2015 Office Visit Reimbursement Rates and Additional Notes

CRFP CPEST Program Office Visits and Additional Notes	CPT Code	Medicare [@]							Medicaid as of 04 / 01 / 2015	
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	$27.33	$45.11	$28.27	$47.09	$29.78	$50.46	N/A	$24.59	$40.97
LEVEL 2: Expanded problem focused history & examination with straightforward medical decision approx. **20 minutes**	99202	$51.37	$76.93	$53.05	$80.12	$55.82	$85.54	N/A	$46.14	$78.32
LEVEL 3: Detailed history & examination requiring low complexity medical decision approx. **30 minutes**	99203	$78.97	$111.56	$81.81	$116.32	$86.08	$123.99	N/A	$71.17	$113.59
LEVEL 4: Comprehensive history & exam ination requiring moderately complex medical decision approx. **45 minutes**	99204	$133.61	$169.54	$138.18	$176.23	$145.33	$187.12	N/A	$120.21	$174.10
LEVEL 5: Comprehensive history & exam ination requiring highly complex medical decision approx. **60 minutes**	99205	$173.64	$212.90	$179.58	$221.15	$188.84	$234.51	N/A	$156.22	$216.65
Office Visit, Established Patient										
LEVEL 1: Eval/management, may not require presence of MD - problems usually minimal	99211	$9.47	$20.59	$9.75	$21.52	$10.24	$23.16	N/A	$8.48	$21.21
LEVEL 2: Problem focused history and examination with straightforward medical decision	99212	$26.22	$45.11	$27.09	$47.09	$28.49	$50.46	N/A	$23.57	$46.05
LEVEL 3: Expanded problem focused history & examination with low complexity medical decision	99213	$52.10	$74.70	$53.70	$77.63	$56.43	$82.71	N/A	$46.71	$76.72
LEVEL 4: Detailed history & exam- ination requiring moderately complex medical decision	99214	$80.50	$110.88	$83.01	$115.18	$87.23	$122.55	N/A	$72.22	$113.09
LEVEL 5: Comprehensive history & examination requiring highly complex medical decision	99215	$114.36	$149.55	$118.06	$155.32	$124.10	$165.03	N/A	$102.71	$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 B	Not in Part B	N/A	$31.13	$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 B	Not in Part B	N/A	$64.81	$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 B	Not in Part B	N/A	$90.30	$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 B	Not in Part B	N/A	$142.70	$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 B	Not in Part B	N/A	$177.34	$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	$45.31	$45.31
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	$69.52	$69.52
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	$106.04	$106.04
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	$152.91	$152.91
Initial inpatient consultation (comprehensive - high)	99255	DxTx	DxTx	DxTx	DxTx	DxTx	DxTx	N/A	$184.88	$184.88
Initial Hospital Care										
Initial hospital care, per day, for the evaluation and management of a patient which requires detailed H&P - Low	99221	DxTx	DxTx	DxTx	DxTx	DxTx	DxTx	N/A	$94.01	$94.01
…comprehensive H&P - Moderate	99222	DxTx	DxTx	DxTx	DxTx	DxTx	DxTx	N/A	$126.60	$126.60
…comprehensive H&P - High	99223	DxTx	DxTx	DxTx	DxTx	DxTx	DxTx	N/A	$187.43	$187.43

Subsequent Hospital Care										
Subsequent care - Focused - Low	**99231**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**N/A**	**$35.91**	**$35.91**
… care - Expanded - Moderate complexity	**99232**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**N/A**	**$66.65**	**$66.65**
… care - Detailed - High complexity	**99233**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**N/A**	**$96.08**	**$96.08**
Hospital Discharge Services										
Discharge day management 30 minutes or less	**99238**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**N/A**	**$67.58**	**$67.58**
Discharge day management more than 30 minutes	**99239**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**DxTx**	**N/A**	**$99.54**	**$99.54**
Emergency Department Services										
Emergency department visit - focused	**99281**	**$21.45**		**$22.04**		**$23.02**		**N/A**	**$19.17**	**$19.17**
… expanded - low	**99282**	**$42.15**		**$43.38**		**$45.32**		**N/A**	**$37.74**	**$37.74**
…expanded - medium	**99283**	**$63.54**		**$65.46**		**$68.34**		**N/A**	**$56.95**	**$56.95**
… detailed - high	**99284**	**$120.87**		**$124.56**		**$130.02**		**N/A**	**$108.37**	**$108.37**
.. comprehensive - high	**99285**	**$178.88**		**$184.46**		**$192.50**		**N/A**	**$160.48**	**$160.48**

ADDITIONAL NOTES:

1. **New Definition.** A Colonoscopy is the examination of the entire colon, from the rectum to the cecum or colon-small intestine anastomosis, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis. For screening or diagnostic colonoscopy, report 45378 with modifier 53 if unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances and provide appropriate documentation. For therapeutic examinations that do not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy code with modifier 52 and provide appropriate documentation.

The new definition includes anesthesia separately furnished in conjunction with screening colonoscopies in the Medicare regulations at Section 410.37(a)(1)(iii). As a result, beneficiary coinsurance and deductible does not apply to anesthesia services associated with screening colonoscopies. As a result, effective for claims with dates of service on or after January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (HCPCS code 00810 performed in conjunction with G0105 and G0121) shall include the Modifier 33 on the claim for the services that qualify for the waiver of coinsurance and deductible.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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 100% of the calculated amount (modifier QZ).**

7. 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.

8. 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.

9. 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**	**$22.82**		**$23.56**		**$24.60**		**N/A Screening**	
15 Minutes = 1 Unit + 5 Base Units=	**6**	**6 X $22.82=$136.92**		**$141.36**		**$147.60**			
60 Minutes = 4 Units + 5 Base Units=	**9**	**$205.38**		**$212.04**		**$221.40**			
2 hours and 10 minutes (130 Minutes) = 8.7 Unit + 5 Base Units=	**13.7**	**$312.63**		**$322.77**		**$337.02**			

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:** The Medicare and the Maryland Medical Assistance (MMA)/Medicaid Programs will only reimburse J Coded drugs at the providers acquisition price.
- **c.** **^^ FAC (In-facility) rate:** when the service is performed in a inpatient or outpatient hospital or psychiatric facility, comprehensive inpatient or outpatient rehabilitation facility (CORF), ambulatory surgical
- **d.** **NFAC (Not In-facility) rate** is the rate to use when the service is performed in a office, home, or school (institution) setting, or facility other than those places of service listed in item 5.c., above.
- **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 Screening 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 or by contractural allowance.
- **h.** **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.** **The Indicator (B.I.)** indicates **"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.** **The "By Report (BR, B.R., and +B.R.)"** which means "the Physician sends in a report with their claim". It is reviewed **(B.R.)** or will be reviewed **(+B.R.)** by Medical Assistance who then assigns a reimbursement rate for the procedure.

ADDITIONAL NOTES CONTINUED:

K. & I.	**Multiple Endoscopic Procedures. If Field 21 of the Medicare fee schedule payment (MFSDB) contains an indicator of "3," and multiple endoscopies are billed, the special rules for multiple endoscopic procedures apply. Pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy. Access Field 31A of the MFSDB to determine the base endoscopy.** **EXAMPLE: In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378). Carriers assume the following fee schedule amounts for these codes:** **CY15 CPT Codes — Region 1 — Region 99 — DC Metro** **45378 - $234.71 $225.22 $247.88** **45380 - $280.51 $269.25 $296.20** **45385 - $332.73 $319.41 $351.22** **In Region 1; the program would pay the full value of the highest endoscopic procedure 45385 ($332.73), plus the difference between 45380 and 45378 ($30.58), for a total of $405.14. The Base or Completed Colonoscopy is included in the highest endoscopic procedure's rate.**
m.	**The CMS is using the new Core Based Statistical Area (CBSA) delineations issued by the Office of Management and Budget (OMB) for CY 2015.** Review the charts below to determine your 2015 CBSA number and locations for individual Maryland counties including Baltimore City are included in the CRC Reimbursement Chart:
	CBSA-21 (Caroline, Dorchester, Garrett, Kent, and Talbot Counties)
	CBSA-12580 (Anne Arundel, Baltimore City, Baltimore Co, Carroll, Harford, Howard, and Queen Anne's Counties)
	CBSA-15680 (St. Mary's County)
	CBSA-19060 (Allegany County)
	CBSA-25180 (Washington County)
	CBSA-41540 (Somerset and Wicomico Counties)
	CBSA-43524 (Frederick, Montgomery, Counties)
	CBSA-47894 (Calvert, Charles, and Prince George's Counties)
	CBSA-48864 (Cecil County)
	CBSA-50091 (Worcester County)
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
o.	**NEW - Billing Surgical Trays In An Office Setting**

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.
33	**NEW-**Preventive Services: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used. The Center for Medicare and Medicaid Services (CMMS) Preventive and Screening Services revised update #8874; the definition of "colorectal cancer screening tests" includes anesthesia separately furnished in conjunction with screening colonoscopies in the Medicare regulations at Section 410.37(a)(1)(iii). As a result, beneficiary coinsurance and deductible does not apply to anesthesia services associated with screening colonoscopies.
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 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. This circumstance may be reported by adding the **Modifier 53** to the code reported by the physician for the discontinued procedure. In many instances, attachments, medical records, etc. are not required. **NOTE:** The **Modifier 53** is not to be used to report elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the wellbeing of the patient prior to or after administration of anesthesia, see **Modifiers 73 and 74**. An incomplete colonoscopy, e.g., the inability to extend beyond the splenic flexure, is billed and paid using colonoscopy code **45378** with **Modifier 53.** The Medicare physician fee schedule database has specific values for code **45378-53**. These values are the same as for code **45330**, sigmoidoscopy, as failure to extend beyond the splenic flexure means that a sigmoidoscopy rather than a colonoscopy has been performed. However, code **45378-53** should be used when an incomplete colonoscopy has been done because other MPFSDB indicators are different for codes **45378** and **45330**.

ADDITIONAL NOTES CONTINUED:

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	**NEW-**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 and Radiation Treatment Management, 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. The Centers for Medicare & Medicaid Services (CMS) implemented Change Request (CR) # 8863 effective January 1, 2015. This CR established four (4) new HCPCS modifiers **(XE, XP, XS, XU)** to define specific subsets of the **Modifier 59**. These modifiers are collectively referred to as –X {EPSU} modifiers.
73	A discontinued out-patient hospital/ASC procedure **prior** to administration of anesthesia due to extenuating circumstances as with **Modifier 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 **(100%)**

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.