23	62.23		000	N	82104		16.10	16.10		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
82105		18.68	18.68		000	N	82375		13.72	13.72		000	N
82106		18.68	18.68		000	N	82376		6.67	6.67		000	N
82108		28.37	28.37		000	N	82378		21.13	21.13		000	N
82120		1.86	1.86		000	N	82379		6.11	6.11		000	N
82127		15.44	15.44		000	N	82380		10.27	10.27		000	N
82128		15.44	15.44		000	N	82382		19.14	19.14		000	N
82131		18.79	18.79		000	N	82383		27.90	27.90		000	N
82135		18.33	18.33		000	N	82384		19.38	19.38		000	N
82136		6.11	6.11		000	N	82387		4.38	4.38		000	N
82139		6.11	6.11		000	N	82390		11.96	11.96		000	N
82140		16.23	16.23		000	N	82397		14.59	14.59		000	N
82143		7.66	7.66		000	N	82415		14.11	14.11		000	N
82145		17.31	17.31		000	N	82435		5.12	5.12		000	N
82150		7.22	7.22		000	N	82436		5.59	5.59		000	N
82154		32.11	32.11		000	N	82438		4.25	4.25		000	N
82157		32.60	32.60		000	N	82441		6.68	6.68		000	N
82160		27.85	27.85		000	N	82465		4.85	4.85		000	N
82163		22.86	22.86		000	N	82480		8.77	8.77		000	N
82164		16.25	16.25		000	N	82482		8.56	8.56		000	N
82172		17.26	17.26		000	N	82485		22.99	22.99		000	N
82175		16.16	16.16		000	N	82486		20.11	20.11		000	N
82180		11.01	11.01		000	N	82487		17.77	17.77		000	N
82190		13.61	13.61		000	N	82488		23.79	23.79		000	N
82205		12.76	12.76		000	N	82489		20.59	20.59		000	N
82232		18.02	18.02		000	N	82491		20.11	20.11		000	N
82239		19.08	19.08		000	N	82492		20.11	20.11		000	N
82240		29.59	29.59		000	N	82495		22.59	22.59		000	N
82247		5.14	5.14		000	N	82507		30.45	30.45		000	N
82248		5.14	5.14		000	N	82520		16.87	16.87		000	N
82252		5.06	5.06		000	N	82523		20.81	20.81		000	N
82261		6.11	6.11		000	N	82525		12.03	12.03		000	N
82270		3.62	3.62		000	N	82528		25.07	25.07		000	N
82273		3.62	3.62		000	N	82530		18.61	18.61		000	N
82274		14.42	14.42		000	N	82533		18.16	18.16		000	N
82286		7.67	7.67		000	N	82540		5.16	5.16		000	N
82300		25.77	25.77		000	N	82541		20.11	20.11		000	N
82306		32.96	32.96		000	N	82542		20.11	20.11		000	N
82307		35.88	35.88		000	N	82543		20.11	20.11		000	N
82308		29.82	29.82		000	N	82544		20.11	20.11		000	N
82310		5.74	5.74		000	N	82550		7.25	7.25		000	N
82330		15.21	15.21		000	N	82552		14.91	14.91		000	N
82331		5.76	5.76		000	N	82553		12.86	12.86		000	N
82340		6.72	6.72		000	N	82554		13.21	13.21		000	N
82355		12.89	12.89		000	N	82565		5.71	5.71		000	N
82360		14.34	14.34		000	N	82570		5.76	5.76		000	N
82365		14.35	14.35		000	N	82575		10.52	10.52		000	N
82370		13.96	13.96		000	N	82585		9.53	9.53		000	N
82373		20.11	20.11		000	N	82595		7.20	7.20		000	N
82374		5.44	5.44		000	N	82600		21.61	21.61		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
82607		16.78	16.78		000	N
82608		15.95	15.95		000	N
82615		5.48	5.48		000	N
82626		28.14	28.14		000	N
82627		24.76	24.76		000	N
82633		18.45	18.45		000	N
82634		22.68	22.68		000	N
82638		13.64	13.64		000	N
82646		22.99	22.99		000	N
82649		28.62	28.62		000	N
82651		28.75	28.75		000	N
82652		42.86	42.86		000	N
82654		15.41	15.41		000	N
82657		20.11	20.11		000	N
82658		20.11	20.11		000	N
82664		18.14	18.14		000	N
82666		23.92	23.92		000	N
82668		20.93	20.93		000	N
82670		31.11	31.11		000	N
82671		35.97	35.97		000	N
82672		24.15	24.15		000	N
82677		26.93	26.93		000	N
82679		22.42	22.42		000	N
82690		19.25	19.25		000	N
82693		10.21	10.21		000	N
82696		26.26	26.26		000	N
82705		5.18	5.18		000	N
82710		18.71	18.71		000	N
82715		3.10	3.10		000	N
82725		10.98	10.98		000	N
82726		20.11	20.11		000	N
82728		15.17	15.17		000	N
82731		71.72	71.72		000	N
82735		20.65	20.65		000	N
82742		22.05	22.05		000	N
82746		16.37	16.37		000	N
82747		19.29	19.29		000	N
82757		19.32	19.32		000	N
82759		23.92	23.92		000	N
82760		12.47	12.47		000	N
82775		23.46	23.46		000	N
82776		9.33	9.33		000	N
82784		10.35	10.35		000	N
82785		18.34	18.34		000	N
82787		4.68	4.68		000	N
82800		7.26	7.26		000	N
82803		13.57	13.57		000	N
82805		27.11	27.11		000	N
82810		9.72	9.72		000	N

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
82820		11.13	11.13		000	N
82926		4.34	4.34		000	N
82928		6.15	6.15		000	N
82938		19.70	19.70		000	N
82941		19.64	19.64		000	N
82943		15.92	15.92		000	N
82945		4.37	4.37		000	N
82946		16.78	16.78		000	N
82947		4.37	4.37		000	N
82948		3.53	3.53		000	N
82950		5.29	5.29		000	N
82951		14.34	14.34		000	N
82952		4.37	4.37		000	N
82953		16.86	16.86		000	N
82955		10.80	10.80		000	N
82960		6.75	6.75		000	N
82962		2.02	2.02		000	N
82963		23.92	23.92		000	N
82965		8.61	8.61		000	N
82975		16.36	16.36		000	N
82977		8.02	8.02		000	N
82978		15.87	15.87		000	N
82979		7.67	7.67		000	N
82980		20.40	20.40		000	N
82985		13.06	13.06		000	N
83001		19.06	19.06		000	N
83002		19.38	19.38		000	N
83003		18.42	18.42		000	N
83008		18.69	18.69		000	N
83010		14.01	14.01		000	N
83012		19.14	19.14		000	N
83013		75.01	75.01		000	N
83014		8.75	8.75		000	N
83015		20.97	20.97		000	N
83018		9.32	9.32		000	N
83020		11.20	11.20		000	N
83020	26	12.24	12.24		000	N
83021		20.11	20.11		000	N
83026		2.63	2.63		000	N
83030		9.21	9.21		000	N
83033		5.80	5.80		000	N
83036		10.81	10.81		000	N
83045		5.52	5.52		000	N
83050		8.15	8.15		000	N
83051		8.14	8.14		000	N
83055		5.48	5.48		000	N
83060		9.21	9.21		000	N
83065		7.67	7.67		000	N
83068		9.43	9.43		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
83069		4.39	4.39		000	N	83789		20.11	20.11		000	N
83070		5.29	5.29		000	N	83805		19.63	19.63		000	N
83071		7.66	7.66		000	N	83825		18.11	18.11		000	N
83080		6.11	6.11		000	N	83835		18.86	18.86		000	N
83088		32.88	32.88		000	N	83840		18.18	18.18		000	N
83090		18.79	18.79		000	N	83857		11.96	11.96		000	N
83150		7.79	7.79		000	N	83858		16.51	16.51		000	N
83491		19.50	19.50		000	N	83864		22.17	22.17		000	N
83497		14.35	14.35		000	N	83866		10.97	10.97		000	N
83498		30.25	30.25		000	N	83872		6.53	6.53		000	N
83499		28.07	28.07		000	N	83873		19.16	19.16		000	N
83500		20.79	20.79		000	N	83874		14.38	14.38		000	N
83505		27.07	27.07		000	N	83880		37.80	37.80		000	N
83516		12.85	12.85		000	N	83883		15.14	15.14		000	N
83518		9.44	9.44		000	N	83885		27.28	27.28		000	N
83519		14.13	14.13		000	N	83887		26.37	26.37		000	N
83520		14.42	14.42		000	N	83890		5.60	5.60		000	N
83525		12.74	12.74		000	N	83891		5.60	5.60		000	N
83527		14.42	14.42		000	N	83892		5.60	5.60		000	N
83528		17.71	17.71		000	N	83893		5.60	5.60		000	N
83540		7.21	7.21		000	N	83894		5.60	5.60		000	N
83550		9.73	9.73		000	N	83896		5.60	5.60		000	N
83570		9.30	9.30		000	N	83897		5.60	5.60		000	N
83582		15.44	15.44		000	N	83898		23.42	23.42		000	N
83586		14.26	14.26		000	N	83901		23.42	23.42		000	N
83593		29.29	29.29		000	N	83902		12.01	12.01		000	N
83605		11.89	11.89		000	N	83903		23.42	23.42		000	N
83615		6.73	6.73		000	N	83904		23.42	23.42		000	N
83625		14.25	14.25		000	N	83905		23.42	23.42		000	N
83632		22.51	22.51		000	N	83906		23.42	23.42		000	N
83633		6.13	6.13		000	N	83912		5.60	5.60		000	N
83634		12.83	12.83		000	N	83912	26	12.02	12.02		000	N
83655		13.48	13.48		000	N	83915		12.42	12.42		000	N
83661		19.38	19.38		000	N	83916		15.53	15.53		000	N
83662		21.06	21.06		000	N	83918		23.00	23.00		000	N
83663		21.06	21.06		000	N	83919		18.33	18.33		000	N
83664		21.06	21.06		000	N	83921		18.33	18.33		000	N
83670		10.20	10.20		000	N	83925		21.67	21.67		000	N
83690		7.67	7.67		000	N	83930		7.36	7.36		000	N
83715		12.54	12.54		000	N	83935		7.15	7.15		000	N
83716		7.15	7.15		000	N	83937		33.24	33.24		000	N
83718		9.12	9.12		000	N	83945		14.34	14.34		000	N
83719		12.96	12.96		000	N	83950		71.72	71.72		000	N
83721		10.62	10.62		000	N	83970		45.96	45.96		000	N
83727		19.14	19.14		000	N	83986		3.20	3.20		000	N
83735		7.46	7.46		000	N	83992		16.37	16.37		000	N
83775		8.21	8.21		000	N	84022		14.14	14.14		000	N
83785		27.38	27.38		000	N	84030		5.94	5.94		000	N
83788		20.11	20.11		000	N	84035		2.34	2.34		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
84060		7.36	7.36		000	N
84061		8.81	8.81		000	N
84066		10.76	10.76		000	N
84075		5.76	5.76		000	N
84078		8.13	8.13		000	N
84080		16.47	16.47		000	N
84081		18.40	18.40		000	N
84085		7.51	7.51		000	N
84087		11.49	11.49		000	N
84100		5.28	5.28		000	N
84105		5.76	5.76		000	N
84106		4.77	4.77		000	N
84110		9.01	9.01		000	N
84119		9.59	9.59		000	N
84120		16.38	16.38		000	N
84126		16.47	16.47		000	N
84127		12.98	12.98		000	N
84132		5.12	5.12		000	N
84133		4.79	4.79		000	N
84134		16.24	16.24		000	N
84135		21.30	21.30		000	N
84138		21.09	21.09		000	N
84140		23.03	23.03		000	N
84143		25.42	25.42		000	N
84144		22.90	22.90		000	N
84146		21.58	21.58		000	N
84150		9.74	9.74		000	N
84152		20.48	20.48		000	N
84153		20.48	20.48		000	N
84154		20.48	20.48		000	N
84155		4.08	4.08		000	N
84156		4.08	4.08		000	N
84157		4.08	4.08		000	N
84160		5.76	5.76		000	N
84165		11.96	11.96		000	N
84165	26	12.24	12.24		000	N
84181	26	11.79	11.79		000	N
84181		18.97	18.97		000	N
84182	26	12.47	12.24		000	N
84182		20.04	20.04		000	N
84202		15.98	15.98		000	N
84203		9.59	9.59		000	N
84206		19.84	19.84		000	N
84207		19.26	19.26		000	N
84210		12.09	12.09		000	N
84220		10.50	10.50		000	N
84228		12.96	12.96		000	N
84233		71.72	71.72		000	N
84234		72.24	72.24		000	N
84235		58.28	58.28		000	N
84238		40.72	40.72		000	N
84244		24.49	24.49		000	N
84252		5.18	5.18		000	N
84255		28.43	28.43		000	N
84260		34.49	34.49		000	N
84270		24.20	24.20		000	N
84275		9.01	9.01		000	N
84285		26.22	26.22		000	N
84295		5.36	5.36		000	N
84300		5.41	5.41		000	N
84302		5.41	5.41		000	N
84305		23.67	23.67		000	N
84307		20.36	20.36		000	N
84311		7.79	7.79		000	N
84315		1.86	1.86		000	N
84375		4.26	4.26		000	N
84376		6.13	6.13		000	N
84377		6.13	6.13		000	N
84378		12.83	12.83		000	N
84379		12.83	12.83		000	N
84392		5.29	5.29		000	N
84402		28.35	28.35		000	N
84403		28.76	28.76		000	N
84425		23.65	23.65		000	N
84430		11.82	11.82		000	N
84432		17.88	17.88		000	N
84436		7.66	7.66		000	N
84437		5.80	5.80		000	N
84439		9.74	9.74		000	N
84442		7.79	7.79		000	N
84443		18.64	18.64		000	N
84445		56.63	56.63		000	N
84446		15.79	15.79		000	N
84449		20.04	20.04		000	N
84450		5.75	5.75		000	N
84460		5.90	5.90		000	N
84466		14.22	14.22		000	N
84478		6.41	6.41		000	N
84479		7.20	7.20		000	N
84480		15.79	15.79		000	N
84481		8.08	8.08		000	N
84482		17.55	17.55		000	N
84484		10.96	10.96		000	N
84485		8.36	8.36		000	N
84488		8.13	8.13		000	N
84490		8.47	8.47		000	N
84510		6.73	6.73		000	N
84512		8.58	8.58		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
84520		4.39	4.39		000	N	85230		15.53	15.53		000	N
84525		1.86	1.86		000	N	85240		19.94	19.94		000	N
84540		5.18	5.18		000	N	85244		22.74	22.74		000	N
84545		6.93	6.93		000	N	85245		25.55	25.55		000	N
84550		5.03	5.03		000	N	85246		25.55	25.55		000	N
84560		5.29	5.29		000	N	85247		25.55	25.55		000	N
84577		13.89	13.89		000	N	85250		18.14	18.14		000	N
84578		3.62	3.62		000	N	85260		19.94	19.94		000	N
84580		4.57	4.57		000	N	85270		18.14	18.14		000	N
84583		5.59	5.59		000	N	85280		21.55	21.55		000	N
84585		17.26	17.26		000	N	85290		18.14	18.14		000	N
84586		39.35	39.35		000	N	85291		9.90	9.90		000	N
84588		37.80	37.80		000	N	85292		21.09	21.09		000	N
84590		12.91	12.91		000	N	85293		21.09	21.09		000	N
84591		12.91	12.91		000	N	85300		13.19	13.19		000	N
84597		15.26	15.26		000	N	85301		12.04	12.04		000	N
84600		17.89	17.89		000	N	85302		13.39	13.39		000	N
84620		13.19	13.19		000	N	85303		15.40	15.40		000	N
84630		11.78	11.78		000	N	85305		12.91	12.91		000	N
84681		23.17	23.17		000	N	85306		17.06	17.06		000	N
84702		16.76	16.76		000	N	85307		17.06	17.06		000	N
84703		8.36	8.36		000	N	85335		14.34	14.34		000	N
84830		4.18	4.18		000	N	85337		11.60	11.60		000	N
84999		7.17	7.17		000	N	85345		4.79	4.79		000	N
85002		5.01	5.01		000	N	85347		4.74	4.74		000	N
85004		7.20	7.20		000	N	85348		4.14	4.14		000	N
85007		3.83	3.83		000	N	85360		9.36	9.36		000	N
85008		3.83	3.83		000	N	85362		7.67	7.67		000	N
85009		4.14	4.14		000	N	85366		9.59	9.59		000	N
85013		2.64	2.64		000	N	85370		12.65	12.65		000	N
85014		2.64	2.64		000	N	85378		7.95	7.95		000	N
85018		2.64	2.64		000	N	85379		11.33	11.33		000	N
85025		8.66	8.66		000	N	85380		11.33	11.33		000	N
85027		7.20	7.20		000	N	85384		8.95	8.95		000	N
85032		4.79	4.79		000	N	85385		8.95	8.95		000	N
85041		3.35	3.35		000	N	85390		5.75	5.75		000	N
85044		4.79	4.79		000	N	85390	26	12.02	12.02		000	N
85045		5.59	5.59		000	N	85396		12.92	12.92	PA	000	N
85046		6.22	6.22		000	N	85400		9.85	9.85		000	N
85048		2.83	2.83		000	N	85410		8.58	8.58		000	N
85049		4.98	4.98		000	N	85415		12.45	12.45		000	N
85055		20.15	20.15	PA	000	N	85420		7.28	7.28		000	N
85060		15.19	15.19		000	N	85421		11.34	11.34		000	N
85097		62.12	31.51		000	N	85441		4.69	4.69		000	N
85130		13.25	13.25		000	N	85445		7.59	7.59		000	N
85170		3.20	3.20		000	N	85460		2.79	2.79		000	N
85175		5.06	5.06		000	N	85461		7.38	7.38		000	N
85210		6.84	6.84		000	N	85475		9.63	9.63		000	N
85220		18.14	18.14		000	N	85520		14.58	14.58		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
85525		13.19	13.19		000	N
85530		15.79	15.79		000	N
85536		7.20	7.20		000	N
85540		9.58	9.58		000	N
85547		9.58	9.58		000	N
85549		19.38	19.38		000	N
85555		6.47	6.47		000	N
85557		14.87	14.87		000	N
85576	26	12.47	12.24		000	N
85576		23.92	23.92		000	N
85597		20.02	20.02		000	N
85610		4.38	4.38		000	N
85611		4.39	4.39		000	N
85612		10.66	10.66		000	N
85613		10.66	10.66		000	N
85635		9.74	9.74		000	N
85651		3.95	3.95		000	N
85652		3.00	3.00		000	N
85660		6.14	6.14		000	N
85670		6.43	6.43		000	N
85675		7.64	7.64		000	N
85705		10.50	10.50		000	N
85730		6.47	6.47		000	N
85732		7.20	7.20		000	N
85810		9.14	9.14		000	N
85999		B.R.	B.R.		000	N
86000		7.77	7.77		000	N
86001		5.82	5.82		000	N
86003		5.82	5.82		000	N
86005		5.53	5.53		000	N
86021		16.76	16.76		000	N
86022		16.72	16.72		000	N
86023		13.87	13.87		000	N
86038		13.46	13.46		000	N
86039		12.43	12.43		000	N
86060		8.13	8.13		000	N
86063		5.59	5.59		000	N
86077		32.64	31.51		000	N
86078		33.32	31.28		000	N
86079		33.32	31.51		000	N
86140		5.76	5.76		000	N
86141		14.42	14.42		000	N
86146		28.33	28.33		000	N
86147		28.33	28.33		000	N
86148		17.88	17.88		000	N
86155		3.89	3.89		000	N
86156		7.46	7.46		000	N
86157		8.98	8.98		000	N
86160		13.37	13.37		000	N
86161		13.37	13.37		000	N
86162		22.63	22.63		000	N
86171		6.47	6.47		000	N
86185		9.96	9.96		000	N
86215		14.75	14.75		000	N
86225		15.30	15.30		000	N
86226		12.31	12.31		000	N
86235		19.97	19.97		000	N
86243		13.26	13.26		000	N
86255	26	12.47	12.24		000	N
86255		13.42	13.42		000	N
86256	26	12.24	12.24		000	N
86256		13.42	13.42		000	N
86277		17.53	17.53		000	N
86280		9.12	9.12		000	N
86294		21.85	21.85		000	N
86300		23.17	23.17		000	N
86301		23.17	23.17		000	N
86304		23.17	23.17		000	N
86308		5.76	5.76		000	N
86309		5.48	5.48		000	N
86310		8.21	8.21		000	N
86316		23.17	23.17		000	N
86317		15.14	15.14		000	N
86318		14.42	14.42		000	N
86320	26	12.24	12.24		000	N
86320		24.96	24.96		000	N
86325	26	12.24	12.24		000	N
86325		24.90	24.90		000	N
86327	26	14.06	14.06		000	N
86327		25.26	25.26		000	N
86329		15.64	15.64		000	N
86331		13.35	13.35		000	N
86332		27.14	27.14		000	N
86334	26	12.24	12.24		000	N
86334		24.87	24.87		000	N
86336		B.R.	B.R.		000	N
86337		23.85	23.85		000	N
86340		16.78	16.78		000	N
86341		22.04	22.04		000	N
86343		13.88	13.88		000	N
86344		8.89	8.89		000	N
86353		54.59	54.59		000	N
86359		42.00	42.00		000	N
86360		52.32	52.32		000	N
86361		20.15	20.15		000	N
86376		16.20	16.20		000	N
86378		21.93	21.93		000	N
86382		18.83	18.83		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
86384		12.68	12.68		000	N	86684		17.65	17.65		000	N
86403		11.35	11.35		000	N	86687		9.34	9.34		000	N
86406		11.85	11.85		000	N	86688		15.60	15.60		000	N
86430		6.32	6.32		000	N	86689		27.05	27.05		000	N
86431		6.32	6.32		000	N	86692		19.11	19.11		000	N
86485		B.R.	B.R.		000	N	86694		14.65	14.65		000	N
86490		7.03	7.03		000	N	86695		14.69	14.69		000	N
86510		7.71	7.71		000	N	86696		21.56	21.56		000	N
86580		6.35	6.35		000	N	86698		13.92	13.92		000	N
86585		4.99	4.99		000	N	86701		9.89	9.89		000	N
86586		B.R.	B.R.		000	N	86702		15.05	15.05		000	N
86590		12.28	12.28		000	N	86703		15.28	15.28		000	N
86592		4.75	4.75		000	N	86704		13.42	13.42		000	N
86593		4.91	4.91		000	N	86705		13.10	13.10		000	N
86602		11.33	11.33		000	N	86706		11.96	11.96		000	N
86603		14.33	14.33		000	N	86707		12.88	12.88		000	N
86606		16.76	16.76		000	N	86708		13.80	13.80		000	N
86609		14.35	14.35		000	N	86709		12.54	12.54		000	N
86611		11.33	11.33		000	N	86710		15.10	15.10		000	N
86612		14.37	14.37		000	N	86713		17.05	17.05		000	N
86615		14.69	14.69		000	N	86717		13.64	13.64		000	N
86617		17.25	17.25		000	N	86720		14.69	14.69		000	N
86618		18.97	18.97		000	N	86723		14.69	14.69		000	N
86619		14.90	14.90		000	N	86727		14.33	14.33		000	N
86622		9.95	9.95		000	N	86729		13.30	13.30		000	N
86625		14.61	14.61		000	N	86732		14.69	14.69		000	N
86628		13.37	13.37		000	N	86735		14.53	14.53		000	N
86631		13.17	13.17		000	N	86738		14.75	14.75		000	N
86632		14.14	14.14		000	N	86741		14.69	14.69		000	N
86635		12.78	12.78		000	N	86744		14.69	14.69		000	N
86638		13.50	13.50		000	N	86747		16.74	16.74		000	N
86641		16.05	16.05		000	N	86750		13.61	13.61		000	N
86644		14.65	14.65		000	N	86753		13.80	13.80		000	N
86645		18.76	18.76		000	N	86756		14.35	14.35		000	N
86648		13.61	13.61		000	N	86757		21.56	21.56		000	N
86651		14.69	14.69		000	N	86759		14.69	14.69		000	N
86652		14.69	14.69		000	N	86762		14.65	14.65		000	N
86653		14.69	14.69		000	N	86765		14.35	14.35		000	N
86654		14.69	14.69		000	N	86768		11.48	11.48		000	N
86658		14.51	14.51		000	N	86771		14.69	14.69		000	N
86663		14.61	14.61		000	N	86774		9.68	9.68		000	N
86664		17.04	17.04		000	N	86777		14.65	14.65		000	N
86665		20.20	20.20		000	N	86778		16.04	16.04		000	N
86666		11.33	11.33		000	N	86781		14.74	14.74		000	N
86668		11.58	11.58		000	N	86784		13.99	13.99		000	N
86671		8.51	8.51		000	N	86787		14.35	14.35		000	N
86674		16.39	16.39		000	N	86790		14.35	14.35		000	N
86677		16.16	16.16		000	N	86793		14.69	14.69		000	N
86682		14.48	14.48		000	N	86800		17.71	17.71		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
86803		15.89	15.89		000	N	86999		12.99	12.99		000	N
86804		17.25	17.25		000	N	87001		5.80	5.80		000	N
86805		24.00	24.00		000	N	87003		18.75	18.75		000	N
86806		19.38	19.38		000	N	87015		7.44	7.44		000	N
86807		23.27	23.27		000	N	87040		11.49	11.49		000	N
86808		14.65	14.65		000	N	87045		10.50	10.50		000	N
86812		28.74	28.74		000	N	87046		10.50	10.50		000	N
86813		64.57	64.57		000	N	87070		9.59	9.59		000	N
86816		31.02	31.02		000	N	87071		10.50	10.50		000	N
86817		71.69	71.69		000	N	87073		10.50	10.50		000	N
86821		62.87	62.87		000	N	87075		10.54	10.54		000	N
86822		40.70	40.70		000	N	87076		9.00	9.00		000	N
86849		B.R.	B.R.		000	N	87077		9.00	9.00		000	N
86850		7.74	7.74		000	N	87081		7.38	7.38		000	N
86860		B.R.	B.R.		000	N	87084		9.59	9.59		000	N
86870		B.R.	B.R.		000	N	87086		8.99	8.99		000	N
86880		5.98	5.98		000	N	87088		7.15	7.15		000	N
86885		6.37	6.37		000	N	87101		8.58	8.58		000	N
86886		5.76	5.76		000	N	87102		9.36	9.36		000	N
86890		112.03	112.03		000	N	87103		10.04	10.04		000	N
86891		B.R.	B.R.		000	N	87106		11.49	11.49		000	N
86900		3.32	3.32		000	N	87107		11.49	11.49		000	N
86901		3.32	3.32		000	N	87109		12.03	12.03		000	N
86903		10.51	10.51		000	N	87110		21.81	21.81		000	N
86904		10.58	10.58		000	N	87116		12.03	12.03		000	N
86905		3.89	3.89		000	N	87118		12.19	12.19		000	N
86906		8.28	8.28		000	N	87140		6.21	6.21		000	N
86910		#	#		000	N	87143		13.96	13.96		000	N
86911		#	#		000	N	87147		5.76	5.76		000	N
86920		B.R.	B.R.		000	N	87149		22.33	22.33		000	N
86921		B.R.	B.R.		000	N	87152		5.83	5.83		000	N
86922		B.R.	B.R.		000	N	87158		5.83	5.83		000	N
86927		B.R.	B.R.		000	N	87164	26	11.34	11.34		000	N
86930		B.R.	B.R.		000	N	87164		11.96	11.96		000	N
86931		B.R.	B.R.		000	N	87166		5.18	5.18		000	N
86932		B.R.	B.R.		000	N	87168		4.75	4.75		000	N
86940		9.13	9.13		000	N	87169		4.75	4.75		000	N
86941		13.49	13.49		000	N	87172		4.75	4.75		000	N
86945		B.R.	B.R.		000	N	87176		5.80	5.80		000	N
86950		3.66	3.66		000	N	87177		9.91	9.91		000	N
86965		B.R.	B.R.		000	N	87181		5.29	5.29		000	N
86970		B.R.	B.R.		000	N	87184		7.68	7.68		000	N
86971		B.R.	B.R.		000	N	87185		5.29	5.29		000	N
86972		B.R.	B.R.		000	N	87186		9.63	9.63		000	N
86975		B.R.	B.R.		000	N	87187		11.54	11.54		000	N
86976		B.R.	B.R.		000	N	87188		7.39	7.39		000	N
86977		B.R.	B.R.		000	N	87190		6.30	6.30		000	N
86978		B.R.	B.R.		000	N	87197		16.73	16.73		000	N
86985		B.R.	B.R.		000	N	87205		4.75	4.75		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
87206		5.98	5.98		000	N	87390		19.65	19.65		000	N
87207		6.67	6.67		000	N	87391		19.65	19.65		000	N
87207	26	12.47	12.24		000	N	87400		13.36	13.36		000	N
87210		4.75	4.75		000	N	87420		13.36	13.36		000	N
87220		4.75	4.75		000	N	87425		13.36	13.36		000	N
87230		21.99	21.99		000	N	87427		13.36	13.36		000	N
87250		21.34	21.34		000	N	87430		13.36	13.36		000	N
87252		29.03	29.03		000	N	87449		13.36	13.36		000	N
87253		22.49	22.49		000	N	87450		10.67	10.67		000	N
87254		21.34	21.34		000	N	87451		10.67	10.67		000	N
87255		37.71	37.71		000	N	87470		22.33	22.33		000	N
87260		13.36	13.36		000	N	87471		39.08	39.08		000	N
87265		13.36	13.36		000	N	87472		47.70	47.70		000	N
87267		13.36	13.36		000	N	87475		22.33	22.33		000	N
87269		13.36	13.36		000	N	87476		39.08	39.08		000	N
87270		13.36	13.36		000	N	87477		47.70	47.70		000	N
87271		13.36	13.36		000	N	87480		22.33	22.33		000	N
87272		13.36	13.36		000	N	87481		39.08	39.08		000	N
87273		13.36	13.36		000	N	87482		46.49	46.49		000	N
87274		13.36	13.36		000	N	87485		22.33	22.33		000	N
87275		13.36	13.36		000	N	87486		39.08	39.08		000	N
87276		13.36	13.36		000	N	87487		47.70	47.70		000	N
87277		13.36	13.36		000	N	87490		22.33	22.33		000	N
87278		13.36	13.36		000	N	87491		39.08	39.08		000	N
87279		13.36	13.36		000	N	87492		38.93	38.93		000	N
87280		13.36	13.36		000	N	87495		22.33	22.33		000	N
87281		13.36	13.36		000	N	87496		39.08	39.08		000	N
87283		13.36	13.36		000	N	87497		47.70	47.70		000	N
87285		13.36	13.36		000	N	87510		22.33	22.33		000	N
87290		13.36	13.36		000	N	87511		39.08	39.08		000	N
87299		13.36	13.36		000	N	87512		46.49	46.49		000	N
87300		13.36	13.36		000	N	87515		22.33	22.33		000	N
87301		13.36	13.36		000	N	87516		39.08	39.08		000	N
87320		13.36	13.36		000	N	87517		47.70	47.70		000	N
87324		13.36	13.36		000	N	87520		22.33	22.33		000	N
87327		13.36	13.36		000	N	87521		39.08	39.08		000	N
87328		13.36	13.36		000	N	87522		47.70	47.70		000	N
87329		13.36	13.36		000	N	87525		22.33	22.33		000	N
87332		13.36	13.36		000	N	87526		39.08	39.08		000	N
87335		13.36	13.36		000	N	87527		46.49	46.49		000	N
87336		13.36	13.36		000	N	87528		22.33	22.33		000	N
87337		13.36	13.36		000	N	87529		39.08	39.08		000	N
87338		13.36	13.36		000	N	87530		47.70	47.70		000	N
87339		13.36	13.36		000	N	87531		22.33	22.33		000	N
87340		11.50	11.50		000	N	87532		39.08	39.08		000	N
87341		11.50	11.50		000	N	87533		46.49	46.49		000	N
87350		12.83	12.83		000	N	87534		22.33	22.33		000	N
87380		18.28	18.28		000	N	87535		39.08	39.08		000	N
87385		13.36	13.36		000	N	87536		94.76	94.76		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
87537		22.33	22.33		000	N	88014		#	#		000	N
87538		39.08	39.08		000	N	88016		#	#		000	N
87539		47.70	47.70		000	N	88020		#	#		000	N
87540		22.33	22.33		000	N	88025		#	#		000	N
87541		39.08	39.08		000	N	88027		#	#		000	N
87542		46.49	46.49		000	N	88028		#	#		000	N
87550		22.33	22.33		000	N	88029		#	#		000	N
87551		39.08	39.08		000	N	88036		#	#		000	N
87552		47.70	47.70		000	N	88037		#	#		000	N
87555		22.33	22.33		000	N	88040		#	#		000	N
87556		39.08	39.08		000	N	88045		#	#		000	N
87557		47.70	47.70		000	N	88099		#	#		000	N
87560		22.33	22.33		000	N	88104	TC	11.79	11.79		000	N
87561		39.08	39.08		000	N	88104	26	18.82	18.82		000	N
87562		47.70	47.70		000	N	88104		30.60	30.60		000	N
87580		22.33	22.33		000	N	88106	TC	8.84	8.84		000	N
87581		39.08	39.08		000	N	88106	26	18.82	18.82		000	N
87582		46.49	46.49		000	N	88106		27.66	27.66		000	N
87590		22.33	22.33		000	N	88107	TC	14.96	14.96		000	N
87591		39.08	39.08		000	N	88107	26	25.84	25.84		000	N
87592		47.70	47.70		000	N	88107		40.81	40.81		000	N
87620		22.33	22.33		000	N	88108	TC	13.15	13.15		000	N
87621		39.08	39.08		000	N	88108	26	18.82	18.82		000	N
87622		46.49	46.49		000	N	88108		31.96	31.96		000	N
87650		22.33	22.33		000	N	88112	TC	34.01	34.01		000	N
87651		39.08	39.08		000	N	88112	26	39.67	39.67		000	N
87652		46.49	46.49		000	N	88112		73.68	73.68		000	N
87660		22.33	22.33		000	N	88125	TC	3.40	3.40		000	N
87797		22.33	22.33		000	N	88125	26	8.84	8.84		000	N
87798		39.08	39.08		000	N	88125		12.24	12.24		000	N
87799		47.70	47.70		000	N	88130		16.75	16.75		000	N
87800		44.66	44.66		000	N	88140		8.90	8.90		000	N
87801		78.16	78.16		000	N	88141		13.83	13.83		000	N
87802		13.36	13.36		000	N	88142		28.31	28.31		000	N
87803		13.36	13.36		000	N	88143		28.31	28.31		000	N
87804		13.36	13.36		000	N	88147		15.90	15.90		000	N
87810		13.36	13.36		000	N	88148		21.23	21.23		000	N
87850		13.36	13.36		000	N	88150		14.76	14.76		000	N
87880		13.36	13.36		000	N	88152		14.76	14.76		000	N
87899		13.36	13.36		000	N	88153		14.76	14.76		000	N
87901		286.67	286.67		000	N	88154		14.76	14.76		000	N
87902		286.67	286.67		000	N	88155		8.37	8.37		000	N
87903		544.13	544.13		000	N	88160	TC	16.32	16.32		000	N
87904		29.03	29.03		000	N	88160	26	16.78	16.78		000	N
87999		B.R.	B.R.		000	N	88160		33.10	33.10		000	N
88000		#	#		000	N	88161	TC	15.42	15.42		000	N
88005		#	#		000	N	88161	26	16.78	16.78		000	N
88007		#	#		000	N	88161		32.19	32.19		000	N
88012		#	#		000	N	88162	TC	8.16	8.16		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
88162	26	25.84	25.84		000	N
88162		34.01	34.01		000	N
88164		14.76	14.76		000	N
88165		14.76	14.76		000	N
88166		14.76	14.76		000	N
88167		14.76	14.76		000	N
88172	TC	9.29	9.29		000	N
88172	26	20.18	20.18		000	N
88172		29.47	29.47		000	N
88173	TC	26.75	26.75		000	N
88173	26	46.47	46.47		000	N
88173		73.22	73.22		000	N
88174		29.53	29.53		000	N
88175		36.61	36.61		000	N
88180	26	12.02	12.02		000	N
88180	TC	29.47	29.47		000	N
88180		41.49	41.49		000	N
88182	26	26.07	26.07		000	N
88182	TC	29.47	29.47		000	N
88182		55.31	55.31		000	N
88199		B.R.	B.R.		000	N
88199	26	B.R.	B.R.		000	N
88199	TC	B.R.	B.R.		000	N
88230		129.73	129.73		000	N
88233		156.71	156.71		000	N
88235		163.97	163.97		000	N
88237		140.65	140.65		000	N
88239		164.28	164.28		000	N
88240		#	#		000	N
88241		#	#		000	N
88245		165.76	165.76		000	N
88248		192.84	192.84		000	N
88249		192.84	192.84		000	N
88261		196.80	196.80		000	N
88262		138.79	138.79		000	N
88263		167.35	167.35		000	N
88264		138.79	138.79		000	N
88267		200.18	200.18		000	N
88269		185.21	185.21		000	N
88271		23.85	23.85		000	N
88272		29.82	29.82		000	N
88273		35.78	35.78		000	N
88274		38.76	38.76		000	N
88275		44.72	44.72		000	N
88280		27.95	27.95		000	N
88283		31.66	31.66		000	N
88285		21.15	21.15		000	N
88289		38.34	38.34		000	N
88291		18.59	18.59		000	N
88299		15.25	15.25		000	N
88300	26	2.95	2.95		000	N
88300	TC	5.67	5.67		000	N
88300		8.61	8.61		000	N
88302	26	4.53	4.53		000	N
88302	TC	14.74	14.74		000	N
88302		19.27	19.27		000	N
88304	26	7.48	7.48		000	N
88304	TC	17.91	17.91		000	N
88304		25.39	25.39		000	N
88305	26	25.16	25.16		000	N
88305	TC	32.87	32.87		000	N
88305		58.04	58.04		000	N
88307	TC	46.02	46.02		000	N
88307	26	53.27	53.27		000	N
88307		99.29	99.29		000	N
88309	TC	52.59	52.59		000	N
88309	26	76.62	76.62		000	N
88309		129.22	129.22		000	N
88311	TC	2.27	2.27		000	N
88311	26	8.16	8.16		000	N
88311		10.43	10.43		000	N
88312	26	18.14	18.14		000	N
88312	TC	25.62	25.62		000	N
88312		43.75	43.75		000	N
88313	26	8.16	8.16		000	N
88313	TC	22.67	22.67		000	N
88313		30.83	30.83		000	N
88314	26	15.19	15.19		000	N
88314	TC	16.10	16.10		000	N
88314		31.28	31.28		000	N
88318	26	14.06	14.06		000	N
88318	TC	14.06	14.06		000	N
88318		28.34	28.34		000	N
88319	26	17.68	17.68		000	N
88319	TC	38.31	38.31		000	N
88319		55.99	55.99		000	N
88321		49.19	43.30		000	N
88323	TC	19.95	19.95		000	N
88323	26	45.34	45.34		000	N
88323		65.06	65.06		000	N
88325		118.79	74.58		000	N
88329		29.92	22.44		000	N
88331	TC	11.34	11.34		000	N
88331	26	39.90	39.90		000	N
88331		51.23	51.23		000	N
88332	TC	5.89	5.89		000	N
88332	26	19.72	19.72		000	N
88332		25.62	25.62		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
88342	TC	22.90	22.90		000	N
88342	26	28.56	28.56		000	N
88342		51.23	51.23		000	N
88346	TC	24.94	24.94		000	N
88346	26	28.79	28.79		000	N
88346		53.73	53.73		000	N
88347	26	28.56	28.56		000	N
88347	TC	32.42	32.42		000	N
88347		60.98	60.98		000	N
88348	26	50.33	50.33		000	N
88348	TC	180.45	180.45		000	N
88348		230.78	230.78		000	N
88349	26	25.84	25.84		000	N
88349	TC	222.17	222.17		000	N
88349		248.01	248.01		000	N
88355	TC	42.39	42.39		000	N
88355	26	61.89	61.89		000	N
88355		104.06	104.06		000	N
88356	TC	37.86	37.86		000	N
88356	26	99.97	99.97		000	N
88356		137.83	137.83		000	N
88358	TC	4.53	4.53		000	N
88358	26	33.32	33.32		000	N
88358		37.86	37.86		000	N
88361	26	32.87	32.87		000	N
88361	TC	51.23	51.23		000	N
88361		84.11	84.11		000	N
88362	26	72.09	72.09		000	N
88362	TC	80.71	80.71		000	N
88362		152.80	152.80		000	N
88365	26	31.28	31.28		000	N
88365	TC	41.71	41.71		000	N
88365		72.77	72.77		000	N
88371	26	11.56	11.56		000	N
88371		13.78	13.78		000	N
88372	26	12.47	12.47		000	N
88372		20.67	20.67		000	N
88380		B.R.	B.R.	PA	000	N
88380	26	B.R.	B.R.	PA	000	N
88380	TC	B.R.	B.R.	PA	000	N
88399		B.R.	B.R.		000	N
88399	26	B.R.	B.R.		000	N
88399	TC	B.R.	B.R.		000	N
88400		5.14	5.14		000	N
89050		5.27	5.27		000	N
89051		6.14	6.14		000	N
89055		4.75	4.75		000	N
89060		7.96	7.96		000	N
89060	26	12.47	12.24		000	N

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
89100		50.55	19.04		000	N
89105		63.02	15.64		000	N
89125		4.81	4.81		000	N
89130		50.55	13.60		000	N
89132		38.31	5.89		000	N
89135		55.09	24.48		000	N
89136		41.71	7.03		000	N
89140		69.37	28.56		000	N
89141		82.29	27.88		000	N
89160		2.61	2.61		000	N
89190		5.29	5.29		000	N
89220		9.52	9.52		000	N
89225		2.61	2.61		000	N
89230		10.43	10.43		000	N
89235		2.96	2.96		000	N
89240		#	#		000	N
89250		#	#		000	N
89251		#	#		000	N
89253		#	#		000	N
89254		#	#		000	N
89255		#	#		000	N
89257		#	#		000	N
89258		#	#		000	N
89259		#	#		000	N
89260		#	#		000	N
89261		#	#		000	N
89264		#	#		000	N
89268		#	#		000	N
89272		#	#		000	N
89280		#	#		000	N
89281		#	#		000	N
89290		#	#		000	N
89291		#	#		000	N
89300		#	#		000	N
89310		#	#		000	N
89320		#	#		000	N
89321		Bundled	Bundled		000	N
89325		#	#		000	N
89329		#	#		000	N
89330		#	#		000	N
89335		#	#		000	N
89342		#	#		000	N
89343		#	#		000	N
89344		#	#		000	N
89346		#	#		000	N
89352		#	#		000	N
89353		#	#		000	N
89354		#	#		000	N
89356		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
90281		#	#		000	N
90283		#	#		000	N
90287		#	#		000	N
90288		#	#		000	N
90291		#	#		000	N
90296		#	#		000	N
90371		116.28	116.28		000	N
90375		65.18	65.18		000	N
90376		69.89	69.89		000	N
90378		597.35	597.34	PA	000	N
90379		#	#		000	N
90384		#	#		000	N
90385		#	#		000	N
90386		#	#		000	N
90389		#	#		000	N
90393		#	#		000	N
90396		96.32	96.32		000	N
90399		#	#		000	N
90471		5.00	5.00		000	N
90472		3.00	3.00		000	N
90473		#	#		000	N
90474		#	#		000	N
90476		#	#		000	N
90477		#	#		000	N
90581		#	#		000	N
90585		143.28	143.28		000	N
90586		151.49	151.49		000	N
90632		62.94	62.94		000	N
90633		26.66	26.66		000	N
90634		#	#		000	N
90636		83.33	83.33		000	N
90645		21.76	21.76		000	N
90646		36.82	36.82		000	N
90647		23.25	23.25		000	N
90648		21.78	21.78		000	N
90655		12.90	12.90		000	N
90656		9.00	9.00		000	N
90657		3.10	3.10		000	N
90658		9.00	9.00		000	N
90659		2.59	2.59		000	N
90660		#	#		000	N
90665		49.23	49.23		000	N
90669		65.47	65.47		000	N
90675		121.83	121.83		000	N
90676		67.04	67.04		000	N
90680		#	#		000	N
90690		36.84	36.84		000	N
90691		37.58	37.58		000	N
90692		2.07	2.07		000	N
90693		#	#		000	N
90698		#	#		000	N
90700		20.05	20.05		000	N
90701		18.21	18.21		000	N
90702		4.60	4.60		000	N
90703		12.86	12.86		000	N
90704		17.38	17.38		000	N
90705		13.45	13.45		000	N
90706		14.97	14.97		000	N
90707		34.93	34.93		000	N
90708		21.81	21.81		000	N
90710		#	#		000	N
90712		17.59	17.59		000	N
90713		23.00	23.00		000	N
90715		A.C.	A.C.		000	N
90716		57.86	57.86		000	N
90717		52.93	52.93		000	N
90718		10.31	10.31		000	N
90719		#	#		000	N
90720		33.63	33.63		000	N
90721		#	#		000	N
90723		#	#		000	N
90725		2.78	2.78		000	N
90727		#	#		000	N
90732		16.85	16.85		000	N
90733		58.66	58.66		000	N
90734		A.C.	A.C.	PA	000	N
90735		71.37	71.37		000	N
90740		100.41	100.41		000	N
90743		24.49	24.49		000	N
90744		24.49	24.49		000	N
90746		50.21	50.21		000	N
90747		100.41	100.41		000	N
90748		92.02	92.02		000	N
90749		#	#		000	N
90780		54.41	54.41		000	N
90781		15.19	15.19		000	N
90782		11.34	11.34		000	N
90783		11.56	11.56		000	N
90784		22.90	22.90		000	N
90788		10.20	10.20		000	N
90799		A.C..	A.C.		000	N
90801		91.59	86.37		000	N
90802		97.25	92.27		000	N
90804		39.45	36.95		000	N
90805		43.30	41.49		000	N
90806		59.17	56.90		000	N
90807		63.02	61.44		000	N
90808		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
90809		#	#		000	N
90810		42.17	40.35		000	N
90811		47.38	44.89		000	N
90812		63.93	60.53		000	N
90813		67.10	64.84		000	N
90814		#	#		000	N
90815		#	#		000	N
90816		39.67	39.67		000	N
90817		43.07	43.07		000	N
90818		59.62	59.62		000	N
90819		62.57	62.57		000	N
90821		#	#		000	N
90822		#	#		000	N
90823		42.62	42.62		000	N
90824		46.47	46.47		000	N
90826		63.25	63.25		000	N
90827		65.97	65.97		000	N
90828		#	#		000	N
90829		#	#		000	N
90845		54.86	54.18		000	N
90846		#	#		000	N
90847		70.05	68.69		000	N
90849		#	#		000	N
90853		19.27	18.82		000	N
90857		21.54	20.63		000	N
90862		31.06	29.24		000	N
90865		102.47	86.37		000	N
90870		61.66	61.66		000	N
90871		87.51	87.51		000	N
90875		#	#		000	N
90876		#	#		000	N
90880		#	#		000	N
90882		#	#		000	N
90885		Bundled	Bundled		000	N
90887		#	#		000	N
90889		Bundled	Bundled		000	N
90899		B.R.	B.R.		000	N
90901		#	#		000	N
90911		58.04	28.34		000	N
90918		428.24	428.24		000	N
90919		292.22	292.22		000	N
90920		256.40	256.40		000	N
90921		160.73	160.73		000	N
90922		13.60	13.60		000	N
90923		9.52	9.52		000	N
90924		8.39	8.39		000	N
90925		5.44	5.44		000	N
90935		43.75	43.75		000	N
90937		71.64	71.64		000	N

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
90939		B.R.	B.R.		000	N
90940		B.R.	B.R.		000	N
90945		46.02	46.02		000	N
90947		73.45	73.45		000	N
90989		B.R.	B.R.		000	N
90993		B.R.	B.R.		000	N
90997		75.26	75.26		000	N
90999		B.R.	B.R.		000	N
91000	TC	2.04	2.04		000	N
91000	26	23.12	23.12		000	N
91000		25.16	25.16		000	N
91010	26	39.45	39.45		000	N
91010	TC	53.27	53.27		000	N
91010		92.72	92.72		000	N
91011	26	47.38	47.38		000	N
91011	TC	62.34	62.34		000	N
91011		109.50	109.50		000	N
91012	26	46.02	46.02		000	N
91012	TC	66.20	66.20		000	N
91012		112.22	112.22		000	N
91020	26	44.89	44.89		000	N
91020	TC	57.36	57.36		000	N
91020		102.24	102.24		000	N
91030	26	29.02	29.02		000	N
91030	TC	47.83	47.83		000	N
91030		76.85	76.85		000	N
91032	26	38.09	38.09		000	N
91032	TC	85.69	85.69		000	N
91032		123.55	123.55		000	N
91033	26	41.03	41.03		000	N
91033	TC	87.05	87.05		000	N
91033		127.86	127.86		000	N
91052	26	25.16	25.16		000	N
91052	TC	44.21	44.21		000	N
91052		69.14	69.14		000	N
91055	26	28.34	28.34		000	N
91055	TC	48.51	48.51		000	N
91055		76.85	76.85		000	N
91060	TC	4.08	4.08		000	N
91060	26	13.83	13.83		000	N
91060		17.91	17.91		000	N
91065	26	6.35	6.35		000	N
91065	TC	43.75	43.75		000	N
91065		50.10	50.10		000	N
91100		32.42	32.42		000	N
91105		10.88	10.88		000	N
91110		#	#		000	N
91110	26	#	#		000	N
91110	TC	#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
91122	26	56.22	56.22		000	N
91122	TC	126.50	126.50		000	N
91122		182.72	182.72		000	N
91123		Bundled	Bundled		000	N
91132	26	17.00	17.00		000	N
91132		B.R.	B.R.		000	N
91132	TC	B.R.	B.R.		000	N
91133	26	21.31	21.31		000	N
91133		B.R.	B.R.		000	N
91133	TC	B.R.	B.R.		000	N
91299		B.R.	B.R.		000	N
91299	26	B.R.	B.R.		000	N
91299	TC	B.R.	B.R.		000	N
92002		42.39	28.34		000	N
92004		77.08	54.18		000	N
92012		38.77	21.99		000	N
92014		56.90	35.82	LE	000	N
92015		43.07	12.24	LE	000	N
92018		82.29	82.29		000	N
92019		43.30	43.30		000	N
92020		16.10	12.24		000	N
92060	TC	9.97	9.97		000	N
92060	26	22.44	22.44		000	N
92060		32.64	32.64		000	N
92065		#	#		000	N
92065	26	#	#		000	N
92065	TC	#	#		000	N
92070		40.81	23.35		000	N
92081	26	11.79	11.79		000	N
92081	TC	16.32	16.32		000	N
92081		28.11	28.11		000	N
92082	26	14.51	14.51		000	N
92082	TC	22.22	22.22		000	N
92082		36.73	36.73		000	N
92083	26	16.55	16.55		000	N
92083	TC	25.62	25.62		000	N
92083		42.17	42.17		000	N
92100		50.10	29.70		000	N
92120		42.62	26.07		000	N
92130		46.93	27.20		000	N
92135	26	11.79	11.79		000	N
92135	TC	14.28	14.28		000	N
92135		26.30	26.30		000	N
92136	26	18.14	18.14		000	N
92136	TC	35.59	35.59		000	N
92136		53.73	53.73		000	N
92140		33.10	16.32		000	N
92225		13.83	12.47		000	N
92226		12.47	11.11		000	N
92230		52.37	18.59		000	N
92235	26	27.20	27.20		000	N
92235	TC	59.85	59.85		000	N
92235		87.05	87.05		000	N
92240	26	36.50	36.50		000	N
92240	TC	150.98	150.98		000	N
92240		187.48	187.48		000	N
92250	26	14.74	14.74		000	N
92250	TC	35.14	35.14		000	N
92250		50.10	50.10		000	N
92260		11.34	6.80		000	N
92265	26	25.16	25.16		000	N
92265	TC	36.95	36.95		000	N
92265		62.12	62.12		000	N
92270	26	26.98	26.98		000	N
92270	TC	28.34	28.34		000	N
92270		55.31	55.31		000	N
92275	26	32.87	32.87		000	N
92275	TC	34.91	34.91		000	N
92275		68.01	68.01		000	N
92283	26	5.67	5.67		000	N
92283	TC	17.68	17.68		000	N
92283		23.35	23.35		000	N
92284	26	7.71	7.71		000	N
92284	TC	51.01	51.01		000	N
92284		58.72	58.72		000	N
92285	26	6.80	6.80		000	N
92285	TC	22.67	22.67		000	N
92285		29.47	29.47		000	N
92286	26	21.99	21.99		000	N
92286	TC	70.73	70.73		000	N
92286		92.72	92.72		000	N
92287		80.48	25.84		000	N
92310		53.05	37.63		000	N
92311		52.37	33.32		000	N
92312		55.99	40.58		000	N
92313		47.83	27.88		000	N
92314		#	#		000	N
92315		#	#		000	N
92316		#	#		000	N
92317		#	#		000	N
92325		#	#		000	N
92326		#	#		000	N
92330		#	#		000	N
92335		#	#		000	N
92340		24.80	24.80	LE	000	N
92341		27.98	27.98	LE	000	N
92342		29.80	29.80	LE	000	N
92352		24.80	24.80		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
92353		29.12	29.12		000	N
92354		205.62	205.62		000	N
92355		#	#		000	N
92358		#	#		000	N
92370		20.18	10.65		000	N
92371		14.51	14.51		000	N
92390		15.17	15.17		000	N
92391		#	#		000	N
92392		#	#		000	N
92393		#	#		000	N
92395		#	#		000	N
92396		#	#		000	N
92499		B.R.	B.R.		000	N
92499	26	B.R.	B.R.		000	N
92499	TC	B.R.	B.R.		000	N
92502		61.44	61.44		000	N
92504		15.42	6.35		000	N
92506		80.25	29.70		000	N
92507		38.09	17.68		000	N
92508		17.91	8.84		000	N
92510		82.97	54.18		000	N
92511		91.81	37.86		000	N
92512		37.63	17.00		000	N
92516		30.60	15.19		000	N
92520		29.47	26.75		000	N
92526		51.01	17.46		000	N
92531		Bundled	Bundled		000	N
92532		Bundled	Bundled		000	N
92533		Bundled	Bundled		000	N
92534		Bundled	Bundled		000	N
92541	26	13.83	13.83		000	N
92541	TC	18.14	18.14		000	N
92541		31.96	31.96		000	N
92542	26	11.34	11.34		000	N
92542	TC	21.08	21.08		000	N
92542		32.42	32.42		000	N
92543	26	3.63	3.63		000	N
92543	TC	11.11	11.11		000	N
92543		14.74	14.74		000	N
92544	26	8.84	8.84		000	N
92544	TC	16.78	16.78		000	N
92544		25.62	25.62		000	N
92545	26	7.93	7.93		000	N
92545	TC	15.87	15.87		000	N
92545		23.80	23.80		000	N
92546	26	9.75	9.75		000	N
92546	TC	38.54	38.54		000	N
92546		48.29	48.29		000	N
92547		27.43	27.43		000	N
92548		#	#		000	N
92548	26	#	#		000	N
92548	TC	#	#		000	N
92551		10.18	10.18		000	N
92552		10.88	10.88		000	N
92553		16.32	16.32		000	N
92555		9.29	9.29		000	N
92556		14.06	14.06		000	N
92557		29.47	29.47		000	N
92559		#	#		000	N
92560		#	#		000	N
92561		#	#		000	N
92562		#	#		000	N
92563		#	#		000	N
92564		#	#		000	N
92565		#	#		000	N
92567		12.92	12.92		000	N
92568		9.29	9.29		000	N
92569		9.97	9.97		000	N
92571		#	#		000	N
92572		#	#		000	N
92573		#	#		000	N
92575		#	#		000	N
92576		#	#		000	N
92577		#	#		000	N
92579		17.91	17.91		000	N
92582		17.91	17.91		000	N
92583		#	#		000	N
92584		60.98	60.98		000	N
92585	26	16.78	16.78		000	N
92585	TC	45.11	45.11		000	N
92585		61.89	61.89		000	N
92586		45.11	45.11		000	N
92587	26	4.76	4.76		000	N
92587	TC	31.96	31.96		000	N
92587		36.73	36.73		000	N
92588	26	12.24	12.24		000	N
92588	TC	36.05	36.05		000	N
92588		48.29	48.29		000	N
92589		13.15	13.15		000	N
92590		#	#		000	N
92591		#	#		000	N
92592		#	#		000	N
92593		#	#		000	N
92594		#	#		000	N
92595		#	#		000	N
92596		#	#		000	N
92597		59.17	30.83		000	N
92601		79.34	79.34		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
92602		55.31	55.31		000	N
92603		52.37	52.37		000	N
92604		34.91	34.91		000	N
92605		Bundled	Bundled		000	N
92606		Bundled	Bundled		000	N
92607		74.81	74.81		000	N
92608		16.32	16.32		000	N
92609		37.41	37.41		000	N
92610		80.25	80.25		000	N
92611		80.25	80.25		000	N
92612		92.49	45.57		000	N
92613		Bundled	Bundled		000	N
92614		85.47	44.21		000	N
92615		Bundled	Bundled		000	N
92616		119.47	66.42		000	N
92617		Bundled	Bundled		000	N
92700		B.R.	B.R.		000	N
92950		113.12	113.12		000	N
92953		10.65	10.65		000	N
92960		205.62	79.80		000	N
92961		155.97	155.97		000	N
92970		108.14	108.14		000	N
92971		60.98	60.98		000	N
92973		106.55	106.55		000	N
92974		98.39	98.39		000	N
92975		233.73	233.73		000	N
92977		193.60	193.60		000	N
92978	26	58.49	58.49		000	N
92978	TC	109.27	109.27		000	N
92978		167.76	167.76		000	N
92979	26	46.47	46.47		000	N
92979	TC	55.09	55.09		000	N
92979		101.56	101.56		000	N
92980		491.49	491.49		000	N
92981		136.47	136.47		000	N
92982		364.76	364.76		000	N
92984		97.25	97.25		000	N
92986		785.74	785.74		090	N
92987		816.12	816.12		090	N
92990		633.85	633.85		090	N
92992		B.R.	B.R.		090	Y
92993		B.R.	B.R.		090	Y
92995		401.03	401.03		000	N
92996		106.78	106.78		000	N
92997		397.18	397.18		000	N
92998		193.38	193.38		000	N
93000		16.10	16.10		000	N
93005		10.65	10.65		000	N
93010		5.44	5.44		000	N

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
93012		140.37	56.65		000	N
93014		16.55	16.55		000	N
93015		64.84	64.84		000	N
93016		14.28	14.28		000	N
93017		40.81	40.81		000	N
93018		9.75	9.75		000	N
93024	TC	27.20	27.20		000	N
93024	26	37.86	37.86		000	N
93024		64.84	64.84		000	N
93025		#	#		000	N
93025	26	#	#		000	N
93025	TC	#	#		000	N
93040		8.61	8.61		000	N
93041		3.63	3.63		000	N
93042		4.99	4.99		000	N
93224		99.29	99.29		000	N
93225		29.92	29.92		000	N
93226		52.82	52.82		000	N
93227		16.78	16.78		000	N
93230		105.87	105.87		000	N
93231		36.95	36.95		000	N
93232		52.37	52.37		000	N
93233		16.78	16.78		000	N
93235		76.85	76.85		000	N
93236		62.57	62.57		000	N
93237		14.28	14.28		000	N
93268		188.16	188.16		000	N
93270		29.92	29.92		000	N
93271		141.69	141.69		000	N
93272		16.55	16.55		000	N
93278	26	8.16	8.16		000	N
93278	TC	28.34	28.34		000	N
93278		36.50	36.50		000	N
93303	26	41.49	41.49		000	N
93303	TC	92.95	92.95		000	N
93303		134.43	134.43		000	N
93304	26	23.80	23.80		000	N
93304	TC	47.15	47.15		000	N
93304		70.96	70.96		000	N
93307	26	29.92	29.92		000	N
93307	TC	92.95	92.95		000	N
93307		122.87	122.87		000	N
93308	26	17.23	17.23		000	N
93308	TC	47.15	47.15		000	N
93308		64.38	64.38		000	N
93312	26	69.82	69.82		000	N
93312	TC	92.04	92.04		000	N
93312		162.09	162.09		000	N
93313		27.43	27.43		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
93314	26	40.13	40.13		000	N
93314	TC	92.04	92.04		000	N
93314		132.17	132.17		000	N
93315	TC	86.60	86.60		000	N
93315	26	88.64	88.64		000	N
93315		175.47	175.47		000	N
93316		28.11	28.11		000	N
93317	26	58.26	58.26		000	N
93317	TC	86.60	86.60		000	N
93317		144.86	144.86		000	N
93318	26	62.12	62.12		000	N
93318		B.R.	B.R.		000	N
93318	TC	B.R.	B.R.		000	N
93320	26	12.24	12.24		000	N
93320	TC	41.71	41.71		000	N
93320		53.95	53.95		000	N
93321	26	4.99	4.99		000	N
93321	TC	27.20	27.20		000	N
93321		32.19	32.19		000	N
93325	26	2.49	2.49		000	N
93325	TC	70.50	70.50		000	N
93325		73.00	73.00		000	N
93350	TC	42.85	42.85		000	N
93350	26	47.15	47.15		000	N
93350		90.00	90.00		000	N
93501	26	98.39	98.39		000	N
93501	TC	407.83	407.83		000	N
93501		506.22	506.22		000	N
93503		85.24	85.24		000	N
93505	TC	48.51	48.51		000	N
93505	26	143.05	143.05		000	N
93505		191.56	191.56		000	N
93508	26	145.31	145.31		000	N
93508	TC	301.51	301.51		000	N
93508		446.83	446.83		000	N
93510	26	153.02	153.02		000	N
93510	TC	891.61	891.61		000	N
93510		1,044.63	1,044.63		000	N
93511	26	175.92	175.92		000	N
93511	TC	868.03	868.03		000	N
93511		1,043.73	1,043.73		000	N
93514	26	240.08	240.08		000	N
93514	TC	868.03	868.03		000	N
93514		1,108.11	1,108.11		000	N
93524	26	238.49	238.49		000	N
93524	TC	1,134.41	1,134.41		000	N
93524		1,373.12	1,373.12		000	N
93526	26	207.20	207.20		000	N
93526	TC	1,165.69	1,165.69		000	N
93526		1,372.90	1,372.90		000	N
93527	26	249.82	249.82		000	N
93527	TC	1,134.41	1,134.41		000	N
93527		1,384.23	1,384.23		000	N
93528	26	307.41	307.41		000	N
93528	TC	1,134.41	1,134.41		000	N
93528		1,441.81	1,441.81		000	N
93529	26	166.85	166.85		000	N
93529	TC	1,134.41	1,134.41		000	N
93529		1,301.26	1,301.26		000	N
93530	26	145.54	145.54		000	N
93530	TC	407.83	407.83		000	N
93530		553.37	553.37		000	N
93531	26	281.79	281.79		000	N
93531	TC	1,165.69	1,165.69		000	N
93531		1,447.48	1,447.48		000	N
93532	26	336.20	336.20		000	N
93532	TC	1,134.41	1,134.41		000	N
93532		1,470.60	1,470.60		000	N
93533	26	225.79	225.79		000	N
93533	TC	1,134.41	1,134.41		000	N
93533		1,360.20	1,360.20		000	N
93539		12.92	12.92		000	N
93540		13.83	13.83		000	N
93541		9.29	9.29		000	N
93542		9.29	9.29		000	N
93543		9.52	9.52		000	N
93544		8.16	8.16		000	N
93545		12.92	12.92		000	N
93555	26	26.52	26.52		000	N
93555	TC	150.53	150.53		000	N
93555		177.05	177.05		000	N
93556	26	27.20	27.20		000	N
93556	TC	236.90	236.90		000	N
93556		264.11	264.11		000	N
93561	TC	12.92	12.92		000	N
93561	26	15.42	15.42		000	N
93561		28.34	28.34		000	N
93562	26	4.99	4.99		000	N
93562	TC	8.16	8.16		000	N
93562		12.92	12.92		000	N
93571	26	58.94	58.94		000	N
93571	TC	109.27	109.27		000	N
93571		168.21	168.21		000	N
93572	26	48.06	48.06		000	N
93572	TC	55.09	55.09		000	N
93572		103.15	103.15		000	N
93580		598.49	598.49		000	N
93581		800.48	800.48		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
93600	TC	47.38	47.38		000	N
93600	26	69.60	69.60		000	N
93600		116.75	116.75		000	N
93602	TC	26.98	26.98		000	N
93602	26	69.82	69.82		000	N
93602		96.57	96.57		000	N
93603	TC	40.81	40.81		000	N
93603	26	69.37	69.37		000	N
93603		109.95	109.95		000	N
93609	TC	65.52	65.52		000	N
93609	26	169.57	169.57		000	N
93609		234.86	234.86		000	N
93610	TC	33.10	33.10		000	N
93610	26	99.07	99.07		000	N
93610		131.94	131.94		000	N
93612	TC	39.22	39.22		000	N
93612	26	99.07	99.07		000	N
93612		138.06	138.06		000	N
93613		233.50	233.50		000	N
93615	TC	7.71	7.71		000	N
93615	26	29.47	29.47		000	N
93615		37.18	37.18		000	N
93616	TC	7.71	7.71		000	N
93616	26	44.66	44.66		000	N
93616		52.37	52.37		000	N
93618	TC	95.67	95.67		000	N
93618	26	139.87	139.87		000	N
93618		235.54	235.54		000	N
93619	TC	185.89	185.89		000	N
93619	26	247.78	247.78		000	N
93619		433.68	433.68		000	N
93620	TC	203.12	203.12		000	N
93620	26	387.20	387.20		000	N
93620		590.33	590.33		000	N
93621	26	69.82	69.82		000	N
93621	TC	83.65	83.65		000	N
93621		153.48	153.48		000	N
93622	26	112.90	112.90		000	N
93622	TC	131.71	131.71		000	N
93622		244.61	244.61		000	N
93623	26	93.63	93.63		000	N
93623	TC	112.90	112.90		000	N
93623		206.52	206.52		000	N
93624	TC	48.06	48.06		000	N
93624	26	164.81	164.81		000	N
93624		212.87	212.87		000	N
93631	TC	152.80	152.80		000	N
93631	26	250.73	250.73		000	N
93631		403.30	403.30		000	N
93640	26	114.94	114.94		000	N
93640	TC	172.75	172.75		000	N
93640		287.68	287.68		000	N
93641	TC	172.75	172.75		000	N
93641	26	194.28	194.28		000	N
93641		367.03	367.03		000	N
93642	26	165.26	165.26		000	N
93642	TC	172.75	172.75		000	N
93642		337.78	337.78		000	N
93650		352.29	352.29		000	N
93651		532.97	532.97		000	N
93652		579.45	579.45		000	N
93660	TC	38.99	38.99		000	N
93660	26	61.21	61.21		000	N
93660		100.20	100.20		000	N
93662	26	97.93	97.93		000	N
93662		B.R.	B.R.		000	N
93662	TC	B.R.	B.R.		000	N
93668		#	#		000	N
93701		#	#		000	N
93701	26	#	#		000	N
93701	TC	#	#		000	N
93720		22.44	22.44		000	N
93721		17.46	17.46		000	N
93722		5.21	5.21		000	N
93724	TC	95.67	95.67		000	N
93724	26	158.92	158.92		000	N
93724		254.36	254.36		000	N
93727		17.46	17.46		000	N
93731	TC	12.02	12.02		000	N
93731	26	14.74	14.74		000	N
93731		26.75	26.75		000	N
93732	TC	12.47	12.47		000	N
93732	26	29.92	29.92		000	N
93732		42.39	42.39		000	N
93733	26	5.67	5.67		000	N
93733	TC	17.91	17.91		000	N
93733		23.58	23.58		000	N
93734	TC	8.39	8.39		000	N
93734	26	12.24	12.24		000	N
93734		20.63	20.63		000	N
93735	TC	10.88	10.88		000	N
93735	26	24.26	24.26		000	N
93735		34.91	34.91		000	N
93736	26	4.99	4.99		000	N
93736	TC	15.64	15.64		000	N
93736		20.40	20.40		000	N
93740		Bundled	Bundled		000	N
93740	26	Bundled	Bundled		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
93740	TC	Bundled	Bundled		000	N
93741	TC	16.10	16.10		000	N
93741	26	25.84	25.84		000	N
93741		41.94	41.94		000	N
93742	TC	16.10	16.10		000	N
93742	26	29.24	29.24		000	N
93742		45.34	45.34		000	N
93743	TC	17.68	17.68		000	N
93743	26	33.32	33.32		000	N
93743		51.01	51.01		000	N
93744	TC	16.10	16.10		000	N
93744	26	38.09	38.09		000	N
93744		54.18	54.18		000	N
93760		#	#		000	N
93762		#	#		000	N
93770		Bundled	Bundled		000	N
93770	26	Bundled	Bundled		000	N
93770	TC	Bundled	Bundled		000	N
93784		44.66	44.66		000	N
93786		21.08	21.08		000	N
93788		11.79	11.79		000	N
93790		11.79	11.79		000	N
93797		#	#		000	N
93798		#	#		000	N
93799		B.R.	B.R.		000	N
93799	26	B.R.	B.R.		000	N
93799	TC	B.R.	B.R.		000	N
93875	26	7.03	7.03		000	N
93875	TC	38.31	38.31		000	N
93875		45.34	45.34		000	N
93880	26	19.27	19.27		000	N
93880	TC	97.25	97.25		000	N
93880		116.75	116.75		000	N
93882	26	13.15	13.15		000	N
93882	TC	69.82	69.82		000	N
93882		82.97	82.97		000	N
93886	26	30.83	30.83		000	N
93886	TC	101.11	101.11		000	N
93886		131.94	131.94		000	N
93888	26	20.18	20.18		000	N
93888	TC	68.92	68.92		000	N
93888		89.09	89.09		000	N
93922	26	8.16	8.16		000	N
93922	TC	44.43	44.43		000	N
93922		52.59	52.59		000	N
93923	26	14.51	14.51		000	N
93923	TC	69.37	69.37		000	N
93923		83.88	83.88		000	N
93924	26	16.32	16.32		000	N
93924	TC	86.83	86.83		000	N
93924		103.15	103.15		000	N
93925	26	18.59	18.59		000	N
93925	TC	113.35	113.35		000	N
93925		132.17	132.17		000	N
93926	26	12.47	12.47		000	N
93926	TC	81.16	81.16		000	N
93926		93.85	93.85		000	N
93930	26	14.74	14.74		000	N
93930	TC	91.36	91.36		000	N
93930		106.10	106.10		000	N
93931	26	9.97	9.97		000	N
93931	TC	66.42	66.42		000	N
93931		76.40	76.40		000	N
93965	26	11.11	11.11		000	N
93965	TC	42.17	42.17		000	N
93965		53.05	53.05		000	N
93970	26	21.76	21.76		000	N
93970	TC	92.95	92.95		000	N
93970		114.71	114.71		000	N
93971	26	14.28	14.28		000	N
93971	TC	67.10	67.10		000	N
93971		81.39	81.39		000	N
93975	26	56.90	56.90		000	N
93975	TC	127.41	127.41		000	N
93975		184.53	184.53		000	N
93976	26	37.86	37.86		000	N
93976	TC	75.49	75.49		000	N
93976		113.58	113.58		000	N
93978	26	20.86	20.86		000	N
93978	TC	83.65	83.65		000	N
93978		104.74	104.74		000	N
93979	26	14.28	14.28		000	N
93979	TC	61.66	61.66		000	N
93979		75.94	75.94		000	N
93980	26	39.22	39.22		000	N
93980	TC	106.32	106.32		000	N
93980		145.54	145.54		000	N
93981	26	13.83	13.83		000	N
93981	TC	107.91	107.91		000	N
93981		121.74	121.74		000	N
93990	26	8.16	8.16		000	N
93990	TC	80.48	80.48		000	N
93990		88.64	88.64		000	N
94010	26	5.21	5.21		000	N
94010	TC	14.51	14.51		000	N
94010		19.72	19.72		000	N
94014		29.92	29.92		000	N
94015		13.83	13.83		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
94016		16.10	16.10		000	N
94060	26	9.52	9.52		000	N
94060	TC	24.48	24.48		000	N
94060		34.01	34.01		000	N
94070	26	18.36	18.36		000	N
94070	TC	65.97	65.97		000	N
94070		84.33	84.33		000	N
94150		Bundled	Bundled		000	N
94150	26	Bundled	Bundled		000	N
94150	TC	Bundled	Bundled		000	N
94200	26	3.40	3.40		000	N
94200	TC	9.75	9.75		000	N
94200		13.15	13.15		000	N
94240	26	7.93	7.93		000	N
94240	TC	15.19	15.19		000	N
94240		23.12	23.12		000	N
94250	26	3.40	3.40		000	N
94250	TC	14.28	14.28		000	N
94250		17.68	17.68		000	N
94260	26	4.08	4.08		000	N
94260	TC	12.92	12.92		000	N
94260		17.00	17.00		000	N
94350	26	7.93	7.93		000	N
94350	TC	16.10	16.10		000	N
94350		24.03	24.03		000	N
94360	26	7.93	7.93		000	N
94360	TC	14.96	14.96		000	N
94360		22.90	22.90		000	N
94370	26	7.93	7.93		000	N
94370	TC	14.96	14.96		000	N
94370		22.90	22.90		000	N
94375	26	9.52	9.52		000	N
94375	TC	12.02	12.02		000	N
94375		21.54	21.54		000	N
94400	26	12.02	12.02		000	N
94400	TC	17.68	17.68		000	N
94400		29.70	29.70		000	N
94450	26	12.24	12.24		000	N
94450	TC	13.15	13.15		000	N
94450		25.39	25.39		000	N
94620	26	19.50	19.50		000	N
94620	TC	52.59	52.59		000	N
94620		72.09	72.09		000	N
94621	TC	39.22	39.22		000	N
94621	26	43.30	43.30		000	N
94621		82.29	82.29		000	N
94640		7.71	7.71		000	N
94642		39.85	39.85		000	N
94656		55.99	36.27		000	N
94657		42.39	25.39		000	N
94660		33.10	23.58		000	N
94662		23.12	23.12		000	N
94664		8.16	8.16		000	N
94667		13.38	13.38		000	N
94668		10.88	10.88		000	N
94680	26	7.93	7.93		000	N
94680	TC	42.62	42.62		000	N
94680		50.55	50.55		000	N
94681	26	6.35	6.35		000	N
94681	TC	60.53	60.53		000	N
94681		66.88	66.88		000	N
94690	26	2.27	2.27		000	N
94690	TC	45.34	45.34		000	N
94690		47.61	47.61		000	N
94720	26	7.93	7.93		000	N
94720	TC	22.22	22.22		000	N
94720		30.15	30.15		000	N
94725	26	7.93	7.93		000	N
94725	TC	67.33	67.33		000	N
94725		75.26	75.26		000	N
94750	26	7.03	7.03		000	N
94750	TC	30.15	30.15		000	N
94750		37.18	37.18		000	N
94760		Bundled	Bundled		000	N
94761		Bundled	Bundled		000	N
94762		10.88	10.88		000	N
94770	26	4.53	4.53		000	N
94770	TC	38.54	38.54		000	N
94770		43.07	43.07		000	N
94772	26	79.64	79.64		000	N
94772	TC	97.32	97.32		000	N
94772		176.97	176.97		000	N
94799		B.R.	B.R.		000	N
94799	26	B.R.	B.R.		000	N
94799	TC	B.R.	B.R.		000	N
95004		2.49	2.49		000	N
95010		11.11	4.99		000	N
95015		7.03	4.99		000	N
95024		3.63	3.63		000	N
95027		3.63	3.63		000	N
95028		5.67	5.67		000	N
95044		4.99	4.99		000	N
95052		6.12	6.12		000	N
95056		4.31	4.31		000	N
95060		8.39	8.39		000	N
95065		4.99	4.99		000	N
95070		52.82	52.82		000	N
95071		67.56	67.56		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
95075		41.26	31.06		000	N
95078		#	#		000	N
95115		9.07	9.07		000	N
95117		11.79	11.79		000	N
95120		#	#		000	N
95125		#	#		000	N
95130		#	#		000	N
95131		#	#		000	N
95132		#	#		000	N
95133		#	#		000	N
95134		#	#		000	N
95144		5.89	2.04		000	N
95145		9.07	2.04		000	N
95146		11.56	2.27		000	N
95147		11.11	2.04		000	N
95148		14.74	2.27		000	N
95149		20.18	2.27		000	N
95165		6.12	2.04		000	N
95170		4.76	2.04		000	N
95180		81.39	65.29		000	N
95199		B.R.	B.R.		000	N
95250		#	#		000	N
95805	26	59.17	59.17		000	N
95805	TC	363.63	363.63		000	N
95805		422.80	422.80		000	N
95806		#	#		000	N
95806	26	#	#		000	N
95806	TC	#	#		000	N
95807	26	51.01	51.01		000	N
95807	TC	262.97	262.97		000	N
95807		313.98	313.98		000	N
95808	26	83.43	83.43		000	N
95808	TC	282.24	282.24		000	N
95808		365.67	365.67		000	N
95810	26	109.50	109.50		000	N
95810	TC	370.65	370.65		000	N
95810		480.15	480.15		000	N
95811	26	118.11	118.11		000	N
95811	TC	401.49	401.49		000	N
95811		519.60	519.60		000	N
95812	26	35.82	35.82		000	N
95812	TC	81.39	81.39		000	N
95812		116.98	116.98		000	N
95813	26	56.68	56.68		000	N
95813	TC	98.84	98.84		000	N
95813		155.52	155.52		000	N
95816	26	36.05	36.05		000	N
95816	TC	63.25	63.25		000	N
95816		99.29	99.29		000	N
95819	26	36.05	36.05		000	N
95819	TC	75.94	75.94		000	N
95819		111.76	111.76		000	N
95822	26	35.82	35.82		000	N
95822	TC	91.81	91.81		000	N
95822		127.41	127.41		000	N
95824	TC	9.97	9.97		000	N
95824	26	25.16	25.16		000	N
95824		35.14	35.14		000	N
95827	26	34.46	34.46		000	N
95827	TC	55.31	55.31		000	N
95827		89.77	89.77		000	N
95829	26	201.08	201.08		000	N
95829	TC	664.23	664.23		000	N
95829		865.31	865.31		000	N
95830		117.20	56.90		000	N
95831		14.28	9.52		000	N
95832		12.47	9.52		000	N
95833		21.08	16.10		000	N
95834		25.39	20.40		000	N
95851		12.24	5.67		000	N
95852		8.61	3.85		000	N
95857		26.30	17.68		000	N
95858	TC	9.75	9.75		000	N
95858	26	51.69	51.69		000	N
95858		61.44	61.44		000	N
95860	TC	24.03	24.03		000	N
95860	26	32.19	32.19		000	N
95860		56.22	56.22		000	N
95861	TC	18.14	18.14		000	N
95861	26	51.69	51.69		000	N
95861		69.82	69.82		000	N
95863	TC	22.67	22.67		000	N
95863	26	62.34	62.34		000	N
95863		85.01	85.01		000	N
95864	TC	43.30	43.30		000	N
95864	26	66.42	66.42		000	N
95864		109.72	109.72		000	N
95867	TC	14.06	14.06		000	N
95867	26	26.75	26.75		000	N
95867		40.81	40.81		000	N
95868	TC	17.00	17.00		000	N
95868	26	39.45	39.45		000	N
95868		56.45	56.45		000	N
95869	TC	5.44	5.44		000	N
95869	26	12.24	12.24		000	N
95869		17.68	17.68		000	N
95870	TC	5.44	5.44		000	N
95870	26	12.24	12.24		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
95870		17.68	17.68		000	N
95872	TC	14.74	14.74		000	N
95872	26	49.42	49.42		000	N
95872		64.16	64.16		000	N
95875	TC	24.03	24.03		000	N
95875	26	36.50	36.50		000	N
95875		60.53	60.53		000	N
95900	26	14.06	14.06		000	N
95900	TC	25.62	25.62		000	N
95900		39.67	39.67		000	N
95903	26	19.95	19.95		000	N
95903	TC	22.22	22.22		000	N
95903		42.17	42.17		000	N
95904	26	11.34	11.34		000	N
95904	TC	22.44	22.44		000	N
95904		33.78	33.78		000	N
95920	TC	31.28	31.28		000	N
95920	26	72.54	72.54		000	N
95920		103.83	103.83		000	N
95921	TC	8.84	8.84		000	N
95921	26	28.79	28.79		000	N
95921		37.63	37.63		000	N
95922	TC	8.84	8.84		000	N
95922	26	31.74	31.74		000	N
95922		40.58	40.58		000	N
95923	26	29.70	29.70		000	N
95923	TC	39.45	39.45		000	N
95923		69.14	69.14		000	N
95925	26	17.91	17.91		000	N
95925	TC	21.99	21.99		000	N
95925		39.90	39.90		000	N
95926	26	18.14	18.14		000	N
95926	TC	21.99	21.99		000	N
95926		40.13	40.13		000	N
95927	26	18.82	18.82		000	N
95927	TC	21.99	21.99		000	N
95927		40.58	40.58		000	N
95930	26	11.56	11.56		000	N
95930	TC	29.47	29.47		000	N
95930		41.03	41.03		000	N
95933	26	19.27	19.27		000	N
95933	TC	19.27	19.27		000	N
95933		38.54	38.54		000	N
95934	TC	5.44	5.44		000	N
95934	26	17.00	17.00		000	N
95934		22.44	22.44		000	N
95936	TC	5.44	5.44		000	N
95936	26	18.36	18.36		000	N
95936		23.80	23.80		000	N
95937	TC	8.16	8.16		000	N
95937	26	21.31	21.31		000	N
95937		29.47	29.47		000	N
95950	26	50.78	50.78		000	N
95950	TC	95.67	95.67		000	N
95950		146.45	146.45		000	N
95951	26	199.27	199.27		000	N
95951	TC	854.89	854.89		000	N
95951		1,054.84	1,054.84		000	N
95953	26	101.79	101.79		000	N
95953	TC	153.48	153.48		000	N
95953		255.04	255.04		000	N
95954	TC	75.26	75.26		000	N
95954	26	81.84	81.84		000	N
95954		157.33	157.33		000	N
95955	26	32.19	32.19		000	N
95955	TC	48.29	48.29		000	N
95955		80.48	80.48		000	N
95956	26	102.02	102.02		000	N
95956	TC	302.19	302.19		000	N
95956		404.21	404.21		000	N
95957	TC	41.49	41.49		000	N
95957	26	65.97	65.97		000	N
95957		107.23	107.23		000	N
95958	TC	42.39	42.39		000	N
95958	26	140.33	140.33		000	N
95958		182.95	182.95		000	N
95961	TC	31.28	31.28		000	N
95961	26	101.79	101.79		000	N
95961		133.07	133.07		000	N
95962	TC	31.28	31.28		000	N
95962	26	108.59	108.59		000	N
95962		139.87	139.87		000	N
95965	26	266.60	266.60		000	N
95965		B.R.	B.R.		000	N
95965	TC	B.R.	B.R.	PA	000	N
95966	26	133.53	133.53	PA	000	N
95966		B.R.	B.R.	PA	000	N
95966	TC	B.R.	B.R.	PA	000	N
95967	26	112.67	112.67	PA	000	N
95967		B.R.	B.R.	PA	000	N
95967	TC	B.R.	B.R.	PA	000	N
95970		14.74	14.28		000	N
95971		#	#		000	N
95972		#	#		000	N
95973		#	#		000	N
95974		100.88	100.88		000	N
95975		56.90	56.90		000	N
95990		35.37	35.37		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
95991		51.46	22.90		000	N
95999		21.71	21.71		000	N
96000		#	#		000	N
96001		#	#		000	N
96002		#	#		000	N
96003		#	#		000	N
96004		#	#		000	N
96100		#	#		000	N
96105		#	#		000	N
96110		#	#		000	N
96111		#	#		000	N
96115		#	#		000	N
96117		#	#		000	N
96150		#	#		000	N
96151		#	#		000	N
96152		#	#		000	N
96153		#	#		000	N
96154		#	#		000	N
96155		#	#		000	N
96400		29.70	29.70		000	N
96405		65.97	17.68		000	N
96406		89.55	25.39		000	N
96408		71.64	71.64		000	N
96410		100.65	100.65		000	N
96412		21.99	21.99		000	N
96414		124.91	124.91		000	N
96420		69.82	69.82		000	N
96422		124.23	124.23		000	N
96423		49.19	49.19		000	N
96425		113.80	113.80		000	N
96440		249.37	84.79		000	N
96445		247.10	78.66		000	N
96450		211.96	69.37		000	N
96520		95.21	95.21		000	N
96530		70.50	70.50		000	N
96542		134.89	48.51		000	N
96545		Bundled	Bundled		000	N
96549		B.R.	B.R.		000	N
96567		#	#		000	N
96570		#	#		000	N
96571		#	#		000	N
96900		11.34	11.34		000	N
96902		Bundled	Bundled		000	N
96910		25.16	25.16		000	N
96912		31.51	31.51		000	N
96913		42.62	42.62		000	N
96920		203.80	41.03		000	N
96921		206.07	41.71		000	N
96922		245.52	75.04		000	N
96999		B.R.	B.R.		000	N
97001		45.11	38.77		000	N
97002		23.80	19.50		000	N
97003		48.06	37.41		000	N
97004		#	#		000	N
97005		#	#		000	N
97006		#	#		000	N
97010		Bundled	Bundled		000	N
97012		9.07	9.07	LE	000	N
97014		8.61	8.61	LE	000	N
97016		8.61	8.61	LE	000	N
97018		4.08	4.08	LE	000	N
97020		2.95	2.95	LE	000	N
97022		9.07	9.07	LE	000	N
97024		3.63	3.63	LE	000	N
97026		2.95	2.95	LE	000	N
97028		3.63	3.63	LE	000	N
97032		9.52	9.52	LE	000	N
97033		12.70	12.70	LE	000	N
97034		8.61	8.61	LE	000	N
97035		7.48	7.48	LE	000	N
97036		14.06	14.06	LE	000	N
97039		7.03	7.03	LE	000	N
97110		17.46	17.46	LE	000	N
97112		17.46	17.46	LE	000	N
97113		19.95	19.95	LE	000	N
97116		14.96	14.96	LE	000	N
97124		13.38	13.38	LE	000	N
97139		9.52	9.52	LE	000	N
97140		16.10	16.10	LE	000	N
97150		10.65	10.65	LE	000	N
97504		18.59	18.59		000	N
97520		17.00	17.00	LE	000	N
97530		17.68	17.68	LE	000	N
97532		14.96	14.96	LE	000	N
97533		15.64	15.64	LE	000	N
97535		18.14	18.14	LE	000	N
97537		16.55	16.55	LE	000	N
97542		#	#		000	N
97545		#	#		000	N
97546		#	#		000	N
97601		23.58	23.58		000	N
97602		19.50	19.50		000	N
97703		15.42	15.42		000	N
97750		17.46	17.46		000	N
97755		21.08	21.08	PA	000	N
97780		#	#		000	N
97781		#	#		000	N
97799		B.R.	B.R.		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
97802		10.88	10.88		000	N
97803		10.88	10.88		000	N
97804		4.53	4.53		000	N
98925		17.91	13.60		000	N
98926		24.71	20.86		000	N
98927		32.19	27.43		000	N
98928		37.86	32.19		000	N
98929		43.53	36.50		000	N
98940		15.87	13.15		000	N
98941		21.99	19.27		000	N
98942		28.79	26.07		000	N
98943		#	#		000	N
99000		Bundled	Bundled		000	N
99001		Bundled	Bundled		000	N
99002		Bundled	Bundled		000	N
99024		Bundled	Bundled		000	N
99026		#	#		000	N
99027		#	#		000	N
99050		7.93	7.93		000	N
99052		11.34	11.34		000	N
99054		11.34	11.34		000	N
99056		Bundled	Bundled		000	N
99058		Bundled	Bundled		000	N
99070		Bundled	Bundled		000	N
99071		Bundled	Bundled		000	N
99075		10.00	10.00		000	N
99078		19.57	19.57		000	N
99080		Bundled	Bundled		000	N
99082		5.49	5.49		000	N
99090		Bundled	Bundled		000	N
99091		#	#		000	N
99100		Bundled	Bundled		000	N
99116		Bundled	Bundled		000	N
99135		Bundled	Bundled		000	N
99140		Bundled	Bundled		000	N
99141		Bundled	Bundled		000	N
99142		Bundled	Bundled		000	N
99170		80.71	53.05		000	N
99172		#	#		000	N
99173		Bundled	Bundled		000	N
99175		34.01	34.01		000	N
99183		164.58	72.32		000	N
99185		15.42	15.42		000	N
99186		49.19	49.19		000	N
99190		73.68	73.68		000	N
99191		45.11	45.11		000	N
99192		33.55	33.55		000	N
99195		23.12	23.12		000	N
99199		#	#		000	N
99201		24.25	15.75		000	N
99201	HA	33.57	21.58		000	N
99202		43.25	31.25		000	N
99202	HA	58.91	42.47		000	N
99203		64.25	47.75		000	N
99203	HA	88.37	65.42		000	N
99204		90.75	70.50		000	N
99204	HA	125.01	96.24		000	N
99205		115.25	93.75		000	N
99205	HA	157.89	127.07		000	N
99211		14.25	6.00		000	N
99211	HA	20.21	8.22		000	N
99212		25.25	15.75		000	N
99212	HA	35.28	21.58		000	N
99213		35.25	23.75		000	N
99213	HA	48.64	32.20		000	N
99214		55.00	38.75		000	N
99214	HA	75.35	52.40		000	N
99215		79.75	62.25		000	N
99215	HA	109.60	84.26		000	N
99217		42.39	42.39		000	N
99218		40.13	40.13		000	N
99219		66.88	66.88		000	N
99220		93.85	93.85		000	N
99221		40.58	40.58	EX*	000	N
99222		67.33	67.33	EX*	000	N
99223		93.85	93.85	EX*	000	N
99231		20.18	20.18		000	N
99232		33.32	33.32		000	N
99233		47.38	47.38		000	N
99234		83.43	83.43		000	N
99235		109.95	109.95		000	N
99236		136.93	136.93		000	N
99238		42.39	42.39		000	N
99239		57.81	57.81		000	N
99241		30.38	20.40		000	N
99242		55.31	41.94		000	N
99243		73.22	55.77		000	N
99244		103.38	82.52		000	N
99245		133.53	109.50		000	N
99251		21.54	21.54		000	N
99252		43.30	43.30		000	N
99253		58.94	58.94		000	N
99254		85.01	85.01		000	N
99255		116.98	116.98		000	N
99261		13.60	13.60		000	N
99262		27.20	27.20		000	N
99263		40.13	40.13		000	N
99271		23.58	14.51		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
99272		39.22	27.43		000	N
99273		53.73	38.54		000	N
99274		72.54	55.99		000	N
99275		92.27	73.90		000	N
99281		9.97	9.97		000	N
99282		16.55	16.55		000	N
99283		37.18	37.18		000	N
99284		57.58	57.58		000	N
99285		90.23	90.23		000	N
99288		#	#		000	N
99289		#	#		000	N
99290		#	#		000	N
99291		147.36	123.10		000	N
99292		65.52	61.66		000	N
99293		491.94	491.94		000	N
99294		243.70	243.70		000	N
99295		558.14	558.14		000	N
99296		245.06	245.06		000	N
99298		85.92	85.92		000	N
99299		80.71	80.71		000	N
99301		43.53	37.41		000	N
99302		59.40	50.10		000	N
99303		73.45	62.34		000	N
99311		24.71	18.59		000	N
99312		38.31	31.28		000	N
99313		52.37	43.98		000	N
99315		#	#		000	N
99316		#	#		000	N
99321		24.48	24.48		000	N
99322		34.23	34.23		000	N
99323		42.62	42.62		000	N
99331		21.31	21.31		000	N
99332		27.66	27.66		000	N
99333		33.78	33.78		000	N
99341		35.14	35.14		000	N
99342		51.23	51.23		000	N
99343		74.81	74.81		000	N
99344		98.16	98.16		000	N
99345		121.51	121.51		000	N
99347		26.98	26.98		000	N
99348		45.79	45.79		000	N
99349		70.96	70.96		000	N
99350		103.15	103.15		000	N
99354		58.72	56.68		000	N
99355		58.26	55.77		000	N
99356		54.41	54.41		000	N
99357		54.63	54.63		000	N
99358		Bundled	Bundled		000	N
99359		Bundled	Bundled		000	N
99360		27.20	27.20		000	N
99361		41.03	28.34		000	N
99362		72.32	56.45		000	N
99371		6.35	4.31		000	N
99372		12.70	8.61		000	N
99373		19.27	12.92		000	N
99374		Bundled	Bundled		000	N
99375		76.17	76.17		000	N
99377		Bundled	Bundled		000	N
99378		85.01	85.01		000	N
99379		Bundled	Bundled		000	N
99380		63.25	63.25		000	N
99381		75.65	46.48		000	N
99382		83.67	54.55		000	N
99383		87.07	57.95		000	N
99384		93.56	64.74		000	N
99385		95.77	66.28		000	N
99386		#	#		000	N
99387		#	#		000	N
99391		57.75	40.25		000	N
99392		66.29	48.28		000	N
99393		69.98	51.64		000	N
99394		76.65	58.00		000	N
99395		79.38	59.38		000	N
99396		#	#		000	N
99397		#	#		000	N
99401		25.39	15.42		000	N
99402		42.62	31.06		000	N
99403		#	#		000	N
99404		#	#		000	N
99411		#	#		000	N
99412		#	#		000	N
99420		#	#		000	N
99429		#	#		000	N
99431		54.80	54.80		000	N
99432		76.38	58.91		000	N
99433		28.77	28.77		000	N
99435		70.56	70.56		000	N
99436		45.79	45.79		000	N
99440		90.45	90.45		000	N
99450		#	#		000	N
99455		#	#		000	N
99456		#	#		000	N
99499		B.R.	B.R.		000	N
99500		#	#		000	N
99501		#	#		000	N
99502		#	#		000	N
99503		#	#		000	N
99504		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
99505		#	#		000	N
99506		#	#		000	N
99507		#	#		000	N
99509		#	#		000	N
99510		#	#		000	N
99511		#	#		000	N
99512		#	#		000	N
99600		#	#		000	N
99601		#	#		000	N
99602		#	#		000	N
0001F		#	#		000	N
0001T		B.R.	B.R.		000	N
0002F		#	#		000	N
0003F		#	#		000	N
0003T		#	#		000	N
0004F		#	#		000	N
0005F		#	#		000	N
0005T		B.R.	B.R.		000	N
0006F		#	#		000	N
0006T		B.R.	B.R.		000	N
0007F		#	#		000	N
0007T		B.R.	B.R.		000	N
0008F		#	#		000	N
0008T		B.R.	B.R.		000	N
0009F		#	#		000	N
0009T		B.R.	B.R.	PA	000	N
0010F		#	#		000	N
0010T		B.R.	B.R.	PA	000	N
0011F		#	#		000	N
0012T		B.R.	B.R.	PA	000	N
0013T		B.R.	B.R.	PA	000	N
0014T		#	#		000	N
0016T		#	#		000	N
0017T		#	#		000	N
0018T		#	#		000	N
0019T		#	#		000	N
0020T		#	#		000	N
0021T		#	#		000	N
0023T		288.18	288.18		000	N
0024T		#	#		000	N
0026T		#	#		000	N
0027T		B.R.	B.R.		000	N
0028T		#	#		000	N
0029T		#	#		000	N
0030T		#	#		000	N
0031T		#	#		000	N
0032T		#	#		000	N
0033T		B.R.	B.R.		000	N
0034T		B.R.	B.R.		000	N
0035T		B.R.	B.R.		000	N
0036T		B.R.	B.R.		000	N
0037T		B.R.	B.R.		000	N
0038T		B.R.	B.R.		000	N
0039T		B.R.	B.R.		000	N
0040T		B.R.	B.R.		000	N
0041T		#	#		000	N
0042T		#	#		000	N
0043T		#	#		000	N
0044T		#	#		000	N
0045T		#	#		000	N
0046T		#	#		000	N
0047T		#	#		000	N
0048T		#	#		000	N
0049T		#	#		000	N
0050T		#	#		000	N
0051T		#	#		000	N
0052T		#	#		000	N
0053T		#	#		000	N
0054T		B.R.	B.R.		000	N
0055T		B.R.	B.R.		000	N
0056T		B.R.	B.R.		000	N
0057T		B.R.	B.R.		000	N
0058T		#	#		000	N
0059T		#	#		000	N
0060T		B.R.	B.R.		000	N
0061T		B.R.	B.R.		000	N
0062T		#	#		000	N
0063T		#	#		000	N
0064T		#	#		000	N
0065T		#	#		000	N
0066T		#	#		000	N
0067T		#	#		000	N
0068T		#	#		000	N
0069T		#	#		000	N
0070T		#	#		000	N
0071T		#	#		000	N
0072T		#	#		000	N
0073T		#	#		000	N
0074T		#	#		000	N
A4250		A.C.	A.C.		000	N
~~A4260~~		~~#~~	~~#~~		~~000~~	~~N~~
A4261		47.00	47.00		000	N
A4561		A.C.	A.C.		000	N
A4562		A.C.	A.C.		000	N
A4565		10.32	10.32		000	N
A4570		14.52	14.52		000	N
A4614		23.78	23.78		000	N
A4627		23.70	23.70		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
A4641		A.C.	A.C.		000	N	G0030	TC	1,179.38	1,179.38	PA	000	N
A4642		A.C.	A.C.		000	N	G0030		1,225.79	1,225.79	PA	000	N
A4643		A.C.	A.C.		000	N	G0031	26	60.30	60.30	PA	000	N
A4644		A.C.	A.C.		000	N	G0031	TC	1,503.13	1,503.13	PA	000	N
A4645		A.C.	A.C.		000	N	G0031		1,562.28	1,562.28	PA	000	N
A4646		A.C.	A.C.		000	N	G0032	26	47.61	47.61	PA	000	N
A4647		Bundled	Bundled		000	N	G0032	TC	1,185.22	1,185.22	PA	000	N
A9500		80.00	80.00		000	N	G0032		1,231.86	1,231.86	PA	000	N
A9502		A.C.	A.C.		000	N	G0033	26	60.76	60.76	PA	000	N
A9503		A.C.	A.C.		000	N	G0033	TC	1,503.13	1,503.13	PA	000	N
A9504		A.C.	A.C.		000	N	G0033		1,562.28	1,562.28	PA	000	N
A9505		34.00	34.00		000	N	G0034	26	48.29	48.29	PA	000	N
A9507		A.C.	A.C.		000	N	G0034	TC	1,185.22	1,185.22	PA	000	N
A9508		A.C.	A.C.		000	N	G0034		1,231.86	1,231.86	PA	000	N
A9510		A.C.	A.C.		000	N	G0035	26	60.53	60.53	PA	000	N
A9511		A.C.	A.C.		000	N	G0035	TC	1,503.13	1,503.13	PA	000	N
A9512		A.C.	A.C.		000	N	G0035		1,562.28	1,562.28	PA	000	N
A9513		A.C.	A.C.		000	N	G0036	26	47.83	47.83	PA	000	N
A9514		A.C.	A.C.		000	N	G0036	TC	1,179.38	1,179.38	PA	000	N
A9515		A.C.	A.C.		000	N	G0036		1,225.79	1,225.79	PA	000	N
A9516		A.C.	A.C.		000	N	G0037	26	60.08	60.08	PA	000	N
A9517		A.C.	A.C.		000	N	G0037	TC	1,503.13	1,503.13	PA	000	N
A9519		A.C.	A.C.		000	N	G0037		1,562.28	1,562.28	PA	000	N
A9520		A.C.	A.C.		000	N	G0038	26	46.93	46.93	PA	000	N
A9521		A.C.	A.C.		000	N	G0038	TC	1,179.38	1,179.38	PA	000	N
A9522		A.C.	A.C.		000	N	G0038		1,225.79	1,225.79	PA	000	N
A9523		A.C.	A.C.		000	N	G0039	26	60.30	60.30	PA	000	N
A9524		A.C.	A.C.		000	N	G0039	TC	1,508.98	1,508.98	PA	000	N
A9525		A.C.	A.C.		000	N	G0039		1,568.36	1,568.36	PA	000	N
A9526		A.C.	A.C.		000	N	G0040	26	48.51	48.51	PA	000	N
A9528		A.C.	A.C.		000	N	G0040	TC	1,179.38	1,179.38	PA	000	N
A9529		A.C.	A.C.		000	N	G0040		1,225.79	1,225.79	PA	000	N
A9530		A.C.	A.C.		000	N	G0041	26	60.30	60.30	PA	000	N
A9531		A.C.	A.C.		000	N	G0041	TC	1,503.13	1,503.13	PA	000	N
A9532		A.C.	A.C.		000	N	G0041		1,562.28	1,562.28	PA	000	N
A9533		A.C.	A.C.		000	N	G0042	26	48.97	48.97	PA	000	N
A9534		A.C.	A.C.		000	N	G0042	TC	1,179.38	1,179.38	PA	000	N
A9600		A.C.	A.C.		000	N	G0042		1,225.79	1,225.79	PA	000	N
A9605		A.C.	A.C.		000	N	G0043	26	60.98	60.98	PA	000	N
A9699		#	#		000	N	G0043	TC	1,503.13	1,503.13	PA	000	N
A9700		A.C.	A.C.		000	N	G0043		1,562.28	1,562.28	PA	000	N
A9900		A.C.	A.C.	PA	000	N	G0044	26	48.51	48.51	PA	000	N
D1203		13.39	13.39		000	N	G0044	TC	1,179.38	1,179.38	PA	000	N
G0001		#	#		000	N	G0044		1,225.79	1,225.79	PA	000	N
G0008		B.R.	B.R.		000	N	G0045	26	60.30	60.30	PA	000	N
G0009		B.R.	B.R.		000	N	G0045	TC	1,503.13	1,503.13	PA	000	N
G0010		B.R.	B.R.		000	N	G0045		1,562.28	1,562.28	PA	000	N
G0027		#	#		000	N	G0046	26	48.51	48.51	PA	000	N
G0030	26	48.29	48.29	PA	000	N	G0046	TC	1,179.38	1,179.38	PA	000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
G0046		1,225.79	1,225.79	PA	000	N
G0047	26	60.53	60.53	PA	000	N
G0047	TC	1,503.13	1,503.13	PA	000	N
G0047		1,562.28	1,562.28	PA	000	N
G0101		22.22	14.28		000	N
G0102		Bundled	Bundled		000	N
G0103		20.48	20.48		000	N
G0104		73.22	34.91		000	N
G0105	53	73.22	34.91		000	N
G0105		226.70	124.46		000	N
G0106	26	31.06	31.06		000	N
G0106	TC	53.73	53.73		000	N
G0106		84.56	84.56		000	N
G0107		3.62	3.62		000	N
G0108		#	#		000	N
G0109		#	#		000	N
G0110		#	#		000	N
G0111		#	#		000	N
G0112		#	#		000	N
G0113		#	#		000	N
G0114		#	#		000	N
G0115		#	#		000	N
G0116		#	#		000	N
G0117		Bundled	Bundled		000	N
G0118		Bundled	Bundled		000	N
G0120	26	31.06	31.06		000	N
G0120	TC	53.73	53.73		000	N
G0120		84.56	84.56		000	N
G0121	53	73.22	34.91		000	N
G0121		226.70	124.46		000	N
G0122	26	32.19	32.19		000	N
G0122	TC	52.59	52.59		000	N
G0122		84.56	84.56		000	N
G0123		#	#		000	N
G0124		#	#		000	N
G0125	26	47.15	47.15	EX	000	N
G0125	TC	1,185.22	1,185.22	EX	000	N
G0125		1,231.86	1,231.86	EX	000	N
G0127		#	#		000	N
G0128		#	#		000	N
G0129		B.R.	B.R.		000	N
G0130	26	6.80	6.80		000	N
G0130	TC	19.50	19.50		000	N
G0130		26.30	26.30		000	N
G0141		#	#		000	N
G0143		#	#		000	N
G0144		#	#		000	N
G0145		#	#		000	N
G0147		#	#		000	N
G0148		#	#		000	N
G0151		#	#		000	N
G0152		#	#		000	N
G0153		#	#		000	N
G0154		#	#		000	N
G0155		#	#		000	N
G0156		#	#		000	N
G0166		#	#		000	N
G0168		54.41	14.06		000	N
G0173		B.R.	B.R.		000	N
G0175		#	#		000	N
G0176		#	#		000	N
G0177		#	#		000	N
G0179		34.91	34.91		000	N
G0180		45.11	45.11		000	N
G0181		75.49	75.49		000	N
G0182		79.80	79.80		000	N
G0186		B.R.	B.R.		090	N
G0202	26	21.99	21.99		000	N
G0202	TC	59.85	59.85		000	N
G0202		81.84	81.84		000	N
G0204	26	27.43	27.43		000	N
G0204	TC	58.94	58.94		000	N
G0204		86.37	86.37		000	N
G0206	26	21.99	21.99		000	N
G0206	TC	47.38	47.38		000	N
G0206		69.37	69.37		000	N
G0210	26	46.70	46.70	EX	000	N
G0210	TC	1,219.78	1,219.78	EX	000	N
G0210		1,267.78	1,267.78	EX	000	N
G0211	26	46.70	46.70	EX	000	N
G0211	TC	1,219.78	1,219.78	EX	000	N
G0211		1,267.78	1,267.78	EX	000	N
G0212	26	46.70	46.70	EX	000	N
G0212	TC	1,219.78	1,219.78	EX	000	N
G0212		1,267.78	1,267.78	EX	000	N
G0213	26	46.70	46.70	EX	000	N
G0213	TC	1,219.78	1,219.78	EX	000	N
G0213		1,267.78	1,267.78	EX	000	N
G0214	26	46.70	46.70	EX	000	N
G0214	TC	1,219.78	1,219.78	EX	000	N
G0214		1,267.78	1,267.78	EX	000	N
G0215	26	46.70	46.70	EX	000	N
G0215	TC	1,219.78	1,219.78	EX	000	N
G0215		1,267.78	1,267.78	EX	000	N
G0216	26	46.70	46.70	EX	000	N
G0216	TC	1,219.78	1,219.78	EX	000	N
G0216		1,267.78	1,267.78	EX	000	N
G0217	26	46.70	46.70	EX	000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
G0217	TC	1,219.78	1,219.78	EX	000	N
G0217		1,267.78	1,267.78	EX	000	N
G0218	26	46.93	46.93	EX	000	N
G0218	TC	1,219.78	1,219.78	EX	000	N
G0218		1,267.78	1,267.78	EX	000	N
G0219		#	#		000	N
G0219	26	#	#		000	N
G0219	TC	#	#		000	N
G0220	26	46.70	46.70	EX	000	N
G0220	TC	1,219.78	1,219.78	EX	000	N
G0220		1,267.78	1,267.78	EX	000	N
G0221	26	46.70	46.70	EX	000	N
G0221	TC	1,219.78	1,219.78	EX	000	N
G0221		1,267.78	1,267.78	EX	000	N
G0222	26	46.93	46.93	EX	000	N
G0222	TC	1,219.78	1,219.78	EX	000	N
G0222		1,267.78	1,267.78	EX	000	N
G0223	26	46.70	46.70	EX	000	N
G0223	TC	1,219.78	1,219.78	EX	000	N
G0223		1,267.78	1,267.78	EX	000	N
G0224	26	46.70	46.70	EX	000	N
G0224	TC	1,219.78	1,219.78	EX	000	N
G0224		1,267.78	1,267.78	EX	000	N
G0225	26	46.93	46.93	EX	000	N
G0225	TC	1,219.78	1,219.78	EX	000	N
G0225		1,267.78	1,267.78	EX	000	N
G0226	26	47.15	47.15	EX	000	N
G0226	TC	1,219.78	1,219.78	EX	000	N
G0226		1,267.78	1,267.78	EX	000	N
G0227	26	46.93	46.93	EX	000	N
G0227	TC	1,219.78	1,219.78	EX	000	N
G0227		1,267.78	1,267.78	EX	000	N
G0228	26	46.70	46.70	EX	000	N
G0228	TC	1,219.78	1,219.78	EX	000	N
G0228		1,267.78	1,267.78	EX	000	N
G0229	26	46.70	46.70	EX	000	N
G0229	TC	1,219.78	1,219.78	EX	000	N
G0229		1,267.78	1,267.78	EX	000	N
G0230	26	47.15	47.15	EX	000	N
G0230	TC	1,219.78	1,219.78	EX	000	N
G0230		1,267.78	1,267.78	EX	000	N
G0231	26	46.70	46.70	EX	000	N
G0231	TC	1,219.78	1,219.78	EX	000	N
G0231		1,267.78	1,267.78	EX	000	N
G0232	26	46.93	46.93	EX	000	N
G0232	TC	1,219.78	1,219.78	EX	000	N
G0232		1,267.78	1,267.78	EX	000	N
G0233	26	46.93	46.93	EX	000	N
G0233	TC	1,219.78	1,219.78	EX	000	N
G0233		1,267.78	1,267.78	EX	000	N
G0234	26	46.93	46.93	EX	000	N
G0234	TC	1,219.78	1,219.78	EX	000	N
G0234		1,267.78	1,267.78	EX	000	N
G0237		#	#		000	N
G0238		#	#		000	N
G0239		#	#		000	N
G0242		B.R.	B.R.		000	N
G0243		B.R.	B.R.		000	N
G0244		#	#		000	N
G0245		#	#		000	N
G0246		#	#		000	N
G0247		#	#		000	N
G0248		#	#		000	N
G0249		#	#		000	N
G0250		#	#		000	N
G0251		#	#		000	N
G0252		#	#		000	N
G0252	26	#	#		000	N
G0252	TC	#	#		000	N
G0253	26	60.30	60.30	EX	000	N
G0253	TC	1,526.26	1,526.26	EX	000	N
G0253		1,586.32	1,586.32	EX	000	N
G0254	26	60.30	60.30	EX	000	N
G0254	TC	1,526.26	1,526.26	EX	000	N
G0254		1,586.32	1,586.32	EX	000	N
G0255		#	#		000	N
G0255	26	#	#		000	N
G0255	TC	#	#		000	N
G0257		#	#		000	N
G0258		#	#		000	N
G0259		#	#		000	N
G0260		#	#		000	N
G0263		#	#		000	N
G0264		#	#		000	N
G0265		#	#		000	N
G0266		#	#		000	N
G0267		#	#		000	N
G0268		#	#		000	N
G0269		Bundled	Bundled		000	N
G0270		#	#		000	N
G0271		#	#		000	N
G0275		#	#		000	N
G0278		#	#		000	N
G0279		#	#		000	N
G0280		#	#		000	N
G0281		#	#		000	N
G0282		#	#		000	N
G0283		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
G0288		#	#		000	N
G0289		#	#		000	N
G0290		#	#		000	N
G0291		#	#		000	N
G0292		#	#		000	N
G0293		#	#		000	N
G0294		#	#		000	N
G0295		#	#		000	N
G0296	26	60.30	60.30	EX	000	N
G0296		B.R.	B.R.	EX	000	N
G0296	TC	B.R.	B.R.	EX	000	N
G0297		B.R.	B.R.		000	N
G0298		B.R.	B.R.		000	N
G0299		B.R.	B.R.		000	N
G0300		B.R.	B.R.		000	N
G0302		B.R.	B.R.		000	N
G0303		B.R.	B.R.		000	N
G0304		B.R.	B.R.		000	N
G0305		B.R.	B.R.		000	N
G0306		8.66	8.66		000	N
G0307		7.20	7.20		000	N
G0308		#	#		000	N
G0309		#	#		000	N
G0310		#	#		000	N
G0311		#	#		000	N
G0312		#	#		000	N
G0313		#	#		000	N
G0314		#	#		000	N
G0315		#	#		000	N
G0316		#	#		000	N
G0317		#	#		000	N
G0318		#	#		000	N
G0319		#	#		000	N
G0320		#	#		000	N
G0321		#	#		000	N
G0322		#	#		000	N
G0323		#	#		000	N
G0324		#	#		000	N
G0325		#	#		000	N
G0326		#	#		000	N
G0327		#	#		000	N
G0328		14.42	14.42		000	N
G0329		#	#		000	N
G0338		#	#		000	N
G0339		#	#		000	N
G0340		#	#		000	N
G3001		B.R.	B.R.		000	N
G9001		#	#		000	N
G9002		#	#		000	N
G9003		#	#		000	N
G9004		#	#		000	N
G9005		#	#		000	N
G9006		#	#		000	N
G9007		#	#		000	N
G9008		#	#		000	N
G9009		#	#		000	N
G9010		#	#		000	N
G9011		#	#		000	N
G9012		#	#		000	N
G9016		#	#		000	N
H0009	TS	20.25	20.25		000	N
H0009		40.50	40.50		000	N
J0120		10.83	10.83		000	N
J0130		459.02	459.02		000	N
J0150		34.80	34.80		000	N
J0152		66.56	66.56		000	N
J0170		2.10	2.10		000	N
J0190		2.96	2.96		000	N
J0200		17.03	17.03		000	N
J0205		33.97	33.97		000	N
J0207		405.29	405.29		000	N
J0210		10.63	10.63		000	N
J0215		28.19	28.19	PA	000	N
J0256		2.38	2.38		000	N
J0270		0.31	0.31		000	N
J0275		18.17	18.17		000	N
J0280		0.94	0.94		000	N
J0282		5.51	5.51		000	N
J0285		9.30	9.30		000	N
J0287		19.55	19.55		000	N
J0288		13.60	13.60		000	N
J0289		32.03	32.03		000	N
J0290		1.48	1.48		000	N
J0295		6.64	6.64		000	N
J0300		2.38	2.38		000	N
J0330		0.17	0.17		000	N
J0350		2,523.67	2,523.67		000	N
J0360		14.34	14.34		000	N
J0380		1.14	1.14		000	N
J0390		17.61	17.61		000	N
J0395		163.20	163.20		000	N
J0456		22.72	22.72		000	N
J0460		0.74	0.74		000	N
J0470		21.18	21.18		000	N
J0475		192.53	192.53		000	N
J0476		71.40	71.40		000	N
J0500		15.27	15.27		000	N
J0515		3.49	3.49		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
J0520		4.78	4.78		000	N	J0970		1.44	1.44		000	N
J0530		10.67	10.67		000	N	J1000		1.70	1.70		000	N
J0540		20.94	20.94		000	N	J1020		2.40	2.40		000	N
J0550		44.84	44.84		000	N	J1030		3.70	3.70		000	N
J0560		8.85	8.85		000	N	J1040		7.40	7.40		000	N
J0570		17.70	17.70		000	N	J1051		4.50	4.50		000	N
J0580		35.39	35.39		000	N	J1055		52.98	52.98		000	N
J0583		1.43	1.43		000	N	~~J1056~~		~~22.02~~	~~22.02~~		~~000~~	~~N~~
J0585		4.43	4.43		000	N	J1060		3.99	3.99		000	N
J0587		7.86	7.86		000	N	J1070		4.43	4.43		000	N
J0592		0.92	0.92		000	N	J1080		8.44	8.44		000	N
J0595		3.94	3.94		000	N	J1094		0.64	0.64		000	N
J0600		39.46	39.46		000	N	J1100		0.10	0.10		000	N
J0610		0.90	0.90		000	N	J1110		36.04	36.04		000	N
J0620		5.55	5.55		000	N	J1120		18.36	18.36		000	N
J0630		34.37	34.37		000	N	J1160		1.59	1.59		000	N
J0636		1.24	1.24		000	N	J1165		0.77	0.77		000	N
J0637		29.48	29.48		000	N	J1170		1.38	1.38		000	N
J0640		3.00	3.00		000	N	J1180		8.07	8.07		000	N
J0670		1.85	1.85		000	N	J1190		209.34	209.34		000	N
J0690		2.01	2.01		000	N	J1200		1.43	1.43		000	N
J0692		7.28	7.28		000	N	J1205		9.38	9.38		000	N
J0694		9.56	9.56		000	N	J1212		39.91	39.91		000	N
J0696		13.35	13.35		000	N	J1230		0.68	0.68		000	N
J0697		5.75	5.75		000	N	J1240		0.34	0.34		000	N
J0698		8.51	8.51		000	N	J1245		5.10	5.10		000	N
J0702		4.45	4.45		000	N	J1250		4.24	4.24		000	N
J0704		0.96	0.96		000	N	J1260		13.85	13.85		000	N
J0706		3.07	3.07		000	N	J1270		4.92	4.92		000	N
J0710		1.46	1.46		000	N	J1320		2.15	2.15		000	N
J0713		6.04	6.04		000	N	J1325		16.16	16.16		000	N
J0715		4.44	4.44		000	N	J1327		11.48	11.48		000	N
J0720		6.46	6.46		000	N	J1330		4.22	4.22		000	N
J0725		2.39	2.39		000	N	J1335		21.24	21.24		000	N
J0735		49.35	49.35		000	N	J1364		3.14	3.14		000	N
J0740		754.80	754.80		000	N	J1380		0.48	0.48		000	N
J0743		14.20	14.20		000	N	J1390		1.02	1.02		000	N
J0744		12.25	12.25		000	N	J1410		55.04	55.04		000	N
J0745		0.41	0.41		000	N	J1435		0.51	0.51		000	N
J0760		6.32	6.32		000	N	J1436		68.85	68.85		000	N
J0770		48.45	48.45		000	N	J1438		138.83	138.83		000	N
J0780		3.74	3.74		000	N	J1440		158.50	158.50		000	N
J0800		83.15	83.15		000	N	J1441		267.79	267.79		000	N
J0835		75.06	75.06		000	N	J1450		85.83	85.83		000	N
J0850		637.12	637.12		000	N	J1452		850.00	850.00		000	N
J0880		21.20	21.20		000	N	J1455		11.70	11.70		000	N
J0895		13.98	13.98		000	N	J1460		10.20	10.20		000	N
J0900		1.46	1.46		000	N	J1470		20.40	20.40		000	N
J0945		0.85	0.85		000	N	J1480		30.63	30.63		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
J1490		40.80	40.80		000	N
J1500		51.00	51.00		000	N
J1510		61.08	61.08		000	N
J1520		71.33	71.33		000	N
J1530		81.60	81.60		000	N
J1540		91.89	91.89		000	N
J1550		102.00	102.00		000	N
J1560		16.02	16.02		000	N
J1563		66.00	66.00		000	N
J1564		0.72	0.72		000	N
J1565		14.81	14.81		000	N
J1570		31.53	31.53		000	N
J1580		1.70	1.70		000	N
J1590		0.81	0.81		000	N
J1595		30.13	30.13		000	N
J1600		12.10	12.10		000	N
J1610		40.80	40.80		000	N
J1620		180.72	180.72		000	N
J1626		15.62	15.62		000	N
J1630		6.11	6.11		000	N
J1631		8.16	8.16		000	N
J1642		0.05	0.05		000	N
J1644		0.35	0.35		000	N
J1645		14.04	14.04		000	N
J1650		5.46	5.46		000	N
J1652		7.40	7.40		000	N
J1655		3.43	3.43		000	N
J1670		106.25	106.25		000	N
J1700		0.30	0.30		000	N
J1710		4.98	4.98		000	N
J1720		1.55	1.55		000	N
J1730		110.01	110.01		000	N
J1742		224.89	224.89		000	N
J1745		58.79	58.79		000	N
J1750		16.03	16.03		000	N
J1756		0.58	0.58		000	N
J1785		3.40	3.40		000	N
J1790		2.50	2.50		000	N
J1800		8.45	8.45		000	N
J1810		#	#		000	N
J1815		0.09	0.09		000	N
J1817		2.53	2.53		000	N
J1825		211.82	211.82		000	N
J1830		60.14	60.14		000	N
J1835		32.97	32.97		000	N
J1840		2.94	2.94		000	N
J1850		0.44	0.44		000	N
J1885		3.19	3.19		000	N
J1890		9.18	9.18		000	N
J1940		0.88	0.88		000	N
J1950		453.79	453.79		000	N
J1955		30.60	30.60		000	N
J1956		18.62	18.62		000	N
J1960		3.37	3.37		000	N
J1980		7.66	7.66		000	N
J1990		22.37	22.37		000	N
J2001		0.88	0.88		000	N
J2010		2.84	2.84		000	N
J2020		32.93	32.93	PA	000	N
J2060		2.81	2.81		000	N
J2150		2.92	2.92		000	N
J2175		0.48	0.48		000	N
J2180		4.02	4.02		000	N
J2185		4.40	4.40		000	N
J2210		3.67	3.67		000	N
J2250		1.14	1.14		000	N
J2260		46.15	46.15		000	N
J2270		0.60	0.60		000	N
J2271		6.99	6.99		000	N
J2275		1.70	1.70		000	N
J2280		9.30	9.30		000	N
J2300		1.35	1.35		000	N
J2310		2.12	2.12		000	N
J2320		3.43	3.43		000	N
J2321		6.25	6.25		000	N
J2322		14.08	14.08		000	N
J2324		135.66	135.66		000	N
J2353		72.11	72.11	PA	000	N
J2354		3.81	3.81	PA	000	N
J2355		239.67	239.67		000	N
J2360		4.85	4.85		000	N
J2370		1.15	1.15		000	N
J2400		5.72	5.72		000	N
J2405		5.51	5.51		000	N
J2410		2.64	2.64		000	N
J2430		237.88	237.88		000	N
J2440		2.98	2.98		000	N
J2460		0.91	0.91		000	N
J2501		4.49	4.49		000	N
J2505		2,507.50	2,507.50		000	N
J2510		8.59	8.59		000	N
J2515		1.18	1.18		000	N
J2540		0.26	0.26		000	N
J2543		4.36	4.36		000	N
J2545		40.12	40.12		000	N
J2550		2.55	2.55		000	N
J2560		1.44	1.44		000	N
J2590		1.15	1.15		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
J2597		3.09	3.09		000	N
J2650		0.22	0.22		000	N
J2670		3.51	3.51		000	N
J2675		3.18	3.18		000	N
J2680		8.02	8.02		000	N
J2690		1.24	1.24		000	N
J2700		0.71	0.71		000	N
J2710		0.59	0.59		000	N
J2720		0.68	0.68		000	N
J2725		21.83	21.83		000	N
J2730		92.12	92.12		000	N
J2760		28.56	28.56		000	N
J2765		1.67	1.67		000	N
J2770		102.52	102.52		000	N
J2780		1.29	1.29		000	N
J2783		105.54	105.54		000	N
J2788		45.82	45.82		000	N
J2790		89.76	89.76		000	N
J2792		18.39	18.39		000	N
J2795		0.06	0.06		000	N
J2800		3.40	3.40		000	N
J2810		1.01	1.01		000	N
J2820		24.47	24.47		000	N
J2910		15.49	15.49		000	N
J2912		0.44	0.44		000	N
J2916		7.31	7.31		000	N
J2920		1.41	1.41		000	N
J2930		1.72	1.72		000	N
J2940		40.76	40.76	PA	000	N
J2941		41.09	41.09	PA	000	N
J2950		0.41	0.41		000	N
J2993		1,168.75	1,168.75		000	N
J2995		79.69	79.69		000	N
J2997		32.83	32.83		000	N
J3000		5.67	5.67		000	N
J3010		0.83	0.83		000	N
J3030		23.76	23.76		000	N
J3070		4.67	4.67		000	N
J3100		2,407.63	2,407.63		000	N
J3105		26.30	26.30		000	N
J3120		8.03	8.03		000	N
J3130		16.07	16.07		000	N
J3140		0.28	0.28		000	N
J3150		0.84	0.84		000	N
J3230		3.93	3.93		000	N
J3240		559.62	559.62		000	N
J3245		421.77	421.77		000	N
J3250		1.25	1.25		000	N
J3260		3.99	3.99		000	N
J3265		1.39	1.39		000	N
J3280		5.06	5.06		000	N
J3301		1.43	1.43		000	N
J3302		0.31	0.31		000	N
J3303		0.90	0.90		000	N
J3305		127.50	127.50		000	N
J3310		6.68	6.68		000	N
J3315		356.66	356.66		000	N
J3320		25.30	25.30		000	N
J3350		1.19	1.19		000	N
J3360		0.77	0.77		000	N
J3364		50.65	50.65		000	N
J3365		457.66	457.66		000	N
J3370		2.58	2.58		000	N
J3395		1327.10	1327.10		000	N
J3400		11.11	11.11		000	N
J3410		1.08	1.08		000	N
J3411		0.81	0.81		000	N
J3415		0.47	0.47		000	N
J3420		0.15	0.15		000	N
J3430		1.98	1.98		000	N
J3465		4.51	4.51	PA	000	N
J3470		5.81	5.81		000	N
J3475		0.20	0.20		000	N
J3480		0.07	0.07		000	N
J3485		0.91	0.91		000	N
J3486		18.60	18.60		000	N
J3487		194.54	194.54		000	N
J3490		A.C.	A.C.		000	N
J3520		#	#		000	N
J3530		A.C.	A.C.		000	N
J3535		A.C.	A.C.		000	N
J3570		#	#		000	N
J3590		A.C.	A.C.		000	N
J7030		8.89	8.89		000	N
J7040		5.64	5.64		000	N
J7042		8.45	8.45		000	N
J7050		2.22	2.22		000	N
J7051		0.68	0.68		000	N
J7060		8.09	8.09		000	N
J7070		9.78	9.78		000	N
J7100		22.47	22.47		000	N
J7110		12.72	12.72		000	N
J7120		11.13	11.13		000	N
J7130		0.44	0.44		000	N
J7190		0.79	0.79		000	N
J7191		1.85	1.85		000	N
J7192		1.17	1.17		000	N
J7193		1.01	1.01		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
J7194		0.36	0.36		000	N
J7195		0.86	0.86		000	N
J7197		1.36	1.36		000	N
J7198		1.29	1.29		000	N
J7199		A.C.	A.C.		000	N
J7300		336.26	336.26		000	N
J7302		405.81	405.81		000	N
J7303		#	#		000	N
J7308		#	#		000	N
J7310		4,250.00	4,250.00		000	N
J7317		124.11	124.11		000	N
J7320		204.03	204.03		000	N
J7330		#	#		000	N
J7340		26.21	26.21	PA	000	N
J7342		13.93	13.93		000	N
J7350		A.C.	A.C.		000	N
J7500		#	#		000	N
J7501		53.54	53.54		000	N
J7502		#	#		000	N
J7504		#	#		000	N
J7505		#	#		000	N
J7506		#	#		000	N
J7507		3.13	3.13		000	N
J7509		0.44	0.44		000	N
J7510		0.03	0.03		000	N
J7511		319.94	319.94		000	N
J7513		380.36	380.36		000	N
J7515		1.17	1.17		000	N
J7516		23.50	23.50		000	N
J7517		2.55	2.55		000	N
J7520		6.38	6.38		000	N
J7525		106.29	106.29		000	N
J7599		A.C.	A.C.		000	N
J7608		5.33	5.33		000	N
J7618		0.12	0.12		000	N
J7619		0.39	0.39		000	N
J7621		3.40	3.40		000	N
J7622		0.58	0.58		000	N
J7624		0.05	0.05		000	N
J7626		4.04	4.04		000	N
J7628		0.23	0.23		000	N
J7629		0.25	0.25		000	N
J7631		0.31	0.31		000	N
J7633		0.05	0.05		000	N
J7635		0.20	0.20		000	N
J7636		0.32	0.32		000	N
J7637		0.09	0.09		000	N
J7638		0.16	0.16		000	N
J7639		14.92	14.92		000	N
J7641		0.63	0.63		000	N
J7642		0.50	0.50		000	N
J7643		0.83	0.83		000	N
J7644		2.82	2.82		000	N
J7648		0.16	0.16		000	N
J7649		0.17	0.17		000	N
J7658		6.51	6.51		000	N
J7659		6.56	6.56		000	N
J7668		0.23	0.23		000	N
J7669		0.25	0.25		000	N
J7680		2.00	2.00		000	N
J7681		25.71	25.71		000	N
J7682		44.08	44.08		000	N
J7683		0.10	0.10		000	N
J7684		0.17	0.17		000	N
J7699		A.C.	A.C.		000	N
J7799		A.C.	A.C.		000	N
J8499		#	#		000	N
J8510		1.86	1.86		000	N
J8520		3.07	3.07		000	N
J8521		10.21	10.21		000	N
J8530		1.75	1.75		000	N
J8560		40.49	40.49		000	N
J8600		2.24	2.24		000	N
J8610		2.61	2.61		000	N
J8700		6.58	6.58		000	N
J8999		#	#		000	N
J9000		8.16	8.16		000	N
J9001		352.06	352.06		000	N
J9010		523.00	523.00		000	N
J9015		657.15	657.15		000	N
J9017		32.94	32.94		000	N
J9020		56.02	56.02		000	N
J9031		143.28	143.28		000	N
J9040		150.61	150.61		000	N
J9045		134.41	134.41		000	N
J9050		121.84	121.84		000	N
J9060		13.56	13.56		000	N
J9062		67.79	67.79		000	N
J9065		45.90	45.90		000	N
J9070		5.13	5.13		000	N
J9080		9.74	9.74		000	N
J9090		20.45	20.45		000	N
J9091		40.92	40.92		000	N
J9092		81.82	81.82		000	N
J9093		5.21	5.21		000	N
J9094		10.41	10.41		000	N
J9095		20.45	20.45		000	N
J9096		40.92	40.92		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
J9097		83.95	83.95		000	N
J9098		332.35	332.35		000	N
J9100		7.33	7.33		000	N
J9110		7.65	7.65		000	N
J9120		12.41	12.41		000	N
J9130		10.04	10.04		000	N
J9140		19.47	19.47		000	N
J9150		66.42	66.42		000	N
J9151		57.80	57.80		000	N
J9160		1,190.85	1,190.85		000	N
J9165		12.89	12.89		000	N
J9170		301.40	301.40		000	N
J9178		24.73	24.73		000	N
J9181		1.53	1.53		000	N
J9182		15.30	15.30		000	N
J9185		318.59	318.59		000	N
J9190		1.85	1.85		000	N
J9200		122.40	122.40		000	N
J9201		110.05	110.05		000	N
J9202		375.99	375.99		000	N
J9206		130.24	130.24		000	N
J9208		134.55	134.55		000	N
J9209		31.45	31.45		000	N
J9211		375.73	375.73		000	N
J9212		3.67	3.67		000	N
J9213		31.21	31.21		000	N
J9214		13.31	13.31		000	N
J9215		7.03	7.03		000	N
J9216		187.19	187.19		000	N
J9217		500.58	500.58		000	N
J9218		23.26	23.26		000	N
J9219		4,831.40	4,831.40		000	N
J9230		10.74	10.74		000	N
J9245		375.88	375.88		000	N
J9250		0.35	0.35		000	N
J9260		4.25	4.25		000	N
J9263		8.45	8.45		000	N
J9265		138.28	138.28		000	N
J9266		1,277.13	1,277.13		000	N
J9268		1,644.27	1,644.27		000	N
J9270		83.93	83.93		000	N
J9280		57.12	57.12		000	N
J9290		185.64	185.64		000	N
J9291		255.00	255.00		000	N
J9293		321.52	321.52		000	N
J9300		1,953.94	1,953.94		000	N
J9310		427.28	427.28		000	N
J9320		126.58	126.58		000	N
J9340		83.73	83.73		000	N
J9350		706.17	706.17		000	N
J9355		52.01	52.01		000	N
J9357		471.24	471.24		000	N
J9360		2.81	2.81		000	N
J9370		30.40	30.40		000	N
J9375		60.81	60.81		000	N
J9380		152.02	152.02		000	N
J9390		76.19	76.19		000	N
J9395		81.57	81.57		000	N
J9600		2,329.60	2,329.60		000	N
J9999		A.C.	A.C.		000	N
L0120		26.63.	26.63		000	N
L0210		33.33	33.33		000	N
L0220		99.18	99.18		000	N
L0515		239.40	239.40		000	N
L1800		150.83	150.83		000	N
L1810		85.82	85.82		000	N
L1815		88.48	88.48		000	N
L1820		108.58	108.58		000	N
L1830		84.16	84.16		000	N
L1902		73.68	73.68		000	N
L1906		90.53	90.53		000	N
L3000		176.29	176.29	EPA	000	N
L3030		88.15	88.15	EPA	000	N
L3100		59.13	59.13		000	N
L3140		118.07	118.07		000	N
L3150		59.03	59.03		000	N
L3170		A.C.	A.C.	PA	000	N
L3215		84.34	84.34	EPA	000	N
L3219		97.02	97.02	EPA	000	N
L3230		277.90	277.90	PA	000	N
L3310		66.69	66.69	EPA	000	N
L3320		66.69	66.69	EPA	000	N
L3334		49.04	49.04	EPA	000	N
L3340		50.02	50.02	PA	000	N
L3350		27.79	27.79	PA	000	N
L3360		50.02	50.02	PA	000	N
L3400		61.13	61.13	PA	000	N
L3410		50.02	50.02	PA	000	N
L3420		61.13	61.13	PA	000	N
L3430		129.74	129.74		000	N
L3650		46.56.	46.56		000	N
L3700		58.06	58.06		000	N
L3908		58.85	58.85		000	N
L3928		46.75	46.75		000	N
L4350		74.10	74.10		000	N
L4360		277.90	277.90	PA	000	N
L4380		103.70	103.70		000	N
L4386		A.C.	A.C.	PA	000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
L8000		33.13	33.13		000	N
L8010		57.97	57.97		000	N
L8600		650.00	650.00		000	N
L8603		333.13	333.13		000	N
L8606		170.87	170.87		000	N
L9900		A.C.	A.C.		000	N
P3000		14.76	14.76		000	N
P3001		13.83	13.83		000	N
P9010		55.11	55.11		000	N
P9011		B.R.	B.R.		000	N
P9012		26.20	26.20		000	N
P9016		45.53	45.53		000	N
P9017		47.82	47.82		000	N
P9019		B.R.	B.R.		000	N
P9020		B.R.	B.R.		000	N
P9021		66.64	66.64		000	N
P9022		20.50	20.50		000	N
P9023		B.R.	B.R.		000	N
P9031		B.R.	B.R.		000	N
P9032		B.R.	B.R.		000	N
P9033		B.R.	B.R.		000	N
P9034		B.R.	B.R.		000	N
P9035		B.R.	B.R.		000	N
P9036		B.R.	B.R.		000	N
P9037		B.R.	B.R.		000	N
P9038		B.R.	B.R.		000	N
P9039		B.R.	B.R.		000	N
P9040		B.R.	B.R.		000	N
P9041		13.01	13.01		000	N
P9043		13.01	13.01		000	N
P9044		B.R.	B.R.		000	N
P9045		49.30	49.30		000	N
P9046		13.01	13.01		000	N
P9047		49.30	49.30		000	N
P9048		26.04	26.04		000	N
P9050		B.R.	B.R.		000	N
P9612		2.45	2.45		000	N
P9615		#	#		000	N
Q0035		#	#		000	N
Q0035	26	#	#		000	N
Q0035	TC	#	#		000	N
Q0081		#	#		000	N
Q0083		#	#		000	N
Q0084		#	#		000	N
Q0085		#	#		000	N
Q0091		#	#		000	N
Q0092		#	#		000	N
Q0111		4.75	4.75		000	N
Q0112		4.75	4.75		000	N
Q0113		6.03	6.03		000	N
Q0114		7.96	7.96		000	N
Q0115		11.02	11.02		000	N
Q0136		11.49	11.49		000	N
Q0137		4.24	4.24		000	N
Q0144		A.C.	A.C.		000	N
Q0163		0.08	0.08		000	N
Q0164		0.51	0.51		000	N
Q0165		0.77	0.77		000	N
Q0166		39.98	39.98		000	N
Q0167		2.93	2.93		000	N
Q0168		7.96	7.96		000	N
Q0169		0.28	0.28		000	N
Q0170		0.02	0.02		000	N
Q0171		0.06	0.06		000	N
Q0172		0.08	0.08		000	N
Q0173		0.40	0.40		000	N
Q0174		0.67	0.67		000	N
Q0175		0.51	0.51		000	N
Q0176		0.83	0.83		000	N
Q0177		0.38	0.38		000	N
Q0178		0.27	0.27		000	N
Q0179		27.22	27.22		000	N
Q0180		64.80	64.80		000	N
Q0181		A.C.	A.C.		000	N
Q0182		#	#		000	N
Q0183		#	#		000	N
Q0187		1,522.20	1,522.20		000	N
Q1001		50.00	50.00		000	N
Q1002		50.00	50.00		000	N
Q1003		#	#		000	N
Q1004		#	#		000	N
Q1005		#	#		000	N
Q2001		27.86	27.86		000	N
Q2002		13.35	13.35		000	N
Q2003		183.95	183.95		000	N
Q2004		22.05	22.05		000	N
Q2005		331.53	331.53		000	N
Q2006		496.94	496.94		000	N
Q2007		25.49	25.49		000	N
Q2008		682.33	682.33		000	N
Q2009		5.44	5.44		000	N
Q2011		6.62	6.62		000	N
Q2012		130.53	130.53		000	N
Q2013		14.16	14.16		000	N
Q2014		14.78	14.78		000	N
Q2017		182.95	182.95		000	N
Q2018		#	#		000	N
Q2019		1,171.06	1,171.06		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
Q2020		13.97	13.97		000	N
Q2021		116.63	116.63		000	N
Q2022		0.86	0.86		000	N
Q3000		A.C.	A.C.		000	N
Q3001		A.C.	A.C.		000	N
Q3002		A.C.	A.C.		000	N
Q3003		A.C.	A.C.		000	N
Q3004		A.C.	A.C.		000	N
Q3005		A.C.	A.C.		000	N
Q3006		A.C.	A.C.		000	N
Q3007		A.C.	A.C.		000	N
Q3008		A.C.	A.C.		000	N
Q3009		A.C.	A.C.		000	N
Q3010		A.C.	A.C.		000	N
Q3011		A.C.	A.C.		000	N
Q3012		A.C.	A.C.		000	N
Q3014		20.00	20.00		000	N
Q3019		#	#		000	N
Q3020		#	#		000	N
Q3025		77.52	77.52		000	N
Q3026		A.C.	A.C.		000	N
Q3031		Bundled	Bundled		000	N
Q4001		36.28	36.28		000	N
Q4002		137.14	137.14		000	N
Q4003		26.06	26.06		000	N
Q4004		90.23	90.23		000	N
Q4005		9.60	9.60		000	N
Q4006		21.66	21.66		000	N
Q4007		4.81	4.81		000	N
Q4008		10.83	10.83		000	N
Q4009		6.41	6.41		000	N
Q4010		14.44	14.44		000	N
Q4011		3.20	3.20		000	N
Q4012		7.22	7.22		000	N
Q4013		11.67	11.67		000	N
Q4014		19.69	19.69		000	N
Q4015		5.83	5.83		000	N
Q4016		9.85	9.85		000	N
Q4017		6.75	6.75		000	N
Q4018		10.77	10.77		000	N
Q4019		3.38	3.38		000	N
Q4020		5.39	5.39		000	N
Q4021		4.99	4.99		000	N
Q4022		9.02	9.02		000	N
Q4023		2.51	2.51		000	N
Q4024		4.51	4.51		000	N
Q4025		28.02	28.02		000	N
Q4026		87.48	87.48		000	N
Q4027		14.01	14.01		000	N
Q4028		43.75	43.75		000	N
Q4029		21.42	21.42		000	N
Q4030		56.39	56.39		000	N
Q4031		10.72	10.72		000	N
Q4032		28.20	28.20		000	N
Q4033		19.98	19.98		000	N
Q4034		49.71	49.71		000	N
Q4035		10.00	10.00		000	N
Q4036		24.86	24.86		000	N
Q4037		12.19	12.19		000	N
Q4038		30.54	30.54		000	N
Q4039		6.11	6.11		000	N
Q4040		15.28	15.28		000	N
Q4041		14.82	14.82		000	N
Q4042		25.31	25.31		000	N
Q4043		7.41	7.41		000	N
Q4044		12.66	12.66		000	N
Q4045		8.60	8.60		000	N
Q4046		13.84	13.84		000	N
Q4047		4.30	4.30		000	N
Q4048		6.93	6.93		000	N
Q4049		1.57	1.57		000	N
Q4050		A.C.	A.C.		000	N
Q4051		A.C.	A.C.		000	N
Q4054		4.24	4.24		000	N
Q4055		11.49	11.49		000	N
Q4075		0.42	0.42		000	N
Q4076		A.C.	A.C.		000	N
Q4077		A.C.	A.C.		000	N
R0070		43.69	43.69		000	N
R0075		14.19	14.19		000	N
R0076		Bundled	Bundled		000	N
S0012		#	#		000	N
S0014		#	#		000	N
S0016		#	#		000	N
S0017		#	#		000	N
S0020		#	#		000	N
S0021		#	#		000	N
S0023		#	#		000	N
S0028		#	#		000	N
S0030		#	#		000	N
S0032		#	#		000	N
S0034		#	#		000	N
S0039		#	#		000	N
S0040		#	#		000	N
S0071		#	#		000	N
S0072		#	#		000	N
S0073		#	#		000	N
S0074		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
S0077		A.C.	A.C.		000	N
S0078		#	#		000	N
S0080		#	#		000	N
S0081		#	#		000	N
S0088		A.C.	A.C.		000	N
S0090		#	#		000	N
S0091		A.C.	A.C.		000	N
S0092		A.C.	A.C.		000	N
S0093		A.C.	A.C.	PA	000	N
S0104		A.C.	A.C.		000	N
S0106		A.C.	A.C.		000	N
S0107		A.C.	A.C.	PA	000	N
S0108		A.C.	A.C.		000	N
S0114		A.C.	A.C.		000	N
S0115		A.C.	A.C.		000	N
S0122		#	#		000	N
S0126		#	#		000	N
S0128		#	#		000	N
S0132		#	#		000	N
S0136		#	#	PA	000	N
S0137		#	#		000	N
S0138		#	#		000	N
S0139		#	#		000	N
S0140		#	#		000	N
S0141		#	#		000	N
S0155		A.C.	A.C.		000	N
S0156		A.C.	A.C.		000	N
S0157		A.C.	A.C.		000	N
S0158		A.C.	A.C.		000	N
S0159		A.C.	A.C.		000	N
S0160		A.C.	A.C.		000	N
S0161		A.C.	A.C.		000	N
S0162		A.C.	A.C.		000	N
S0163		A.C.	A.C.		000	N
S0164		A.C.	A.C.		000	N
S0165		A.C.	A.C.		000	N
S0170		A.C.	A.C.		000	N
S0171		A.C.	A.C.		000	N
S0172		A.C.	A.C.		000	N
S0173		A.C.	A.C.		000	N
S0174		A.C.	A.C.		000	N
S0175		A.C.	A.C.		000	N
S0176		A.C.	A.C.		000	N
S0177		A.C.	A.C.		000	N
S0178		A.C.	A.C.		000	N
S0179		A.C.	A.C.		000	N
S0181		A.C.	A.C.		000	N
S0182		A.C.	A.C.		000	N
S0183		A.C.	A.C.		000	N
S0187		A.C.	A.C.		000	N
S0189		A.C.	A.C.		000	N
S0190		77.40	77.40		000	N
S0191		1.03	1.03		000	N
S0194		#	#		000	N
S0195		#	#		000	N
S0199		#	#		000	N
S0201		#	#		000	N
S0207		#	#		000	N
S0208		#	#		000	N
S0209		#	#		000	N
S0215		#	#		000	N
S0220		#	#		000	N
S0221		#	#		000	N
S0250		#	#		000	N
S0255		#	#		000	N
S0260		#	#		000	N
S0302		#	#		000	N
S0310		#	#		000	N
S0315		#	#		000	N
S0316		#	#		000	N
S0317		#	#		000	N
S0320		#	#		000	N
S0340		#	#		000	N
S0341		#	#		000	N
S0342		#	#		000	N
S0390		#	#		000	N
S0395		#	#		000	N
S0400		#	#		000	N
S0500		#	#		000	N
S0504		#	#		000	N
S0506		#	#		000	N
S0508		#	#		000	N
S0510		#	#		000	N
S0512		#	#		000	N
S0514		#	#		000	N
S0516		#	#		000	N
S0518		#	#		000	N
S0580		#	#		000	N
S0581		#	#		000	N
S0590		#	#		000	N
S0592		#	#		000	N
S0601		#	#		000	N
S0605		#	#		000	N
S0610		#	#		000	N
S0612		#	#		000	N
S0618		#	#		000	N
S0620		#	#		000	N
S0621		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
S0622		#	#		000	N	S2211		#	#		000	N
S0630		#	#		000	N	S2213		#	#		000	N
S0800		#	#		000	N	S2225		#	#		000	N
S0810		#	#		000	N	S2230		#	#		000	N
S0812		#	#		000	N	S2235		#	#		000	N
S0820		#	#		000	N	S2250		#	#		000	N
S0830		#	#		000	N	S2255		#	#		000	N
S1001		#	#		000	N	S2260		#	#		000	N
S1002		#	#		000	N	S2262		#	#		000	N
S1015		#	#		000	N	S2265		#	#		000	N
S1016		#	#		000	N	S2266		#	#		000	N
S1025		#	#		000	N	S2267		#	#		000	N
S1030		#	#		000	N	S2300		#	#		000	N
S1031		#	#		000	N	S2340		#	#		000	N
S1040		#	#		000	N	S2341		#	#		000	N
S2053		#	#		000	N	S2342		#	#		000	N
S2054		#	#		000	N	S2350		#	#		000	N
S2055		#	#		000	N	S2351		#	#		000	N
S2060		#	#		000	N	S2360		#	#		000	N
S2061		#	#		000	N	S2361		#	#		000	N
S2065		#	#		000	N	S2362		#	#		000	N
S2070		#	#		000	N	S2363		#	#		000	N
S2080		#	#		000	N	S2370		#	#		000	N
S2082		#	#		000	N	S2371		#	#		000	N
S2083		#	#		000	N	S2400		#	#		000	N
S2085		#	#		000	N	S2401		#	#		000	N
S2090		#	#		000	N	S2402		#	#		000	N
S2091		#	#		000	N	S2403		#	#		000	N
S2095		#	#		000	N	S2404		#	#		000	N
S2102		#	#		000	N	S2405		#	#		000	N
S2103		#	#		000	N	S2409		#	#		000	N
S2107		#	#		000	N	S2411		#	#		000	N
S2112		#	#		000	N	S3000		#	#		000	N
S2113		#	#		000	N	S3600		3.35	3.35		000	N
S2115		#	#		000	N	S3601		#	#		000	N
S2120		#	#		000	N	S3620		60.90	60.90		000	N
S2130		#	#		000	N	S3625		#	#		000	N
S2131		#	#		000	N	S3630		#	#		000	N
S2135		#	#		000	N	S3645		#	#		000	N
S2140		#	#		000	N	S3650		#	#		000	N
S2142		#	#		000	N	S3652		#	#		000	N
S2150		#	#		000	N	S3655		#	#		000	N
S2152		#	#		000	N	S3701		#	#		000	N
S2202		#	#		000	N	S3708		#	#		000	N
S2205		#	#		000	N	S3818		#	#		000	N
S2206		#	#		000	N	S3819		#	#		000	N
S2207		#	#		000	N	S3820		#	#		000	N
S2208		#	#		000	N	S3822		#	#		000	N
S2209		#	#		000	N	S3823		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
S3828		#	#		000	N	~~S4989~~		#	#		~~000~~	~~N~~
S3829		#	#		000	N	S4990		#	#		000	N
S3830		#	#		000	N	S4991		#	#		000	N
S3831		#	#		000	N	S4993		#	#		000	N
S3833		#	#		000	N	S4995		#	#		000	N
S3834		#	#		000	N	S5000		#	#		000	N
S3835		#	#		000	N	S5001		#	#		000	N
S3837		#	#		000	N	S5010		A.C.	A.C.		000	N
S3840		#	#		000	N	S5011		A.C.	A.C.		000	N
S3841		#	#		000	N	S5012		A.C.	A.C.		000	N
S3842		#	#		000	N	S5013		A.C.	A.C.		000	N
S3843		#	#		000	N	S5014		A.C.	A.C.		000	N
S3844		#	#		000	N	S5035		#	#		000	N
S3845		#	#		000	N	S5036		#	#		000	N
S3846		#	#		000	N	S5100		#	#		000	N
S3847		#	#		000	N	S5101		#	#		000	N
S3848		#	#		000	N	S5102		#	#		000	N
S3849		#	#		000	N	S5105		#	#		000	N
S3850		#	#		000	N	S5108		#	#		000	N
S3851		#	#		000	N	S5109		#	#		000	N
S3852		#	#		000	N	S5110		#	#		000	N
S3853		#	#		000	N	S5111		#	#		000	N
S3890		#	#		000	N	S5115		#	#		000	N
S3900		#	#		000	N	S5116		#	#		000	N
S3902		#	#		000	N	S5120		#	#		000	N
S3904		#	#		000	N	S5121		#	#		000	N
S4005		366.68	366.68		000	N	S5125		#	#		000	N
S4011		#	#		000	N	S5126		#	#		000	N
S4013		#	#		000	N	S5130		#	#		000	N
S4014		#	#		000	N	S5131		#	#		000	N
S4015		#	#		000	N	S5135		#	#		000	N
S4016		#	#		000	N	S5136		#	#		000	N
S4017		#	#		000	N	S5140		#	#		000	N
S4018		#	#		000	N	S5141		#	#		000	N
S4020		#	#		000	N	S5145		#	#		000	N
S4021		#	#		000	N	S5146		#	#		000	N
S4022		#	#		000	N	S5150		#	#		000	N
S4023		#	#		000	N	S5151		#	#		000	N
S4025		#	#		000	N	S5160		#	#		000	N
S4026		#	#		000	N	S5161		#	#		000	N
S4027		#	#		000	N	S5162		#	#		000	N
S4028		#	#		000	N	S5165		#	#		000	N
S4030		#	#		000	N	S5170		#	#		000	N
S4031		#	#		000	N	S5175		#	#		000	N
S4035		#	#		000	N	S5180		#	#		000	N
S4036		#	#		000	N	S5181		#	#		000	N
S4037		#	#		000	N	S5185		#	#		000	N
S4040		#	#		000	N	S5190		#	#		000	N
S4981		#	#		000	N	S5199		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
S5497		#	#		000	N	S8265		#	#		000	N
S5498		#	#		000	N	S8301		#	#		000	N
S5501		#	#		000	N	S8415		45.00	45.00		000	N
S5502		#	#		000	N	S8420		#	#		000	N
S5517		#	#		000	N	S8421		#	#		000	N
S5518		#	#		000	N	S8422		#	#		000	N
S5520		#	#		000	N	S8423		#	#		000	N
S5521		#	#		000	N	S8424		#	#		000	N
S5522		#	#		000	N	S8425		#	#		000	N
S5523		#	#		000	N	S8426		#	#		000	N
S5550		#	#		000	N	S8427		#	#		000	N
S5551		#	#		000	N	S8428		#	#		000	N
S5552		#	#		000	N	S8429		#	#		000	N
S5553		#	#		000	N	S8430		#	#		000	N
S5560		#	#		000	N	S8431		#	#		000	N
S5561		#	#		000	N	S8450		#	#		000	N
S5565		#	#		000	N	S8451		#	#		000	N
S5566		#	#		000	N	S8452		#	#		000	N
S5570		#	#		000	N	S8460		#	#		000	N
S5571		#	#		000	N	S8490		#	#		000	N
S8004		#	#		000	N	S8948		#	#		000	N
S8030		#	#		000	N	S8950		#	#		000	N
S8035		#	#		000	N	S8990		#	#		000	N
S8037		#	#		000	N	S8999		#	#		000	N
S8040		#	#		000	N	S9001		#	#		000	N
S8042		#	#		000	N	S9007		#	#		000	N
S8049		#	#		000	N	S9015		#	#		000	N
S8055		#	#		000	N	S9022		#	#		000	N
S8075		#	#		000	N	S9024		#	#		000	N
S8080		#	#		000	N	S9025		#	#		000	N
S8085		#	#		000	N	S9034		#	#		000	N
S8092		#	#		000	N	S9055		#	#		000	N
S8095		#	#		000	N	S9056		#	#		000	N
S8096		#	#		000	N	S9061		#	#		000	N
S8097		#	#		000	N	S9075		#	#		000	N
S8100		#	#		000	N	S9083		#	#		000	N
S8101		#	#		000	N	S9088		#	#		000	N
S8110		#	#		000	N	S9090		#	#		000	N
S8120		#	#		000	N	S9092		#	#		000	N
S8121		#	#		000	N	S9098		#	#		000	N
S8182		#	#		000	N	S9109		#	#		000	N
S8183		#	#		000	N	S9117		#	#		000	N
S8185		#	#		000	N	S9122		#	#		000	N
S8186		#	#		000	N	S9123		#	#		000	N
S8189		#	#		000	N	S9124		#	#		000	N
S8190		#	#		000	N	S9125		#	#		000	N
S8210		#	#		000	N	S9126		#	#		000	N
S8260		#	#		000	N	S9127		#	#		000	N
S8262		#	#		000	N	S9128		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
S9129		#	#		000	N	S9376		#	#		000	N
S9131		#	#		000	N	S9377		#	#		000	N
S9140		#	#		000	N	S9379		#	#		000	N
S9141		#	#		000	N	S9381		#	#		000	N
S9145		#	#		000	N	S9401		#	#		000	N
S9150		#	#		000	N	S9430		#	#		000	N
S9208		#	#		000	N	S9434		#	#		000	N
S9209		#	#		000	N	S9435		#	#		000	N
S9211		#	#		000	N	S9436		#	#		000	N
S9212		#	#		000	N	S9437		#	#		000	N
S9213		#	#		000	N	S9438		#	#		000	N
S9214		#	#		000	N	S9439		#	#		000	N
S9325		#	#		000	N	S9441		#	#		000	N
S9326		#	#		000	N	S9442		#	#		000	N
S9327		#	#		000	N	S9443		#	#		000	N
S9328		#	#		000	N	S9444		#	#		000	N
S9329		#	#		000	N	S9445		#	#		000	N
S9330		#	#		000	N	S9446		#	#		000	N
S9331		#	#		000	N	S9447		#	#		000	N
S9335		#	#		000	N	S9449		#	#		000	N
S9336		#	#		000	N	S9451		#	#		000	N
S9338		#	#		000	N	S9452		#	#		000	N
S9339		#	#		000	N	S9453		#	#		000	N
S9340		#	#		000	N	S9454		#	#		000	N
S9341		#	#		000	N	S9455		#	#		000	N
S9342		#	#		000	N	S9460		#	#		000	N
S9343		#	#		000	N	S9465		#	#		000	N
S9345		#	#		000	N	S9470		#	#		000	N
S9346		#	#		000	N	S9472		#	#		000	N
S9347		#	#		000	N	S9473		#	#		000	N
S9348		#	#		000	N	S9474		#	#		000	N
S9349		#	#		000	N	S9475		#	#		000	N
S9351		#	#		000	N	S9476		#	#		000	N
S9353		#	#		000	N	S9480		#	#		000	N
S9355		#	#		000	N	S9484		#	#		000	N
S9357		#	#		000	N	S9485		#	#		000	N
S9359		#	#		000	N	S9490		#	#		000	N
S9361		#	#		000	N	S9494		#	#		000	N
S9363		#	#		000	N	S9497		#	#		000	N
S9364		#	#		000	N	S9500		#	#		000	N
S9365		#	#		000	N	S9501		#	#		000	N
S9366		#	#		000	N	S9502		#	#		000	N
S9367		#	#		000	N	S9503		#	#		000	N
S9368		#	#		000	N	S9504		#	#		000	N
S9370		#	#		000	N	S9529		#	#		000	N
S9372		#	#		000	N	S9537		#	#		000	N
S9373		#	#		000	N	S9538		#	#		000	N
S9374		#	#		000	N	S9542		#	#		000	N
S9375		#	#		000	N	S9558		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

2004 PROCEDURE CODES AND MAXIMUM ALLOWABLE FEES

Effective July 1, 2004

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
S9559		#	#		000	N	T1030		#	#		000	N
S9560		#	#		000	N	T1031		#	#		000	N
S9562		#	#		000	N	T1500		#	#		000	N
S9590		#	#		000	N	T1502		#	#		000	N
S9810		#	#		000	N	T1999		#	#		000	N
S9900		#	#		000	N	T2001		#	#		000	N
S9970		#	#		000	N	T2002		#	#		000	N
S9975		#	#		000	N	T2003		#	#		000	N
S9976		#	#		000	N	T2004		#	#		000	N
S9977		#	#		000	N	T2005		#	#		000	N
S9981		#	#		000	N	T2006		#	#		000	N
S9982		#	#		000	N	T2007		#	#		000	N
S9986		#	#		000	N	T2010		#	#		000	N
S9988		#	#		000	N	T2011		#	#		000	N
S9989		#	#		000	N	T2012		#	#		000	N
S9990		#	#		000	N	T2013		#	#		000	N
S9991		#	#		000	N	T2014		#	#		000	N
S9992		#	#		000	N	T2015		#	#		000	N
S9994		#	#		000	N	T2016		#	#		000	N
S9996		#	#		000	N	T2017		#	#		000	N
S9999		#	#		000	N	T2018		#	#		000	N
T1000		#	#		000	N	T2019		#	#		000	N
T1001		#	#		000	N	T2020		#	#		000	N
T1002		#	#		000	N	T2021		#	#		000	N
T1003		#	#		000	N	T2022		#	#		000	N
T1004		#	#		000	N	T2023		#	#		000	N
T1005		#	#		000	N	T2024		#	#		000	N
T1006		#	#		000	N	T2025		#	#		000	N
T1007		#	#		000	N	T2026		#	#		000	N
T1009		#	#		000	N	T2027		#	#		000	N
T1010		#	#		000	N	T2028		#	#		000	N
T1012		#	#		000	N	T2029		#	#		000	N
T1013		#	#		000	N	T2030		#	#		000	N
T1014		#	#		000	N	T2031		#	#		000	N
T1015		#	#		000	N	T2032		#	#		000	N
T1016		#	#		000	N	T2033		#	#		000	N
T1017		#	#		000	N	T2034		#	#		000	N
T1018		#	#		000	N	T2035		#	#		000	N
T1019		#	#		000	N	T2036		#	#		000	N
T1020		35.87	35.87		000	N	T2037		#	#		000	N
T1021		#	#		000	N	T2038		#	#		000	N
T1022		#	#		000	N	T2039		#	#		000	N
T1023		#	#		000	N	T2040		#	#		000	N
T1024		#	#		000	N	T2041		#	#		000	N
T1025		#	#		000	N	T2042		#	#		000	N
T1026		#	#		000	N	T2043		#	#		000	N
T1027		#	#		000	N	T2044		#	#		000	N
T1028		#	#		000	N	T2045		#	#		000	N
T1029		#	#		000	N	T2046		#	#		000	N

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery	Procedure Code	Mod	NFS Setting Fee	FS Setting Fee	PA Req?	Global Days	Asst at Surgery
T2048		#	#		000	N							
T2049		#	#		000	N							
T2101		#	#		000	N							
T5001		#	#		000	N							
T5999		#	#		000	N							
V2623		862.80	862.80		000	N							
V2624		65.09	65.09		000	N							
V2625		395.77	395.77		000	N							
V2626		213.33	213.33		000	N							
V2627		1,377.82	1,377.82		000	N							
V2628		325.33	325.33		000	N							
V2630		342.42	342.42		000	N							
V2631		342.42	342.42		000	N							
V2632		342.42	342.42		000	N							
V2785		#	#		000	N							

Effective 7/01/04

- Not Covered
A.C. – Acquisition Cost
B.R. – By Report

PA – Written/Fax Authorization
EX – Expedited Prior Authorization
LE – Limitation Extension

CPT codes and descriptions are copyright 2003 American Medical Association.

This page intentionally left blank.

Selected HCPCS Procedure Codes

Policies and limitations for selected HCPCS codes once found on this page have been integrated into other sections of these billing instructions. Refer to the sections listed below for information on the following services:

AIDS Counseling Services	Refer to Section B.
Cast Materials Only	Refer to Section K.
Clozaril Care Coordination	Refer to Section E.
Detox	Refer to Section B.
Developmental Disabilities Program	Refer to Section B.
Drug-Induced Abortions (RU-486)	Refer to Section F.
Family Planning	Refer to Section H.
Hyalgan/Synvisc	Refer to Section C.
Involuntary Treatment Act (ITA)	Refer to Section E.
Laboratory STAT	Refer to Section E.
Maternity Care And Delivery	Refer to Section F.
Norplant/IUD/Diaphragm	Refer to Section H.
Ophthalmology	Refer to Section D.
Physical Medicine	Refer to Section G.
Podiatry/Orthotics	Refer to Section E.
Radiology	Refer to Section E.
Tuberculosis Treatment Services	Refer to Section B.

This is a blank page.

Medical Supplies and Equipment

General Payment Policies

- MAA reimburses providers for certain medical supplies and equipment (MSE) dispensed from their offices when these items are considered prosthetics and are used for a client's permanent condition (see the list beginning on page K.2).

- Most MSE used to treat a client's temporary or acute condition are considered incident to a provider's professional services and are bundled in the office visit reimbursement (see list beginning on page K.2). MAA reimburses providers separately for only those MSE listed beginning on page K.4.

- MAA does not reimburse providers separately for surgical trays, as these are bundled within the appropriate surgical procedure. The fees for these procedures include the cost of the surgical trays.

- Procedure codes for MSE that do not have a maximum allowable fee and cost less than $50.00 are reimbursed at acquisition cost. A manufacturer's invoice must be maintained in the client's records for MSE under $50.00 and made available to MAA upon request. **DO NOT send in an invoice with your claim** for MSE under $50.00 unless requested by MAA.

- Procedure codes for MSE that do not have a maximum allowable fee and cost $50.00 or more are reimbursed at acquisition cost. **You must attach a copy of the manufacturer's invoice** to your claim for MSE costing $50.00 or more.

☞ **Note:** To request prior authorization for MSE, write or fax:

Division of Medical Management
DME Program Management Unit
PO Box 45506
Olympia, WA 98504-5506
360-586-5299 (fax)

Supplies Included in an Office Call (Bundled Supplies)

Items with an asterisk (*) in the following list are considered prosthetics when used for a permanent condition. MAA reimburses providers for these supplies when they are provided in the office for permanent conditions **only**. They are not considered prosthetics if the condition is acute or temporary. Providers must indicate "prosthetic for permanent condition" in the *Comments* section of the claim form.

For example, if a patient has an indwelling Foley catheter for permanent incontinence and a problem develops for which the physician is required to replace the catheter, it is considered a prosthetic and is paid separately. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction is not paid separately because it is treating a temporary problem.

☞ **Note:** MAA continues to evaluate and adopt Medicare's Correct Coding Initiative (CCI) policies and edits. Therefore, any procedures or services that are currently bundled by Medicare are bundled by MAA as well.

HCPCS Code	Brief Description
A4206	Syringe with needle, sterile 1cc
A4207	Syringe with needle, sterile 2cc
A4208	Syringe with needle, sterile 3cc
A4209	Syringe with needle, sterile 5cc
A4211	Supplies for self-administered injections
A4212	Huber-type needle, each
A4213	Syringe, sterile, 20 CC or greater
A4215	Needles only, sterile, any size
A4220	Refill kit for implantable infusion pump
A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or phisohex solution, per pint
A4247	Betadine or iodine swabs/wipes, per box
A4253	Blood glucose test, per 50 strips
A4256	Normal, low and high cal solution/chips
A4258	Spring-powered device for lancet, each

HCPCS Code	Brief Description
A4259	Lancets, per box of 100
A4262	Temporary lacrimal duct implant, each
A4263	Permanent lacrimal duct implant, each
A4265	Paraffin, per pound
A4270	Disposable endoscope sheath, each
A4300	Implantable access partial/catheter
A4301	Implantable access total system
A4305	Disposable drug delivery system, flow rate 50 ML or more per hour
A4306	Disposable drug delivery system, flow rate 5 ML or less per hour
A4310	Insertion tray w/o drainage bag
A4311	Insertion tray without drainage bag
A4312	Insertion tray without drainage bag

HCPCS Code	Brief Description
A4313	Insertion tray without drainage bag
A4314	Insertion tray with drainage bag
A4315	Insertion tray with drainage bag
A4316	Insertion tray with drainage bag
A4320	Irrigation tray for bladder
A4330	Perianal fecal collection pouch
A4335*	Incontinence supply; miscellaneous
A4338*	Indwelling catheter; Foley type
A4340*	Indwelling catheter; Spec type
A4344*	Indwelling catheter; Foley type
A4346*	Indwelling catheter; Foley type
A4347*	Male external catheter
A4351	Intermittent urinary catheter
A4352	Intermittent urinary catheter
A4353	Catheter insert tray with cath/tube/bag
A4354	Insertion tray with drainage bag
A4355	Irrigation tubing set
A4356*	External urethral clamp device
A4357*	Bedside drainage bag, day or night
A4358*	Urinary leg bag; vinyl
A4359*	Urinary suspensory, without leg bag
A4361*	Ostomy faceplate
A4362*	Skin barrier; solid, 4 x 4
A4364*	Adhesive for ostomy or catheter
A4365*	Adhesive remover wipes, per 50
A4367*	Ostomy belt
A4368*	Ostomy filter, each
A4397	Irrigation supply; sleeve
A4398*	Irrigation supply; bags
A4399*	Irrigation supply; cone/catheter
A4400*	Ostomy irrigation set
A4402	Lubricant

HCPCS Code	Brief Description
A4404*	Ostomy rings
A4421*	Ostomy supply; miscellaneous
A4455	Adhesive remover or solvent
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical tray
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4647	Supply of paramagnetic contrast material (e.g., gadolinium)
A4649	Surgical supply; miscellaneous
A5051*	Ostomy pouch, closed; with barrier
A5052*	Ostomy pouch, closed; without barrier
A5053*	Ostomy pouch, closed; use on faceplate
A5054*	Ostomy pouch, closed; use on barrier
A5055*	Stoma cap
A5061*	Ostomy pouch, drainable; with barrier
A5062*	Ostomy pouch, drainable; without barrier
A5063*	Ostomy pouch, drainable; use on barrier
A5071*	Pouch, urinary; with barrier
A5072*	Pouch, urinary; without barrier
A5073*	Pouch, urinary; use on barrier
A5081*	Continent device ; plug
A5082*	Continent device ; catheter
A5093*	Ostomy accessory; convex insert
A5102*	Bedside drainage bottle
A5105*	Urinary supensory; with leg bag
A5112*	Urinary leg bag; latex

HCPCS Code	Brief Description
A5113*	Leg strap; latex, per set
A5114*	Leg strap; foam or fabric
A5119*	Skin barrier; wipes, box per 50
A5121*	Skin barrier; solid, 6 x 6
A5122*	Skin barrier; solid, 8 x 8
A5126*	Adhesive; disc or foam pad
A5131*	Appliance cleaner
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in

HCPCS Code	Brief Description
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch, each
A6231	Hydrogel dsg <=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
99070	Special supplies

Supplies Reimbursed Separately When Dispensed from a Provider's Office

Miscellaneous Supplies

HCPCS Code	Brief Description
A4250	Urine test or reagent strips
A4561	Pessary rubber, any type
A4562	Pessary, nonrubber, any type
A4565	Slings
A4570	Splint
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code. **(To be used only for cochlear implant replacement parts. PA is required for the replacement parts and is manually priced by MAA's authorization department.)**

Casting Materials

Bill the appropriate HCPCS code (Q4001-Q4049) for fiberglass and plaster casting materials. Do not bill for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

Metered Dose Inhalers and Accessories

HCPCS Code	Brief Description
A4614	Peak flow meter
A4627	Spacer bag, or reservoir, with/ without mask (for use with metered does inhaler)

Inhalatio7n Solutions

Refer to the fee schedule (Section L) for those specific codes for inhalation solutions that are reimbursed separately.

Radiopharmaceutical Diagnostic Imaging Agents

Refer to the fee schedule (Section L) for those specific codes for imaging agents that are reimbursed separately.

Miscellaneous Prosthetics & Orthotics

HCPCS Code	Brief Description
L0120	Collar-philadelphia child
L0210	Universal rib belt
L0515	Industrial back support *(not covered for scoliosis)*
L1800	Stabiliz knee sleeve-universal
L1810	Knee brace hinged
L1815	Roadrunner knee brace
L1820	Action neoprene brace, knee
L1830	Knee immobilizer 24" universal
L1902	Boot-walkabout med/large
L1906	Canvas ankle brace
L0210	Thoracic, rib belt
L0220	Thoracic, rib belt, custom fabricated
L3030	Hapad metatarsal pad
L3334	Achilles lift
L3350	Adjustable peel-off heel lift
L3360	Achilles heel wedge/west walkr
L3650	Shoulder abduction pillow
L3700	Neoprene butress elbow, s-m-l
L3807	WHFO, extension assist, with inflatable palmer air support, with or without thumb extension
L3908	Wrist comfort form all sizes
L3909	Wrist Orthosis
L3928	Lmb 504 extension
L4350	Air support - purple med/large
L4360	Walker, pneumatic s-m-l
L4380	Aircast infrapatellar band
L4386	Diabetic walker
L8000	Post mastedtomy implants bra
L8010	Breast binder
L8600	Breast implants

Urinary Tract Implants

See important policy limitations for urinary tract implants on page F.24.

HCPCS Code	Brief Description
L8603	Collagen implant, urinary tract, per 2.5 ml syringe
L8606	Synthetic implant, urinary tract, per 1 ml syringe

☞ **Note:** MAA does not reimburse providers for L8603 and L8606 if the implants are done outside the physician's office.

MAA covers the first three (3) implants only, using a combination of L8603 and/or L8606, per client. Each 2.5 ml syringe of L8603 or each 1 ml syringe of L8606 is one implant.

Podiatry

The following codes are payable only to Podiatrists and Orthopedic Surgeons:

HCPCS Code	Brief Description
L3000	Ft insert ucb berkeley shell. **EPA required.**
L3030	Foot arch support remov prem. **EPA required.**
L3100	Hallus-valgus nght dynamic s
L3140	Abduction rotation bar shoe
L3150	Abduct rotation bar w/o shoe
L3215	Orthopedic ftwear ladies oxf. **EPA required.**
L3219	Orthopedic mens shoes oxford. **EPA required.**
L3230	Custom shoes depth inlay. **PA required.**
L3310	Shoe lift elev heel/sole neo. **EPA required.**

HCPCS Code	Brief Description
L3320	Shoe lift elev heel/sole cor. **EPA required.**
L3334	Shoe lifts elevation heel /i. **EPA required.**
L3340	Shoe wedge sach. **PA required.**
L3350	Shoe heel wedge. **PA required.**
L3360	Shoe sole wedge outside sole. **PA required.**
L3400	Shoe metatarsal bar wedge ro. **PA required.**
L3410	Shoe metatarsal bar between. **PA required.**
L3420	Full sole/heel wedge between. **PA required.**
L3430	Shoe heel count plast reinfor

Injectable Drug Codes

MAA's fees for injectable drug codes are the maximum allowances used to reimburse covered drugs and biologicals administered in a provider's office. MAA follows Medicare's payment policy to set the maximum allowances.

MAA obtains the Average Wholesale Price (AWP) for most of the HCPCS level II drug and biological codes from Medicare's Single Drug Pricer (SDP). MAA's maximum allowable fee is 86% of the AWP or Medicare's rate, whichever is less. MAA updates the rates each time the SDP is updated, up to once per quarter. Unlike Medicare, the MAA effective dates are based on dates of service, not the date the claim is received. For HCPCS codes where the SDP does not establish a rate, MAA determines the maximum allowances for covered drugs using the following methodology:

1. For a single-source drug or biological, the AWP equals the AWP of the single product.

2. For a multi-source drug or biological, the AWP is equal to the median AWP of all of the generic forms of the drug or biological, or the lowest brand name product AWP, whichever is less. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

3. After determining the AWP according to #1 and #2 above, MAA multiplies the amount by 0.86 to arrive at the fee schedule maximum allowance.

When billing for injectable drugs and biologicals, providers must use the description of the procedure code to determine the units, and include the correct number of units on the claim form to be reimbursed the appropriate amount. For drugs priced at "acquisition cost," providers must:

- Include a copy of the manufacturer's invoice for each line item in which **billed charges** exceed $1,100.00; or

- Retain a copy of the manufacturer's invoice in the client's record for each line item in which **billed charges** are equal to or less than $1,100.00.

Do not bill using unclassified or unspecified drug codes unless there is no specific code for the drug being administered. The National Drug Code (NDC) and dosage given to the client must be included with the unclassified or unspecified drug code for coverage and payment consideration.

HCPCS codes J8499 and J8999 for oral prescription drugs are not covered.

Injectable drugs can be injected subcutaneously, intramuscularly, or intravenously. The injectable drugs can be billed only from the provider's office supply. The name, strength, and dosage of the drug must be documented and retained in the client's record.

Chemotherapy Drug (J9000-J9999)

- Bill number of units used based on the description of the drug code. For example, if 250 mg of Cisplatin (J9062) is given to the client, the correct number of units is five (5).
- Claims with HCPCS code J9999 must include the NDC and the amount of the drug administered to the client in the *Comments* section of the claim form.
- MAA's maximum allowable fee is 86% of AWP or Medicare's fee, whichever is less.

All Other Drugs

- Bill number of units used based on the description of the drug code. For example, if 20 mg of Hyalgan (J7316) is given to the client, the correct number of units is four (4).
- Claims with HCPCS code J3490 must include the NDC and the amount of the drug administered to the client in the *Comments* section of the claim form.
- MAA's maximum allowable fee is 86% of AWP or Medicare's fee, whichever is less.

Prior Authorization

Drugs requiring written/fax prior authorization are noted in the fee schedule with a "PA" next to them. For information on how to request prior authorization, refer to Section I.

Rounding of Units

The following guidelines should be used to round the dosage given to the client to the appropriate number of units for billing purposes:

I. Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, MAA reimburses providers for the total number of units contained in the vial. **For example:**

> If a total of 150 mg of Etoposide is required for the therapy and two 100 mg single dose vials are used to obtain the total dosage, the total of the two 100 mg vials is reimbursed. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If MAA's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

II. Billing for Multi-Dose Vials:

For multi-dose vials, bill **only** the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, MAA reimburses providers for only the amount of drug administered to the client. **For example:**

> If a total of 750 mg of Cytarabine is required for the therapy and is taken from a 2,000 mg multi-dose vial, only the 750 mg administered to the client is reimbursed. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If MAA's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

III. Unlisted Drugs:

When it is necessary to bill MAA for a drug using an unlisted drug code, providers must report the National Drug Code (NDC) of the drug administered to the client. MAA uses the NDC when unlisted drug codes are billed to appropriately price the claim. Claims must include:

- The dosage (amount) of the drug administered to the client; and
- The 11-digit NDC of the office-administered drug.

For claims billed using a paper HCFA-1500 claim form, list the required information in field 19 of the claim form.

For claims billed using an electronic HCFA-1500 claim form, list the required information in the *Comments* section of the claim form.

For claims billed using an electronic 837P claim form, list the required NDC information in DRUG IDENTIFICATION Loop 2410, LIN02, and LIN03. List the dosage given to the client in the "*Comment*" section of the claim form.

☞ **Note**: If there is an assigned HCPCS code for the administered drug, providers **must bill** MAA using the appropriate HCPCS code. **DO NOT** bill using an unlisted drug code for a drug that has an assigned HCPCS code. MAA will recoup payment for drugs paid using an unlisted drug code if an assigned HCPCS code exists for the administered drug.

The list of all injectable drug codes and maximum allowable fees are listed in the fee schedule section (Section J).

This page intentionally left blank.

CPT/HCPCS Modifiers

[Refer to WAC 388-531-1850(10) and (11)]

Italics indicate additional MAA language not found in CPT.

21: **Prolonged Evaluation and Management Services***: For informational purposes only; no extra allowance is allowed.*

22: **Unusual Procedural 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 code number. *This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight or trauma.*

For informational purposes only; no extra allowance is allowed.

23: **Unusual Anesthesia**: *For informational purposes only; no extra allowance is allowed.*

24: **Unrelated Evaluation and Management (E&M) by the Same Physician During a Postoperative Period**: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) ***unrelated*** to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E&M service. *Payment for the E&M service during postoperative period is made when the reason for the E&M service is unrelated to original procedure.*

25: **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure**: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the client's condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier 25 to the appropriate level of E&M service. *Payment for the E&M service is the billed charge or MAA's maximum allowable, whichever is less.*

26: **Professional Component**: Certain procedures are a combination of professional and technical components. When only the professional component is reported, the service is identified by adding modifier 26 to the procedure code.

TC: **Technical Component**: Certain procedures are a combination of professional and technical components. When only the technical component is reported, the service is identified by adding modifier TC to the procedure code. *A contract with MAA is required if services are performed in a hospital setting.*

32: **Mandated Services**: *For informational purposes only; no extra allowance is allowed.*

47: **Anesthesia By Surgeon**: *Not covered by MAA.*

50: **Bilateral Procedure**: Unless otherwise identified in the listing, bilateral procedures that are performed at the same operative session should be identified by adding this modifier to the appropriate five-digit code describing the first procedure.

For surgical procedures typically performed on both sides of the body, payment for the E&M service is the billed charge or MAA's maximum allowable, whichever is less.

For surgical procedures that are typically performed on one side of the body, but performed bilaterally in a specific case, payment is 150% of the global surgery fee for the procedure.

51: **Multiple Procedures**: *When multiple surgeries are performed at the same operative session, total payment is equal to the sum of the following: 100% of the highest value procedure; 50% of the global fee for each of the second through fifth procedures. More than five procedures require submission of documentation and individual review to determine the payment amount.*

52: **Reduced Services**: Under certain circumstances, a service or procedure is partially reduced at the physician's discretion. 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. *Using this modifier reduces the allowance to the provider. Note: Modifier 52 may be used with computerized tomography procedure codes for a limited study or a follow-up study.*

53: **Discontinued Procedure**: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 and HCPCS codes G0105 and G0121 only. It is "information only" for all other surgical procedures.

54, 55, 56 – Providers providing less than the global surgical package should use modifiers 54, 55, & 56. *These modifiers are designed to ensure that the sum of all allowances for all practitioners who furnished parts of the services included in a global surgery fee do not exceed the total amount of the payment that would have been paid to a single practitioner under the global fee for the procedure. The payment policy pays each physician directly for that portion of the global surgery services provided to the client. The breakdown is as follows:*

54: **Surgical Care Only**: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

55: **Postoperative Management Only**: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

56: **Preoperative Management Only**: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

57: **Decision for Surgery**: An evaluation and management (E&M) service provided the day before the day of surgery that resulted in the initial decision to perform the surgery, may be identified by adding the modifier 57 to the appropriate level of E&M service. *This does not apply to minor surgeries (those with a follow-up period of less than 90 days).*

58: **Staged or Related Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. *NOTE: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.*

59: **Distinct Procedural Service**: The physician must indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of surgery in extensive injuries). *This modifier is for informational purchases only; no extra allowance is allowed.*

62: **Two Surgeons**: Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances, separate services may be identified by adding modifier 62 to the procedure code used by each surgeon for reporting his/her services. *Payment for this modifier is 125% of the global surgical fee in the fee schedule. The payment is divided equally between the two surgeons. No payment is made for an assistant surgeon.*

66: **Team surgery**: *For informational purposes only; no extra allowance is allowed.*

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

77: **Repeat Procedure by Another Physician**: *For informational purposes only; no extra allowance is allowed.*

78: **Return to the Operating Room for a Related Procedure During the Postoperative Period**: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure. ***When multiple procedures are performed, use modifier 78 on EACH detail line.*** *Payment for these procedures is the percentage of the global package for the intra-operative services. Assistant surgeons and anesthesiologists must use modifier 99 to indicate an additional operating room procedure. They must indicate in the Comments section on the claim form:*

- *Modifier 78 and 80; or*
- *Modifier 78 and the appropriate anesthesia modifier.*

79: **Unrelated Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79.

80: **Assistant Surgeon**: Surgical assistant and/or physician assistant services must be identified by adding modifier 80 to the usual procedure code(s). *A physician assistant, employed by a physician, must use the physician's provider number and must bill on the same claim form as the physician/surgeon. Payment is 20% of the maximum allowance.*

81: **Minimum Assistant Surgeon**: Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number. *Payment is 20% of the maximum allowance.*

82: **Assistant Surgeon (When Qualified Resident Surgeon Not Available)**: The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s). *Payment is 20% of the maximum allowance.*

90: **Reference (Outside) Laboratory**: When laboratory procedures are performed by a lab other than the referring lab, the procedure must be identified by adding modifier 90 to the procedure code. *The reference lab provider number must be entered in the performing number field on the HCFA-1500 claim form or electronic claim record. The reference lab must be CLIA-certified.*

91: **Repeat Clinical Diagnostic Laboratory Test** performed on the same day to obtain subsequent report test value(s). *Modifier 91 must be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times, only when it is necessary to obtain multiple results in the course of treatment. When billing for a repeat test, use modifier 91 with the appropriate procedure code.*

99: **Multiple Modifiers**: Under certain circumstances, two or more modifiers may be necessary to completely describe a service. *Modifier 99 must be used* ***only when two or more modifiers affect pricing*** *(applicable modifiers listed below). Modifier 99 must be added to the basic procedure, and all applicable modifiers from the list below must be listed in field 24D.* ***Modifier 99 must be the first modifier listed on the claim.***

26	Professional component
50	Bilateral surgery
53	Discontinued procedure
54	Surgical care only
55	Postoperative management only
56	Preoperative management only
62	Two surgeons
66	Surgical team
78	Return to operating room for related procedure during post-op period
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
91	Repeat clinical diagnostic lab, same day
HA	Children's services
LT	Left
RT	Right
ST	Major trauma
TC	Technical component
TH	Obstetrical treatment/service, prenatal or postpartum
TG	Complex/high level of care

LT **Left Side**: Used to identify procedures performed on the left side of the body. *MAA requires this modifier with some procedure codes for proper reimbursement.*

QP **Documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT recognized panel other than automated profile codes**. *This modifier is now used FOR INFORMATION ONLY. Internal control reimbursement methodology for automated multi-channel test is applied. This modifier is not appropriate to use when billing for repeat tests or to indicate not as a panel.*

Q6 **Physician Services**: Services furnished by a locum tenens physician. *For informational purposes only; no extra allowance is allowed.*

RT **Right Side**: Used to identify procedures performed on the right side of the body. *MAA requires this modifier with some procedure codes for proper reimbursement.*

SL **State-supplied Vaccine**: *This modifier must be used with those immunization procedure codes indicated in section C to identify those immunization materials obtained from the Department of Health (DOH).*

Anesthesia Modifiers

AA Anesthesia services personally furnished by an anesthesiologist. *This includes services provided by faculty anesthesiologists involving a physician-in-training (resident). Reimbursement is 100% of the allowed amount. Modifier AA must not be billed in combination with QX.*

When supervising, the physician must use one of the modifiers below. Reimbursement for these modifiers is 50% of the allowed amount. Modifier QX must be billed by the Certified Registered Nurse Anesthetist (CRNA).

AD Medical supervision by a physician for more than four concurrent anesthesia services.

QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.

QS Monitored anesthesia services. ***This modifier is not covered by MAA.***

To bill for monitored anesthesia care services, the following applies:

If the physician personally performs the case, modifier AA must be used and reimbursement is 100% of the allowed amount.

If the physician directs four or fewer concurrent cases and monitored care represents two or more of the case modifiers, modifier QK must be used and reimbursement is 50% of the allowed amount.

QX CRNA service with medical direction by a physician should be used when under the supervision of a physician. *Reimbursement is 50% of the allowed amount. This modifier is payable in combination with Modifiers AD or QK, which is used by the supervising anesthesiologist. Modifier QX must not be billed in combination with AA.*

QY CRNA and anesthesiologist are involved in a single procedure and the physician is performing the medical direction. *The physician must use modifier QY and the medically directed CRNA must use modifier QX. The anesthesiologist and CRNA each receive 50% of the allowance that would have been paid had the service been provided by the anesthesiologist or CRNA alone.*

QZ CRNA service without medical direction by a physician. *Must be used when practicing independently. Reimbursement is 100% of the allowed amount. This modifier must not be billed in combination with any other modifier.*

This page intentionally left blank.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services;
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria; or
  - ✓ The date an MAA managed care plan or Basic Health Plus client's premium has been recouped by MAA.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

---

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

> ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee must I bill MAA?

Bill MAA your usual and customary fee.

Third-Party Liability

Bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card prior to sending the claim to MAA. An insurance carrier's time limit for claim submissions may be different than MAA's. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report (RA) for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement; or
- If rebilling, attach a copy of the RA showing the previous denial, or list the internal control number (ICN) in the *Comments* section of the claim form.

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits Section at 1-800-562-6136.

Primary Care Case Management (PCCM) Clients

Clients who obtain care with a PCCM will have a "PCCM" identifier in the HMO column. These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. Please refer to the client's DSHS Medical ID card for the PCCM. When billing MAA, place the PCCM's provider number in the referring provider field.

Note:	**Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborn.**

How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations.** MAA may make an additional payment after Medicare reimburses you.

- If the Medicare EOMB shows Medicare has allowed any of the charges (whether applied to the copay or deductible) on the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims (see page M.1).

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (younger than 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if the client has Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Payment for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service had the service been reimbursed under the ratio of costs-to-charges (RCC) payment methodology (whether normally reimbursed using the DRG or RCC methodologies).

When billing Medicare:

- Indicate *Medicaid* and include the patient identification code (PIC) on the claim form as shown on the client's DSHS Medical ID card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes the claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing (see *Important Contacts* for address).
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

Note:

- ✓ **Medicare/Medicaid billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Medicare Part B

Benefits covered under Part B include **physician, outpatient hospital, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on the RA within 30 days from Medicare's statement date, bill MAA directly.

- If the Medicare EOMB shows Medicare has allowed any of the charges (whether applied to the copay or deductible) on the claim and there is a balance due from MAA, submit a HCFA-1500 claim form with an "XO" indicator in field 19. Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies the service, but MAA covers it, bill MAA on a HCFA-1500 claim form**. Do not list an "XO" indicator in field 19**. Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the **prior** authorization requirement. However, providers must obtain an authorization number from MAA after the service has been performed (see Section I). Authorization or denial of your request will be based upon medical necessary.

Note:

- ✓ **Medicare/Medicaid billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Payment Methodology

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, MMIS uses Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA does not make direct payments to clients to cover the deductible and/or coinsurance amount of Medicare Part B. MAA *can* pay these costs to the provider on behalf of the client when:

- The provider accepts assignment; and

- The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their DSHS Medical ID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only Medicaid **and not Medicare** covers the service, and the service is covered under the CNP or MNP program, MAA reimburses for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **neither Medicare or Medicaid** covers the service, MAA does not reimburse providers for the service.

What general records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications (including NDC numbers), equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

See MAA's program-specific billing instructions for information that may be necessary to keep in addition to those general records listed above.

How to Complete the HCFA-1500 Claim Form

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or 'SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i. (characters per inch). Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light or faded. (Use black ink for the "XO" indicator on crossover claims.)**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form.** If more that six detail lines are needed, use additional claim forms. MAA does not accept "continued" claim forms.

- **Show the total amount for each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form; **total each claim form.**

Field **Description/Instructions for Completion**

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC) – an alphanumeric code assigned to each Medical Assistance client – exactly as shown on the client's DSHS Medical ID card. The PIC consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available)
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY)
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker)

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB Baby on Parent's PIC.

NOTE: Use the PIC code of either parent if a newborn has not been issued a PIC. Enter a **B** in *field 19* to indicate the baby is on a parent's PIC.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing.).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2.*)

9. **Other Insured's Name**: When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
9b. Enter the other insured's date of birth.
9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, EPSDT, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her Social Security Number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?**: Indicate *yes* or *no*. If yes, you should have completed *fields 9a. – d*.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

19. **Reserved For Local Use**: When applicable, enter indicator **B**, *Baby on Parent's PIC*, or other comments necessary to process the claim.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report).

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 4, 2004 = 070404).

24B. **Place of Service**: Required. See pages J.2 and J.3 for correct POS codes. These are the only appropriate place of service codes:

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

24F. **$ Charges**: Required. Enter your usual and customary charges for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units for each line. These figures must be whole units.

24H. **EPSDT Family Plan**: When billing the department for one of the EPSDT screening procedure codes, enter an **X** in this field.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: This is any nine-digit alphanumeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

32. **Name and Address of Facility Where Services Were Rendered**: When required, put the name of the facility where services were performed.

33. **Physician's Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the Name, *Address*, and *Phone #* on all claim forms.

P.I.N.:

This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); **or**
B. An identification number for individuals only when they are part of a group practice (see below).

Group:

This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

☞ **Note:** Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

SAMPLE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MJ070160SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, MARY, J

3. PATIENT'S BIRTH DATE MM 07 DD 01 YY 60 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 5555 NEVERENDING ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: ANYWHERE STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 461.0 3. ___.__

2. 465.0 4. ___.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11	01	04	11	01	04	11		99201		1, 2	5000	1				
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. $ TOTAL CHARGE 5000

29. $ AMOUNT PAID

30. $ BALANCE DUE 5000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

JAMES W WILLIAMS 1500 N MADISON
ANYTOWN WA 98926 (360) 777-8888

PIN# GRP# 1234567

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500