Program Memorandum Intermediaries/Carriers

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

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This Program Memorandum re-issues Program Memorandum AB-02-023, Change Request 2034, dated February 12, 2002. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 2034

SUBJECT: Common Working File (CWF) Edits with Unsolicited Responses for Skilled Nursing Facility (SNF) Consolidated Billing

This Program Memorandum (PM) is for intermediary action and carrier information only.

I. Edits for CWF and Intermediaries

A. General

This PM describes SNF PPS Part A consolidated billing edits to be implemented in CWF effective July 1, 2002, to detect duplicate payments.

CWF will generate an unsolicited response when the outpatient or inpatient Part B claim is received before the covered inpatient Part A claim. Services considered included in the SNF Part A PPS rate cannot be billed by other providers or suppliers. Such billing would be duplicate billing.

The intermediary must initiate overpayment recovery procedures to retract the original, incorrect, outpatient Part B payment, and must generate an adjustment or cancel claim to update CWF and intermediary history.

To detect duplicates, HCPCS codes, modifiers and line item dates of service (LIDOSs) on inpatient or outpatient Part B claims will be compared to HCPCS codes, modifiers and LIDOSs on outpatient Part B records.

When comparing Part B claims containing HCPCS, LIDOSs and modifiers to inpatient Part A SNF claims, use the from and through dates of the Part A claim.

This instruction contains two new remark codes (effective January 31, 2002) that need to be added to your system.

B. Standard Systems (SSs) Edits

Additional edits for HCPCS Codes: SNFs are to bill all Part B services with a HCPCS code if one exists and a LIDOS. Intermediaries are instructed to edit to assure that HCPCS codes and LIDOS are reported with the revenue codes identified in section II.A.7. As HCPCS codes are developed for more services, we will expand the list of revenue codes to be edited.

For bill types 22X and 23X, return to the provider as incomplete, any claims with the revenue codes in section II.A.7 if not billed with a HCPCS code and LIDOS. The provider may not charge the beneficiary for services reported incorrectly. The provider may correct and resubmit the claim with appropriate HCPCS coding, LIDOS, and a new filing date.

Services considered included in the SNF Part A PPS rate cannot be billed by other providers. Such billing would be duplicate billing. Services that may be billed separately are identified by HCPCS code and modifiers (if necessary).

Therapy to a SNF Part B resident must be billed under Part B by the SNF for the service to be covered. Preventive and screening services rendered to Part A inpatients must be bundled to the SNF. These claims are submitted on type of bill 22x with LIDOS(s) during the beneficiary's inpatient stay.

Emergency services rendered to a SNF inpatient by a hospital or Critical Access Hospitals (CAH) can only be identified by the presence of revenue code 0450 on the bill.

C. Specific Edits

1. Inpatient Part A SNF Claim Against Outpatient or Inpatient Part B Therapy Claim History

If a SNF inpatient claim (21X or 22X) is received in CWF against a posted Outpatient Part B therapy claim(s) on history ('12X', '13X', '14X', '22x', '23X', '34X', '74X', '75X', '83X' or '85X'), which contains any HCPCS code listed in section II A.1, CWF will accept the inpatient claim and send an unsolicited response to the appropriate intermediary identifying the posted Part B claim. Use the SNF inpatient from and through dates that overlap the LIDOS on the Part B therapy history claim.

Bypass the edit in the following situations:

- The type of bill on the history claim is '22X,' and the LIDOS on the history claim is greater than an Occurrence Code 'A3', 'B3', or 'C3' date (Benefits Exhausted) or 22 (Date Active Care Ended) on the incoming claim. The provider number of the '22X' history claim is the same as the incoming '21X' claim.

- One of the following occurrence span codes is present on the '21X' SNF incoming bill:

  - '74' (Non-covered level of care);
  - '76' (Patient Liability);
  - '77' (Provider Liability--Utilization Charged);
  - '79' (Provider Liability--No Utilization Charged);or
  - 'M1' (Provider Liability-No Utilization Charged).

AND the history claim is a SNF '22X' type of bill (SNF Inpatient B) with the same provider number AND contains a LIDOS(s) between one of the occurrence span codes from and through dates.

- The incoming SNF '21X' claim discharge date equals the history claim LIDOS or the incoming SNF '21X' claim admission date equals the history LIDOS.

- The history claim type of bill is '22X' with the same provider number as the SNF incoming '21X' claim and the incoming '21X' claim has a no-pay code of 'B', 'C', 'N', or 'R.'

- The history claim contains a cancel date.

CWF Response on Receipt of SNF 21x Types Of Bills (TOB)

CWF will generate an unsolicited response containing an error code and send it to the intermediary that processed the Part B therapy claim, identifying the line(s) on which the LIDOS(s) fall within the dates of the SNF inpatient claim.

Intermediary Action Upon Receipt of CWF Unsolicited Response

Recoup the Part B overpayment from the provider and cancel the claim if all lines are rejected. If some line items are rejected, appropriately adjust the claim and return it to CWF and update your history.

Remittance Codes:

Use Adjustment Reason Code B15: Payment adjusted because this procedure/service is not paid separately.

Use Group Code CO: Contractual Obligation (Indicates the provider may not bill the beneficiary for this service.) Payment amount is zero.

Use Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.

If the history bill is 22x or 23x (Part B SNF outpatient) and the provider number is the same, use Remark Code N107: Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services. (New code effective January31, 2002.

MSN Code

Use Beneficiary MSN code 31.1. This is a correction to a previously processed claim and/or deductible record.

2. Inpatient Part A SNF Claim Against an Outpatient or Inpatient Part B Claim Without Therapy on History

If a Part A inpatient SNF '21X' TOB is received containing From/Thru Dates that include the LIDOS(s) on an outpatient or inpatient Part B claim (TOB '12X', '13X', '14X', '22X', '23X', '34X', '74X', '75X', '83X', or '85X'), CWF will process the Part A inpatient claim and send an unsolicited response to the appropriate intermediary identifying the posted Part B claim. If the incoming SNF '21X' claim has occurrence code '22' (Date Active Care Ended), use the occurrence code '22' date instead of the through date.

Bypass the edit in the following situations:

- The Part B history claim contains ambulance HCPCS modifiers other than 'N' (SNF) in both the origin and destination on the same claim.
- The Part B history claim contains any of the HCPCS codes listed in section II.A.3.
- The Part B history claim TOB is '13X' (Hospital Outpatient) or '85X' (Critical Access Hospital) and contains revenue code '0450' (emergency) or any of the HCPCS codes identified in section II.A.4.
- The Part B history claim TOB '13X' or '85X' contains any of the HCPCS codes listed in section II.A.4 except Part B surgical procedures listed in section II.A.4.f.
- The revenue codes on the outpatient claim on history are:
  - 0634 Epoetin (EPO) - Administrations for an injection of less than 10,000 units of EPO was administered, and/or
  - 0635 Epoetin (EPO) - Administrations for an injection of 10,000 units or more of EPO was administered
- The Part B history claim (TOB 22X) contains preventive services, screening services and their administration identified in section II.A.6.
- The history claim TOB is '22X', and the LIDOSs are greater than the date shown in occurrence code 'A3', 'B3', or 'C3', (Benefits Exhausted) on the incoming '21X' claim.
- The incoming SNF '21X' claim admission or discharge date equals the outpatient history claim LIDOS(s).

- The incoming '21X' claim contains a no-pay code of 'B', 'C', 'N', 'R.'
- The incoming '21X' claim contains a cancel date.
- The outpatient history claim contains a cancel date.
- One of the following occurrence span codes is present on the incoming 21X SNF claim.
  - '74' (Non-covered level of care/leave of absence);
  - '76'(Patient Liability);
  - '77' (Provider Liability--Utilization Charged);
  - '79' (Provider Liability--No Utilization Charged); or
  - 'M1' (Provider Liability-No Utilization).

AND the LIDOS(s) of the Part B history claim falls between the from and through dates of the occurrence span code on the incoming '21X' claim.

CWF Response on Receipt of a Covered SNF 21X Claim

CWF will generate an unsolicited response containing an error code(s) and send it to the intermediary that processed the Part B claim, identifying the line(s) on which the LIDOS(s) fall within the dates of the SNF inpatient claim.

Intermediary Action Upon Receipt of CWF Unsolicited Response

Recoup the Part B overpayment from the provider and cancel the claim if all lines are rejected. If some line items are rejected, appropriately adjust the claim and return it to CWF and update your history.

Remittance Codes

Use Adjustment Reason Code B15: Payment adjusted because this procedure/service is not paid separately.

Use Group Code CO: Contractual Obligation (Indicates the provider may not bill the beneficiary for this service.) Payment amount is zero.

Use Claim Remark Code N106: Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service. (New Code effective January 31, 2002.)

MSN Codes

Use Beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

II. Tables and Reference Material

A. Tables

1. Therapy Revenue and HCPCS Codes--Revenue Codes for therapies are '42X' (physical therapy), '43X' (occupational therapy), and'44X' (speech therapy.

The applicable HCPCS codes for reporting outpatient rehabilitation services are as follows:

*29065	*29075	*29085	*29105	*29125	*29126	*29130	*29131	*29200
*29220	*29240	*29260	*29280	*29345	*29365	*29405	*29445	*29505
*29515	29520	29530	*29540	*29550	*29580	*29590	*64550	90901
90911	92506	92507	92508	92510	92526	95831	95832	95833

95834	95851	95852	96000	96001	96002	96003	96105	96110
96111	96115	97001	97002	97003	**97010	97012	97014	97016
97018	97020	97022	97024	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97504	97520	97530	97532	97533	97535	97537
97542	97545	97546	97601	97602	97703	97750	97799	†G0192
G0193	G0194	G0195	G0196	G0197	G0198	G0199	G0200	G0201
V5362	V5363	V5364						

* For Part B, these codes are defined as therapy when rendered by a therapist (revenue codes '042X' (physical therapy), '043X' (occupational therapy) and, '044X' (speech therapy)). When they are rendered by physicians (including nurse practitioners, clinical nurse specialists, or physician assistants) (any other revenue codes), they are defined as surgery and may be billed by the rendering provider.

** Payment for code 97010 is bundled with other rehabilitation services. It may be bundled with any therapy code.

† G0192 is not covered by Medicare.

Carriers receive place of service code '31' to identify a SNF Part A or Part B resident.

HCPCS Codes (1500, and UB 92 regardless of revenue code)

2. Ambulance Claims--If the intermediary outpatient claim includes ambulance services (outpatient revenue code '054X') and/or one of the following HCPCS code, reject if both characters of the HCPCS modifier is 'N' (origin and destination is SNF).

A0380	A0390	A0425	A0246			
A0427	A0428	A0429	A0430	A0431	A0432	A0433
A0434	A0435	A0436	A0999			

3. Services Excluded from Consolidated Billing--Intermediary and carrier claims with only the following services may be paid when provided by any Medicare provider, other than the SNF, that is licensed to provide them.

a. CHEMOTHERAPY ITEMS THAT MAY BE PAID

J9000	J9001	J9015	J9017	J9020	J9040	J9045	J9050	J9060
J9062	J9065	J9070	J9080	J9090	J9091	J9093	J9094	J9095
J9096	J9097	J9100	J9110	J9120	J9130	J9140	J9150	J9151
J9160	J9170	J9180	J9181	J9182	J9185	J9200	J9201	J9206
J9208	J9211	J9230	J9245	J9265	J9266	J9268	J9270	J9280
J9290	J9291	J9293	J9300	J9310	J9320	J9340	J9350	J9355
J9357	J9360	J9370	J9375	J9380	J9390	J9600		

b. CHEMOTHERAPY ADMINISTRATION SERVICES THAT MAY BE PAID

36260	36261	36262	*36489	*36491	36530	36531	36532	36533
36534	36535	36640	36823	96405	96406	96408	96410	96412
96414	96420	96422	96423	96425	96440	96445	96450	96520
96530	96542	Q0083	Q0084	Q0085				

* These codes are included in Part A payment when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent.

c. RADIOISOTOPE SERVICES THAT MAY BE PAID

79030	79035	79100	79200	79300	79400	79420	79440

d. CUSTOMIZED PROSTHETIC DEVICES THAT MAY BE PAID

L5050	L5060	L5100	L5105	L5150	L5160	L5200	L5210	L5220	L5230
L5250	L5270	L5280	L5301	L5311	L5321	L5331	L5341	L5500	L5505
L5510	L5520	L5530	L5535	L5540	L5560	L5570	L5580	L5585	L5590
L5595	L5600	L5610	L5611	L5613	L5614	L5616	L5617	L5618	L5620
L5622	L5624	L5626	L5628	L5629	L5630	L5631	L5632	L5634	L5636
L5637	L5638	L5639	L5640	L5642	L5643	L5644	L5645	L5646	L5647
L5648	L5649	L5650	L5651	L5652	L5653	L5654	L5655	L5656	L5658
L5660	L5661	L5662	L5663	L5664	L5665	L5666	L5668	L5670	L5671
L5672	L5674	L5675	L5676	L5677	L5678	L5680	L5682	L5684	L5686
L5688	L5690	L5692	L5694	L5695	L5696	L5697	L5698	L5699	L5700
L5701	L5702	L5704	L5705	L5706	L5707	L5710	L5711	L5712	L5714
L5716	L5718	L5722	L5724	L5726	L5728	L5780	L5785	L5790	L5795
L5810	L5811	L5812	L5814	L5816	L5818	L5822	L5824	L5826	L5828
L5830	L5840	L5845	L5846	L5850	L5855	L5910	L5920	L5925	L5930
L5940	L5950	L5960	L5962	L5964	L5966	L5968	L5970	L5972	L5974
L5975	L5976	L5978	L5979	L5980	L5981	L5982	L5984	L5985	L5986
L5988	L5989	L5990	L6050	L6055	L6100	L6110	L6120	L6130	L6200
L6205	L6250	L6300	L6310	L6320	L6350	L6360	L6370	L6400	L6450

L6500	L6550	L6570	L6580	L6582	L6584	L6586	L6588	L6590	L6600
L6605	L6610	L6615	L6616	L6620	L6623	L6625	L6628	L6629	L6630
L6632	L6635	L6637	L6640	L6641	L6642	L6645	L6650	L6655	L6660
L6665	L6670	L6672	L6675	L6676	L6680	L6682	L6684	L6686	L6687
L6688	L6689	L6690	L6691	L6692	L6693	L6700	L6705	L6710	L6715
L6720	L6725	L6730	L6735	L6740	L6745	L6750	L6755	L6765	L6770
L6775	L6780	L6790	L6795	L6800	L6805	L6806	L6807	L6808	L6809
L6810	L6825	L6830	L6835	L6840	L6845	L6850	L6855	L6860	L6865
L6867	L6868	L6870	L6872	L6873	L6875	L6880	L6881	L6882	L6920
L6925	L6930	L6935	L6940	L6945	L6950	L6955	L6960	L6965	L6970
L6975	L7010	L7015	L7020	L7025	L7030	L7035	L7040	L7045	L7170
L7180	L7185	L7186	L7190	L7191	L7260	L7261	L7266	L7272	L7274
L7362	L7364	L7366							

4. Emergency and Intensive Services Excluded from Consolidated Billing--Hospital Outpatient ('13X'), and Critical Access Hospital (CAH) '85X' claims that contain revenue code '045X' (Emergency Room) or any of the following HCPCS codes may be paid. Other services are allowed on the same claim.

a. CT SCANS CODES

70450	70460	70470	70480	70481	70482	70486	70487	70488
70490	70491	70492	70496	70498	71250	71260	71270	71275
72125	72126	72127	72128	72129	72130	72131	72132	72133
72191	72192	72193	72194	73200	73201	73202	73206	73700
73701	73702	73706	74150	74160	74170	74175	75635	76355
76360	76362	76370	76375	76380	G0131	G0132		

b. CARDIAC CATHETERIZATION CODES

93501	93503	93505	93508	93510	93511	93514	93524	93526
93527	93528	93529	93530	93531	93532	93533	93539	93540
93541	93542	93543	93544	93545	93555	93556	93561	93562
93571	93572							

c. MRI CODES

70336	70540	70542	70543	70544	70545	70546	70547	70548
70549	70551	70552	70553	71550	71551	71552	71555	72141
72142	72146	72147	72148	72149	72156	72157	72158	72195
72196	72197	73218	73219	73220	73221	73222	73223	73718
73719	73720	73721	73722	73723	73725	74181	74182	74182
74183	74185	75552	75553	75554	75555	76093	76094	76390
76394	76400							

d. RADIATION THERAPY CODES

77261	77262	77263	77280	77285	77290	77295	77299	77300
77301	77305	77310	77315	77321	77326	77327	77328	77331
77332	77333	77334	77336	77370	77399	77401	77402	77403
77404	77406	77407	77408	77409	77411	77412	77413	77414
77416	77417	77418	77427	77431	77432	77470	77499	77520
77522	77523	77525	77600	77605	77610	77615	77620	77750
77761	77762	77763	77776	77777	77778	77781	77782	77783
77784	77789	77790	77799	G0173	G0242	G0243		

e. ANGIOGRAPHY CODES

75600	75605	75625	75630	75635	75650	75658	75660	75662
75665	75671	75676	75680	75685	75705	75710	75716	75722
75724	75726	75731	75733	75736	75741	75743	75746	75756
75774	75790	75801	75803	75805	75807	75809	75810	75820
75822	75825	75827	75831	75833	75840	75842	75860	75870
75872	75880	75885	75887	75889	75891	75893	75894	75896
75898	75900	75940	75960	75961	75962	75964	75966	75968
75970	75978	75980	75982	75992	75993	75994	75995	75996

f. Outpatient surgery codes ranging from 10040 - 69979 EXCEPT those codes below, which should reject because they are included in the Part A SNF payment.

THESE CODES MAY NOT BE PAID SEPARATELY

10040	10060	10080	10120	11040	11041	11042	11043	11044
11055	11056	11057	11200	11300	11305	11400	11719	11720
11721	11740	11900	11901	11920	11921	11922	11950	11951
11952	11954	11975	11976	11977	15780	15781	15782	15783
15786	15787	15788	15789	15792	15793	15810	15811	16000
16020	17000	17003	17004	17110	17111	17250	17340	17360
17380	17999	20000	20551	20552	20553	20974	21084	21085
21497	26010	29058	29065	29075	29085	29086	29105	29125
29126	29130	29131	29200	29220	29240	29260	29280	29345
29355	29358	29365	29405	29425	29435	29440	29445	29450
29505	29515	29540	29550	29580	29590	29700	29705	29710
29715	29720	29730	29740	29750	29799	30300	30901	31720
31725	31730	36000	36002	36140	36400	36405	36406	36430
36468	36469	36470	36471	††36489	††36491	36600	36620	36680
38220	38221	44500	♦51772	♦51784	♦51785	♦51792	♦51795	♦51797
53601	53660	53661	53670	53675	54150	54235	♦54240	♦54250
55870	57160	57170	58301	58321	58323	♦59020	♦59025	59425
59426	59430	♦62367	♦62368	64550	65205	69000	69200	69210
95970	95971	95972	95973	95974	95975	99183	G0167	G0168

For Part A inpatients the professional portion of these services are billed by the rendering provider to the carrier. Any hospital outpatient charges are bundled to the SNF.

†† These codes are included in Part A payment when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent.

♦ Intermediaries must pay these services when billed by the SNF with a TC modifier for Part B residents and outpatients.

5. EPO Services--These services are not included in the SNF Part A PPS rate and are excluded from consolidated billing.

Intermediary EPO claims for ESRD beneficiaries are identified with the following revenue codes ‘0634’ and ‘0635’.

6. Preventive and Screening Service--These services are specifically covered as Part B benefits and are not included in SNF PPS. They must be billed by the SNF for SNF Part A inpatients on TOB 22X.

Preventive, screening services and their administration are identified by the following codes:

76092	G0202	G0203	Mammography screening codes are billed with revenue code '0403' and no other services on the bill.
90657	90658	90659	Pneumococcal, Flu or Hepatitis B vaccines are billed with revenue code '0636'.
90723	90732	90740	
90743	90744	90746	
90747	90748		
G0008	G0009	G0010	Vaccine administration codes are billed with revenue code '0771'.
Q0091	P3000	G0123	Screening Pap smear and pelvic examination codes are billed with diagnosis codes V76.2 or V15.89.
G0143	G0144	G0145	
G0147	G0148	G0101	
G0107	G0104	G0105	Colorectal screening services are billed with any of the following diagnosis codes: 'V10.05', 'V10.06', '555.0', '555.1', '555.2', '555.9', '556.0', '556.1', '556.2', '556.3', '556.8', '556.9', '558.2', '558.9'
G0106	G0120	G0121	
G0102			Prostate cancer screening digital rectal examination is billed with revenue code '0770'.
G0103			Prostate cancer screening specific antigen testing is billed with revenue code '030x'.
G0117	G0118		Glaucoma screening
76075	76076	76078	Bone mass screening
78350	76977	G0130	

7. Revenue Codes Requiring HCPCS Codes on Bill Types 22X and 23X

027X	**Medical/Surgical Supplies. (Also see 62X)**
0271	Nonsterile Supply
0272	Sterile Supply
0273	Take Home Supplies
0274	Prosthetic/Orthotic Devices
0279	Other Supplies/Devices

030X	**Laboratory**
0301	Chemistry
0302	Immunology
0305	Hematology
0306	Bacteriology & Microbiology
0307	Urology
0309	Other Laboratory
031X	**Laboratory Pathological**
0310	General Classification
0311	Cytology
0312	Histology
0314	Biopsy
0319	Other
032X	**Radiology - Diagnostic**
0321	Angiocardiography
0322	Arthrography
0323	Arteriography
0324	Chest X-Ray
0329	Other
033X	**Radiology - Therapeutic**
0330	Radiology - Therapeutic, General Classification
0332	Chemotherapy - Oral
0333	Radiation Therapy
0339	Other
034X	**Nuclear Medicine**
0340	General Classification (NUC MED)
0341	Diagnostic
0342	Therapeutic
0349	Other
035X	**CT Scan**
0350	General Classification
0351	Head Scan
0352	Body Scan
0359	Other CT Scans
040X	**Other Imaging Services**
0400	General Classification
0401	Diagnostic Mammography
0402	Ultrasound
0403	Screening Mammography
0404	Positron Emission Tomography

0409	Other Imaging Services
041X	**Respiratory Services**
0410	General Classification
0412	Inhalation Services
0413	Hyperbaric Oxygen Therapy
0419	Other Respiratory Services
042X	**Physical Therapy**
0420	General Classification
0421	Visit Charge
0422	Hourly Charge
0423	Group Rate
0424	Evaluation or Re-evaluation
0429	Other Physical Therapy
043X	**Occupational Therapy**
0430	General Classification
0431	Visit Charge
0432	Hourly Charge
0433	Group Rate
0434	Evaluation or Re-evaluation
0439	Other Occupational Therapy (may include Restorative Therapy)
044X	**Speech-Language Pathology**
0440	General Classification
0441	Visit Charge
0442	Hourly Charge
0443	Group Rate
0444	Evaluation or Re-evaluation
0449	Other Speech-Language Pathology
045X	**Emergency Room**
0450	General Classification
0451	EMTALA Emergency Medical screening services
0452	ER Beyond EMTALA Screening
0456	Urgent Care
0459	Other Emergency Room
046X	**Pulmonary Function**
0460	General Classification
0469	Other Pulmonary Function
047X	**Audiology**
0470	General Classification
0471	Diagnostic
0472	Treatment

0479	Other Audiology
048X	**Cardiology**
0480	General Classification
0481	Cardiac Cath Lab
0482	Stress Test
0483	Echocardiology
0489	Other Cardiology
049X	**Ambulatory Surgical Care**
0490	General Classification
0499	Other Ambulatory Surgical Care
051X	**Clinic**
0510	General Classification
0511	Chronic Pain Center
0512	Dental Clinic
0513	Psychiatric Clinic
0514	OB-GYN Clinic
0515	Pediatric Clinic
0516	Urgent Care Clinic
0517	Family Practice Clinic
0519	Other Clinic
054X	**Ambulance**
0540	General Classification
0541	Supplies
0542	Medical Transport
0543	Heart Mobile
0544	Oxygen
0545	Air Ambulance
0546	Neo-natal Ambulance
0547	Pharmacy
0548	Telephone Transmission EKG
0549	Other Ambulance
061X	**Magnetic Resonance Technology (MRT)**
0610	General Classification
0611	Brain (including Brainstem)
0612	Spinal Cord (including Spine)
0614	MRI – Other
0615	MRA - Head and Neck
0616	MRA - Lower Extremities
0618	MRA - Other
0619	Other MRI
062X	**Medical/Surgical Supplies - Extension of 27X**
0621	Supplies Incident to Radiology

0622	Supplies Incident to Other Diagnostic Services
0623	Surgical Dressings
0654	Investigational Device
063X	**Pharmacy-Extension of 25X**
0636	Drugs Requiring Detailed Coding
073X	**EKG/ECG (Electrocardiogram)**
0730	General Classification
0731	Holter Monitor
0732	Telemetry
0739	Other EKG/ECG
074X	**EEG (Electroencephalogram)**
0740	General Classification
0749	Other EEG
075X	**Gastro-Intestinal Services**
0750	General Classification
0759	Other Gastro-Intestinal
077X	**Preventative Care Services**
0770	General Classification
0771	Vaccine Administration
0779	Other
078X	**Telemedicine**
0780	General Classification
0789	Other Telemedicine
079X	**Lithotripsy**
0790	General Classification
0799	Other Lithotripsy
082X	**Hemodialysis - Outpatient or Home Dialysis**
0820	General Classification
0821	Hemodialysis/Composite or Other Rate
0822	Home Supplies
0823	Home Equipment
0824	Maintenance 100 percent
0825	Support Services
0829	Other Hemodialysis Outpatient
083X	**Peritoneal Dialysis - Outpatient or Home**
0830	General Classification
0831	Peritoneal/Composite or Other Rate
0832	Home Supplies
0833	Home Equipment

0834	Maintenance 100 percent
0835	Support Services
0839	Other Peritoneal Dialysis
084X	**Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient**
0840	General Classification
0842	Home Supplies
0843	Home Equipment
0844	Maintenance 100 percent
0845	Support Services
0849	Other CAPD Dialysis
085X	**Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient**
0850	General Classification
0852	Home Supplies
0853	Home Equipment
0854	Maintenance 100%
0855	Support Services
0859	Other CCPD Dialysis
088X	**Miscellaneous Dialysis**
0880	General Classification
0881	Ultrafiltration
0889	Misc. Dialysis Other
091X	**Psychiatric/Psychological Services**
0910	General Classification
0917	Bio Feedback
0918	Testing
0919	Other
092X	**Other Diagnostic Services**
0920	General Classification
0921	Peripheral Vascular Lab
0922	Electromyelogram
0923	Pap Smear
0924	Allergy test
0925	Pregnancy test
0929	Other Diagnostic Service

The *effective date* for this PM is claims processed on and after July 1, 2002.

The *implementation date* for this PM is July 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2004.

If you have any questions contact Cindy Murphy at (410) 786-5733.