CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 240 **Date: JULY 23, 2004**

CHANGE REQUEST 3279

I. SUMMARY OF CHANGES: The Common Working File (CWF) shall make system's changes to account for changes in the interrupted stay policy for long term care hospitals (LTCH) paid under the prospective payment system (PPS). The new policy is as follows: (1) there is now a 3-day interrupted stay policy (in addition to the normal interrupted stay policy already in place for this PPS)-this means that if a patient returns to the LTCH within 3 days, the LTCH will be paid only 1 diagnosis related group (DRG) payment (this is regardless of where the patient goes); (2) Medicare will not pay separately for claims submitted by other providers (acute hospital, skilled nursing facility, swing bed, inpatient rehabilitation facility, or any outpatient bill) during this 3 day interruption - this will force the LTCH to bill for these services as they should be performed "under arrangements"; and (3) Medicare will allow and pay for an acute bill from an inpatient hospital only if it is a surgical DRG.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: January 3, 2005**

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated)*
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

***III. FUNDING:**
These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 240	Date: July 23, 2004	Change Request 3279

SUBJECT: Expansion of the Existing Interrupted Stay Policy Under Long Term Care Hospital (LTCH) Prospective Payment System

I. GENERAL INFORMATION

Background: Medicare defines "interruption of a stay" as a stay at an LTCH during which a Medicare inpatient is discharged from a LTCH, and is readmitted to the same LTCH within a specified period of time. Originally, at the start of the LTCH PPS for FY 2003, the interrupted stay policy addressed the situation where a LTCH patient was admitted to an acute care hospital, an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF) or swing bed and then returns to the LTCH for additional care. In the May 7, 2004, final rule for the LTCHPPS, we revised the interrupted stay policy to include a discharge and readmission to the same LTCH within 3 days, regardless of where the patient goes upon discharge.

This transmittal describes the original policy, now called the "greater than 3-day interruption of stay " and the expansion of this policy, the "3-day or less interruption of stay," effective on July 1, 2004, particularly, situations governed by each policy, and the relationship between them. The "greater than three day interruption of stay policy" begins on day 4.

As defined above, all interrupted stays are treated as one discharge from the LTCH. The day-count of the applicable fixed-day period of an interrupted stay begins on the day of discharge from the LTCH. For a "greater than 3-day interruption of stay, " when a patient is discharged from an LTCH and directly admitted to an acute care hospital, the applicable fixed-day period is 9 days, for an IRF, 27 days, and for an SNF/swing bed 45 days. The counting of the days begins on the day of discharge from the LTCH and ends on the 9th, 27th, or 45th day for an acute care hospital, an IRF, or an SNF, respectively, after the discharge.

If the patient is readmitted to the LTCH within the fixed-day threshold, return to the LTCH is considered part of the first admission and only a single LTCH PPS payment is made. In implementing this policy, a Medicare inpatient is discharged from an LTCH and is readmitted and the stay qualifies as an interrupted stay, the provider should cancel the claim generated by the original stay in the LTCH and submit one claim for the entire stay. On the other hand, if the patient stay exceeds the total fixed-day threshold outside of the LTCH at another facility before being readmitted, two separate payments would be made.

Implemented at the start of the LTCH PPS for hospital cost reporting periods beginning on or after October 1, 2002, this original interrupted stay policy, now the **"**greater than 3-day interruption of stay,**"** applied only when LTCH patients who were discharged and subsequently readmitted were inpatients at one of the above inpatient settings during the interruption. In the May 7, 2004, final rule for the LTCH PPS, we finalized a revision of the interrupted stay policy, under the "3-day or less interruption of stay policy," which includes a discharge and readmission to the LTCH within 3 days, regardless of where the patient goes upon discharge.

This means that if a patient is readmitted to the LTCH within 3 days of discharge, Medicare will pay only one LTC-DRG. This policy is intended to cover discharges and readmissions following an outpatient treatment (outpatient treatments include any services paid under OPPS, lab services in a hospital lab, therapies, and kidney dialysis in a hospital based dialysis facility), a 3-day or less inpatient stay (to an IRF, SNF, swingbed, or acute hospital), as well as a discharge and readmission with an intervening patient-stay at home. Furthermore, Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the "interruption" is the responsibility of the LTCH "under arrangements" with one exception for LTCH rate year (RY) 2005 (July 1, 2004 – June 30, 2005): If treatment at an inpatient acute care hospital is grouped to a surgical DRG, a separate Medicare payment is made under the IPPS for that care.

Therefore, under the " 3-day or less interruption of stay policy," any tests or procedures, that were administered to the patient during that period of time, other than inpatient surgical care at an acute care hospital for RY 2005, are considered part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH is required to pay any other providers without additional Medicare program payment liability. If any tests or procedures are delivered any time during the 3-day interruption (with payment being made by the LTCH to the intervening provider under arrangements), all days of the interruption are included in the total day count for that patient. If no care is provided during the interruption, the days away from the LTCH are not included in the patient stay.

If the interruption exceeds 3 days, LTCH payment is determined under the original interrupted stay policy (now referred to as a " greater than 3-day interruption of stay ") but the day count for purposes of determining the length of the stay away from the LTCH begins on the day that the patient is first discharged from the LTCH.

B. Policy: §412.531(a) and LTCH PPS Final Rule published on May 7, 2004**.**

C. Provider Education: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3279.1	CWF shall reject as an interrupted stay, LTCH bills, where patient returns to the same LTCH within 3 days of being discharged, i.e. the admit	CWF

	date of the incoming LTCH claim is 3 days or less than the discharge date of history claim for the same LTCH and vise versa. For example, if the LTCH discharges the patient on 7/1/04 and patient is readmitted to the same LTCH on 7/3/04, this is an interrupted stay and should be billed as one claim with a occurrence span code 74 from 7/1/04 through 7/2/04.	
3279.1.1	The FI shall return to the provider (RTP) the claim rejected from CWF.	FI
3279.2	CWF shall reject outpatient claims (TOBs 12X, 13X, and 83X; 72X, specifically provider ranges of 2300-2499 and 3500-3699,), during the interruption of the LTCH claim in history with dates of interruption on or after July 1, 2004.	CWF
3279.2.1	CWF shall reject an inpatient claim (non-surgical DRG acute hospital, both IPPS and non-IPPS; IRF, SNF, and swingbed) during the interruption of the LTCH claim in history with dates of interruption on or after July 1, 2004. **NOTE:** List of surgical DRGs is attached (this list is valid through September 30, 2004). Surgical DRGs effective for discharges on or after October 1, 2004 will be issued when known.	CWF
3279.2.2	CWF shall bypass this editing for claims with pay codes of N or B.	CWF
3279.2.3	FIs shall reject above bills back to the provider; however FIs shall not recycle these rejected claims back to CWF to post as noncovered.	FIs
3279.3	CWF shall return an unsolicited response for the outpatient and inpatient bills listed above upon receipt of a LTCH claim with interruption	CWF
3279.3.1	FISS shall create a cancel for the claim in the unsolicited response.	FISS
3279.4	CWF shall perform a utility retroactive to LTCH bills with interrupted stays on or after July 1, 2004 applying this expanded policy, determining the interrupted stay and looking for date spans of three days and canceling bills within the date span	CWF

3279.5	CWF shall create an override for appeals for all of these requirements based on CR 3190, for April 2005.	CWF
3279.5.1	FIs shall not enforce timeliness standards if a case is pended for override.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3279.1.1, 3279.2, 3279.2.1, 3279.2.3, and 3279.3.1	Rejected claims services shall be included on the LTCH bill as they were performed under arrangements. Occurrence Span Code 74 days cannot be used for days where other services were performed. The LTCH shall adjust their bill to include under arrangement services so that proper days are counted for beneficiary. Should the patient not receive any services during the interruption, the occurrence span code 74 days will continue to be utilized, however if one outpatient service is performed on a particular day, all days shall be included as a covered day on the LTCH bill.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date: January 3, 2005** **Pre-Implementation Contact(s):** Sarah Shirey at sshirey@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate CMS Regional Office	**These instructions shall be implemented within your current operating budget.**

Surgical CMS DRGs

Effective October 1, 2003, through September 30, 2004

DRG	DRG DESCRIPTION
001	CRANIOTOMY AGE >17 W CC
103	HEART TRANSPLANT
104	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH
105	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CA
106	CORONARY BYPASS W PTCA
107	CORONARY BYPASS W CARDIAC CATH
108	OTHER CARDIOTHORACIC PROCEDURES
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH
110	MAJOR CARDIOVASCULAR PROCEDURES W CC
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB &
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS
115	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR
116	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT
118	CARDIAC PACEMAKER DEVICE REPLACEMENT
119	VEIN LIGATION & STRIPPING
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES
146	RECTAL RESECTION W CC
147	RECTAL RESECTION W/O CC
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC
150	PERITONEAL ADHESIOLYSIS W CC
151	PERITONEAL ADHESIOLYSIS W/O CC
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17
157	ANAL & STOMAL PROCEDURES W CC
158	ANAL & STOMAL PROCEDURES W/O CC
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O C
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC
163	HERNIA PROCEDURES AGE 0-17
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC
168	MOUTH PROCEDURES W CC
169	MOUTH PROCEDURES W/O CC
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E.
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E.
195	CHOLECYSTECTOMY W C.D.E. W CC
196	CHOLECYSTECTOMY W C.D.E. W/O CC

197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY
2	CRANIOTOMY AGE >17 W/O CC
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTRE
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISOR
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN T
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O
225	FOOT PROCEDURES
226	SOFT TISSUE PROCEDURES W CC
227	SOFT TISSUE PROCEDURES W/O CC
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMU
232	ARTHROSCOPY
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCI
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITI
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITI
267	PERIANAL & PILONIDAL PROCEDURES
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISO
286	ADRENAL & PITUITARY PROCEDURES
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISO
288	O.R. PROCEDURES FOR OBESITY
289	PARATHYROID PROCEDURES
290	THYROID PROCEDURES
291	THYROGLOSSAL PROCEDURES
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC
3	CRANIOTOMY AGE 0-17
302	KIDNEY TRANSPLANT
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC
306	PROSTATECTOMY W CC

307	PROSTATECTOMY W/O CC
308	MINOR BLADDER PROCEDURES W CC
309	MINOR BLADDER PROCEDURES W/O CC
310	TRANSURETHRAL PROCEDURES W CC
311	TRANSURETHRAL PROCEDURES W/O CC
312	URETHRAL PROCEDURES, AGE >17 W CC
313	URETHRAL PROCEDURES, AGE >17 W/O CC
314	URETHRAL PROCEDURES, AGE 0-17
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES
334	MAJOR MALE PELVIC PROCEDURES W CC
335	MAJOR MALE PELVIC PROCEDURES W/O CC
336	TRANSURETHRAL PROSTATECTOMY W CC
337	TRANSURETHRAL PROSTATECTOMY W/O CC
338	TESTES PROCEDURES, FOR MALIGNANCY
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17
341	PENIS PROCEDURES
342	CIRCUMCISION AGE >17
343	CIRCUMCISION AGE 0-17
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGN
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVE
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC
36	RETINAL PROCEDURES
360	VAGINA, CERVIX & VULVA PROCEDURES
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION
362	ENDOSCOPIC TUBAL INTERRUPTION
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES
37	ORBITAL PROCEDURES
370	CESAREAN SECTION W CC
371	CESAREAN SECTION W/O CC
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE
38	PRIMARY IRIS PROCEDURES
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY
392	SPLENECTOMY AGE >17
393	SPLENECTOMY AGE 0-17
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGA
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS

424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS
439	SKIN GRAFTS FOR INJURIES
440	WOUND DEBRIDEMENTS FOR INJURIES
441	HAND PROCEDURES FOR INJURIES
442	OTHER O.R. PROCEDURES FOR INJURIES W CC
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMIT
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGN
478	OTHER VASCULAR PROCEDURES W CC
479	OTHER VASCULAR PROCEDURES W/O CC
480	LIVER TRANSPLANT
481	BONE MARROW TRANSPLANT
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES
483	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK D
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIF
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA
488	HIV W EXTENSIVE O.R. PROCEDURE
49	MAJOR HEAD & NECK PROCEDURES
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTRE
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC
495	LUNG TRANSPLANT
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION
497	SPINAL FUSION EXCEPT CERVICAL W CC
498	SPINAL FUSION EXCEPT CERVICAL W/O CC
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC
50	SIALOADENECTOMY
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC
501	KNEE PROCEDURES W PDX OF INFECTION W CC
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC
503	KNEE PROCEDURES W/O PDX OF INFECTION
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SI
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY
512	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT
513	PANCREAS TRANSPLANT
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH
516	PERCUTANEOUS CARDIOVASC PROC W AMI
517	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI
518	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI
519	CERVICAL SPINAL FUSION W CC
52	CLEFT LIP & PALATE REPAIR
520	CERVICAL SPINAL FUSION W/O CC
525	HEART ASSIST SYSTEM IMPLANT
526	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI
527	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O A
528	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE
529	VENTRICULAR SHUNT PROCEDURES W CC
53	SINUS & MASTOID PROCEDURES AGE >17
530	VENTRICULAR SHUNT PROCEDURES W/O CC
531	SPINAL PROCEDURES W CC
532	SPINAL PROCEDURES W/O CC

533	EXTRACRANIAL PROCEDURES W CC
534	EXTRACRANIAL PROCEDURES W/O CC
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK
537	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W C
538	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O
539	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC
54	SINUS & MASTOID PROCEDURES AGE 0-17
540	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES
56	RHINOPLASTY
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, A
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, A
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17
6	CARPAL TUNNEL RELEASE
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17
61	MYRINGOTOMY W TUBE INSERTION AGE >17
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC
75	MAJOR CHEST PROCEDURES
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC