ForwardHealth
Wisconsin serving you

Update
October 2012

No. 2012-55

Affected Programs: BadgerCare Plus, Medicaid, Wisconsin Chronic Disease Program
To: Hospital Providers, HMOs and Other Managed Care Programs

Implementation of the Enhanced Ambulatory Patient Groups Reimbursement Methodology

Effective for dates of service on and after January 1, 2013, ForwardHealth will be implementing Enhanced Ambulatory Patient Groups (EAPG) system software version 3.7 to classify and calculate reimbursement for outpatient hospital services. The EAPGs used in the EAPG system categorize the amount and type of resources used in various outpatient visits.

Implementation of the EAPG System

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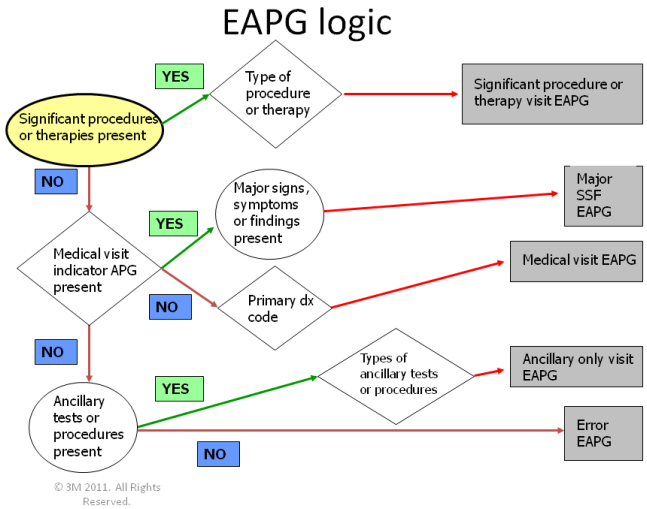
Under the EAPG system, ForwardHealth will reimburse hospital providers for outpatient hospital services based on the quantity and type of services they provide. The new system will ensure that both low- and high-cost services are reimbursed appropriately.

Information in this *ForwardHealth Update* applies to the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, Wisconsin Medicaid, and the Wisconsin Chronic Disease Program (WCDP).

Changes to Reimbursement Under the EAPG System

Under the EAPG system, ForwardHealth reimbursement of outpatient hospital services will change from a rate-per-visit reimbursement to a packaged reimbursement, similar to diagnosis-related groupings (DRGs) for inpatient hospital services. Rather than being grouped by diagnosis and surgical codes, however, EAPGs are grouped by Healthcare Common Procedure Coding System (HCPCS) or *Current Procedural Terminology* (CPT) procedure codes.

The EAPG payment methodology pays different amounts for outpatient hospital services based on the resources required for each visit; it provides greater reimbursement for



Note: ForwardHealth does not reimburse therapy services through the EAPG system, as this flowchart indicates.

high-intensity services and relatively less reimbursement for low-intensity services. It also allows for greater payment homogeneity for comparable services across all outpatient hospital settings. By linking payments to the specific array of services rendered, EAPGs make BadgerCare Plus, Medicaid, and WCDP reimbursement more transparent.

Refer to Attachment 1 of this *ForwardHealth Update* for an example of how EAPG would process information sent on a claim.

Classification of Services

The EAPG system classifies EAPGs into one of the following types:

- Significant procedure — a normally scheduled procedure that constitutes the reason for the visit and dominates the time and resources expended during the visit. A billing example of a significant procedure is found in Detail 5 of Attachment 1.
- Medical visit — a visit during which medical treatment was received but no significant procedure was performed. One example of a medical visit would be a preventive care visit. A billing example of a medical visit is found in Detail 2 of Attachment 1.
- Ancillary service — the term "ancillary service" is used to refer to both ancillary tests and ancillary procedures. A billing example of an ancillary service is found in Detail 3 of Attachment 1.
  - ✓ An ancillary test is a test ordered by the primary physician to assist in patient diagnosis or treatment.
  - ✓ An ancillary procedure is a procedure that increases but does not dominate the time and resources expended during the visit.

Rate Setting

Rates for use in the EAPG system will be established prior to implementation and posted on the Inpatient DRG Weights and Outpatient EAPG Weights and Inpatient and Outpatient Hospital Rates page on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*, accessed via the Provider-specific resources link in the Provider area of the Portal. Once these rates are set, providers will receive a message via their secure Provider account on the Portal.

A rate will be determined for each hospital. This rate will be multiplied by the appropriate EAPG weight to determine reimbursement.

Packaging

Using the EAPG system, ForwardHealth will package some, but not necessarily all, ancillary services; this simply means these services are included in the EAPG payment rate for a significant procedure or medical visit, rather than being separately reimbursed. For example, a chest X-ray may be packaged into the payment for a pneumonia visit. Although the detail of the packaged ancillary will show an allowed amount of $0, the packaging of ancillary services does not imply that there is no payment associated with the packaged ancillary. The cost of the packaged ancillaries is included in the payment amount for the significant procedure or medical visit EAPG. Refer to Details 4 and 6 of Attachment 1 for examples of packaged ancillary services.

The ancillary services to be packaged are selected primarily on clinical grounds, as established by the EAPG system. Thus, only ancillaries that are clinically expected to be a routine part of the specific procedure or medical visit are packaged.

Ancillary Services That Are Not Separately Reimbursable

Ancillary services that are not separately reimbursable will be denied if the primary procedure is denied and there is no significant procedure or medical visit to which the ancillary service can be packaged.

Weight

The EAPG system examines the revenue code along with the procedure code and, if applicable, the diagnosis code and gender in order to assign each detail line an EAPG, along with other relevant values (weights, packaging flags, discounting percentages, etc.). Each EAPG carries a

"weight" based on the group's average cost, from which appropriate payment levels are established.

Version Indicator

ForwardHealth will post the current version number of the EAPG software in use on the Inpatient DRG Weights and Outpatient EAPG Weights and Inpatient and Outpatient Hospital Rates page on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*, accessed via the Provider-specific Resources link in the Provider area of the Portal. For purposes of reimbursement, the version indicator will be determined using the header "from" DOS entered on the claim.

Multiple Significant Procedure Discounting

When multiple significant procedures are performed by the same provider for the same member during the same visit, ForwardHealth will reimburse the first significant procedure at 100 percent of the allowed amount, the second at 50 percent, and any subsequent procedures at 25 percent. The significant procedure with the highest weight on the claim is reimbursed as the first significant procedure, the next highest is reimbursed as the second significant procedure, etc. Refer to Detail 1 of Attachment 1 for an example of billing more than one significant procedure.

ForwardHealth separately reimburses procedures provided at different visits, even if they occur on the same DOS. Refer to the Billing Under the EAPG System section of this *Update* for information about billing multiple visits on the same DOS.

Bilateral Discounting

When a bilateral procedure is indicated on a detail by the use of modifier 50 (Bilateral procedure), ForwardHealth will reimburse the procedure at 150 percent of the allowed amount; that is, 100 percent for the first procedure and 50 percent for the second.

Repeat Ancillary Discounting

When non-routine ancillary services (as determined by the EAPG system) are repeated by the same provider on the same DOS for the same member, ForwardHealth will reimburse these items as follows: 100 percent of the allowed amount for the first ancillary item, 50 percent for the second, and 25 percent for any subsequent items.

Reimbursement of Laboratory Services

Claims for laboratory services will not be processed through the EAPG system. These services will be reimbursed at the lower of the usual and customary charge or the maximum allowable fee.

Billing Under the EAPG System

Outpatient hospital providers will receive accurate and appropriate reimbursement under EAPG when they do the following:

- Bill usual and customary charges. ForwardHealth may pay more than the billed amount for some procedures. Lab fees will be paid at the lower of the usual and customary amount or the maximum allowable fee.
- Include all appropriate details on claims, as all details may be considered for reimbursement by the EAPG system. Omission of details may affect reimbursement.
- Indicate the appropriate HCPCS or CPT procedure codes, as the EAPG system considers procedure codes without regard to revenue codes, except in the case of revenue codes indicating a continuous visit (refer to the September 2012 *Update* [2012-49], titled "Entering Dates for Outpatient Continuous Visits" for more information). ForwardHealth will continue to accept exempt revenue codes with no associated procedure code. However, these codes will result in a 999 EAPG (Unassigned) and the associated details will pay $0. All non-exempt revenue codes are required to have an appropriate procedure code.
- Use modifiers, as appropriate. For more information, refer to the June 2012 *Update* (2012-26), titled "Appropriate Modifiers and Most Specific Diagnosis Codes Required on Outpatient Hospital Claims." The following are examples of modifiers that may be appropriate:

- ✓ 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).
- ✓ 27 (Multiple outpatient hospital E/M encounters on the same date).
- ✓ 59 (Distinct procedural service).
- ✓ 76 (Repeat procedure or service by same physician or other qualified health care professional).
- ✓ 77 (Repeat procedure by another physician or other qualified health care professional).
- ✓ RT (Right side).
- ✓ LT (Left side).

- Enter a single DOS per detail line; ForwardHealth recommends avoiding range dates at the detail level on claims. This may involve splitting a single detail with range dates into separate, unique details. The EAPG software recognizes only the first, or "from," DOS at the detail level. The claim may be priced inappropriately and reimbursement may be less than expected if range dates are used.
- Bill multiple visits using the following guidelines:
  - ✓ For multiple medical visits with different DOS, providers may bill more than one visit on a claim. The EAPG software treats details with different DOS as separate visits unless certain revenue codes (e.g. 045X, 0762) are used.
  - ✓ For multiple unrelated medical visits with the same DOS, ForwardHealth recommends providers use condition code "G0" and bill the visits on *separate claims*. The EAPG software is able to identify separate visits on the same DOS only when they are submitted on separate claims.

Billing Outpatient Hospital Crossover Claims

Under the EAPG system, Wisconsin Medicaid will reimburse providers the Medicare coinsurance cost share at the lesser of the difference between the Medicare allowed amount and paid amount or the difference between the Medicaid allowed amount and the Medicare paid amount. The Medicare deductible will continue to be reimbursed in full.

In addition to the billing recommendations listed in the previous section of this *Update*, outpatient hospital providers submitting Medicare crossover claims should note the following:

- For those details that do not include HCPCS procedure codes on a Medicare crossover claim, ForwardHealth will show an allowed amount of $0 for the detail. If procedure codes are available for these details, the provider may adjust the claim to include this information.
- Providers who receive Explanation of Benefits (EOB) code 273, which states "Resubmit charges for ForwardHealth covered service(s) denied by Medicare on a ForwardHealth claim," for a denied detail or claim on an 835 Health Care Claim Payment/Advice (835) transaction or a Remittance Advice (RA) may resubmit the claim to be considered for reimbursement.
- When adjudicating reimbursement for therapy crossover claims, the maximum allowable fee will be used in the reimbursement calculation.

Billing for Provider-Administered Drugs

Providers billing for provider-administered drugs do not need to include a National Drug Code on outpatient hospital claims but are required to include the appropriate HCPCS codes — e.g., a J- or Q-code — in addition to the appropriate revenue code.

Claim Adjustments

When adjusting outpatient hospital claims, providers should note the following:

- Providers are reminded they may file adjustment requests for reasons including the following:
  - ✓ To correct billing or processing errors.
  - ✓ To correct inappropriate payments (overpayments and underpayments).
  - ✓ To add and delete services.
  - ✓ To supply additional information that may affect the amount of reimbursement.
- When adjusting a claim that originally processed under the EAPG system, providers may add or change information as needed to appropriately process the

claim under EAPG. For example, if a provider did not include a HCPCS procedure code with the revenue code on the original claim, he or she may adjust the claim to add the appropriate code.

- Reimbursement may or may not change following an adjustment, depending on how the new or revised information is packaged by the EAPG system.
- Depending on the DOS, an adjustment may or may not be processed using the EAPG system. If the DOS on the original claim was prior to the January 1, 2013, implementation date for EAPG, the claim adjustment will not process under the EAPG system.

Coordination of Benefits

Under the EAPG system, coordination of benefit payments, including Medicare, will be applied in the same manner as they are currently for claim adjudication.

EAPGs, Reason and Remark Codes, and Explanation of Benefit Codes

The EAPG system assigns an EAPG to applicable details in order to categorize the services for payment. For a list of EAPGs, refer to the Inpatient DRG Weights and Outpatient EAPG Weights and Inpatient and Outpatient Hospital Rates page on the Portal at *www.forwardhealth.wi.gov/*, accessed via the Provider-specific Resources link in the Provider area of the Portal.

Enhanced Ambulatory Patient Groups will appear in the detail section of the text (.TXT) format file of the RA. On the 835 transaction, qualifier 1S will appear in Loop 2110, Ref 01, and the EAPG will appear in Loop 2110, Ref 02. The Instructions Related to 835 Health Care Claim Payment/ Advice (835) Based on ASC X12 Implementation Guide companion guide, P-00271, will be revised to reflect changes due to the EAPG system. Refer to Attachment 2 for a sample RA showing the location of EAPG and EOB codes.

Explanation of Benefit codes will appear on the RA, and RA remark codes and claim adjustment reason codes will appear on the 835 as they currently do. Refer to Attachment 3 for a list of EOB codes that will be used with the EAPG system.

Unassigned Procedures

Enhanced Ambulatory Patient Groups 999 identifies services that cannot be assigned to any valid EAPG. For example, an EAPG 999 would be given to claim details that lack a HCPCS code. Details with EAPG 999 will pay an amount of $0; these services may *not* be billed back to the member.

Inpatient-Only Procedures

Enhanced Ambulatory Patient Groups 993 identifies procedures that ForwardHealth will not reimburse on an outpatient hospital claim. An outpatient hospital claim containing one of these procedures will be denied in its entirety.

A list of procedures that will not be reimbursed in an outpatient hospital setting is found in Attachment 4. This list is effective for dates of service on and after January 1, 2013, and may be periodically updated.

Enhanced Ambulatory Patient Groups 994 identifies procedures that are defined as inpatient only but are considered payable as an outpatient hospital procedure by ForwardHealth.

One Day Stays

Providers are reminded that a member is considered an inpatient when the member is admitted to the hospital and counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

Professional and Other Services Must Be Submitted on a Professional Claim

Certain professional and other services are excluded from the outpatient hospital rate per visit reimbursement and are therefore not eligible for reimbursement under the EAPG system. This policy affects BadgerCare Plus, Medicaid, and WCDP providers.

Claims for services performed by the following providers must be billed on a professional claim by a separately certified provider:

- Air, water, and land ambulance providers.
- Anesthesia assistants.
- Audiologists.
- Certified registered nurse anesthetists.
- Chiropractors.
- Dentists.
- Hearing aid dealers.
- Independent nurse practitioners.
- Providers of medical equipment and supplies for non-hospital use.
- Nurse midwives.
- Occupational therapists.
- Optometrists.
- Physical therapists.
- Physicians.
- Physician assistants.
- Podiatrists.
- Psychiatrists.
- Psychologists.
- Specialized medical vehicle transportation providers.
- Speech-language pathologists.

Outpatient Hospital Claims Subject to National Correct Coding Initiative

With the implementation of the EAPG system, outpatient hospital claims will be subject to the National Correct Coding Initiative (NCCI). The NCCI is the Centers for Medicare and Medicaid Services' (CMS) response to the requirement by the federal Patient Protection and Affordable Care Act of 2010 to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI includes the creation and implementation of claims processing edits to ensure correct coding on claims submitted for Medicaid reimbursement.

ForwardHealth is required to implement the NCCI in order to monitor all outpatient hospital and professional claims submitted with CPT or HCPCS procedure codes for Wisconsin Medicaid, BadgerCare Plus, and WCDP for compliance with the following NCCI edits:

- Medically Unlikely Edits (MUE), or units-of-service detail edits.
- Procedure-to-procedure detail edits.

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by McKesson ClaimCheck® and in ForwardHealth interChange.

Medically Unlikely Detail Edits

Medically Unlikely Edits, or units-of-service detail edits, define the maximum units of service that a provider would report under most circumstances for a single member on a single DOS for each CPT or HCPCS code. If a detail on a claim is denied for MUE, providers will receive EOB code 1690, which states "Quantity indicated for this service exceeds the maximum quantity limit established by the National Correct Coding Initiative," on the RA.

An example of an MUE would be if procedure code 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) was billed with a quantity of two or more. This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

Procedure-to-procedure detail edits define pairs of CPT or HCPCS procedure codes that should not be reported together on the same DOS for a variety of reasons. This edit applies across details on a single claim or across different claims. For example, an earlier claim that was paid may be denied and recouped if a more complete code is billed for the same DOS on a separate claim. If a detail on a claim is denied for a procedure-to-procedure edit, providers will receive one of the following EOB codes and descriptions on the RA:

- 1686, which states "This service is not payable with another service on the same date of service due to National Correct Coding Initiative."

- 1691, which states "This service is not payable for the same date of service as another service included on the same claim, according to the National Correct Coding Initiative."

An example of a procedure-to-procedure edit would be if procedure codes 11451 (Excision of skin and subcutaneous tissue for hidradenitis, axillary, with complex repair) and 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000 and therefore, the secondary procedure would be denied.

Quarterly Code List Updates

The CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the CMS Web site at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html for downloadable code lists.

Claim Details Denied as a Result of National Correct Coding Initiative Edits

Providers should take the following steps if they are uncertain why particular services on a claim were denied:

- Review ForwardHealth remittance information for the EOB message related to the denial.
- Review the claim submitted to ensure all information is accurate and complete.
- Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
- Consult current ForwardHealth publications, including the Online Handbook, to make sure current policy and billing instructions were followed.
- Call Provider Services at (800) 947-9627 for further information or explanation.

If reimbursement for a claim or a detail on a claim is denied due to an MUE or procedure-to-procedure edit, providers may appeal the denial. Following are instructions for submitting an appeal:

- Complete the Adjustment/Reconsideration Request form, F-13046 (07/12). In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Implementation for HMO and Other Managed Care Programs

Medicaid HMOs and other ForwardHealth managed care programs will not be implementing the EAPG system at this time. Providers will be notified of implementation plans for Medicaid HMOs and other managed care programs.

Effective January 1, 2013, outpatient hospital per-visit rates for these groups will be posted on the DRG Weights and Outpatient EAPG Weights and Inpatient and Outpatient Hospital Rates page of the Provider area of the Portal.

E-mail for EAPG Questions

Providers with questions regarding EAPG may e-mail them to *vedseapgsupport@wisconsin.gov*.

Hospital Page of the Portal

For more information on outpatient hospital reimbursement, providers are encouraged to visit the Inpatient DRG Weights and Outpatient EAPG Weights and Inpatient and Outpatient Hospital Rates page, accessed via the Provider-specific Resources link in the Provider area of the Portal.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
Example of Claim Information Processed by the EAPG System

This attachment contains a fictional example of how ForwardHealth would process a claim using the Enhanced Ambulatory Patient Groups (EAPG) system. This example does not represent actual reimbursement dollars; it is only intended to demonstrate certain functions of the EAPG system.

Example: John, who is diabetic, was working at his farm when he deeply cut two of his fingers on barbed wire. He went to the emergency room, where the provider repaired the damaged fingers. John also received a tetanus shot and his blood was drawn for a blood glucose test. The table below includes some of the information that would be submitted on the claim as well as information on how the claim would be processed using the EAPG system.

Detail	Date of Service	Revenue Code	Procedure Code	EAPG	Pkg?[1]	Percent Paid	Adj. Weight[2]	Base Rate	Pricing Method	Payment[3]	Detail Description
1	10/1/12	0921	11200	012	N	0.50	0.6555	$75.32	EAPG	$49.37	This detail was grouped as a significant procedure, EAPG 012 (Level I skin repair). Because there was already another significant procedure on the same visit, this detail was discounted by 50 percent. This is reflected in the adjusted weight. The calculated total when the discounted weight was multiplied by the base rate is $49.37.
2	10/1/12	0450	99282-25	674	N	1.00	0.9485	$75.32	EAPG	$71.44	This detail was grouped as a medical visit, EAPG 674 (Contusion, open wound & other trauma to skin & subcutaneous tissue). The use of modifier 25 allowed it to be separately reimbursed and not packaged (due to the significant procedure present on Detail 1). The calculated total after receiving full weight for the EAPG and being multiplied by the base rate is $71.44.
3	10/1/12	0636	90715	415	N	1.00	0.3719	$75.32	EAPG	$28.01	This detail was grouped as an ancillary service, EAPG 415 (Level II immunization). The calculated total after receiving full weight for the EAPG and being multiplied by the base rate is $28.01.

Detail	Date of Service	Revenue Code	Procedure Code	EAPG	Pkg?[1]	Percent Paid	Adj. Weight[2]	Base Rate	Pricing Method	Payment[3]	Detail Description
4	10/1/12	0771	90471	490	Y	0.00	0.0000	$75.32	EAPG	$0.00	This detail was grouped as an incidental service, EAPG 490 (Incidental to medical, significant procedure or therapy visit). It was packaged and thus received a weight of zero.
5	10/1/12	0450	12001	012	N	1.00	1.3110	$75.32	EAPG	$98.74	This detail was grouped as a significant procedure, EAPG 012 (Level I skin repair). The calculated total after receiving full weight for the EAPG and being multiplied by the base rate is $98.74.
6	10/1/12	0921	99282	491	Y	0.00	0.0000	$75.32	EAPG	$0.00	This detail was grouped as an additional medical visit, EAPG 491 (Medical visit indicator). It was packaged and thus received a weight of zero.
7	10/1/12	0300	87001	-	-	-	-		MAX FEE	$19.06	This detail had a laboratory procedure code and thus bypassed the EAPG system and priced at the maximum allowable fee, which is $19.06.
8	10/1/12	0250	-	999	N	0.00	0.0000	$75.32	EAPG	$0.00	This detail shows a service for which ForwardHealth has paid $0.00 because a HCPCS procedure code was not included. EAPG 999 indicates that the service was unassigned.
Total										$266.62	

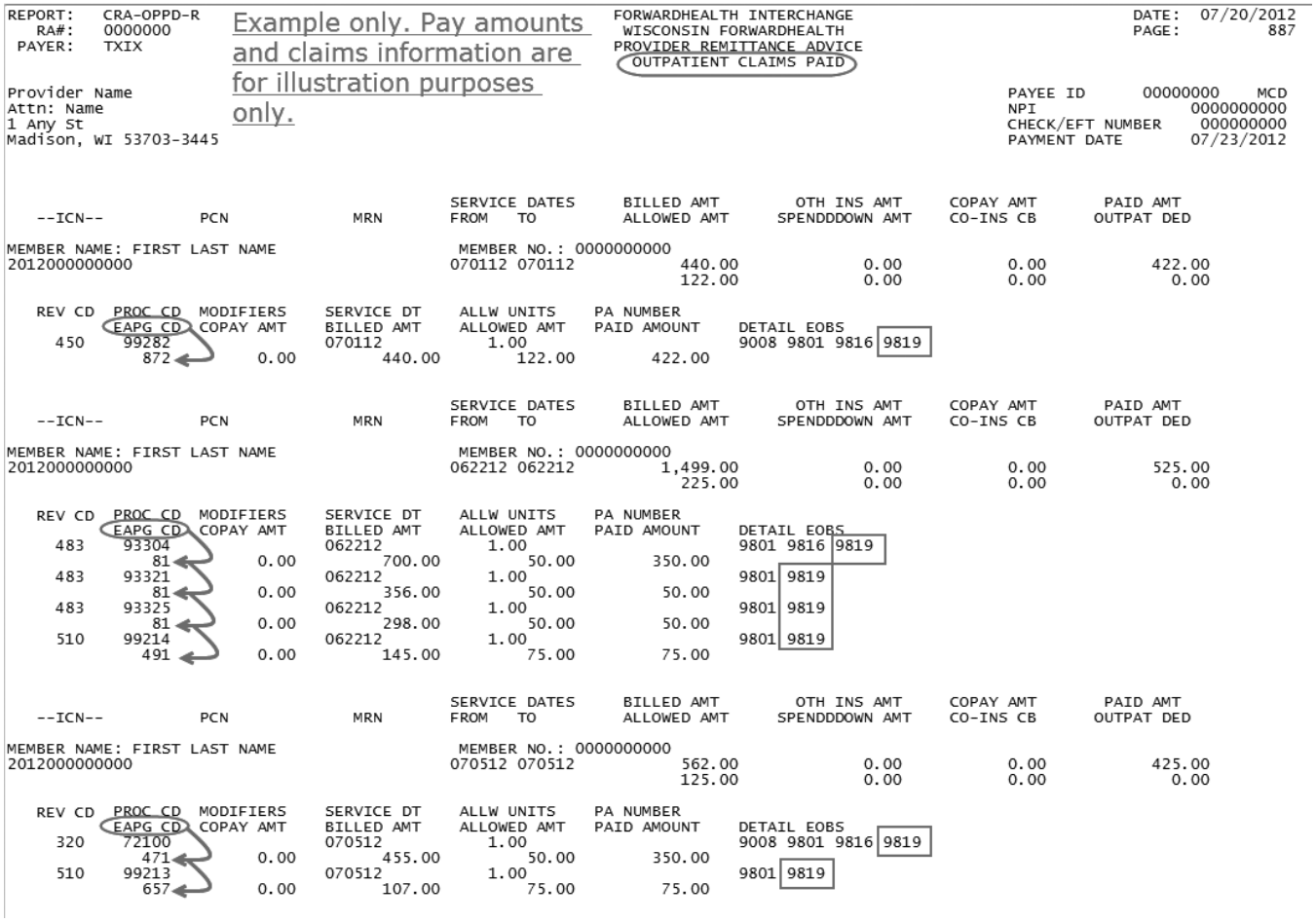
[1] Information in this column indicates whether or not the service was packaged.

[2] Information in this column indicates the detail's adjusted weight.

[3] The information in this column does not represent actual reimbursement dollars for the service described. It is only intended to demonstrate certain functions of the EAPG system, such as packaging and discounting.

ATTACHMENT 2
Remittance Advice Example Showing Location of EAPGs and Explanation of Benefits Codes

This attachment shows an example of a text format (.TXT) Remittance Advice with the location of Enhanced Ambulatory Patient Groups and related Explanation of Benefit codes marked. The sample data in this example is not reflective of sample data in the previous attachment.



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REPORT:   CRA-OPPD-R                                FORWARDHEALTH INTERCHANGE                          DATE:  07/20/2012
   RA#:   0000000                                    WISCONSIN FORWARDHEALTH                            PAGE:       887
 PAYER:   TXIX                                       PROVIDER REMITTANCE ADVICE
                                                       OUTPATIENT CLAIMS PAID

Provider Name                                                                          PAYEE ID      00000000    MCD
Attn: Name                                                                             NPI                  0000000000
1 Any St                                                                               CHECK/EFT NUMBER     000000000
Madison, WI 53703-3445                                                                 PAYMENT DATE       07/23/2012

                                                  SERVICE DATES     BILLED AMT       OTH INS AMT     COPAY AMT       PAID AMT
   --ICN--          PCN            MRN           FROM    TO        ALLOWED AMT      SPENDDDOWN AMT  CO-INS CB       OUTPAT DED

MEMBER NAME: FIRST LAST NAME                      MEMBER NO.: 0000000000
2012000000000                                     070112 070112          440.00             0.00          0.00           422.00
                                                                         122.00             0.00          0.00             0.00

   REV CD  PROC CD  MODIFIERS    SERVICE DT    ALLW UNITS    PA NUMBER
           EAPG CD  COPAY AMT    BILLED AMT    ALLOWED AMT   PAID AMOUNT    DETAIL EOBS
     450    99282                070112           1.00                      9008 9801 9816 9819
              872         0.00         440.00        122.00         422.00

                                                  SERVICE DATES     BILLED AMT       OTH INS AMT     COPAY AMT       PAID AMT
   --ICN--          PCN            MRN           FROM    TO        ALLOWED AMT      SPENDDDOWN AMT  CO-INS CB       OUTPAT DED

MEMBER NAME: FIRST LAST NAME                      MEMBER NO.: 0000000000
2012000000000                                     062212 062212        1,499.00             0.00          0.00           525.00
                                                                         225.00             0.00          0.00             0.00

   REV CD  PROC CD  MODIFIERS    SERVICE DT    ALLW UNITS    PA NUMBER
           EAPG CD  COPAY AMT    BILLED AMT    ALLOWED AMT   PAID AMOUNT    DETAIL EOBS
     483    93304                062212           1.00                      9801 9816 9819
               81         0.00         700.00         50.00         350.00
     483    93321                062212           1.00                      9801 9819
               81         0.00         356.00         50.00          50.00
     483    93325                062212           1.00                      9801 9819
               81         0.00         298.00         50.00          50.00
     510    99214                062212           1.00                      9801 9819
              491         0.00         145.00         75.00          75.00

                                                  SERVICE DATES     BILLED AMT       OTH INS AMT     COPAY AMT       PAID AMT
   --ICN--          PCN            MRN           FROM    TO        ALLOWED AMT      SPENDDDOWN AMT  CO-INS CB       OUTPAT DED

MEMBER NAME: FIRST LAST NAME                      MEMBER NO.: 0000000000
2012000000000                                     070512 070512          562.00             0.00          0.00           425.00
                                                                         125.00             0.00          0.00             0.00

   REV CD  PROC CD  MODIFIERS    SERVICE DT    ALLW UNITS    PA NUMBER
           EAPG CD  COPAY AMT    BILLED AMT    ALLOWED AMT   PAID AMOUNT    DETAIL EOBS
     320    72100                070512           1.00                      9008 9801 9816 9819
              471         0.00         455.00         50.00         350.00
     510    99213                070512           1.00                      9801 9819
              657         0.00         107.00         75.00          75.00
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ATTACHMENT 3
Explanation of Benefits Codes Used with EAPG

The following are Explanation of Benefits (EOB) codes that will be used with the Enhanced Ambulatory Patient Groups (EAPG) system.

EOB Code	Description
3010	This detail was packaged according to EAPG grouping.
3011	E-diagnosis codes are not allowed as a primary diagnosis.
3012	This service cannot be performed in an outpatient hospital setting.
3013	This detail has been discounted according to EAPG pricing.
3014	Diagnosis is either invalid for date(s) of service or requires greater specificity.
3017	Professional services are not reimbursed on outpatient hospital claims.
3018	Detail denied because a related significant procedure and/or medical visit was denied for the same visit.
3019	Services for this date of service have been previously paid. Providers may adjust a previously paid claim for this date of service to request reimbursement for additional services provided during the same outpatient hospital visit.
9819	EAPG pricing applied.

ATTACHMENT 4
Procedures Not Allowed in an Outpatient Hospital Setting

The list below shows Healthcare Common Procedure Coding System and *Current Procedural Terminology* procedures that ForwardHealth will not reimburse when rendered as an outpatient hospital service.

Procedure Code	Description
01990	Support for organ donor
19305	Mast radical
19306	Mast rad urban type
19361	Breast reconstr w/lat flap
19368	Breast reconstruction
20661	Application of head brace
20802	Replantation arm complete
20805	Replant forearm complete
20808	Replantation hand complete
20816	Replantation digit complete
20824	Replantation thumb complete
20955	Fibula bone graft microvasc
20956	Iliac bone graft microvasc
20962	Other bone graft microvasc
20969	Bone/skin graft microvasc
20970	Bone/skin graft iliac crest
21154	Reconstruct midface lefort
21155	Reconstruct midface lefort
21159	Reconstruct midface lefort
21160	Reconstruct midface lefort
21179	Reconstruct entire forehead
21180	Reconstruct entire forehead
21182	Reconstruct cranial bone
21183	Reconstruct cranial bone
21188	Reconstruction of midface
21194	Reconst lwr jaw w/graft
21247	Reconstruct lower jaw bone
21268	Revise eye sockets
21344	Treatment of sinus fracture
21347	Treat nose/jaw fracture
21348	Treat nose/jaw fracture
21366	Treat cheek bone fracture
21423	Treat mouth roof fracture
21431	Treat craniofacial fracture
21432	Treat craniofacial fracture
21433	Treat craniofacial fracture
21435	Treat craniofacial fracture
21436	Treat craniofacial fracture
21510	Drainage of bone lesion
21615	Removal of rib
21616	Removal of rib and nerves
21620	Partial removal of sternum
21630	Extensive sternum surgery
21632	Extensive sternum surgery

Procedure Code	Description
21705	Revision of neck muscle/rib
21740	Reconstruction of sternum
21750	Repair of sternum separation
21810	Treatment of rib fracture(s)
22010	I&d p-spine c/t/cerv-thor
22015	I&d p-spine l/s/ls
22110	Remove part of neck vertebra
22112	Remove part thorax vertebra
22114	Remove part lumbar vertebra
22116	Remove extra spine segment
22210	Revision of neck spine
22212	Revision of thorax spine
22214	Revision of lumbar spine
22216	Revise extra spine segment
22220	Revision of neck spine
22224	Revision of lumbar spine
22226	Revise extra spine segment
22318	Treat odontoid fx w/o graft
22319	Treat odontoid fx w/graft
22325	Treat spine fracture
22326	Treat neck spine fracture
22327	Treat thorax spine fracture
22328	Treat each add spine fx
22532	Lat thorax spine fusion
22533	Lat lumbar spine fusion
22534	Lat thor/lumb addl seg
22548	Neck spine fusion
22551	Neck spine fuse&remov bel c2
22552	Addl neck spine fusion
22556	Thorax spine fusion
22590	Spine & skull spinal fusion
22595	Neck spinal fusion
22610	Thorax spine fusion
22633	Lumbar spine fusion combined
22634	Spine fusion extra segment
22800	Fusion of spine
22802	Fusion of spine
22804	Fusion of spine
22808	Fusion of spine
22810	Fusion of spine
22812	Fusion of spine
22818	Kyphectomy 1-2 segments
22819	Kyphectomy 3 or more
22841	Insert spine fixation device

Procedure Code	Description
22842	Insert spine fixation device
22843	Insert spine fixation device
22844	Insert spine fixation device
22847	Insert spine fixation device
22848	Insert pelv fixation device
22849	Reinsert spinal fixation
22852	Remove spine fixation device
22857	Lumbar artif diskectomy
23200	Resect clavicle tumor
23210	Resect scapula tumor
23220	Resect prox humerus tumor
23332	Remove shoulder foreign body
23900	Amputation of arm & girdle
23920	Amputation at shoulder joint
24900	Amputation of upper arm
24920	Amputation of upper arm
24930	Amputation follow-up surgery
24940	Revision of upper arm
25900	Amputation of forearm
25905	Amputation of forearm
25915	Amputation of forearm
25920	Amputate hand at wrist
25927	Amputation of hand
26551	Great toe-hand transfer
26553	Single transfer toe-hand
27030	Drainage of hip joint
27036	Excision of hip joint/muscle
27054	Removal of hip joint lining
27070	Part remove hip bone super
27071	Part removal hip bone deep
27075	Resect hip tumor
27076	Resect hip tum incl acetabul
27077	Resect hip tum w/innom bone
27078	Rsect hip tum incl femur
27090	Removal of hip prosthesis
27091	Removal of hip prosthesis
27120	Reconstruction of hip socket
27122	Reconstruction of hip socket
27125	Partial hip replacement
27132	Total hip arthroplasty
27134	Revise hip joint replacement
27137	Revise hip joint replacement
27138	Revise hip joint replacement
27140	Transplant femur ridge
27146	Incision of hip bone
27147	Revision of hip bone
27151	Incision of hip bones
27156	Revision of hip bones
27158	Revision of pelvis
27161	Incision of neck of femur
27165	Incision/fixation of femur
27170	Repair/graft femur head/neck
27175	Treat slipped epiphysis
27177	Treat slipped epiphysis

Procedure Code	Description
27178	Treat slipped epiphysis
27181	Treat slipped epiphysis
27185	Revision of femur epiphysis
27187	Reinforce hip bones
27215	Treat pelvic fracture(s)
27217	Treat pelvic ring fracture
27218	Treat pelvic ring fracture
27222	Treat hip socket fracture
27226	Treat hip wall fracture
27227	Treat hip fracture(s)
27228	Treat hip fracture(s)
27232	Treat thigh fracture
27236	Treat thigh fracture
27240	Treat thigh fracture
27244	Treat thigh fracture
27245	Treat thigh fracture
27248	Treat thigh fracture
27253	Treat hip dislocation
27254	Treat hip dislocation
27258	Treat hip dislocation
27259	Treat hip dislocation
27280	Fusion of sacroiliac joint
27282	Fusion of pubic bones
27284	Fusion of hip joint
27286	Fusion of hip joint
27290	Amputation of leg at hip
27295	Amputation of leg at hip
27365	Resect femur/knee tumor
27445	Revision of knee joint
27448	Incision of thigh
27450	Incision of thigh
27454	Realignment of thigh bone
27465	Shortening of thigh bone
27466	Lengthening of thigh bone
27468	Shorten/lengthen thighs
27470	Repair of thigh
27472	Repair/graft of thigh
27485	Surgery to stop leg growth
27486	Revise/replace knee joint
27487	Revise/replace knee joint
27488	Removal of knee prosthesis
27495	Reinforce thigh
27506	Treatment of thigh fracture
27507	Treatment of thigh fracture
27511	Treatment of thigh fracture
27513	Treatment of thigh fracture
27514	Treatment of thigh fracture
27519	Treat thigh fx growth plate
27556	Treat knee dislocation
27557	Treat knee dislocation
27558	Treat knee dislocation
27580	Fusion of knee
27590	Amputate leg at thigh
27591	Amputate leg at thigh

Procedure Code	Description
27592	Amputate leg at thigh
27596	Amputation follow-up surgery
27598	Amputate lower leg at knee
27645	Resect tibia tumor
27646	Resect fibula tumor
27702	Reconstruct ankle joint
27703	Reconstruction ankle joint
27712	Realignment of lower leg
27725	Repair of lower leg
27727	Repair of lower leg
27880	Amputation of lower leg
27881	Amputation of lower leg
27882	Amputation of lower leg
27888	Amputation of foot at ankle
28800	Amputation of midfoot
31230	Removal of upper jaw
31360	Removal of larynx
31365	Removal of larynx
31367	Partial removal of larynx
31368	Partial removal of larynx
31370	Partial removal of larynx
31380	Partial removal of larynx
31382	Partial removal of larynx
31390	Removal of larynx & pharynx
31395	Reconstruct larynx & pharynx
31584	Treat larynx fracture
31587	Revision of larynx
31725	Clearance of airways
31760	Repair of windpipe
31766	Reconstruction of windpipe
31770	Repair/graft of bronchus
31775	Reconstruct bronchus
31780	Reconstruct windpipe
31781	Reconstruct windpipe
31786	Remove windpipe lesion
31800	Repair of windpipe injury
31805	Repair of windpipe injury
32035	Thoracostomy w/rib resection
32036	Thoracostomy w/flap drainage
32096	Open wedge/bx lung infiltr
32097	Open wedge/bx lung nodule
32100	Exploration of chest
32110	Explore/repair chest
32120	Re-exploration of chest
32124	Explore chest free adhesions
32140	Removal of lung lesion(s)
32141	Remove/treat lung lesions
32150	Removal of lung lesion(s)
32151	Remove lung foreign body
32160	Open chest heart massage
32200	Drain open lung lesion
32215	Treat chest lining
32220	Release of lung
32225	Partial release of lung
32310	Removal of chest lining

Procedure Code	Description
32320	Free/remove chest lining
32440	Remove lung pneumonectomy
32442	Sleeve pneumonectomy
32445	Removal of lung extrapleural
32480	Partial removal of lung
32482	Bilobectomy
32484	Segmentectomy
32486	Sleeve lobectomy
32488	Completion pneumonectomy
32501	Repair bronchus add-on
32503	Resect apical lung tumor
32504	Resect apical lung tum/chest
32505	Wedge resect of lung initial
32506	Wedge resect of lung add-on
32507	Wedge resect of lung diag
32540	Removal of lung lesion
32652	Thoracoscopy rem totl cortex
32663	Thoracoscopy w/lobectomy
32665	Thoracoscop w/esoph musc exc
32666	Thoracoscopy w/wedge resect
32667	Thoracoscopy w/w resect addl
32668	Thoracoscopy w/w resect diag
32669	Thoracoscopy remove segment
32671	Thoracoscopy pneumonectomy
32674	Thoracoscopy lymph node exc
32800	Repair lung hernia
32810	Close chest after drainage
32815	Close bronchial fistula
32820	Reconstruct injured chest
32850	Donor pneumonectomy
32851	Lung transplant single
32852	Lung transplant with bypass
32853	Lung transplant double
32854	Lung transplant with bypass
32855	Prepare donor lung single
32856	Prepare donor lung double
32900	Removal of rib(s)
32905	Revise & repair chest wall
32906	Revise & repair chest wall
32940	Revision of lung
32997	Total lung lavage
33015	Incision of heart sac
33020	Incision of heart sac
33025	Incision of heart sac
33030	Partial removal of heart sac
33031	Partial removal of heart sac
33050	Resect heart sac lesion
33120	Removal of heart lesion
33130	Removal of heart lesion
33140	Heart revascularize (tmr)
33141	Heart tmr w/other procedure
33202	Insert epicard eltrd open
33203	Insert epicard eltrd endo
33236	Remove electrode/thoracotomy
33237	Remove electrode/thoracotomy

Procedure Code	Description
33238	Remove electrode/thoracotomy
33243	Remove eltrd/thoracotomy
33250	Ablate heart dysrhythm focus
33251	Ablate heart dysrhythm focus
33254	Ablate atria lmtd
33255	Ablate atria w/o bypass ext
33256	Ablate atria w/bypass exten
33257	Ablate atria lmtd add-on
33258	Ablate atria x10sv add-on
33259	Ablate atria w/bypass add-on
33261	Ablate heart dysrhythm focus
33265	Ablate atria lmtd endo
33266	Ablate atria x10sv endo
33300	Repair of heart wound
33305	Repair of heart wound
33310	Exploratory heart surgery
33315	Exploratory heart surgery
33320	Repair major blood vessel(s)
33322	Repair major blood vessel(s)
33330	Insert major vessel graft
33332	Insert major vessel graft
33335	Insert major vessel graft
33400	Repair of aortic valve
33401	Valvuloplasty open
33403	Valvuloplasty w/cp bypass
33404	Prepare heart-aorta conduit
33405	Replacement of aortic valve
33406	Replacement of aortic valve
33410	Replacement of aortic valve
33411	Replacement of aortic valve
33412	Replacement of aortic valve
33413	Replacement of aortic valve
33414	Repair of aortic valve
33415	Revision subvalvular tissue
33416	Revise ventricle muscle
33417	Repair of aortic valve
33420	Revision of mitral valve
33422	Revision of mitral valve
33425	Repair of mitral valve
33426	Repair of mitral valve
33427	Repair of mitral valve
33430	Replacement of mitral valve
33460	Revision of tricuspid valve
33463	Valvuloplasty tricuspid
33464	Valvuloplasty tricuspid
33465	Replace tricuspid valve
33468	Revision of tricuspid valve
33470	Revision of pulmonary valve
33471	Valvotomy pulmonary valve
33472	Revision of pulmonary valve
33474	Revision of pulmonary valve
33475	Replacement pulmonary valve
33476	Revision of heart chamber
33478	Revision of heart chamber

Procedure Code	Description
33496	Repair prosth valve clot
33500	Repair heart vessel fistula
33501	Repair heart vessel fistula
33502	Coronary artery correction
33503	Coronary artery graft
33504	Coronary artery graft
33505	Repair artery w/tunnel
33506	Repair artery translocation
33507	Repair art intramural
33510	Cabg vein single
33511	Cabg vein two
33512	Cabg vein three
33513	Cabg vein four
33514	Cabg vein five
33516	Cabg vein six or more
33517	Cabg artery-vein single
33518	Cabg artery-vein two
33519	Cabg artery-vein three
33521	Cabg artery-vein four
33522	Cabg artery-vein five
33523	Cabg art-vein six or more
33530	Coronary artery bypass/reop
33533	Cabg arterial single
33534	Cabg arterial two
33535	Cabg arterial three
33536	Cabg arterial four or more
33542	Removal of heart lesion
33545	Repair of heart damage
33548	Restore/remodel ventricle
33572	Open coronary endarterectomy
33600	Closure of valve
33602	Closure of valve
33606	Anastomosis/artery-aorta
33608	Repair anomaly w/conduit
33610	Repair by enlargement
33611	Repair double ventricle
33612	Repair double ventricle
33615	Repair modified fontan
33617	Repair single ventricle
33619	Repair single ventricle
33620	Apply r&l pulm art bands
33622	Redo compl cardiac anomaly
33641	Repair heart septum defect
33645	Revision of heart veins
33647	Repair heart septum defects
33660	Repair of heart defects
33665	Repair of heart defects
33670	Repair of heart chambers
33675	Close mult vsd
33676	Close mult vsd w/resection
33677	Cl mult vsd w/rem pul band
33681	Repair heart septum defect
33684	Repair heart septum defect

Procedure Code	Description
33688	Repair heart septum defect
33690	Reinforce pulmonary artery
33692	Repair of heart defects
33694	Repair of heart defects
33697	Repair of heart defects
33702	Repair of heart defects
33710	Repair of heart defects
33720	Repair of heart defect
33722	Repair of heart defect
33724	Repair venous anomaly
33726	Repair pul venous stenosis
33730	Repair heart-vein defect(s)
33732	Repair heart-vein defect
33735	Revision of heart chamber
33736	Revision of heart chamber
33737	Revision of heart chamber
33750	Major vessel shunt
33755	Major vessel shunt
33764	Major vessel shunt & graft
33766	Major vessel shunt
33767	Major vessel shunt
33768	Cavopulmonary shunting
33770	Repair great vessels defect
33771	Repair great vessels defect
33774	Repair great vessels defect
33776	Repair great vessels defect
33777	Repair great vessels defect
33778	Repair great vessels defect
33779	Repair great vessels defect
33780	Repair great vessels defect
33786	Repair arterial trunk
33788	Revision of pulmonary artery
33800	Aortic suspension
33802	Repair vessel defect
33803	Repair vessel defect
33813	Repair septal defect
33814	Repair septal defect
33820	Revise major vessel
33822	Revise major vessel
33824	Revise major vessel
33840	Remove aorta constriction
33845	Remove aorta constriction
33851	Remove aorta constriction
33852	Repair septal defect
33853	Repair septal defect
33860	Ascending aortic graft
33863	Ascending aortic graft
33864	Ascending aortic graft
33870	Transverse aortic arch graft
33875	Thoracic aortic graft

Procedure Code	Description
33877	Thoracoabdominal graft
33880	Endovasc taa repr incl subcl
33881	Endovasc taa repr w/o subcl
33883	Insert endovasc prosth taa
33884	Endovasc prosth taa add-on
33889	Artery transpose/endovas taa
33891	Car-car bp grft/endovas taa
33910	Remove lung artery emboli
33915	Remove lung artery emboli
33916	Surgery of great vessel
33917	Repair pulmonary artery
33920	Repair pulmonary atresia
33922	Transect pulmonary artery
33924	Remove pulmonary shunt
33925	Rpr pul art unifocal w/o cpb
33926	Repr pul art unifocal w/cpb
33930	Removal of donor heart/lung
33933	Prepare donor heart/lung
33935	Transplantation heart/lung
33940	Removal of donor heart
33944	Prepare donor heart
33945	Transplantation of heart
33960	External circulation assist
33961	External circulation assist
33967	Insert ia percut device
33968	Remove aortic assist device
33970	Aortic circulation assist
33971	Aortic circulation assist
33973	Insert balloon device
33974	Remove intra-aortic balloon
33975	Implant ventricular device
33976	Implant ventricular device
33977	Remove ventricular device
33978	Remove ventricular device
33979	Insert intracorporeal device
33980	Remove intracorporeal device
33981	Replace vad pump ext
33982	Replace vad intra w/o bp
34001	Removal of artery clot
34051	Removal of artery clot
34151	Removal of artery clot
34401	Removal of vein clot
34451	Removal of vein clot
34502	Reconstruct vena cava
34800	Endovas aaa repr w/sm tube
34802	Endovas aaa repr w/2-p part
34803	Endovas aaa repr w/3-p part
34804	Endovas aaa repr w/1-p part
34805	Endovas aaa repr w/long tube
34806	Aneurysm press sensor add-on
34808	Endovas iliac a device add-on

Procedure Code	Description
34812	Xpose for endoprosth femorl
34820	Xpose for endoprosth iliac
34825	Endovasc extend prosth init
34826	Endovasc exten prosth addl
34830	Open aortic tube prosth repr
34831	Open aortoiliac prosth repr
34832	Open aortofemor prosth repr
34833	Xpose for endoprosth iliac
34834	Xpose endoprosth brachial
34900	Endovasc iliac repr w/graft
35001	Repair defect of artery
35002	Repair artery rupture neck
35013	Repair artery rupture arm
35021	Repair defect of artery
35022	Repair artery rupture chest
35081	Repair defect of artery
35082	Repair artery rupture aorta
35091	Repair defect of artery
35092	Repair artery rupture aorta
35102	Repair defect of artery
35103	Repair artery rupture groin
35111	Repair defect of artery
35112	Repair artery rupture spleen
35121	Repair defect of artery
35122	Repair artery rupture belly
35131	Repair defect of artery
35132	Repair artery rupture groin
35141	Repair defect of artery
35142	Repair artery rupture thigh
35151	Repair defect of artery
35152	Repair artery rupture knee
35182	Repair blood vessel lesion
35189	Repair blood vessel lesion
35211	Repair blood vessel lesion
35216	Repair blood vessel lesion
35221	Repair blood vessel lesion
35241	Repair blood vessel lesion
35246	Repair blood vessel lesion
35251	Repair blood vessel lesion
35271	Repair blood vessel lesion
35276	Repair blood vessel lesion
35281	Repair blood vessel lesion
35301	Rechanneling of artery
35302	Rechanneling of artery
35311	Rechanneling of artery
35331	Rechanneling of artery
35341	Rechanneling of artery
35351	Rechanneling of artery
35355	Rechanneling of artery
35361	Rechanneling of artery
35363	Rechanneling of artery
35371	Rechanneling of artery

Procedure Code	Description
35372	Rechanneling of artery
35390	Reoperation carotid add-on
35400	Angioscopy
35501	Artery bypass graft
35506	Artery bypass graft
35508	Artery bypass graft
35509	Artery bypass graft
35511	Artery bypass graft
35515	Artery bypass graft
35516	Artery bypass graft
35518	Artery bypass graft
35521	Artery bypass graft
35526	Artery bypass graft
35531	Artery bypass graft
35533	Artery bypass graft
35536	Artery bypass graft
35538	Artery bypass graft
35539	Artery bypass graft
35540	Artery bypass graft
35556	Artery bypass graft
35558	Artery bypass graft
35560	Artery bypass graft
35563	Artery bypass graft
35565	Artery bypass graft
35566	Artery bypass graft
35571	Artery bypass graft
35583	Vein bypass graft
35585	Vein bypass graft
35587	Vein bypass graft
35600	Harvest art for cabg add-on
35601	Artery bypass graft
35606	Artery bypass graft
35612	Artery bypass graft
35621	Artery bypass graft
35623	Bypass graft not vein
35626	Artery bypass graft
35631	Artery bypass graft
35633	Artery bypass graft
35636	Artery bypass graft
35637	Artery bypass graft
35638	Artery bypass graft
35642	Artery bypass graft
35645	Artery bypass graft
35646	Artery bypass graft
35650	Artery bypass graft
35654	Artery bypass graft
35656	Artery bypass graft
35661	Artery bypass graft
35663	Artery bypass graft
35665	Artery bypass graft
35666	Artery bypass graft
35671	Artery bypass graft

Procedure Code	Description
35681	Composite bypass graft
35682	Composite bypass graft
35683	Composite bypass graft
35691	Arterial transposition
35693	Arterial transposition
35694	Arterial transposition
35695	Arterial transposition
35697	Reimplant artery each
35700	Reoperation bypass graft
35800	Explore neck vessels
35840	Explore abdominal vessels
35870	Repair vessel graft defect
35905	Excision graft thorax
35907	Excision graft abdomen
36660	Insertion catheter artery
36822	Insertion of cannula(s)
37140	Revision of circulation
37160	Revision of circulation
37180	Revision of circulation
37181	Splice spleen/kidney veins
37182	Insert hepatic shunt (tips)
37616	Ligation of chest artery
37617	Ligation of abdomen artery
37660	Revision of major vein
37788	Revascularization penis
38100	Removal of spleen total
38101	Removal of spleen partial
38102	Removal of spleen total
38115	Repair of ruptured spleen
38381	Thoracic duct procedure
38382	Thoracic duct procedure
38562	Removal pelvic lymph nodes
38564	Removal abdomen lymph nodes
38724	Removal of lymph nodes neck
38747	Remove abdominal lymph nodes
38765	Remove groin lymph nodes
38770	Remove pelvis lymph nodes
38780	Remove abdomen lymph nodes
39200	Resect mediastinal cyst
39220	Resect mediastinal tumor
39501	Repair diaphragm laceration
39503	Repair of diaphragm hernia
39540	Repair of diaphragm hernia
39541	Repair of diaphragm hernia
39560	Resect diaphragm simple
39561	Resect diaphragm complex
41135	Tongue and neck surgery
41140	Removal of tongue
41145	Tongue removal neck surgery
41150	Tongue mouth jaw surgery
41153	Tongue mouth neck surgery
41155	Tongue jaw & neck surgery
42426	Excise parotid gland/lesion
42845	Extensive surgery of throat

Procedure Code	Description
42894	Revision of pharyngeal walls
42961	Control throat bleeding
42971	Control nose/throat bleeding
43045	Incision of esophagus
43101	Excision of esophagus lesion
43107	Removal of esophagus
43108	Removal of esophagus
43112	Removal of esophagus
43113	Removal of esophagus
43116	Partial removal of esophagus
43117	Partial removal of esophagus
43121	Partial removal of esophagus
43122	Partial removal of esophagus
43123	Partial removal of esophagus
43124	Removal of esophagus
43310	Repair of esophagus
43312	Repair esophagus and fistula
43314	Tracheo-esophagoplasty cong
43325	Revise esophagus & stomach
43327	Esoph fundoplasty lap
43330	Esophagomyotomy abdominal
43331	Esophagomyotomy thoracic
43340	Fuse esophagus & intestine
43341	Fuse esophagus & intestine
43350	Surgical opening esophagus
43351	Surgical opening esophagus
43352	Surgical opening esophagus
43360	Gastrointestinal repair
43361	Gastrointestinal repair
43400	Ligate esophagus veins
43405	Ligate/staple esophagus
43415	Repair esophagus wound
43425	Repair esophagus opening
43460	Pressure treatment esophagus
43496	Free jejunum flap microvasc
43501	Surgical repair of stomach
43502	Surgical repair of stomach
43605	Biopsy of stomach
43610	Excision of stomach lesion
43611	Excision of stomach lesion
43620	Removal of stomach
43621	Removal of stomach
43622	Removal of stomach
43631	Removal of stomach partial
43632	Removal of stomach partial
43633	Removal of stomach partial
43634	Removal of stomach partial
43640	Vagotomy & pylorus repair
43641	Vagotomy & pylorus repair
43800	Reconstruction of pylorus
43810	Fusion of stomach and bowel
43820	Fusion of stomach and bowel
43825	Fusion of stomach and bowel
43832	Place gastrostomy tube

Procedure Code	Description
43840	Repair of stomach lesion
43846	Gastric bypass for obesity
43847	Gastric bypass incl small i
43850	Revise stomach-bowel fusion
43855	Revise stomach-bowel fusion
43860	Revise stomach-bowel fusion
43865	Revise stomach-bowel fusion
43881	Impl/redo electrd antrum
43882	Revise/remove electrd antrum
44010	Incision of small bowel
44015	Insert needle cath bowel
44021	Decompress small bowel
44025	Incision of large bowel
44111	Excision of bowel lesion(s)
44120	Removal of small intestine
44121	Removal of small intestine
44126	Enterectomy w/o taper cong
44127	Enterectomy w/taper cong
44128	Enterectomy cong add-on
44132	Enterectomy cadaver donor
44135	Intestine transplnt cadaver
44139	Mobilization of colon
44140	Partial removal of colon
44144	Partial removal of colon
44145	Partial removal of colon
44146	Partial removal of colon
44147	Partial removal of colon
44150	Removal of colon
44151	Removal of colon/ileostomy
44155	Removal of colon/ileostomy
44156	Removal of colon/ileostomy
44157	Colectomy w/ileoanal anast
44158	Colectomy w/neo-rectum pouch
44160	Removal of colon
44202	Lap enterectomy
44203	Lap resect s/intestine addl
44204	Laparo partial colectomy
44205	Lap colectomy part w/ileum
44210	Laparo total proctocolectomy
44211	Lap colectomy w/proctectomy
44212	Laparo total proctocolectomy
44227	Lap close enterostomy
44300	Open bowel to skin
44310	Ileostomy/jejunostomy
44314	Revision of ileostomy
44316	Devise bowel pouch
44320	Colostomy
44322	Colostomy with biopsies
44345	Revision of colostomy
44604	Suture large intestine
44605	Repair of bowel lesion
44625	Repair bowel opening
44626	Repair bowel opening
44660	Repair bowel-bladder fistula

Procedure Code	Description
44661	Repair bowel-bladder fistula
44680	Surgical revision intestine
44700	Suspend bowel w/prosthesis
44720	Prep donor intestine/venous
44721	Prep donor intestine/artery
44800	Excision of bowel pouch
44960	Appendectomy
45110	Removal of rectum
45111	Partial removal of rectum
45112	Removal of rectum
45114	Partial removal of rectum
45116	Partial removal of rectum
45119	Remove rectum w/reservoir
45120	Removal of rectum
45121	Removal of rectum and colon
45126	Pelvic exenteration
45130	Excision of rectal prolapse
45135	Excision of rectal prolapse
45395	Lap removal of rectum
45397	Lap remove rectum w/pouch
45540	Correct rectal prolapse
45550	Repair rectum/remove sigmoid
45563	Exploration/repair of rectum
45805	Repair fistula w/colostomy
45825	Repair fistula w/colostomy
46730	Construction of absent anus
46735	Construction of absent anus
46742	Repair of imperforated anus
46744	Repair of cloacal anomaly
46746	Repair of cloacal anomaly
46748	Repair of cloacal anomaly
47010	Open drainage liver lesion
47100	Wedge biopsy of liver
47120	Partial removal of liver
47122	Extensive removal of liver
47125	Partial removal of liver
47130	Partial removal of liver
47133	Removal of donor liver
47135	Transplantation of liver
47140	Partial removal donor liver
47142	Partial removal donor liver
47143	Prep donor liver whole
47144	Prep donor liver 3-segment
47145	Prep donor liver lobe split
47146	Prep donor liver/venous
47147	Prep donor liver/arterial
47300	Surgery for liver lesion
47350	Repair liver wound
47360	Repair liver wound
47361	Repair liver wound
47362	Repair liver wound
47380	Open ablate liver tumor rf
47381	Open ablate liver tumor cryo
47400	Incision of liver duct

Procedure Code	Description
47420	Incision of bile duct
47425	Incision of bile duct
47460	Incise bile duct sphincter
47480	Incision of gallbladder
47550	Bile duct endoscopy add-on
47600	Removal of gallbladder
47605	Removal of gallbladder
47610	Removal of gallbladder
47612	Removal of gallbladder
47620	Removal of gallbladder
47700	Exploration of bile ducts
47701	Bile duct revision
47711	Excision of bile duct tumor
47712	Excision of bile duct tumor
47715	Excision of bile duct cyst
47720	Fuse gallbladder & bowel
47721	Fuse upper gi structures
47740	Fuse gallbladder & bowel
47741	Fuse gallbladder & bowel
47760	Fuse bile ducts and bowel
47765	Fuse liver ducts & bowel
47780	Fuse bile ducts and bowel
47785	Fuse bile ducts and bowel
47800	Reconstruction of bile ducts
47900	Suture bile duct injury
48020	Removal of pancreatic stone
48100	Biopsy of pancreas open
48105	Resect/debride pancreas
48120	Removal of pancreas lesion
48145	Partial removal of pancreas
48146	Pancreatectomy
48148	Removal of pancreatic duct
48150	Partial removal of pancreas
48152	Pancreatectomy
48153	Pancreatectomy
48154	Pancreatectomy
48155	Removal of pancreas
48400	Injection intraop add-on
48500	Surgery of pancreatic cyst
48520	Fuse pancreas cyst and bowel
48540	Fuse pancreas cyst and bowel
48545	Pancreatorrhaphy
48547	Duodenal exclusion
48548	Fuse pancreas and bowel
48551	Prep donor pancreas
48554	Transpl allograft pancreas
48556	Removal allograft pancreas
49020	Drain abdominal abscess
49040	Drain open abdom abscess
49060	Drain open retrop abscess
49062	Drain to peritoneal cavity
49203	Exc abd tum 5 cm or less
49204	Exc abd tum over 5 cm
49205	Exc abd tum over 10 cm

Procedure Code	Description
49428	Ligation of shunt
49605	Repair umbilical lesion
49611	Repair umbilical lesion
49905	Omental flap intra-abdom
50010	Exploration of kidney
50040	Drainage of kidney
50045	Exploration of kidney
50060	Removal of kidney stone
50065	Incision of kidney
50070	Incision of kidney
50075	Removal of kidney stone
50100	Revise kidney blood vessels
50120	Exploration of kidney
50125	Explore and drain kidney
50130	Removal of kidney stone
50135	Exploration of kidney
50205	Renal biopsy open
50220	Remove kidney open
50225	Removal kidney open complex
50234	Removal of kidney & ureter
50236	Removal of kidney & ureter
50240	Partial removal of kidney
50250	Cryoablate renal mass open
50280	Removal of kidney lesion
50290	Removal of kidney lesion
50300	Remove cadaver donor kidney
50320	Remove kidney living donor
50323	Prep cadaver renal allograft
50325	Prep donor renal graft
50327	Prep renal graft/venous
50328	Prep renal graft/arterial
50340	Removal of kidney
50360	Transplantation of kidney
50365	Transplantation of kidney
50370	Remove transplanted kidney
50380	Reimplantation of kidney
50400	Revision of kidney/ureter
50405	Revision of kidney/ureter
50500	Repair of kidney wound
50520	Close kidney-skin fistula
50540	Revision of horseshoe kidney
50545	Laparo radical nephrectomy
50546	Laparoscopic nephrectomy
50547	Laparo removal donor kidney
50548	Laparo remove w/ureter
50600	Exploration of ureter
50605	Insert ureteral support
50610	Removal of ureter stone
50620	Removal of ureter stone
50630	Removal of ureter stone
50650	Removal of ureter
50660	Removal of ureter
50700	Revision of ureter
50715	Release of ureter

Procedure Code	Description
50722	Release of ureter
50725	Release/revise ureter
50740	Fusion of ureter & kidney
50750	Fusion of ureter & kidney
50760	Fusion of ureters
50770	Splicing of ureters
50780	Reimplant ureter in bladder
50782	Reimplant ureter in bladder
50783	Reimplant ureter in bladder
50785	Reimplant ureter in bladder
50800	Implant ureter in bowel
50810	Fusion of ureter & bowel
50815	Urine shunt to intestine
50820	Construct bowel bladder
50825	Construct bowel bladder
50830	Revise urine flow
50840	Replace ureter by bowel
50860	Transplant ureter to skin
50900	Repair of ureter
50920	Closure ureter/skin fistula
50930	Closure ureter/bowel fistula
50940	Release of ureter
51525	Removal of bladder lesion
51530	Removal of bladder lesion
51550	Partial removal of bladder
51555	Partial removal of bladder
51565	Revise bladder & ureter(s)
51570	Removal of bladder
51575	Removal of bladder & nodes
51580	Remove bladder/revise tract
51585	Removal of bladder & nodes
51590	Remove bladder/revise tract
51595	Remove bladder/revise tract
51596	Remove bladder/create pouch
51597	Removal of pelvic structures
51800	Revision of bladder/urethra
51820	Revision of urinary tract
51841	Attach bladder/urethra
51865	Repair of bladder wound
51900	Repair bladder/vagina lesion
51920	Close bladder-uterus fistula
51925	Hysterectomy/bladder repair
51940	Correction of bladder defect
51960	Revision of bladder & bowel
51980	Construct bladder opening
54125	Removal of penis
54130	Remove penis & nodes
55801	Removal of prostate
55810	Extensive prostate surgery
55812	Extensive prostate surgery
55815	Extensive prostate surgery
55821	Removal of prostate
55831	Removal of prostate
55840	Extensive prostate surgery

Procedure Code	Description
55845	Extensive prostate surgery
56630	Extensive vulva surgery
56631	Extensive vulva surgery
56632	Extensive vulva surgery
56633	Extensive vulva surgery
56634	Extensive vulva surgery
56637	Extensive vulva surgery
56640	Extensive vulva surgery
57110	Remove vagina wall complete
57111	Remove vagina tissue compl
57112	Vaginectomy w/nodes compl
57270	Repair of bowel pouch
57280	Suspension of vagina
57305	Repair rectum-vagina fistula
57307	Fistula repair & colostomy
57308	Fistula repair transperine
57311	Repair urethrovaginal lesion
57531	Removal of cervix radical
57540	Removal of residual cervix
57545	Remove cervix/repair pelvis
58140	Myomectomy abdom method
58146	Myomectomy abdom complex
58150	Total hysterectomy
58152	Total hysterectomy
58180	Partial hysterectomy
58200	Extensive hysterectomy
58210	Extensive hysterectomy
58240	Removal of pelvis contents
58275	Hysterectomy/revise vagina
58280	Hysterectomy/revise vagina
58285	Extensive hysterectomy
58293	Vag hyst w/uro repair compl
58548	Lap radical hyst
58605	Division of fallopian tube
58611	Ligate oviduct(s) add-on
58822	Drain ovary abscess percut
58825	Transposition ovary(s)
58940	Removal of ovary(s)
58943	Removal of ovary(s)
58950	Resect ovarian malignancy
58951	Resect ovarian malignancy
58952	Resect ovarian malignancy
58953	Tah rad dissect for debulk
58954	Tah rad debulk/lymph remove
58956	Bso omentectomy w/tah
58957	Resect recurrent gyn mal
58958	Resect recur gyn mal w/lym
59130	Treat ectopic pregnancy
59136	Treat ectopic pregnancy
59140	Treat ectopic pregnancy
59350	Repair of uterus
59514	Cesarean delivery only
59525	Remove uterus after cesarean
59620	Attempted vbac delivery only

Procedure Code	Description
59852	Abortion
59855	Abortion
59856	Abortion
60254	Extensive thyroid surgery
60270	Removal of thyroid
60505	Explore parathyroid glands
60521	Removal of thymus gland
60522	Removal of thymus gland
60540	Explore adrenal gland
60545	Explore adrenal gland
60600	Remove carotid body lesion
60605	Remove carotid body lesion
60650	Laparoscopy adrenalectomy
61105	Twist drill hole
61107	Drill skull for implantation
61108	Drill skull for drainage
61120	Burr hole for puncture
61140	Pierce skull for biopsy
61150	Pierce skull for drainage
61151	Pierce skull for drainage
61154	Pierce skull & remove clot
61156	Pierce skull for drainage
61210	Pierce skull implant device
61250	Pierce skull & explore
61304	Open skull for exploration
61305	Open skull for exploration
61312	Open skull for drainage
61313	Open skull for drainage
61314	Open skull for drainage
61315	Open skull for drainage
61316	Implt cran bone flap to abdo
61320	Open skull for drainage
61321	Open skull for drainage
61333	Explore orbit/remove lesion
61340	Subtemporal decompression
61343	Incise skull (press relief)
61345	Relieve cranial pressure
61440	Incise skull for surgery
61450	Incise skull for surgery
61458	Incise skull for brain wound
61460	Incise skull for surgery
61480	Incise skull for surgery
61490	Incise skull for surgery
61500	Removal of skull lesion
61501	Remove infected skull bone
61510	Removal of brain lesion
61512	Remove brain lining lesion
61514	Removal of brain abscess
61516	Removal of brain lesion
61517	Implt brain chemotx add-on
61518	Removal of brain lesion
61519	Remove brain lining lesion
61520	Removal of brain lesion
61521	Removal of brain lesion
61522	Removal of brain abscess

Procedure Code	Description
61524	Removal of brain lesion
61526	Removal of brain lesion
61530	Removal of brain lesion
61531	Implant brain electrodes
61533	Implant brain electrodes
61534	Removal of brain lesion
61535	Remove brain electrodes
61536	Removal of brain lesion
61537	Removal of brain tissue
61538	Removal of brain tissue
61539	Removal of brain tissue
61540	Removal of brain tissue
61541	Incision of brain tissue
61542	Removal of brain tissue
61543	Removal of brain tissue
61544	Remove & treat brain lesion
61545	Excision of brain tumor
61546	Removal of pituitary gland
61548	Removal of pituitary gland
61550	Release of skull seams
61552	Release of skull seams
61556	Incise skull/sutures
61557	Incise skull/sutures
61558	Excision of skull/sutures
61559	Excision of skull/sutures
61563	Excision of skull tumor
61564	Excision of skull tumor
61566	Removal of brain tissue
61567	Incision of brain tissue
61570	Remove foreign body brain
61571	Incise skull for brain wound
61575	Skull base/brainstem surgery
61580	Craniofacial approach skull
61581	Craniofacial approach skull
61582	Craniofacial approach skull
61583	Craniofacial approach skull
61584	Orbitocranial approach/skull
61585	Orbitocranial approach/skull
61586	Resect nasopharynx skull
61590	Infratemporal approach/skull
61591	Infratemporal approach/skull
61592	Orbitocranial approach/skull
61595	Transtemporal approach/skull
61596	Transcochlear approach/skull
61597	Transcondylar approach/skull
61598	Transpetrosal approach/skull
61600	Resect/excise cranial lesion
61601	Resect/excise cranial lesion
61605	Resect/excise cranial lesion
61606	Resect/excise cranial lesion
61607	Resect/excise cranial lesion
61608	Resect/excise cranial lesion
61609	Transect artery sinus
61610	Transect artery sinus
61612	Transect artery sinus

Procedure Code	Description
61613	Remove aneurysm sinus
61615	Resect/excise lesion skull
61616	Resect/excise lesion skull
61618	Repair dura
61619	Repair dura
61680	Intracranial vessel surgery
61682	Intracranial vessel surgery
61684	Intracranial vessel surgery
61686	Intracranial vessel surgery
61690	Intracranial vessel surgery
61692	Intracranial vessel surgery
61697	Brain aneurysm repr complx
61698	Brain aneurysm repr complx
61700	Brain aneurysm repr simple
61702	Inner skull vessel surgery
61703	Clamp neck artery
61705	Revise circulation to head
61708	Revise circulation to head
61710	Revise circulation to head
61711	Fusion of skull arteries
61735	Incise skull/brain surgery
61750	Incise skull/brain biopsy
61751	Brain biopsy w/ct/mr guide
61760	Implant brain electrodes
61860	Implant neuroelectrodes
61863	Implant neuroelectrode
61864	Implant neuroelectrde addl
61867	Implant neuroelectrode
61868	Implant neuroelectrde addl
61870	Implant neuroelectrodes
62005	Treat skull fracture
62010	Treatment of head injury
62100	Repair brain fluid leakage
62116	Reduction of skull defect
62117	Reduction of skull defect
62120	Repair skull cavity lesion
62121	Incise skull repair
62140	Repair of skull defect
62141	Repair of skull defect
62142	Remove skull plate/flap
62143	Replace skull plate/flap
62145	Repair of skull & brain
62146	Repair of skull with graft
62147	Repair of skull with graft
62148	Retr bone flap to fix skull
62161	Dissect brain w/scope
62162	Remove colloid cyst w/scope
62163	Zneuroendoscopy w/fb removal
62164	Remove brain tumor w/scope
62165	Remove pituit tumor w/scope
62180	Establish brain cavity shunt
62190	Establish brain cavity shunt
62192	Establish brain cavity shunt
62200	Establish brain cavity shunt
62201	Brain cavity shunt w/scope

Procedure Code	Description
62220	Establish brain cavity shunt
62223	Establish brain cavity shunt
62256	Remove brain cavity shunt
62258	Replace brain cavity shunt
63050	Cervical laminoplasty
63051	C-laminoplasty w/graft/plate
63077	Spine disk surgery thorax
63078	Spine disk surgery thorax
63081	Removal of vertebral body
63082	Remove vertebral body add-on
63085	Removal of vertebral body
63086	Remove vertebral body add-on
63087	Removal of vertebral body
63088	Remove vertebral body add-on
63090	Removal of vertebral body
63091	Remove vertebral body add-on
63101	Removal of vertebral body
63102	Removal of vertebral body
63103	Remove vertebral body add-on
63170	Incise spinal cord tract(s)
63172	Drainage of spinal cyst
63173	Drainage of spinal cyst
63180	Revise spinal cord ligaments
63182	Revise spinal cord ligaments
63185	Incise spinal column/nerves
63190	Incise spinal column/nerves
63194	Incise spinal column & cord
63195	Incise spinal column & cord
63196	Incise spinal column & cord
63197	Incise spinal column & cord
63200	Release of spinal cord
63250	Revise spinal cord vessels
63251	Revise spinal cord vessels
63252	Revise spinal cord vessels
63265	Excise intraspinal lesion
63266	Excise intraspinal lesion
63268	Excise intraspinal lesion
63270	Excise intraspinal lesion
63271	Excise intraspinal lesion
63272	Excise intraspinal lesion
63273	Excise intraspinal lesion
63275	Biopsy/excise spinal tumor
63276	Biopsy/excise spinal tumor
63277	Biopsy/excise spinal tumor
63278	Biopsy/excise spinal tumor
63280	Biopsy/excise spinal tumor
63281	Biopsy/excise spinal tumor
63282	Biopsy/excise spinal tumor
63283	Biopsy/excise spinal tumor
63285	Biopsy/excise spinal tumor
63286	Biopsy/excise spinal tumor
63287	Biopsy/excise spinal tumor
63290	Biopsy/excise spinal tumor
63295	Repair of laminectomy defect
63300	Removal of vertebral body

Procedure Code	Description
63301	Removal of vertebral body
63302	Removal of vertebral body
63303	Removal of vertebral body
63304	Removal of vertebral body
63305	Removal of vertebral body
63306	Removal of vertebral body
63308	Remove vertebral body add-on
63700	Repair of spinal herniation
63702	Repair of spinal herniation
63704	Repair of spinal herniation
63706	Repair of spinal herniation
63709	Repair spinal fluid leakage
63710	Graft repair of spine defect
63740	Install spinal shunt
64752	Incision of vagus nerve
64755	Incision of stomach nerves
64760	Incision of vagus nerve
64809	Remove sympathetic nerves
65273	Repair of eye wound
69155	Extensive ear/neck surgery
69535	Remove part of temporal bone
69554	Remove ear lesion
69950	Incise inner ear nerve
92970	Cardioassist internal
92975	Dissolve clot heart vessel
92992	Revision of heart chamber
92993	Revision of heart chamber
93463	Drug admin & hemodynmic meas
99190	Special pump services
99191	Special pump services
99192	Special pump services
99356	Prolonged service inpatient
99357	Prolonged service inpatient
99460	Init nb em per day hosp
99462	Sbsq nb em per day hosp
99463	Same day nb discharge
99468	Neonate crit care initial
99469	Neonate crit care subsq
99471	Ped critical care initial
99472	Ped critical care subsq
99475	Ped crit care age 2-5 init
99476	Ped crit care age 2-5 subsq
99477	Init day hosp neonate care
99478	Ic lbw inf < 1500 gm subsq
99479	Ic lbw inf 1500-2500 g subsq
99480	Ic inf pbw 2501-5000 g subsq

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