Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Office Visit								
Initial, New Patient								
LEVEL 1: Problem focused history & examination with straightforward medical decision	**99201**	**$24.54**	**$38.36**	**$25.57**	**$40.44**	**$27.16**	**$44.30**	**$29.50**
LEVEL 2: Expanded problem focused history & examination with straightforward medical decision	**99202**	**$47.65**	**$66.43**	**$49.66**	**$69.88**	**$52.75**	**$76.05**	**$52.13**
LEVEL 3: Detailed history & examination requiring low complexity medical decision	**99203**	**$71.80**	**$96.25**	**$74.84**	**$101.16**	**$79.35**	**$109.67**	**$77.42**
LEVEL 4: Comprehensive history & examination requiring moderately complex medical decision	**99204**	**$121.26**	**$149.26**	**$126.28**	**$156.42**	**$133.80**	**$168.53**	**$113.05**
LEVEL 5: Comprehensive history & examination requiring highly complex medical decision	**99205**	**$157.22**	**$187.69**	**$163.65**	**$196.45**	**$173.36**	**$211.16**	**$141.64**
Established Patient								
LEVEL 1: Problem focused history & examination with straightforward medical decision	**99211**	**$8.90**	**$18.82**	**$9.25**	**$19.93**	**$9.81**	**$22.12**	**$17.61**
LEVEL 2: Expanded problem focused history & examination with straightforward medical decision	**99212**	**$24.19**	**$38.36**	**$25.19**	**$40.44**	**$26.72**	**$44.30**	**$31.08**
LEVEL 3: Detailed history & examination requiring low complexity medical decision	**99213**	**$47.71**	**$64.72**	**$49.59**	**$67.89**	**$52.57**	**$73.67**	**$48.29**
LEVEL 4: Comprehensive history & examination requiring highly complex medical decision	**99214**	**$73.69**	**$97.08**	**$76.60**	**$101.77**	**$81.19**	**$110.19**	**$73.14**
LEVEL 5: Comprehensive history & examination requiring highly complex medical decision	**99215**	**$103.96**	**$130.89**	**$108.06**	**$137.05**	**$114.58**	**$147.98**	**$98.77**

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Office Consultation for a New or Established Patient:								
Problem focused history & examination with straightforward medical decision	**99241**							**$38.53**
Expanded problem focused history & examination with straightforward medical decision	**99242**							**$70.93**
Detailed history & examination requiring low complexity medical decision	**99243**							**$95.83**
Comprehensive history & examination requiring moderately complex medical decision	**99244**							**$140.28**
Comprehensive history & examination requiring highly complex medical decision	**99245**							**$173.94**
Services provided at times other than regularly scheduled hours or days when normally closed, in addition to basic service	**99050**							**$0.00**
Services provided during regularly evening, weekend or Holiday office hours, in additon to basic service	**99051**							**$0.00**
Services provided between 10 pm and 8 am at 24 hour facility, in addition to basic service	**99053**							**$0.00**
Office services provided on an emergency basis	**99058**							**$10.00**
Initial Inpatient Consultations								
Initial inpatient consultation (focused)	**99251**							**$35.37**
Initial inpatient consultation (expanded)	**99252**							**$56.85**
Initial inpatient consultation (detailed)	**99253**							**$84.11**
Initial inpatient consultation (comprehensive-moderate)	**99254**							**$121.12**

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Inpatient consultations (continued)								
Initial inpatient consultation (comprehensive - high)	**99255**							**$151.14**
Follow-Up Inpatient Consultations								
Follow-up inpatient consultation (focused)	**99261**							
Follow-up inpatient consultation (expanded)	**99262**							
Follow-up inpatient consultation (detailed)	**99263**							
Confirmatory Consultations								
Confirmatory consultation (focused)	**99271**							
Confirmatory consultation (expanded)	**99272**							
Confirmatory consultation (detailed)	**99273**							
Confirmatory consultation (comprehensive - moderate)	**99274**							
Confirmatory consultation (comprehensive - high)	**99275**							
Initial Hospital Care								
Initial hospital care, per day, for the evaluation and management of a patient which requires H&P - Low	**99221**	**$93.87**		**$97.71**		**$103.31**		**$65.52**
…comprehensive H&P - Moderate	**99222**	**$127.40**		**$132.47**		**$140.23**		**$91.98**
…comprehensive H&P - High	**99223**	**$187.28**		**$194.57**		**$206.02**		**$134.16**
Subsequent Hospital Care								
Subsequent care - Focused	**99231**	**$37.73**		**$39.24**		**$41.63**		**$27.55**
… care - Expanded	**99232**	**$68.01**		**$70.67**		**$74.90**		**$49.24**
… care - Detailed	**99233**	**$97.57**		**$101.36**		**$107.41**		**$70.30**

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Hospital Discharge Services								
Discharge day management 30 minutes or less	**99238**	**$66.94**		**$69.69**		**$74.33**		**$51.39**
Discharge day management more than 30 minutes	**99239**	**$97.60**		**$101.51**		**$108.17**		**$73.68**
Emergency Department Services								
Emergency department visit - focused	**99281**	**$20.63**		**$21.42**		**$22.51**		**$19.85**
… expanded - low	**99282**	**$39.87**		**$41.34**		**$43.46**		**$37.32**
…expanded - medium	**99283**	**$60.86**		**$63.13**		**$66.35**		**$60.34**
… detailed - high	**99284**	**$114.27**		**$118.43**		**$124.28**		**$111.25**
.. comprehensive - high	**99285**	**$168.75**		**$174.85**		**$183.40**		**$166.06**
Comprehensive Nursing Facility Assessments								
Evaluation and management - low	**99304**							
…. - moderate	**99305**							
… - complex	**99306**							
Subsequent Nursing Facility Care								
Subsequent nursing facility care - focused	**99307**							
…- expanded	**99308**							
… - detailed	**99310**							

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Screening and Diagnosis								
Fecal Occult Blood Test; 1-3 simultaneous determinations	**82270**	**$4.66**	**$4.66**	**$4.66**	**$4.66**	**$4.66**	**$4.66**	**$3.51**
Blood, occult, fecal hemoglobin immunoassay	**82274**	**$22.78**	**$22.78**	**$22.78**	**$22.78**	**$22.78**	**$22.78**	**$16.45**
Screening Sigmoidoscopy	**G0104**	**$58.30**	**$123.85**	**$61.06**	**$131.62**	**$65.75**	**$147.06**	**Reimburse using 45330**
Facility Fee for Screening Sigmoidoscopy	**G0104**	**$84.52**		**$90.08**		**$88.73**		**Not Covered**
Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing	**45330**	**$59.87**	**$125.43**	**$63.02**	**$133.58**	**$67.62**	**$148.92**	**$101.80**
^^Facility Fee for Sigmoidoscopy, flexible; diagnostic, with or without collection…	**45330**	**$84.52**		**$85.26**		**$88.73**		**Not Covered**
Sigmoidoscopy, flexible; with biopsy, single or multiple	**45331**	**$72.63**	**$157.68**	**$76.46**	**$168.00**	**$82.13**	**$187.61**	**$132.52**
^^Facility Fee for sigmoidoscopy, flexible; with biopsy, single or multiple	**45331**	**$232.39**		**$234.42**		**$243.97**		##
Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	**45333**	**$105.91**	**$263.24**	**$111.36**	**$280.70**	**$118.96**	**$314.10**	**$216.85**
^^Facility Fee for sigmoidoscopy, flexible; with removal of tumor(s)…by hot biopsy forceps or bipolar cautery	**45333**	**$338.92**		**$341.89**		**$355.81**		##
Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) with control of bleeding, any method	**45334**	**$159.51**	**$159.51**	**$167.51**	**$167.51**	**$178.33**	**$178.99**	**$119.33**
^^Facility Fee for sigmoidoscopy, flexible;	**45334**	**$338.92**		**$341.89**		**$355.81**		**Not Covered**
Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare techniques	**45338**	**$136.82**	**$291.67**	**$143.69**	**$310.37**	**$153.53**	**$345.60**	**$237.69**

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Screening and Diagnosis, (continued)								
^^Facility Fee for sigmoidoscopy, flexible; with removal of tumor(s)...by snare technique	**45338**	**$338.92**		**$341.89**		**$355.81**		##
Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	**45339**	**$180.75**	**$306.55**	**$189.78**	**$325.18**	**$202.49**	**$358.52**	**$229.91**
^^ Facility Fee for sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	**45339**	**$338.92**		**$341.89**		**$355.81**		##
Screening Colonoscopy	**G0105**	**$204.41**	**$361.75**	**$213.57**	**$382.92**	**$228.34**	**$423.48**	
Discontinued procedure (see last page - modifier explanations)	**GO105-53**	**$57.98**	**$123.53**	**$60.66**	**$131.23**	**$65.38**	**$146.69**	**Reimburse using 45378 rates**
^^Facility Fee for Screening	**G0105**							
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression &	**45378**	**$210.09**	**$367.42**	**$220.63**	**$389.97**	**$235.04**	**$430.18**	**$302.32**
^^ && Facility Fee for colonoscopy, flexible, proximal to splenic flexure; diagnostic…	**45378**	**$360.55**		**$363.71**		**$378.52**		##
Discontinued procedure (see last page - modifier explanations)	**45378-53**	**$59.87**	**$125.43**	**$63.02**	**$133.58**	**$67.62**	**$148.92**	
Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple &	**45380**	**$252.35**	**$439.80**	**$264.88**	**$466.64**	**$282.37**	**$514.88**	**$361.10**
^^ && Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with biopsy…	**45380**	**$360.55**		**$363.71**		**$378.52**		##
Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding, any method &	**45382**	**$322.54**	**$577.67**	**$338.50**	**$613.12**	**$360.81**	**$677.26**	**$479.39**
^^ && Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with control of bleeding	**45382**	**$360.55**		**$363.71**		**$378.52**		##

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Screening and Diagnosis, (continued)								
Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique &	**45383**	$325.61	$527.59	$341.69	$559.10	$363.32	$613.84	**$426.27**
^^ &&Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s)...	**45383**	**$360.55**		**$363.71**		**$378.52**		##
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery &	**45384**	**$263.56**	**$435.42**	**$276.72**	**$461.71**	**$294.43**	**$507.59**	**$353.76**
^^ &&Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with removal of tumors(s)…by hot biopsy forceps or bipolar cautery	**45384**	**$360.55**		**$363.71**		**$378.52**		##
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique &	**45385**	**$299.82**	**$496.48**	**$314.68**	**$526.36**	**$335.23**	**$579.16**	**$405.22**
^^ && Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s)...by snare technique	**45385**	**$360.55**		**$363.71**		**$378.52**		##
Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (exploratory)	**44388**	**$160.77**	**$319.87**	**$168.94**	**$340.19**	**$179.86**	**$377.20**	**$249.02**
^^Facility Fee for colonoscopy through stoma….	**44388**	**$334.93**		**$337.86**		**$351.62**		##
Computed tomographic (CT) colonography (ie, virtual colonoscopy); diagnostic	**74261**	**$301.05**		**$319.85**		**$357.90**		
-26 Modifier		**$109.38**		**$113.50**		**$120.19**		
-TC Modifier		**$191.66**		**$206.36**		**$237.71**		
Screening Barium Enema (alternate-flex	**G0106**	**$193.04**	**$193.04**	**$205.92**	**$205.92**	**$232.72**	**$232.72**	**
-26 Modifier	**G0106-26**	**$49.21**	**$49.21**	**$51.06**	**$51.06**	**$54.34**	**$54.34**	**
-TC Modifier	**G0106-TC**	**$143.83**	**$143.83**	**$154.86**	**$154.86**	**$178.37**	**$178.37**	**
Screening Barium Enema (alternate-col)	**G0120**	**$132.09**	**$132.09**	**$140.32**	**$140.32**	**$157.12**	**$157.12**	
-26 Modifier	**G0120-26**	**$49.21**	**$49.21**	**$51.06**	**$51.06**	**$54.34**	**$54.34**	**
-TC Modifier	**G0120-TC**	**$82.88**	**$82.88**	**$89.26**	**$89.26**	**$202.78**	**$202.78**	**
Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	**GO121**	**$204.73**	**$362.06**	**$213.96**	**$383.31**	**$228.71**	**$423.85**	**Reimburse using 45378 rates**
-53 Modifier	**GO121-53**	**$58.93**	**$124.48**	**$61.84**	**$132.40**	**$66.50**	**$147.81**	

Colorectal Cancer	CPT Code	Reimbursement Rate* Medicare@	Medicaid^

Procedure		Region 99		Region 1		DC Metro		All Maryland
		In-Facility	Not In-Facility	In-Facility	Not In-Facility	In-Facility	Not In-Facility	
Screening and Diagnosis, (continued)								
Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	74240	$102.55	$102.55	$109.15	$109.15	$122.49	$122.49	$80.83
-26 Modifier	74240-26	$34.55	$34.55	$35.91	$35.91	$38.17	$38.17	$25.50
-TC Modifier	74240-TC	$68.00	$68.00	$73.24	$73.24	$84.32	$84.32	
Radiologic examination, gastrointestinal tract, upper; with or without delayed films, with KUB	74241	$109.64	$109.64	$116.78	$116.78	$131.28	$131.28	$85.05
-26 Modifier	74241-26	$34.20	$34.20	$35.53	$35.53	$37.73	$37.73	$25.19
-TC Modifier	74241-TC	$75.44	$75.44	$81.25	$81.25	$93.55	$93.55	
Radiologic examination, gastrointestinal tract, upper; with small bowel, includes multiple serial film	74245	$163.55	$163.55	$174.41	$174.41	$196.66	$196.66	$127.76
-26 Modifier	74245-26	$45.60	$45.60	$47.39	$47.39	$50.37	$50.37	$33.32
-TC Modifier	74245-TC	$117.96	$117.96	$127.02	$127.02	$146.29	$146.29	
Radiologic examination, small bowel, includes multiple serial films;	74250	$97.18	$97.18	$103.78	$103.78	$117.32	$117.32	$73.65
-26 Modifier	74250-26	$23.51	$23.51	$24.43	$24.43	$25.97	$25.97	17.09
-TC Modifier	74250-TC	$73.67	$73.67	$79.34	$79.34	$91.35	$91.35	
Barium Enema, radiologic examination, colon; with or without KUB	74270	$120.62	$120.62	$128.60	$128.60	$144.91	$144.91	$95.27
-26 Modifier	74270-26	$34.55	$34.55	$35.91	$35.91	$38.17	$38.17	$25.50
-TC Modifier	74270-TC	$86.07	$86.07	$92.69	$92.69	$106.73	$106.73	
Barium Enema, air contrast with specific high density barium, with or without	74280	$188.39	$188.39	$200.98	$200.98	$226.94	$226.94	$142.71
-26 Modifier	74280-26	$49.53	$49.53	$51.45	$51.45	$54.71	$54.71	$35.92
-TC Modifier	74280-TC	$138.87	$138.87	$149.52	$149.52	$172.22	$172.22	
Usual Charges That Might Be Associated With Colonoscopy Work-Up								
Supplies and Materials provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	99070		**		**		**	9.99
Surgical Tray	A4550	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	B.I.
Moderate sedation requiring presence of independent observer to monitor; first 30 minutes	99144	$39.31		$43.50		$45.80		$28.27

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Usual Charges That Might Be Associated With Colonoscopy Work-Up (cont.)								
Moderate sedation requiring presence of physician other than professional performing service, first 30 minutes	**99149**	**$45.77**		**$50.65**		**$53.33**		**$28.27**
Work-Up: Laboratory, Pathology and Radiology								
Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	**99000**	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**	**$0.00**
Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)	**99001**	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**	**$0.00**
Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	**81000**	**$4.54**	**$4.54**	**$4.54**	**$4.54**	**$4.54**	**$4.54**	**$3.42**
Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents, automated, with microscopy	**81001**	**$4.54**	**$4.54**	**$4.54**	**$4.54**	**$4.54**	**$4.54**	**$3.42**
Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents, non-automated, without microscopy	**81002**	**$3.66**	**$3.66**	**$3.66**	**$3.66**	**$3.66**	**$3.66**	**$2.75**
Urinalysis; qualitative or semiquantitative, except immunoassays	**81005**	**$3.10**	**$3.10**	**$3.10**	**$3.10**	**$3.10**	**$3.10**	**$2.34**
Urinalysis… bacteriuria screen, except by culture or dipstick	**81007**	**$3.68**	**$3.68**	**$3.68**	**$3.68**	**$3.68**	**$3.68**	**$2.77**
Urinalysis… microscopic only	**81015**	**$4.35**	**$4.35**	**$4.35**	**$4.35**	**$4.35**	**$4.35**	**$2.98**
Urinalysis… two or three glass test	**81020**	**$5.28**	**$5.28**	**$5.28**	**$5.28**	**$5.28**	**$5.28**	**$3.97**

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Work-Up (continued)								
Urine pregnancy test, by visual color comparison methods	**81025**	**$9.06**	**$9.06**	**$9.06**	**$9.06**	**$9.06**	**$9.06**	**$6.81**
Volume measurement (urine) for timed collection, each	**81050**	**$4.16**	**$4.16**	**$4.16**	**$4.16**	**$4.16**	**$4.16**	**$3.01**
Unlisted urinalysis procedure	**81099**	**Not Available**	**Not Available**	**Not Available**	**Not Available**	**Not Available**	**Not Available**	**BR+**
Carcinoembryonic Antigen (CEA)	**82378**	**$27.17**	**$27.17**	**$27.17**	**$27.17**	**$27.17**	**$27.17**	**$20.44**
Blood Count; blood smear, micro exam with manual diff WBC count	**85007**	**$4.93**	**$4.93**	**$4.93**	**$4.93**	**$4.93**	**$4.93**	**$3.56**
Renal Function Panel - includes albumin, calcium, bicarbonate, chloride, creatinine, glucose, phosphate, potassium, sodium, urea nitrogen (BUN)	**80069**	**$12.43**	**$12.43**	**$12.43**	**$12.43**	**$12.43**	**$12.43**	**$9.36**
Hepatic Function Panel - includes albumin, bilirubin (total), bilirubin (direct), alanine amino transferase (SGPT), aspartate amino transferase (SGOT) alkaline phosphatase, protein (total)	**80076**	**$11.70**	**$11.70**	**$11.70**	**$11.70**	**$11.70**	**$11.70**	**$8.81**
Electrolyte Panel - includes bicarbonate, chloride, potassium, sodium	**80051**	**$10.05**	**$10.05**	**$10.05**	**$10.05**	**$10.05**	**$10.05**	**$7.56**
Thromboplastin (PTT) time, partial, plasma or whole blood	**85730**	**$6.93**	**$6.93**	**$6.93**	**$6.93**	**$6.93**	**$6.93**	**$5.21**
Prothrombin (PT), specific clotting factor II	**85210**	**$5.88**	**$5.88**	**$5.88**	**$5.88**	**$5.88**	**$5.88**	**$4.24**
Pathology review; comprehensive, for a complex diagnostic problem, with review of patients history and medical records	**80502**	**$62.71**	**$64.48**	**$65.03**	**$66.94**	**$68.74**	**$70.94**	**$47.49**
Surgical Pathology , gross examination only &&&	**88300**	**$22.99**	**$22.99**	**$24.68**	**$24.68**	**$27.94**	**$27.94**	**$17.94**
-26 Modifier	**88300-26**	**$4.25**	**$4.25**	**$4.46**	**$4.46**	**$4.71**	**$4.71**	**$3.18**
-TC Modifier	**88300-TC**	**$18.74**	**$18.74**	**$20.23**	**$20.23**	**$23.23**	**$23.23**	**$14.76**
Surgical Pathology Review Level II, surgical pathology, gross and microscop-ic examination &&&	**88302**	**$47.46**	**$47.46**	**$50.92**	**$50.92**	**$57.96**	**$57.96**	**$38.96**
-26 Modifier	**88302-26**	**$6.40**	**$6.40**	**$6.66**	**$6.66**	**$7.04**	**$7.04**	**$4.93**
TC Modifier	**88302-TC**	**$41.07**	**$41.07**	**$44.25**	**$44.25**	**$50.92**	**$50.92**	**$34.03**
Surgical Pathology Review Level III, surgical pathology, gross and microscopic examination &&&	**88304**	**$59.90**	**$59.90**	**$64.12**	**$64.12**	**$72.79**	**$72.79**	**$48.18**
-26 Modifier	**88304-26**	**$10.69**	**$10.69**	**$11.10**	**$11.10**	**$11.76**	**$11.76**	**$7.82**
-TC Modifier	**88304-TC**	**$49.22**	**$49.22**	**$53.03**	**$53.03**	**$61.02**	**$61.02**	**$40.36**

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Work-Up (continued)								
Surgical Pathology Review-Level IV, gross and microscopic examination, colon, colorectal polyp biopsy &&&	**88305**	**$100.17**	**$100.17**	**$106.36**	**$106.36**	**$119.18**	**$119.18**	**$80.21**
-26 Modifier	**88305-26**	**$36.43**	**$6.43**	**$37.70**	**$37.70**	**$40.14**	**$40.14**	**$27.53**
-TC Modifier	**88305-TC**	**$63.74**	**$63.74**	**$68.67**	**$68.67**	**$79.04**	**$79.04**	**$52.68**
Surgical Pathology Review-Level V, gross and microscopic examination, colon, segmental resection other than for tumor &&&	**88307**	**$205.35**	**$205.35**	**$217.92**	**$217.92**	**$243.96**	**$243.96**	**$157.62**
-26 Modifier	**88307-26**	**$77.82**	**$77.82**	**$80.60**	**$80.60**	**$85.80**	**$85.80**	**$59.14**
-TC Modifier	**88307-TC**	**$127.53**	**$127.53**	**$137.32**	**$137.32**	**$158.16**	**$158.16**	**$98.48**
Surgical Pathology Review-Level VI, gross and microscopic examination, colon, segmental resection for tumor or total resection &&&	**88309**	**$312.02**	**$312.02**	**$330.42**	**$330.42**	**$368.08**	**$368.08**	**$233.64**
-26 Modifier	**88309-26**	**$135.99**	**$135.99**	**$140.83**	**$140.83**	**$149.77**	**$149.77**	**$99.90**
-TC Modifier	**88309-TC**	**$176.03**	**$176.03**	**$189.58**	**$189.58**	**$218.30**	**$218.30**	**$133.74**
Pathology: Special stains (list separately in addition to code for surgical pathology examination); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each	**88312**	**$96.54**	**$96.54**	**$102.89**	**$102.89**	**$116.08**	**$116.08**	**$74.79**
-26 Modifier	**88312-26**	**$25.71**	**$25.71**	**$26.60**	**$26.60**	**$28.25**	**$28.25**	**$20.51**
-TC Modifier	**88312-TC**	**$70.83**	**$70.83**	**$76.29**	**$76.29**	**$87.83**	**$87.83**	**$54.28**
CAT scan, abdomen; with contrast material(s)	**74160**	**$318.17**	**$318.17**	**$340.13**	**$340.13**	**$386.00**	**$386.00**	**$266.14**
-26 Modifier	**74160-26**	**$63.43**	**$63.43**	**$65.88**	**$65.88**	**$70.06**	**$70.06**	**$46.92**
-TC Modifier	**74160-TC**	**$254.74**	**$254.74**	**$274.25**	**$274.25**	**$315.94**	**$315.94**	
CT scan (with and without contrast-abdomen)	**74170**	**$397.56**	**$397.56**	**$425.37**	**$425.37**	**$483.58**	**$483.58**	**$308.43**
-26 Modifier	**74170-26**	**$70.18**	**$70.18**	**$72.93**	**$72.93**	**$77.54**	**$77.54**	**$51.29**
-TC Modifier	**74170-TC**	**$327.38**	**$327.38**	**$352.44**	**$352.44**	**$406.04**	**$406.04**	
Pelvic CT scan; computerized axial tomography without contrast material	**72192**	**$235.17**	**$235.17**	**$251.17**	**$251.17**	**$284.27**	**$284.27**	**$191.47**
-26 Modifier	**72192-26**	**$54.85**	**$54.85**	**$57.02**	**$57.02**	**$60.62**	**$60.62**	**$39.98**
-TC Modifier	**72192-TC**	**$180.33**	**$180.33**	**$194.15**	**$194.15**	**$223.64**	**$223.64**	

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All Maryland
Work-Up (continued)								
CAT scan, pelvis; with contrast material(s)	**72193**	**$281.98**	**$281.98**	**$301.40**	**$301.40**	**$341.85**	**$341.85**	**$261.74**
-26 Modifier	**72193-26**	**$58.07**	**$58.07**	**$60.34**	**$60.34**	**$64.15**	**$64.15**	**$42.59**
-TC Modifier	**72193-TC**	**$223.91**	**$223.91**	**$241.06**	**$241.06**	**$277.70**	**$277.70**	
Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	**72195**	**$416.33**	**$416.33**	**$445.49**	**$445.49**	**$506.44**	**$506.44**	**$324.68**
-26 Modifier	**72195-26**	**$73.00**	**$73.00**	**$75.89**	**$75.89**	**$80.62**	**$80.62**	**$53.28**
-TC Modifier	**72195-TC**	**$343.33**	**$343.33**	**$369.60**	**$369.60**	**$425.82**	**$425.82**	
Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	**72196**	**$502.87**	**$502.87**	**$538.13**	**$538.13**	**$611.95**	**$611.95**	**$377.23**
-26 Modifier	**72196-26**	**$86.54**	**$86.54**	**$89.96**	**$89.96**	**$95.59**	**$95.59**	**$63.45**
-TC Modifier	**72196-TC**	**$416.32**	**$416.32**	**$448.17**	**$448.17**	**$516.36**	**$516.36**	
Endorectal ultrasound; echography, transrectal	**76872**	**$130.90**	**$130.90**	**$139.66**	**$139.66**	**$157.65**	**$157.65**	**$101.59**
-26 Modifier	**76872-26**	**$35.26**	**$35.26**	**$36.67**	**$36.67**	**$39.05**	**$39.05**	**$25.78**
-TC Modifier	**76872-TC**	**$95.64**	**$95.64**	**$102.99**	**$102.99**	**$118.60**	**$118.60**	
Radiologic examination, chest, two views, frontal and lateral;	**71020**	**$29.78**	**$29.78**	**$31.70**	**$31.70**	**$35.43**	**$35.43**	**$25.84**
-26 Modifier	**71020-26**	**$11.04**	**$11.04**	**$11.48**	**$11.48**	**$12.20**	**$12.20**	**$7.82**
-TC Modifier	**71020-TC**	**$18.74**	**$18.74**	**$20.23**	**$20.23**	**$23.23**	**$23.23**	
Chest X-ray, with fluoroscopy	**71034**	**$84.81**	**$84.81**	**$90.43**	**$90.43**	**$102.07**	**$102.07**	**$70.31**
-26 Modifier	**71034-26**	**$23.90**	**$23.90**	**$24.82**	**$24.82**	**$26.54**	**$26.54**	**$17.70**
-TC Modifier	**71034-TC**	**$60.91**	**$60.91**	**$65.61**	**$65.61**	**$75.53**	**$75.53**	
Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	**93000**	**$19.48**	**$19.48**	**$20.72**	**$20.72**	**$22.99**	**$22.99**	**$17.80**
tracing only, without interpretation and report	**93005**	**$10.59**	**$10.59**	**$11.45**	**$11.45**	**$13.12**	**$13.12**	**$11.42**
interpretation and report only	**93010**	**$8.89**	**$8.89**	**$9.27**	**$9.27**	**$9.87**	**$9.87**	**$6.38**

Colorectal Cancer	Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All
Surgery									
	Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure) (Use 44139 in conjunction with codes 44140-44147	**44139**	**$114.88**	**$114.88**	**$120.67**	**$120.67**	**$126.93**	**$126.93**	**$87.27**
	Colectomy, partial; with anastomosis	**44140**	**$1,242.82**	**$1,242.82**	**$1,307.82**	**$1,307.82**	**$1,383.78**	**$1,383.78**	**$930.68**
	Colectomy, partial, with resection, with colostomy or ileostomy and creation of mucofistula	**44144**	**$1,631.49**	**$1,631.49**	**$1,716.64**	**$1,716.64**	**$1,814.69**	**$1,814.69**	**$1,134.20**
	Colectomy, partial, with coloproctostomy (low pelvic anastomosis)	**44145**	**$1,546.21**	**$1,546.21**	**$1,625.74**	**$1,625.74**	**$1,718.51**	**$1,718.51**	**$1,160.69**
	Diverting colostomy or skin level cecostomy	**44320**	**$1,108.33**	**$1,108.33**	**$1,166.41**	**$1,166.41**	**$1,235.75**	**$1,235.75**	**$811.14**
	Low anterior resection and colorectal anastomosis	**44626**	**$1,497.92**	**$1,497.92**	**$1,575.40**	**$1,575.40**	**$1,663.11**	**$1,663.11**	**$1,118.64**
	Proctectomy; complete, combined abdominoperineal, with colostomy	**45110**	**$1,712.87**	**$1,712.87**	**$1,801.21**	**$1,801.21**	**$1,910.39**	**$1,910.39**	**$1,280.49**
	Excision of rectal tumor, transanal approach	**45171**	**$569.54**	**$569.54**	**$601.60**	**$601.60**	**$649.89**	**$649.89**	**$533.03**
	^^ Facility Fee for excision of rectal tumor, transanal approach	**45171**	**$536.15**		**$540.84**		**$562.87**		##
	Destruction of rectal tumor, any method	**45190**	**$624.72**	**$624.72**	**$657.68**	**$657.68**	**$702.45**	**$702.45**	**$457.68**

Colorectal Cancer			Reimbursement Rate*						
			Medicare@						Medicaid^
	Procedure	CPT Code	Region 99		Region 1		DC Metro		All
			In-Facility	Not In-Facility	In-Facility	Not In-Facility	In-Facility	Not In-Facility	Maryland
Other									
	Therapeutic radiology treatment planning, simple	77261	$71.51	$71.51	$74.49	$74.49	$79.23	$79.23	$53.72
	Therapeutic radiology treatment planning, intermediate	77262	$107.46	$107.46	$111.89	$111.89	$118.91	$118.91	$81.15
	Therapeutic radiology treatment planning, complex	77263	$160.08	$160.08	$166.74	$166.74	$177.13	$177.13	$120.66
	Therapeutic radiology simulation-aided field setting; simple	77280	$176.61	$176.61	$188.85	$188.85	$214.29	$214.29	$146.65
	-26 Modifier	77280-26	$35.27	$35.27	$36.65	$36.65	$38.99	$38.99	$25.77
	-TC Modifier	77280-TC	$141.35	$141.35	$152.19	$152.19	$175.30	$175.30	
	Therapeutic radiology simulation-aided field setting; intermediate	77285	$306.42	$306.42	$327.89	$327.89	$372.92	$372.92	$246.33
	-26 Modifier	77285-26	$52.74	$52.74	$54.79	$54.79	$58.30	$58.30	$37.93
	-TC Modifier	77285-TC	$253.68	$253.68	$273.10	$273.10	$314.62	$314.62	
	Therapeutic radiology simulation-aided field setting; complex	77290	$484.45	$484.45	$518.55	$518.55	$590.28	$590.28	$359.42
	-26 Modifier	77290-26	$78.04	$78.04	$81.06	$81.06	$86.22	$86.22	$56.46
	-TC Modifier	77290-TC	$406.40	$406.40	$437.49	$437.49	$504.05	$504.05	
	Therapeutic radiology simulation-aided field setting; three-dimensional	77295	$584.77	$584.77	$621.00	$621.00	$694.33	$694.33	$725.19
	-26 Modifier	77295-26	$228.10	$228.10	$236.88	$236.88	$252.01	$252.01	$167.30
	-TC Modifier	77295-TC	$356.68	$356.68	$384.13	$384.13	$442.32	$442.32	
	Basic radiation dosimetry	77300	$67.83	$67.83	$71.87	$71.87	$79.92	$79.92	$62.01
	-26 Modifier	77300-26	$31.02	$31.02	$32.20	$32.20	$34.28	$34.28	$23.52
	-TC Modifier	77300-TC	$36.81	$36.81	$39.68	$39.68	$45.64	$45.64	
	Teletherapy, isodose plan (hand or computer calculated); simple	77305	$67.12	$67.12	$70.99	$70.99	$78.48	$78.48	$69.96
	-26 Modifier	77305-26	$35.27	$35.27	$36.65	$36.65	$38.99	$38.99	$26.83
	-TC Modifier	77305-TC	$31.85	$31.85	$34.34	$34.34	$39.49	$39.49	
	Teletherapy, isodose plan (hand or computer calculated); intermediate	77310	$94.16	$94.16	$99.42	$99.42	$109.66	$109.66	$94.21
	-26 Modifier	77310-26	$52.74	$52.74	$54.79	$54.79	$58.30	$58.30	$39.50
	-TC Modifier	77310-TC	$41.42	$41.42	$44.64	$44.64	$51.36	$51.36	
	Teletherapy, isodose plan (hand or computer calculated); complex	77315	$140.37	$140.37	$148.20	$148.20	$163.51	$163.51	$129.49
	-26 Modifier	77315-26	$78.04	$78.04	$81.06	$81.06	$86.22	$86.22	$58.79
	-TC Modifier	77315-TC	$62.33	$62.33	$67.14	$67.14	$77.29	$77.29	
	Special dosimetry, only when prescribed by treating physician	77331	$61.52	$61.52	$64.61	$64.61	$70.40	$70.40	$49.46
	-26 Modifier	77331-26	$43.49	$43.49	$45.15	$45.15	$48.05	$48.05	$32.86
	-TC Modifier	77331-TC	$18.03	$18.03	$19.46	$19.46	$22.35	$22.35	
	Treatment devices, design and construction; simple	77332	$74.88	$74.88	$79.63	$79.63	$89.20	$89.20	$65.26
	-26 Modifier	77332-26	$27.09	$27.09	$28.13	$28.13	$29.94	$29.94	$20.49
	-TC Modifier	77332-TC	$47.80	$47.80	$51.50	$51.50	$59.27	$59.27	

Colorectal Cancer			Reimbursement Rate*						
			Medicare@						Medicaid^
	Procedure	CPT Code	Region 99		Region 1		DC Metro		All
			In-Facility	Not In-Facility	In-Facility	Not In-Facility	In-Facility	Not In-Facility	Maryland
Other									
	Treatment devices, design and construction; intermediate	77333	$61.86	$61.86	$65.04	$65.04	$71.02	$71.02	$68.51
	-26 Modifier	77333-26	$42.06	$42.06	$43.67	$43.67	$46.48	$46.48	$31.65
	-TC Modifier	77333-TC	$19.80	$19.80	$21.37	$21.37	$24.55	$24.55	
	Treatment devices, design and construction; complex	77334	$149.13	$149.13	$158.24	$158.24	$176.54	$176.54	$139.05
	-26 Modifier	77334-26	$62.00	$62.00	$64.40	$64.40	$68.49	$68.49	$46.73
	-TC Modifier	77334-TC	$87.13	$87.13	$93.84	$93.84	$108.05	$108.05	
	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy	77336	$52.40	$52.40	$56.46	$56.46	$64.98	$64.98	$66.50
	Special medical radiation physics consultation	77370	$109.38	$109.38	$117.89	$117.89	$135.61	$135.61	$107.99
	Radiation treatment delivery, superficial and/or ortho voltage	77401	$25.47	$25.47	$27.47	$27.47	$31.58	$31.58	$34.53
	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 6-10 MeV	77403	$117.61	$117.61	$126.64	$126.64	$145.85	$145.85	$86.63
	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 6-10 MeV	77408	$159.06	$159.06	$171.27	$171.27	$197.27	$197.27	$113.14
	Radiation treatment delivery, three or more separate treatment areas, custom blocking, transgential ports, wedges, rotational beam, compensators, special particle beam; up to 6-10 MeV	77413	$207.96	$207.96	$223.90	$223.90	$257.93	$257.93	$142.37
	Radiation treatment delivery, three or more separate treatment areas, custom blocking, transgential ports, wedges, rotational beam, compensators, special particle beam; up to 11-19 MeV	77414	$225.10	$225.10	$249.84	$249.84	$287.81	$287.81	$155.34
	Therapeutic radiology port film(s)	77417	$14.49	$14.49	$15.65	$15.65	$17.95	$17.95	$16.25
	Radiation treatment management, five treatments	77427	$191.74	$191.74	$199.80	$199.80	$212.59	$212.59	$134.66
	Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia	96400							

Colorectal Cancer			Reimbursement Rate*						
			Medicare@						Medicaid^
	Procedure	CPT Code	Region 99		Region 1		DC Metro		All
			In-Facility	Not In-Facility	In-Facility	Not In-Facility	In-Facility	Not In-Facility	Maryland
Other									
	Chemotherapy administration, intra-arterial, push technique	96420	$101.89	$101.89	$109.63	$109.63	$125.13	$125.13	$88.55
	Chemotherapy administration, intravenous, push technique, single or initial substance/drug	96409	$105.54	$105.54	$113.30	$113.30	$129.22	$129.22	$93.92
	Chemotherapy administration, intravenous, push technique, each additional substance/drug	96411	$59.19	$59.19	$63.39	$63.39	$72.03	$72.03	$53.57
	Chemotherapy administration, intravenous, infusion technique, one to 1 hour, single or initial substance/drug	96413	$138.12	$138.12	$148.35	$148.35	$169.35	$169.35	$127.28
	Chemotherapy administration, intravenous, infusion technique; each additional hour (use in conjunction with 96413)	96415	$29.81	$29.81	$31.74	$31.74	$35.68	$35.68	$28.25
	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	96445	$116.28	$272.90	$121.30	$289.88	$129.21	$323.47	$262.23
	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	96542	$43.08	$124.23	$44.96	$132.31	$48.35	$149.00	$138.40

Colorectal Cancer Procedure	CPT Code	Reimbursement Rate* Medicare@ Region 99 In-Facility	Region 99 Not In-Facility	Region 1 In-Facility	Region 1 Not In-Facility	DC Metro In-Facility	DC Metro Not In-Facility	Medicaid^ All
Refilling and maintenance of portable pump	**96521**	**$121.48**	**$121.48**	**$130.53**	**$130.53**	**$149.19**	**$149.19**	**$111.15**
Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic	**96522**	**$103.05**	**$103.05**	**$110.69**	**$110.69**	**$126.33**	**$126.33**	**$88.53**
Introduction of needle or intracatheter, vein	**36000**	**$9.57**	**$23.74**	**$10.03**	**$25.28**	**$10.62**	**$28.20**	**$20.23**
IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician, up to one hour	**90780**							
IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician, each additional hour , up to eight hours (use in conjunction with 90780)	**90781**							
Therapeutic, prophylactic and diagnostic injection (specify material injected); subcutaneous or intramuscular	**90782**							
Therapeutic, prophylactic and diagnostic injection (specify material injected); intravenous	**90784**							
Dressing change (for other than burns) under anesthesia (other than local)	**15852**	**$45.30**	**$45.30**	**$47.54**	**$47.54**	**$50.21**	**$50.21**	**$34.35**

Colorectal Cancer

			Reimbursement Rates*			
				Medicare@		Medicaid^
			Region 99	Region 1	DC Metro	
Pharmacy						
√	Venipuncture - routine	**36415**	**$3.00**	**$3.00**	**$3.00**	**$2.22**
	10 cc Sterile Water, Saline & or dextrose/flush, 10 ml	**A4216**	**$0.46**	**$0.46**	**0.46**	**0.45**
√	Amifostine, 500 mg	**J0207**	**$340.11**	**$340.11**	**$340.11**	
√	Leucovorin Calcium, per 50mg	**J0640**	**$1.01**	**$1.01**	**$1.01**	**CCSC recommends reimburse-**
√	Prochlorperazine, up to 10 mg	**J0780**	**$1.63**	**$1.63**	**$1.63**	**ment at 5% less than the**
√	Epoetin Alpha, (non-ESRD use), 1,000 units	**J0885**	**$9.54**	**$9.54**	**$9.54**	**Medicare rate, consistent**
√	Testosterone Cypionate, up to 100 mg	**J1070**	**$3.30**	**$3.30**	**$3.30**	**with the Md. Medical**
√	Dexamethasone sodium phos, 1 mg	**J1100**	**$0.09**	**$0.09**	**$0.09**	**Assistance Program**
√	Diphenhydramine HCl, up to 50 mg	**J1200**	**$0.82**	**$0.82**	**$0.82**	
√	Dolasetron X10 Enzemet 10 mg	**J1260**	**$4.30**	**$4.30**	**$4.30**	**or contact CCSC**
√	Filgrastim (G-CSF), 300 mcg	**J1440**	**$219.71**	**$219.71**	**$219.71**	
√	Filgrastim (G-CSF), 480 mcg	**J1441**	**$342.73**	**$342.73**	**$342.73**	
√	Heparin Sodium, per 1,000 units	**J1644**	**$0.29**	**$0.29**	**$0.29**	
√	Iron Dextran injection, 50 mg	**J1750**	**$12.93**	**$12.93**	**$12.93**	
√	Lorazepam, 2 mg	**J2060**	**$0.75**	**$0.75**	**$0.75**	
√	Meperidine Hydrochloride, per 100 mg	**J2175**	**$1.63**	**$1.63**	**$1.63**	
√	Oprelvekin (Neumega), 5 mg (Inj)	**J2355**	**$245.80**	**$245.80**	**$245.80**	
√	Sargramostim (GM-CSF), 50 mcg	**J2820**	**$24.27**	**$24.27**	**$24.27**	
√	Fentanyl Citrate, up to 0.1mg	**J3010**	**$0.34**	**$0.34**	**$0.34**	
√	Diazepam, up to 5 mg	**J3360**	**$1.02**	**$1.02**	**$1.02**	
√	Vitamin k injection 1 mg	**J3430**	**$1.52**	**$1.52**	**$1.52**	
√	Normal saline 500 cc	**J7040**	**$0.56**	**$0.56**	**$0.56**	
√	5% Dextrose/Normal Saline (500 ml = 1 unit)	**J7042**	**$0.34**	**$0.34**	**$0.34**	
√	Normal saline 250 cc	**J7050**	**$0.28**	**$0.28**	**$0.28**	
	Sterile saline or water, metered dose dispenser 10 ml	**A4218**				**$2.65**
√	5% Dextrose/Water (500 ml)	**J7060**	**$1.13**	**$1.13**	**$1.13**	
√	Doxorubicin HCl, 10 mg	**J9000**	**$3.48**	**$3.48**	**$3.48**	
√	Aldesleukin, per single use vial	**J9015**	**$846.91**	**$846.91**	**$846.91**	
√	Bleomycin Sulfate, 15 units	**J9040**	**$28.47**	**$28.47**	**$28.47**	
√	Carboplatin, 50 mg	**J9045**	**$4.84**	**$4.84**	**$4.84**	
√	Cisplatin, 50 mg	**J9062**	**$10.41**	**$10.41**	**$10.41**	
√	Cyclophosphamide, lyophilized, 100 mg	**J9093**	**$2.23**	**$2.23**	**$2.23**	
√	Cytarabine, 100 mg	**J9100**	**$1.80**	**$1.80**	**$1.80**	
	Docetaxel, 20 mg (limited coverage)	**J9170**	**	**	**	
√	Etoposide, 10 mg	**J9181**	**$0.45**	**$0.45**	**$0.45**	
√	Fludarabine Phosphate, 50 mg.	**J9185**	**$161.68**	**$161.68**	**$161.68**	
√	Fluorouracil, 500 mg	**J9190**	**$1.60**	**$1.60**	**$1.60**	

√	Floxuridine, 500mg	**J9200**	**$43.68**	**$43.68**	**$43.68**
√	Gemcitabine HCl, 200 mg	**J9201**	**$144.93**	**$144.93**	**$144.93**
√	Goserelin Acetate Implant, per 3.6 mg	**J9202**	**$203.87**	**$203.87**	**$203.87**
√	Irinotecan 20 mg	**J9206**	**$6.94**	**$6.94**	**$6.94**
√	Ifosfamide, 1gm	**J9208**	**$30.08**	**$30.08**	**$30.08**
√	Mesna, 200 mg	**J9209**	**$4.64**	**$4.64**	**$4.64**
√	Interferon, Alpha-2B, Recombinant, 1 million units	**J9214**	**$15.84**	**$15.84**	**$15.84**
√	Methotrexate Sodium, 50 mg.	**J9260**	**$2.46**	**$2.46**	**$2.46**
√	Paclitaxel, 30 mg	**J9265**	**$9.44**	**$9.44**	**$9.44**
√	Mitomycin, 5 mg	**J9280**	**$17.15**	**$17.15**	**$17.15**
√	Mitoxantrone HCl, per 5 mg	**J9293**	**$47.77**	**$47.77**	**$47.77**
√	Rituxan (Rituximab), 100 mg	**J9310**	**$563.76**	**$563.76**	**$563.76**
√	Topotecan, 4 mg	**J9350**	**$1,031.91**	**$1,031.91**	**$1,031.91**
√	Herceptin (Trastuzumab), 10 mg	**J9355**	**$64.78**	**$64.78**	**$64.78**
√	Vinblastine Sulfate, 1 mg	**J9360**	**$1.11**	**$1.11**	**$1.11**
√	Vinorelbine Tartrate, per 10 mg	**J9390**	**$11.59**	**$11.59**	**$11.59**
	Levamisole (Ergamisol)	**SO177**	****	****	****
	Epirubicin HCl (Ellence), 50 mg (IV)	**J9180 D(deleted code)**			

Colorectal Cancer

Anesthesia***

Diagnosis and Treatment:		
Codes for Medical Assistance: Use CPT code for procedure being performed and add -30 Modifier (except you can use 00857, and 00955) Example: 44140 is reimbursed for surgeon at $1242.82 for Region 99; 44140-30 would be reimbursed at $372.85		CCSC recommends reimbursement at 30% of the listed Medicare fee for the surgical procedure (minimum allowance is $30), consistent with the Md. Medical Assistance Program.
Screening:		
Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum	**00810**	CCSC recommends using Medicare formula explained below for anesthesiology for screening procedures.

Formula: (Time Units + Base Units) x Conversion Factor = Allowance

Divide time of procedure in minutes by 15 to equal number of **Time Units**. Add Base Units (known as Uniform Relative Value Units [RVUs]) (base units (or RVU) for 00810 is 5).
Multiply by Local/Region specific conversion factor (Region 1 - $21.58, Region 99 - $20.79, Region DC - $22.47)

Examples of Reimbursement for 00801 using Formula Application

	Region 99		**Region 1**		**DC Metro**	
	In-Facility	**Not In-Facility**	**In-Facility**	**Not In-Facility**	**In-Facility**	**Not In-Facility**
1 Unit (=15 Minutes) + 5 Base Units	**$124.74**	**$124.74**	**$129.48**	**$129.48**	**$134.82**	**$134.82**
4 Units (=1 Hour) + 5 Base Units	**$187.11**	**$187.11**	**$194.22**	**$194.22**	**$202.23**	**$202.23**
8.7 Units (=2 Hours 10 minutes = 130 minutes) + 5 Base Units	**$284.82**	**$284.82**	**$295.64**	**$295.64**	**$307.84**	**$307.84**

NOTES:

* Providers may be eligible for additional reimbursement for both physician fees and/or hospital or Ambulatory Surgical Center facility fees.

Effective January 1, 2010, Medical Assistance reimbursement for ambulatory surgical centers will equal 98% of the 2007 Medicare-approved ASC fees. For those procedure codes that were capped by the DRA of 2005, reimbursement will remain at 100% of the Medicare approved facility fee.

@ Maryland Medicare reimburses dependent on location. There are 3 regions for the state and are broken-down below:
Region 1 includes: Anne Arundel, Baltimore, Carroll, Harford, Howard, and Baltimore City.
Region 99 includes: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester.
DC Metro includes: Prince George's and Montgomery.

@ The Medicare reimbursements given are for:
In-facility (when service performed in a facility setting: inpatient hospital, outpatient hospital, inpatient psychiatric facility, comprehensive inpatient rehabilitation facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, skilled nursing facility, and community mental health center) and
Not In-facility (when service performed in a physician's office, in the patient's home, facility, or institution other than the places of service listed under "in-facility")
For HSCRC-regulated facilities, reimburse using HSCRC rates.

^ Medicaid reimburses the same whether the procedure is performed "In-facility" or "Not In-facility."

^^ **Facility Fees:** Ambulatory Surgical Center (ASC) Fee. Medicare and Medicaid reimburse facility fees if procedure is performed in an Ambulatory Surgical Center. If done in an HSCRC-regulated clinic or hospital, the rates will be set by HSCRC. Physician offices are not reimbursable. Note: In Maryland, there are 7 "localities" for the purpose of determining Medicare reimbursement for ASCs. Each locality has a different rate. For simplification, we chose to use a single (high) rate for all localities in Maryland, so our rate may differ from the rate an ASC may have on their fee schedule.

&& **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 50% of the allowable Medicare facility fee for each subsequent technique. For example, in Region 1, CPT code 45383, 45384, and 45385 would be reimbursable as $360.55 for the first technique plus an additional $180.28 for each additional technique.

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.)

+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.

** Reimbursement Rate was unable to be determined at the present time.

*** 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%; however, if using a CRNA, the anesthesiologist receives 50%, and the CRNA receives 50%.

& **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 biopsy/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 for 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.

&&& **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 (e.g., each polyp or biopsy sent for analysis). For example, a laboratory might bill four times for CPT code 88305--once for each of four polyps processed. Local CRF programs may reimburse the lab at the Medicare rate for each of the four specimens.

Modifier:

-26 Modifier: Professional Component
-TC Modifier: Technical Component
A procedure can be split into its "professional" and "technical" components and each can be billed separately as noted; though, a provider cannot bill using both codes. The sum of the two components equals the rate if billed with one code.
-51 Modifier: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The
-53 Modifier: 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 Modifier: Staged or related procedure or service by the same physician during the same postoperative period
-59 Modifier: Distinct procedural service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day, eg, a separate lesion or different site.
-73 Modifier: A discontinued out-patient/ambulatory surgery procedure prior to administration of anesthesia due to extenuating circumstances as with modifier -53.
-74 Modifier: A discontinued out-patient/ambulatory surgery center procedure after the administration of anesthesia due to extenuating circumstances as with modifier -53.
-80 Modifier: 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.