

Fee Schedule Update

This 2008 update to the *Mississippi Workers' Compensation Medical Fee Schedule* includes the following changes to the 2007 edition. Deleted text appears with a ~~strike through~~ while new text is underlined.

INTRODUCTION

Pursuant to Mississippi Code Annotated (MCA), section 71-3-15(3)(Rev. 2000), the following Fee Schedule, including Cost Containment and Utilization Management rules and guidelines, is hereby established in order to implement a medical cost containment program. This Fee Schedule, and accompanying rules and guidelines, applies to medical services rendered after the effective date of ~~August 1, 2007~~ August 1, 2008 and, in the case of inpatient treatment, to services where the discharge date is on or after ~~August 1, 2007~~ August 1, 2008. This Fee Schedule establishes the maximum level of medical and surgical reimbursement for the treatment of work-related injuries and/or illnesses, which the Mississippi Workers' Compensation Commission deems to be fair and reasonable.

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Observation services means services rendered to a person who is designated or admitted to a hospital or facility as observation status.

GENERAL RULES

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X. SELECTION OF PROVIDERS

The selection of appropriate providers for diagnostic testing or analysis, including but not limited to CAT scans, MRI, x-ray, and laboratory, ~~for physical or occupational therapy, including work hardening, functional capacity evaluations, back schools, chronic pain programs, or massage therapy~~ shall be at the direction of the treating or prescribing physician. In the absence of specific direction from the treating or prescribing physician, the selection shall be made by the payer, in consultation with the treating or prescribing physician.

Physical or occupational therapy services, including work hardening, functional capacity evaluations, back schools, chronic pain programs, or massage therapy, shall be provided upon referral from a physician. In the absence of specific direction from the treating or prescribing physician the selection of a provider for these services shall be made by the payer in consultation with the treating or prescribing physician.

The selection of providers for the purchase or rental of durable medical equipment shall be at the direction of the payer.

The selection of providers for medical treatment or service, other than as above provided, shall be in accordance with the provisions of MCA section 71-3-15 (Rev. 2000).

BILLING AND REIMBURSEMENT RULES

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B. **Separate Fee Contract.** An employer/payer may enter into a separate contractual agreement with a medical provider regarding reimbursement for services provided under the provisions of the Mississippi Workers' Compensation Law, and if an employer/payer has such an a contractual agreement with a provider designed to reduce the cost of workers' compensation health care services, the contractual agreement shall control as to the amount of reimbursement and shall not be subject to the maximum reimbursement allowance otherwise established by ~~exempt from~~ the Fee Schedule. However, all other rules, guidelines and policies as provided in this Fee Schedule shall apply and shall be considered to be automatically incorporated into such agreement.

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C. **Billing Forms.** Billing for provider services shall be standardized and submitted on the following forms: Providers must bill outpatient professional services on the most recently authorized paper or electronic version, 837p, of the CMS-1500 (formerly HCFA-1500) form, regardless of the site of service. Health care facilities must bill on the most recently authorized uniform

billing form. The electronic version, 837i, of the UB-04 (CMS-1450) is required beginning May 23, 2007.

1. Injections.

~~5. Anesthetic agents for local infiltration must not be billed separately; this is included in the reimbursement for the procedure.~~

~~5. 6. Reimbursement for intra-articular and intra-bursal injections (steroids and anesthetic agents) may be separately billed. The description must include the name of the medication, strength, and volume given.~~

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B. When modifier 22 is used to report an ~~unusual~~ increased service, a report explaining the medical necessity of the situation must be submitted with the claim to the payer. It is not appropriate to use modifier 22 for routine billing.

I. MODIFIERS FOR CPT (HCPCS LEVEL I) CODES

22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

The physician may need It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and**

Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

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32 Mandated Services

Services related to mandated consultation and/or related services (e.g., ~~PRO~~, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures

When multiple procedures, other than E/M Services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), 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 modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see the applicable CPT book).

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58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

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circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 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. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

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 or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of 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. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **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.

76 Repeat Procedure by Same Physician

The physician may need It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

The physician may need It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

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92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703). The test does not require permanent dedicated space; hence, by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

AS Assistant at Surgery Services Provided by Registered Nurse First Assistant, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist (Mississippi Modified)

Assistant at surgery services provided by a registered nurse first assistant or other qualified individual (excluding assistant at surgery services provided by a physician) are identified by adding modifier AS to the listed applicable surgical procedures. The use of the AS modifier is appropriate for any code that otherwise is reimbursable for a physician assisting a surgeon in the operating room.

PA Physician Assistant (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a physician assistant.

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procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

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C. **Category II Codes.** This Fee Schedule does not include Category II codes as published in *CPT 2007 CPT 2008*. Category II codes are supplemental tracking codes that can be used for performance measurements. These codes describe clinical components that are typically included and reimbursed in other services such as evaluation and management (E/M) or laboratory

services. These codes do not have an associated relative value or fee.

- F. **Codes Exempt From Modifier 51.** Certain codes are exempt from the use of modifier 51 but have not been designated as CPT add-on procedures/services. Please consult the most current CPT book for the list of codes that are exempt from modifier 51. Codes designated as exempt from modifier 51 are identified with a **Ⓞ** symbol, and are listed in the applicable most current CPT book.

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- C. **New and Established Patient Service.** Several code subcategories in the Evaluation and Management section are based on the patient's status as new or established. The new versus established patient guidelines also clarify the situation in which a physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.
- **New Patient.** A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, for this same injury or within the past three years.

Page 42

The CPT book identifies the following organ systems:

- Allergic/immunologic

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VIII. CONSULTATIONS (99241–99255)

Consultations in CPT 2007 CPT 2008 fall under two subcategories:

Office or Other Outpatient Consultations, and Inpatient Consultations. If counseling dominates the encounter, time determines the correct code.

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X. CRITICAL CARE SERVICES (99291–99300)

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, Hematologic data (99090)); gastric intubation (43752, 91105); temporary

transcutaneous pacing (92953); ventilatory management (94002–94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, ~~36540, 36600 36591~~). Any services performed which are not listed above should be reported separately when performed in conjunction with critical services reported with code 99291–99292. When reporting inpatient neonatal and pediatric critical care services 99293–99300, consult the CPT book for additional procedures that are bundled into codes 99293–99300.

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XIV. PROLONGED SERVICES (99354–99359)

- A. *Prolonged Physician Service with Direct Patient Contact (99354–99357).* Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous. Codes 99354 or 99356 report the first hour of prolonged service on a given date, depending on the place of service. Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour. Services lasting less than ~~45~~ 30 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable. For example, services lasting one hour and twelve minutes are reported by code 99354 or code 99356 alone. Services lasting one hour and seventeen minutes are reported using the code for the first hour plus the code for an additional 30 minutes.
- B. *Prolonged Physician Service without Direct Patient Contact.* Use code 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

Prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, ~~99371–99373 99441–99443~~) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service.

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XVI. CASE MANAGEMENT SERVICES (99361–99373) (99363–99368)

For changes to modifiers 25 and 32, see page 2 of this update.

Page 59

I. Introduction

The American Society of Anesthesiologists' (ASA) *Relative Value Guide™ 2007 2008* is recognized as an appropriate assessment of current relative values for specific anesthesiology procedures. It is the basis for the assigned base units for CPT codes in the Anesthesia section of the Fee Schedule.

Page 61

For changes to modifiers 22 and 32, see pages 1 and 2 of this update.

Page 72

D. Multiple Procedure Reimbursement

For purposes of reimbursement, each injection is considered a separate procedure and will be reimbursed according to the multiple procedure rule. Multiple level injection codes reported with add-on codes (e.g., 64480, 64484, ~~64486~~, 64627) shall be reimbursed as additional procedures under applicable multiple injection rules as explained in this section. The reimbursement rate for these add-on procedure codes is fifty percent (50%) of the rate for the primary (base) procedure. Because these are add-on codes, the listed amount for the procedure is fifty percent (50%) of the primary (base) procedure and the add-on code will be reimbursed at the full amount listed in the Fee Schedule.

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~~E. **CPT Code 95990** This CPT code, which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed per the physicians' fee schedule.~~

Page 90

For changes to modifiers 22, 32, and 51, see pages 1 and 2 of this update.

Page 91

For changes to modifiers 58, 59, 76, and 78, see pages 3 and 4 of this update.

Page 92

For changes to modifier 25, see page 2 of this update.

Page 93

For changes to modifiers 58, 59, 76, and 78, see pages 3 and 4 of this update.

Page 275

E. Additional X-rays

No payment shall be made for additional x-rays when recent x-rays are available except when supported by adequate information regarding the need to retake x-rays. The use of photographic or digital media and/or imaging is not reported separately, but is considered to be a component of the basic procedure and shall not merit any additional payment.

Page 277

For changes to modifiers 22, 32 and 51, see pages 1 and 2 of this update.

Page 278

For changes to modifier 76, see page 3 of this update.

Page 305

C. Unlisted Service or Procedures

~~86586 Unlisted antigen, each~~

Pages 306 and 307

For changes to modifiers 22, 32, and 59, see pages 1 and 2 of this update.

Page 307

92 Alternative Laboratory Platform Testing

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Page 344

For changes to modifiers 22, 32, and 51, see pages 1 and 2 of this update.

Page 345

For changes to modifiers 58, 59, 76, and 78, see page 3 and 4 of this update.

Page 385

G. Non-surgical debridement should be billed as CPT code 97597, ~~97598~~, or 97602.

Page 403

I. Definition

Code categories included in this section are as follows:

Outpatient PPS ~~C1300-C9727~~ C1300-C9728

Q Codes (Temporary) ~~Q0035-Q9964~~ Q0035-Q9967

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E. ~~Outpatient PPS (C1300-C9727)~~ (C1300-C9728)

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M. ~~Temporary Codes (Q0035-Q9964)~~ (Q0035-Q9967)

P. ~~Vision, Hearing, and Speech-Language Pathology Services (V2020-V5364)~~ (V2020-V2799, V5008-V5364)

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3. Select Acute Inpatient PPS (currently ~~midway down under Medicare Fee-for-Service Payment heading in the right-hand side column~~)
5. c. Find "Changes to the Hospital Inpatient Prospective Payment Systems and FY ~~2007~~ 2008 Rates" (The year will change annually. Remember, CMS inpatient is on the federal fiscal year, so the new year begins October 1 each year);
5. e. Look for a table headlined: ~~COMPARISON OF FY 2006 STANDARDIZED AMOUNTS TO FINAL FY 2007 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR~~ (The years will change, and the headline may be slightly different. Typically, this is one of the first tables in the document);
5. f. The wage index for Mississippi hospitals is less than 1.0. The full update amount should be used. Therefore, find the line reading: Final Rate for FY 2007 (after multiplying FY 2006 base rate by above factors) where the wage index is less than or equal to 1.0000. Labor: ~~\$3,022.18~~ \$3,094.17. Nonlabor: ~~\$1,852.31~~ \$1,896.43
5. g. Adding those two amounts together produces ~~\$4,874.49~~ \$4,990.60 which is the ~~2007~~ 2008 National Base Rate.
6. ~~c. The DRG relative weight file will be Table 5 DRG Relative Weights. (Make sure you select the correct fiscal year as proposed files for next year maybe in this list)~~
- d. ~~The cost to charge ratio will be in Impact file for IPPS FY 2007 Final Rule October 2006~~

e. After downloading, the Impact File will be an Excel spreadsheet. CMS changes the column names from time to time, but the cost to charge ratio is in a column called ~~OPCCR (Column X in the 2007 version)~~.

~~6. c. The DRG relative weight file will be Table 5 MS-DRG Relative Weighting Factors, and Geometric and Arithmetic Mean Length. (Make sure you select the correct fiscal year as proposed files for next year maybe in this list)~~

d. ~~The cost to charge ratio will be in DRG Cost and Charge Weights for IPPS FY 2008 Final Rule 2007~~

e. ~~After downloading, the DRG Cost and Charge Weights will be an Excel spreadsheet. CMS changes the column names from time to time, but the cost to charge ratio is in a column called Blended Weight (2/3 Cost & 1/3 Charge) (Column D in the 2008 version)~~.

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- B. The IRF must possess a Medicare/Medicaid provider number, ~~also called the OSCAR provider number~~ or CMS Certification Number. The provider number consists of six digits. The first two digits indicate the state, 25 is for Mississippi, and the remaining four digits identify the facility as an IRF. The four digit suffix must be in the range of 3025-3099 for rehabilitation facilities, exempt units must have a T in the third position, e.g., 25TXXX.
(<http://www.cms.hhs.gov/transmittals/downloads/R25SOMA.pdf>) (<http://www.cms.hhs.gov/transmittals/downloads/R29SOMA.pdf>)

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- B. Unless governed by contract between payer and provider, or unless total billed charges are less, the reimbursement for an IRF under this Fee Schedule shall be the IRF PPS calculated rate multiplied by two. Other inpatient DRG or PPS calculations are not appropriate to use for IRF services. The IRF PPS rate is calculated using the formula for the current fiscal year, including outlier. The final calculation is published in the *Federal Register*, prior to October 1 of each year, or at http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms_1540f.pdf. <http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551f.pdf>.
Unadjusted IRF PPS (CMG Tier 1, 2, 3, or no comorbidities)
- x Labor Share (FY 2007 *Federal Register* Table 5)
- = Labor portion of federal payment
- x CBSA Based Wage Index (See *Federal Register addendum 1 and 2*) Table I) Jackson, MS

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- = Wage-Adjusted Amount
- + Non-labor amount (Unadjusted federal PPS less labor portion of federal payment)
- = Wage-adjusted federal payment
- x Rural Adjustment (*See Federal Register*)
- = Wage and rural adjusted federal payment
- x LIP adjustment (low income percentage based on disproportionate share hospital (DSH) calculation)
- = Wage, rural and LIP adjusted federal PPS payment rate
- x 2 (MWCC reimbursement adjustment)
- = MWCC-IRF PPS adjusted payment

DELETED CODES

The following deleted CPT and HCPCS codes are no longer valid for Mississippi Workers' Compensation effective August 1, 2008.

<u>01905</u>	<u>86586</u>	<u>J7613</u>	<u>L3932</u>
<u>24350</u>	<u>99361</u>	<u>J7614</u>	<u>L3934</u>
<u>24351</u>	<u>99362</u>	<u>L0960</u>	<u>L3936</u>
<u>24352</u>	<u>99371</u>	<u>L1855</u>	<u>L3938</u>
<u>24354</u>	<u>99372</u>	<u>L1858</u>	<u>L3940</u>
<u>24356</u>	<u>99373</u>	<u>L1870</u>	<u>L3942</u>
<u>32000</u>	<u>A9565</u>	<u>L1880</u>	<u>L3944</u>
<u>32002</u>	<u>B4086</u>	<u>L3800</u>	<u>L3946</u>
<u>32005</u>	<u>C1718</u>	<u>L3805</u>	<u>L3948</u>
<u>32019</u>	<u>C1720</u>	<u>L3810</u>	<u>L3950</u>
<u>32020</u>	<u>C1879</u>	<u>L3815</u>	<u>L3952</u>
<u>36540</u>	<u>C2633</u>	<u>L3820</u>	<u>L3954</u>
<u>36550</u>	<u>C9232</u>	<u>L3825</u>	<u>L3985</u>
<u>43750</u>	<u>C9233</u>	<u>L3830</u>	<u>L3986</u>
<u>47719</u>	<u>C9234</u>	<u>L3835</u>	<u>Q4079</u>
<u>49200</u>	<u>C9235</u>	<u>L3840</u>	<u>Q4083</u>
<u>49201</u>	<u>C9350</u>	<u>L3845</u>	<u>Q4084</u>
<u>51000</u>	<u>C9351</u>	<u>L3850</u>	<u>Q4085</u>
<u>51005</u>	<u>E2618</u>	<u>L3855</u>	<u>Q4086</u>
<u>51010</u>	<u>G0265</u>	<u>L3860</u>	<u>Q9945</u>
<u>52510</u>	<u>G0266</u>	<u>L3907</u>	<u>Q9946</u>
<u>60001</u>	<u>G0267</u>	<u>L3910</u>	<u>Q9947</u>
<u>67038</u>	<u>G0298</u>	<u>L3916</u>	<u>Q9948</u>
<u>74350</u>	<u>G0299</u>	<u>L3918</u>	<u>Q9949</u>
<u>75552</u>	<u>G0375</u>	<u>L3920</u>	<u>Q9950</u>
<u>75553</u>	<u>G0376</u>	<u>L3922</u>	<u>Q9952</u>
<u>75554</u>	<u>J1567</u>	<u>L3924</u>	<u>S0147</u>
<u>75555</u>	<u>J7345</u>	<u>L3926</u>	<u>S0180</u>
<u>75556</u>	<u>J7611</u>	<u>L3928</u>	<u>S2114</u>
<u>78615</u>	<u>J7612</u>	<u>L3930</u>	<u>S3618</u>

Mississippi Practitioner Fee Schedule

ASC

The following codes and rates have been added effective August 1, 2007 for Mississippi Workers' Compensation for facility services furnished in conjunction with outpatient surgical procedures:

Code	Fee	Code	Fee	Code	Fee	Code	Fee	Code	Fee
49520	\$1,423.50	49590	\$729.00	50200	\$475.00	50544	\$2,100.00	50575	\$2,100.00
49540	\$637.50	49650	\$900.00	50392	\$475.00	50555	\$475.00	50590	\$2,100.00
49555	\$1,024.50	49651	\$1,423.50	50393	\$475.00	50570	\$475.00	50690	\$475.00
49561	\$2,100.00	50020	\$637.50	50396	\$475.00	50572	\$475.00	50972	\$475.00
49568	\$2,100.00	50081	\$2,100.00	50541	\$2,100.00	50574	\$475.00		

The following codes and rates have been added effective August 1, 2008 for Mississippi Workers' Compensation for facility services furnished in conjunction with outpatient surgical procedures:

Code	Fee	Code	Fee	Code	Fee	Code	Fee	Code	Fee
20555	BR	27726	BR	33257	BR	49442	BR	57285	BR
20985	BR	27767	BR	33258	BR	49446	BR	57423	BR
20986	BR	27768	BR	33259	BR	49450	BR	58570	BR
20987	BR	27769	BR	33864	BR	49451	BR	58571	BR
21073	BR	28446	BR	34806	BR	49452	BR	58572	BR
22206	BR	29828	BR	35523	BR	49460	BR	58573	BR
22207	BR	29904	BR	36591	BR	49465	BR	60300	BR
22208	BR	29905	BR	36592	BR	50385	BR	67041	BR
24357	BR	29906	BR	36593	BR	50386	BR	67042	BR
24358	BR	29907	BR	41019	BR	50593	BR	67043	BR
24359	BR	32421	BR	49203	BR	51100	BR	67113	BR
27267	BR	32422	BR	49204	BR	51101	BR	67229	BR
27268	BR	32550	BR	49205	BR	51102	BR	68816	BR
27269	BR	32551	BR	49440	BR	52649	BR		
27416	BR	32560	BR	49441	BR	55920	BR		

CPT CODE UPDATE

ANESTHESIA

Code	Description	Base Unit
01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	5.00
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic	5.00

SURGERY

Code	Description	Relative Value	Amount	PC Amount	FUD	Assist Surgery	ASC Amount
20555	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)	7.89	\$662.76		000	N	BR
+ 20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	3.67	\$308.28		ZZZ	N	BR
+ 20986	Computer-assisted surgical navigational procedure for musculoskeletal procedures; with image guidance based on intraoperatively obtained images (eg, fluoroscopy, ultrasound) (List separately in addition to code for primary procedure)	4.26	\$357.84		ZZZ	N	BR
+ 20987	Computer-assisted surgical navigational procedure for musculoskeletal procedures; with image guidance based on preoperative images (List separately in addition to code for primary procedure)	4.26	\$357.84		ZZZ	N	BR
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	8.86	\$744.24		090	N	BR
22206	Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	56.54	\$4749.36		090	Y	BR
22207	Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	55.82	\$4688.88		090	Y	BR
+ 22208	Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)	14.31	\$1202.04		ZZZ	Y	BR
24357	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous	10.70	\$898.80		090	N	BR
24358	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open	12.56	\$1055.04		090	Y	BR
24359	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment	15.41	\$1294.44		090	Y	BR
27267	Closed treatment of femoral fracture, proximal end, head; without manipulation	10.03	\$842.52		090	Y	BR
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation	12.34	\$1036.56		090	Y	BR
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	29.33	\$2463.72		090	Y	BR
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft(s))	23.04	\$1935.36		090	Y	BR
27726	Repair of fibula nonunion and/or malunion with internal fixation	21.61	\$1815.24		090	Y	BR

CPT CODE UPDATE

Code	Description	Relative Value	Amount	PC Amount	FUD	Assist Surgery	ASC Amount
27767	Closed treatment of posterior malleolus fracture; without manipulation	6.12	\$514.08		090	N	BR
27768	Closed treatment of posterior malleolus fracture; with manipulation	9.49	\$797.16		090	N	BR
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	16.34	\$1372.56		090	N	BR
28446	Open osteochondral autograft, talus (includes obtaining graft(s))	28.22	\$2370.48		090	Y	BR
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	21.80	\$1831.20		090	Y	BR
29904	Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body	14.63	\$1228.92		090	Y	BR
29905	Arthroscopy, subtalar joint, surgical; with synovectomy	15.77	\$1324.68		090	Y	BR
29906	Arthroscopy, subtalar joint, surgical; with debridement	16.61	\$1395.24		090	Y	BR
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis	20.34	\$1708.56		090	Y	BR
32421	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent	4.17	\$350.28		000	N	BR
32422	Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)	5.10	\$428.40		000	N	BR
⊙ 32550	Insertion of indwelling tunneled pleural catheter with cuff	21.56	\$1811.04		000	N	BR
⊙ 32551	Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)	4.49	\$377.16		000	N	BR
32560	Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)	7.92	\$665.28		000	N	BR
+ 33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	14.84	\$1246.56		ZZZ	Y	BR
+ 33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	16.77	\$1408.68		ZZZ	Y	BR
+ 33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	22.03	\$1850.52		ZZZ	Y	BR
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic annulus remodeling (eg, David Procedure, Yacoub Procedure)	79.68	\$6693.12		090	Y	BR
+ 34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)	2.62	\$220.08		ZZZ	Y	BR
35523	Bypass graft, with vein; brachial-ulnar or -radial	32.49	\$2729.16		090	Y	BR
36591	Collection of blood specimen from a completely implantable venous access device	0.55	\$46.20		XXX	N	BR
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified	0.68	\$57.12		XXX	N	BR
36593	Dec clotting by thrombolytic agent of implanted vascular access device or catheter	0.97	\$81.48		XXX	N	BR

CPT CODE UPDATE

Code	Description	Relative Value	Amount	PC Amount	FUD	Assist Surgery	ASC Amount
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application	11.65	\$978.60		000	N	BR
49203	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less	27.54	\$2313.36		090	Y	BR
49204	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5.1-10.0 cm diameter	35.11	\$2949.24		090	Y	BR
49205	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor greater than 10.0 cm diameter	40.17	\$3374.28		090	Y	BR
⊙ 49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	29.23	\$2455.32		010	N	BR
⊙ 49441	Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	34.62	\$2908.08		010	N	BR
⊙ 49442	Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	28.22	\$2370.48		010	N	BR
⊙ 49446	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	28.87	\$2425.08		000	N	BR
49450	Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	20.25	\$1701.00		000	N	BR
49451	Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	21.44	\$1800.96		000	N	BR
49452	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	26.21	\$2201.64		000	N	BR
49460	Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation and report	21.49	\$1805.16		000	N	BR
49465	Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report	4.47	\$375.48		000	N	BR
⊙ 50385	Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	34.82	\$2924.88		000	N	BR
⊙ 50386	Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation	22.49	\$1889.16		000	N	BR
⊙ 50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	123.20	\$10348.80		010	Y	BR
51100	Aspiration of bladder; by needle	1.66	\$139.44		000	N	BR

CPT CODE UPDATE

Code	Description	Relative Value	Amount	PC Amount	FUD	Assist Surgery	ASC Amount
51101	Aspiration of bladder; by trocar or intracatheter	3.41	\$286.44		000	N	BR
51102	Aspiration of bladder; with insertion of suprapubic catheter	8.79	\$738.36		010	N	BR
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	25.54	\$2145.36		090	N	BR
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application	11.04	\$927.36		000	N	BR
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	15.93	\$1338.12		090	Y	BR
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	22.26	\$1869.84		090	Y	BR
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	22.15	\$1860.60		090	Y	BR
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	24.22	\$2034.48		090	Y	BR
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	27.49	\$2309.16		090	Y	BR
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	30.94	\$2598.96		090	Y	BR
60300	Aspiration and/or injection, thyroid cyst	2.59	\$217.56		000	N	BR
67041	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)	27.96	\$2348.64		090	Y	BR
67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)	31.98	\$2686.32		090	Y	BR
67043	Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation	33.59	\$2821.56		090	Y	BR
67113	Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens	36.90	\$3099.60		090	Y	BR
67229	Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy	24.32	\$2042.88		090	N	BR
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	15.55	\$1306.20		010	N	BR

CPT CODE UPDATE

RADIOLOGY

Code	Description	Relative Value	Amount	PC Amount	FUD	Assist Surgery	Facility Fee
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	14.31	\$915.84	\$199.04	XXX	N	\$1007.42
75558	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification	15.75	\$1008.00	\$192.00	XXX	N	\$1108.80
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	20.83	\$1333.12	\$254.08	XXX	N	\$1466.43
75560	Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress	20.48	\$1310.72	\$220.16	XXX	N	\$1441.79
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	19.34	\$1237.76	\$220.16	XXX	N	\$1361.54
75562	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification	20.32	\$1300.48	\$210.56	XXX	N	\$1430.53
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	23.94	\$1532.16	\$264.32	XXX	N	\$1685.38
75564	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress	23.89	\$1528.96	\$246.40	XXX	N	\$1681.86

PATHOLOGY AND LABORATORY

Code	Description	Relative Value	Amount	PC Amount	FUD	Assist Surgery	Facility Fee
80047	Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)	0.50	\$30.00	\$0.00	XXX	N	\$33.00
82610	Cystatin C	0.50	\$30.00	\$0.00	XXX	N	\$33.00
83993	Calprotectin, fecal	0.72	\$43.20	\$0.00	XXX	N	\$47.52
84704	Gonadotropin, chorionic (hCG); free beta chain	0.55	\$33.00	\$0.00	XXX	N	\$36.30
86356	Mononuclear cell antigen, quantitative (eg, flow cytometry), not otherwise specified, each antigen	0.98	\$58.80	\$0.00	XXX	N	\$64.68
86486	Skin test; unlisted antigen, each	0.15	\$9.00	\$0.00	XXX	N	\$9.90
87500	Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance (eg, enterococcus species van A, van B), amplified probe technique	1.29	\$77.40	\$0.00	XXX	N	\$85.14
87809	Infectious agent antigen detection by immunoassay with direct optical observation; adenovirus	0.44	\$26.40	\$0.00	XXX	N	\$29.04
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	5.59	\$335.40	\$85.20	XXX	N	\$368.94
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)	0.57	\$34.20	\$0.00	XXX	N	\$37.62
89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	0.72	\$43.20	\$0.00	XXX	N	\$47.52

CPT CODE UPDATE

MEDICINE SERVICES

Code	Description	Relative Value	Amount	PC Amount	FUD	Assist Surgery
Ⓞ 90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each	0.00	BR		XXX	N
90650	Human Papillomavirus (HPV) vaccine, types 16 and 18, bivalent, 3 dose schedule, for intramuscular use	0.00	BR		XXX	N
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use	0.00	BR		XXX	N
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	0.00	BR		XXX	N
90663	Influenza virus vaccine, pandemic formulation	0.00	BR		XXX	N
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	1.46	\$86.14		XXX	N
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use	0.00	BR		XXX	N
90769	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s)	4.17	\$246.03		XXX	N
+ 90770	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	0.42	\$24.78		ZZZ	N
+ 90771	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	1.87	\$110.33		ZZZ	N
+ 90776	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	0.00	BR		ZZZ	N
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	1.07	\$63.13		XXX	N
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	1.02	\$60.18		XXX	N
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	0.72	\$42.48		XXX	N
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	1.09	\$64.31		XXX	N
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	2.42	\$142.78		XXX	N

CPT CODE UPDATE

Code	Description	Relative Value	Amount	PC Amount	FUD	Assist Surgery
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	0.32	\$18.88	\$	XXX	N
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	0.60	\$35.40	\$	XXX	N
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	0.89	\$52.51	\$	XXX	N
98969	Online assessment and management service provided by a qualified nonphysician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network	0.00	BR		XXX	N
99174	Ocular photoscreening with interpretation and report, bilateral	0.36	\$21.24		XXX	N
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	0.00	BR		XXX	N
99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	0.00	BR		XXX	N
+ 99607	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)	0.00	BR		XXX	N

CPT CODE UPDATE

EVALUATION AND MANAGEMENT

Code	Description	Relative Value	Amount
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional	0.98	\$49.98
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	1.27	\$64.77
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional	0.82	\$41.82
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	0.32	\$16.32
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	0.63	\$32.13
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	0.77	\$39.27
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	1.51	\$77.01
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	0.33	\$16.83
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	0.60	\$30.60
99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	0.89	\$45.39
99444	Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network	0.00	BR
99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services	8.46	\$431.46

HCPCS

Code	Mod	Description	Amount
A4252		Blood ketone test or reagent strip, each	BR
A4648		Tissue marker, implantable, any type, each	BR
A4650		Implantable radiation dosimeter, each	BR
A5083		Continent device, stoma absorptive cover for continent stoma	BR
A6413		Adhesive bandage, first aid type, any size, each	BR
A7027		Combination oral/nasal mask, used with continuous positive airway pressure device, each	BR
A7028		Oral cushion for combination oral/nasal mask, replacement only, each	BR
A7029		Nasal pillows for combination oral/nasal mask, replacement only, pair	BR
A9155		Artificial saliva, 30 ml	BR
A9274		External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories	BR
A9276		Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply	BR
A9277		Transmitter; external, for use with interstitial continuous glucose monitoring system	BR
A9278		Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	BR
A9283		Foot pressure off loading/supportive device, any type, each	BR
A9501		Technetium Tc-99m tetroxime, diagnostic, per study dose	BR
A9509		Iodine I-123 sodium iodide, diagnostic, per millicurie	BR
A9569		Technetium Tc-99m exametazime labeled autologous white blood cells, diagnostic, per study dose	BR
A9570		Indium In-111 labeled autologous white blood cells, diagnostic, per study dose	BR
A9571		Indium In-111 labeled autologous platelets, diagnostic, per study dose	BR
A9572		Indium In-111 pentetreotide, diagnostic, per study dose, up to 6 millicuries	BR
A9576		Injection, gadoteridol, (ProHance multipack), per ml	BR
A9577		Injection, gadobenate dimeglumine (MultiHance), per ml	BR
A9578		Injection, gadobenate dimeglumine (MultiHance multipack), per ml	BR
A9579		Injection, gadolinium based magnetic resonance contrast agent, not otherwise specified, per ml	BR
B4087		Gastrostomy/jejunostomy tube, standard, any material, any type, each	BR
B4088		Gastrostomy/jejunostomy tube, low-profile, any material, any type, each	BR
C8921		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete	BR
C8922		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study	BR
C8923		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D) with or without M-mode recording; complete	BR
C8924		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study	BR
C8925		Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	BR
C8926		Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	BR
C8927		Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment	BR
C8928		Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pha	BR

HCPCS CODE UPDATE

Code	Mod	Description	Amount
C9237		Injection, lanreotide acetate, 1 mg	BR
C9238		Injection, levetiracetam, 10 mg	BR
C9239		Injection, temsirolimus, 1 mg	BR
C9240		Injection, ixabepilone, 1 mg	BR
C9352		Microporous collagen implantable tube (NeuraGen Nerve Guide), per cm. length	BR
C9353		Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per cm. length	BR
C9354		Acellular pericardial tissue matrix of nonhuman origin (Veritas), per square centimeter	BR
C9355		Collagen nerve cuff (NeuroMatrix), per 0.5 centimeter length	BR
E0328		Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard, and side rails up to 24 in. above the spring, includes mattress	BR
E0329		Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard, and side rails up to 24 in. above the spring, includes mattress	BR
E0856		Cervical traction device, cervical collar with inflatable air bladder	BR
E2227		Manual wheelchair accessory, gear reduction drive wheel, each	BR
E2228		Manual wheelchair accessory, wheel braking system and lock, complete, each	BR
E2312		Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware	BR
E2313		Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each	BR
E2397		Power wheelchair accessory, lithium-based battery, each	BR
G0396		Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	BR
G0397		Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes	BR
J0220		Injection, alglucosidase alfa, 10 mg	BR
J0400		Injection, aripiprazole, intramuscular, 0.25 mg	\$0.41
J1300		Injection, eculizumab, 10 mg	BR
J1561		Injection, immune globulin, (Gamunex), intravenous, nonlyophilized (e.g., liquid), 500 mg	\$59.00
J1568		Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg	\$64.58
J1569		Injection, immune globulin, (Gammagard liquid), intravenous, nonlyophilized, (e.g., liquid), 500 mg	\$72.96
J1571		Injection, hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 ml	\$109.31
J1572		Injection, immune globulin, (Flebogamma), intravenous, nonlyophilized (e.g., liquid), 500 mg	\$57.89
J1573		Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5 ml	BR
J1743		Injection, idursulfase, 1 mg	\$628.62
J2323		Injection, natalizumab, 1 mg	\$10.41
J2724		Injection, protein C concentrate, intravenous, human, 10 IU	BR
J2778		Injection, ranibizumab, 0.1 mg	\$583.05
J2791		Injection, Rhof D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 IU	\$1.53
J3488		Injection, zoledronic acid (Reclast), 1 mg	\$294.24
J7307		Etonogestrel (contraceptive) implant system, including implant and supplies	BR
J7321		Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose	\$174.62
J7322		Hyaluronan or derivative, Synvisc, for intra-articular injection, per dose	\$281.06
J7323		Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose	\$173.42
J7324		Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose	BR
J7347		Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Integra Matrix), per sq. cm.	\$22.01

HCPCS CODE UPDATE

Code	Mod	Description	Amount
J7348		Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (TissueMend), per sq. cm.	\$159.07
J7349		Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (PriMatrix), per sq. cm.	\$50.23
J7602		Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)	BR
J7603		Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)	BR
J7604		Acetylcysteine, inhalation solution, compounded product, administered through DME, unit dose form, per g	BR
J7605		Arformoterol, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, 15 mcg	BR
J7632		Cromolyn sodium, inhalation solution, compounded product, administered through DME, unit dose form, per 10 mg	\$0.47
J7676		Pentamidine isethionate, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg	BR
J9226		Histrelin implant (Supprelin LA), 50 mg	BR
J9303		Injection, panitumumab, 10 mg	\$114.82
K0672		Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each	BR
L3925		FO, proximal interphalangeal (PIP)/distal interphalangeal (DIP), nontorsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment	BR
L3927		FO, proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g., static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment	BR
L3929		HFO, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment	BR
L3931		WHFO, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment	BR
L7611		Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric	BR
L7612		Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric	BR
L7613		Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric	BR
L7614		Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric	BR
L7621		Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined	BR
L7622		Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined	BR
Q4096		Injection, von Willebrand factor complex human, ristocetin cofactor (not otherwise specified), per I.U. VWF:RCO	BR
Q4097		Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg	BR
Q4098		Injection, iron dextran, 50 mg	BR
Q4099		Formoterol fumarate, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, 20 micrograms	BR
Q9965		Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml	BR
Q9966		Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml	BR
Q9967		Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml	BR
S3628		Placental alpha microglobulin-1 rapid immunoassay for detection of rupture of fetal membranes	BR
V2787		Astigmatism correcting function of intraocular lens	BR