2014 Office Visit Reimbursement Rates and Additional Notes

Colorectal Cancer	CPT Code	Medicare @							Medicaid	
Procedure		Region 99		Region 1		DC Metro		CBSA	All of MD	
		In-Facility	Not In-Facility	In-Facility	Not In-Facility	In-Facility	Not In-Facility	Hosp/ASC	In-Facility @@	Not In-Facility
Office Visit, Initial, New Patient										
LEVEL 1: Problem focused history & examination with straightforward medical decision for a new patient (or not seen in last 3 years) approx. **10 minutes**	99201	$26.99	$44.43	$27.98	$46.45	$29.25	$49.49	N/A	$27.61	$45.67
LEVEL 2: Expanded problem focused history & examination with straightforward medical decision approx. **20 minutes**	99202	$51.42	$76.28	$53.25	$79.58	$55.66	$84.50	N/A	$52.58	$78.32
LEVEL 3: Detailed history & examination requiring low complexity medical decision approx. **30 minutes**	99203	$78.36	$110.64	$81.28	$115.47	$84.86	$122.32	N/A	$80.17	$113.59
LEVEL 4: Comprehensive history & exam ination requiring moderately complex medical decision approx. **45 minutes**	99204	$134.12	$169.75	$139.11	$176.84	$145.25	$186.59	N/A	$137.23	$174.10
LEVEL 5: Comprehensive history & exam ination requiring highly complex medical decision approx. **60 minutes**	99205	$173.14	$211.37	$179.39	$219.87	$187.30	$231.65	N/A	$177.09	$216.65
Office Visit, Established Patient										
LEVEL 1: Eval/management, may not require presence of MD - problems usually minimal	99211	$9.48	$20.61	$9.79	$21.58	$10.22	$23.13	N/A	$9.68	$21.21
LEVEL 2: Problem focused history and examination with straightforward medical decision	99212	$25.87	$44.80	$26.80	$46.84	$27.96	$49.92	N/A	$26.46	$46.05
LEVEL 3: Expanded problem focused history & examination with low complexity medical decision	99213	$52.50	$74.77	$54.33	$77.91	$56.73	$82.57	N/A	$53.67	$76.72
LEVEL 4: Detailed history & exam- ination requiring moderately complex medical decision	99214	$80.58	$110.27	$83.33	$114.76	$87.00	$121.45	N/A	$82.36	$113.09
LEVEL 5: Comprehensive history & examination requiring highly complex medical decision	99215	$113.42	$147.56	$117.23	$153.38	$122.44	$162.05	N/A	$115.90	$151.24
Problem focused history & examination with straightforward medical decision	99241	Not in Part B	Not in Part B	Not in Part B	Not in Part B	Not in Part E	Not in Part B	N/A	$35.40	$51.53
Expanded problem focused history & examination with straightforward medical decision	99242	Not in Part B	Not in Part B	Not in Part B	Not in Part B	Not in Part E	Not in Part B	N/A	$73.78	$96.44
Detailed history & examination requiring low complexity medical decision	99243	Not in Part B	Not in Part B	Not in Part B	Not in Part B	Not in Part E	Not in Part B	N/A	$102.82	$131.63
Comprehensive history & examination requiring moderately complex medical decision	99244	Not in Part B	Not in Part B	Not in Part B	Not in Part B	Not in Part E	Not in Part B	N/A	$162.75	$194.26
Comprehensive history & examination requiring highly complex medical decision	99245	Not in Part B	Not in Part B	Not in Part B	Not in Part B	Not in Part E	Not in Part B	N/A	$202.19	$237.54
Initial Inpatient Consultations										
Initial inpatient consultation (focused)	99251	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A	$51.70	N/A
Initial inpatient consultation (expanded)	99252	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A	$79.28	N/A
Initial inpatient consultation (detailed)	99253	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A	$121.01	N/A
Initial inpatient consultation (comprehensive- moderate)	99254	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A Dx/Tx	N/A	$174.62	N/A

Anesthesia (CPT Code 00810) - Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum.

1. In accordance with the Medicare Claims Processing Manual anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.

2. Actual anesthesia time in minutes is reported on the claim or invoice. After January 1994 the Medicare administrative contractor (A/B MAC) computes time units dividing reported anesthesia time by 15 minutes. Round the time to one decimal place.

3. For this purpose, anesthesia practitioner means a physician who performs the anesthesia service alone, a CRNA who is not medically directed, or a CRNA or AA, who is medically directed. The physician who medically directs the CRNA or AA would ordinarily report the same time as the CRNA or AA reports for the CRNA service.

4. Monitored Anesthesia Care: Medicare B pays for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services. Anesthesiologists use modifier QS to report monitored anesthesia care cases. Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications and provision of indicated postoperative anesthesia care.

5. Medicare reimburses for anesthesia using a formula based on Uniform Relative Value Unit (RVU) (also referred to as 'base unit') for the procedure, time unit, conversion factor, and if special procedure. RVUs for anesthesia procedures are set by Medicare. Anesthesiologists submit the length of time of procedure: Medicare converts the time to units, then applies the formula. Anesthesiologists are reimbursed at **100%of the calculated amount (no modifier or modifier QS). H**owever, if using a CRNA supervised by an anesthesiologist, the anesthesiologist receives **50% (modifier QK or QY)**, and the CRNA receives **50% (modifier QX). If using a CRNA without medical direction by a physician the reimbursement is 80% of the calculated amount (modifier QZ).**

6. The Medicaid Program does not reimburse anesthesia in the same way as Medicare. Medicaid reimbursement is calculated per one-minute increments instead of per 15-minute increments used in the Medicare formula. The formula for Medicaid anethesia reimbursement is:

   [Time Units (minutes) + (Base Units x 15)] x Fee for the CPT code x Modifier Percent] = Payment or reimbursement amount. Call CRFP Unit for more information on other procedures.

7. All anesthesia procedure codes 00100 – 01999 require modifiers. The appropriate anesthesia modifier identifies who rendered the service and imply what percent of the total amount should be reimbursed (e.g., 100% or 50%). If an appropriate modifier for anesthesia services is not reported, the service will be denied.

8. CCPC recommends using the Medicare formula explained below for anesthesiology for screening procedures.

   Formula: (Time Units + Base Units) x Conversion Factor = Allowance. Time Units are the procedure minutes divided by 15.

   Add Base Units [known as Uniform Relative Value Units (RVUs) for the CPT Code 00810 the Base Unit =5]. Multiply by Local/Region specific Conversion Factor

   Conversion Factor is the $ amount for that CPT code (e.g., for 00810 it is $22.99 for Region 99; see example below)

   Examples of Reimbursement for 00810 using Formula Application:

		Region 99		Region 1		DC Metro		Medicaid MD (ALL)	
		In-Facility	Not In-Facility	In-Facility	Not In-Facility	In-Facility	Not In-Facility	In-Facility	Not In-Facility
Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum. CPT Code 00810 the Base Unit =5	**00810**	\$22.99		\$23.81		\$24.63		N/A Screening	
15 Minutes = 1 Unit + 5 Base Units=	6	6 X \$22.99=\$137.94		\$142.86		\$147.78			
60 Minutes = 4 Units + 5 Base Units=	9	\$206.91		\$214.29		\$221.67			
2 hours and 10 minutes (130 Minutes) = 8.7 Unit + 5 Base Units=	13.7	\$314.96		\$326.20		\$337.43			

ADDITIONAL NOTES:

1.	* Providers may be eligible for additional reimbursement for both physician fees and/or hospital or Ambulatory Surgical Center (ASC) facility fees.
2.	** Reimbursement Amount Not Available.
3.	@ Maryland Medicare reimbursements are dependent on geographic location. Maryland has three payment areas for physician services:

	a.	**Region 1** includes: Anne Arundel Co, Baltimore City, Baltimore Co , Carroll Co, Harford Co, and Howard Co.
	b.	**Region 99** includes: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset,Talbot, Washington, Wicomico and Worcester
	c.	**DC Metro** includes: Prince George's and Montgomery.

4.	@@ If billed a Facility Fee: If MHSCRC, pay MHSCRC fee; if non-HSCRC, call CRFP Unit to obtain the Medicaid Facility Fee rate if not on this sheet
5.	**Medicare/Medicaid Service Reimbursement Notes:**

	a.	**Pharmacy rate:** A manufacturer's ASP must be calculated by the manufacturer every calendar quarter and submitted to CMS within 30 days of the close of the quarter. This document contains the Medicare/Medicaid reimbursement rates for the periods January - March 2014. An update will be published for the period April - June 2014 but programs are not required to update their rates until the end of their current contract period. Call the CRFP Unit if you hve additionalquetions or concerns.
	b.	**J Code Drugs:** In accordance with the FY13 Maryland Medical Assistance (MMA) Physician's Services Billing Manual. You can access the 2014 Maryland Medical Assistance (MMA) Billing Manual and Fee Schedule by going to http://mmcp.dhmh.maryland.gov/SitePages/Home.aspx and then click on "About Our Programs", then scroll down and click on "Provider Information" to find the reimbursement information sites. The laboratory fees and the dental reimbursement amounts are also listed on this site. Call the CRFP Unit for the update as needed.
	c.	**^^ In-facility rate:** when the service is performed in a inpatient hospital, outpatient hospital, inpatient psychiatric facility, comprehensive inpatient rehabilitation facility, comprehensive outpatient rehabilitation facility (CORF), ambulatory surgical center (ASC), skilled nursing facility (SNF), and/or a community mental health center. **CBSA-21 (Caroline, Dorchester, Garrett, Kent, St. Mary's, Talbot, and Worcester Counties)** **CBSA-12580 (Anne Arundel, Baltimore City, Baltimore Co, Carroll, Harford, Howard, and Queen Anne's Counties)** **CBSA-13644 (Frederick County)** **CBSA-19060 (Allegany County)** **CBSA-25180 (Washington County)** **CBSA-41540 (Somerset and Wicomico Counties)** **CBSA-47894 (Calvert, Charles, Montgomery, and Prince George's Counties)** **CBSA-48864 (Cecil County)**
	d.	**Not In-facility rate** is the rate to use when the service is performed in a physician's office, the patient's home, an institution, or facility other than those places of service listed in item 5.b., above. Physician offices are not reimbursable as facilities; if procedure performed in a physician office, then use the Not In-Facility rate for the CPT code.
	e.	**Screening Services** are reimbursed at no more than the Medicare rate, as specified in the attached reimbursement schedule, when the service(s) is not regulated by the MHSCRC.
	f.	**N/A Scr--**means that the rate for the category is not applicable because the service is a Screenin Service. Screening Services are paid at Medicare rates
	g.	**Diagnostic and/or Treatment Services** are reimbursed at the Medicaid rate fee when the service is not regulated by the MHSCRC.
	h.	**N/A Dx/Tx--**means that the rate for the category is not applicable because the CPT code and service are Diagnostic and/or Treatment services and therefore paid at Medicaid rates; Medicare rates are not applicable. If the program cannot get a provider to accept Medicaid rates, the program may negotiate a rate up to the Medicare rate (Health Officer Memo #01-35). To find the Medicare rate for that CPT code, please contact the CRFP Unit at DHMH.
	i.	**B.I.--**"By Invoice" means the physician will submit an invoice of supplies and materials (e.g., drugs, trays, etc.) over and above those usually provided with an office visit. (Invoice needed if >$10 for Medicaid.)
	j.	**+B.R.** = "By Report" means the physician sends in a report with their claim. It will be reviewed by Medical Assistance who will then assign a reimbursement rate for the procedure.
	k.	**B.R.--** "By Report" means the physician sends in a report with their claim. It is reviewed by Medical Assistance who then assigns a reimbursement rate for the procedure.
	l	**& - Reimbursement for Providers when Multiple Biopsies Taken During Colonoscopy**: A provider may submit more than one colonoscopy CPTcode when billing for one procedure if multiple biopsies/removal techniques were used (for example 45383 and 45384 if both snare and hot biopsy forceps were used to obtain biopsies or remove lesions). If more than one CPT code is billed for different techniques used during the same colonoscopy procedure, local CRF programs may reimburse as 100% for the allowable Medicare reimbursement for the CPT code reimbursed at the highest amount, then 50% of the allowable Medicare reimbursement amount for the second technique's CPT Code, and 25% of the allowable Medicare reimbursement amount for the third technique, etc.

ADDITIONAL NOTES CONTINUED:

m.	**&&** - Reimbursement for Facility Fees billed using multiple Colonoscopy CPTs: A facility may submit more than one colonoscopy code if multiple techniques were used (for example **45383**, **45384**, and **45385** if ablation, snare and hot biopsy forceps were used to obtain or remove lesions). Local CRF programs may reimburse the facility fee as **100%** for the allowable Medicare facility fee, then reduce by **50%** of the allowable Medicare facility fee for each subsequent technique. For example, CPT code **45383**, **45384**, and **45385** in **Frederick County (CBSA 13644)** would be reimbursable as **$413.54 for CPT Code 45383,** the first technique (the highest amount), then any additional allowable technique would be reduced by **50%** e.g., **an additional $206.77 for CPT Code 45384,** the second technique. If there is a third technique **then an additional $103.38 for CPT Code 45385**. The total would be **$723.69** for the three designated codes. The specific CBSA amounts for individual Maryland counties including Baltimore City are included in the sheet above.
n.	**&&&** - **Reimbursement for a Laboratory when Multiple Biopsies Taken During Colonoscopy:** A laboratory and pathologist may submit for reimbursement for processing and reading each individual specimen (that is, each individual vial sent for analysis). For example, a laboratory can bill for CPT code 88305--once for each individual specimen vial processed. Local CRF programs may reimburse the lab and pathologist at the Medicare rate for **each** of the specimens processed.

6. COMMON CPT MODIFIERS:

23	Unusual anesthesia **Note:** When using modifier 23, appropriate documentation must be submitted with the claim.
26	Professional Component - A procedure can be split into its "professional" and "technical" components and each can be billed separately as noted (see TC, below). The sum of the two components (professional and technical) equals the rate if billed with one code. When the professional component is reported separately, the service will be identified by adding the modifier 26 to the usual CPT procedure code number. This modifier must be reported in the first modifier field.
47	Anesthesia by surgeon (**not used by the Medicaid program**).
51	When multiple procedures (other than evaluation and management services) are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier "51" to the additional procedure or service code(s).
53	A discontinued procedure due to extenuating circumstances or those that threaten the well being of the patient. Not to be used to report elective cancellation.
58	**Staged or Related Procedures:** Staged or Related Procedure or Service by the Same Physician during the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. Note: For treatment of a problem that required a return to the operating or procedure room (e.g., unanticipated clinical condition), see modifier 78.
59	Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area in injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Modifier 59 should only be used if there is no other more descriptive modifier available and the use of modifier 59 best explains the circumstances. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
73	A discontinued out-patient hospital/ASC procedure **prior** to administration of anesthesia due to extenuating circumstances as with -53.
74	A discontinued out-patient hospital/ASC procedure **after** the administration of anesthesia due to extenuating circumstances as with modifier -53.
80	Assistant surgeon. Maximum payment is **20%** of the listed fee for the primary procedure. The minimum allowance is **$25.00**. Assistant must be a physician. This may not be used to report physician assistant or nurse practitioner assistant surgical services.
C	The payment for the technical component is capped at the OPPS amount.
AA	Anesthesia services performed personally by anesthesiologist (100%)
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures. (**Not used by the Medicaid program**)
ET	Emergency Services.
PI	PET Tumor Initial Treatment Strategy.
PS	PET Tumor Subsequent Treatment Strategy.
PT	Colorectal Screening Test that was converted to Diagnostic Test or other procedure during the procedure (e.g., when a biopsy was taken)
QK	Medically directed by a physician: two, three, or four concurrent procedures (50%)
QS	Monitored anesthesia care (MAC) service. QS is for informational purposes only and will not change payment. (100%)
QW	CLIA Waived Test
QY	Anesthesiologist medically directs one CRNA (50%)
QX	CRNA service: with medical direction by a physician (50%)
QZ	CRNA service: without medical direction by a physician (80%)
TC	Technical Component - A procedure can be split into its "professional" and "technical" components and each can be billed separately as noted (see -26, Professional Component, above). The sum of the two components (professional and technical) equals the rate if billed with one code. When the technical component is reported separately, the service will be identified by adding the modifier TC to the usual CPT procedure code number.