

Nebraska Colon Cancer Screening Program
Fee for Service Schedule - Effective July 1, 2012 through June 30, 2013
 (Services payable for MEN and WOMEN age 50 years and above)

NOTE – Separate Enrollment Required

DESCRIPTION OF SERVICES	CPT Codes	Program Rates
New Patient; history, exam, straightforward decision-making (10 min. face-to-face)	99201	\$39.24
	99201 *	\$24.16
New Patient; <i>expanded</i> history, exam, straightforward decision-making; (20 min. face-to-face)	99202	\$67.19
	99202 *	\$45.96
New Patient; <i>detailed</i> history, exam, straightforward decision-making; (30 min. face-to-face)	99203	\$96.95
	99203 *	\$69.56
New Patient; <i>comprehensive</i> history, exam, decision-making of moderate complexity; (45 min. face-to-face) (Program allowed limit same as 99203)	99204	\$96.95
	99204 *	\$69.56
New Patient; <i>comprehensive</i> history, exam, decision-making of moderate complexity; (60 min. face-to-face) (Program allowed limit same as 99203)	99205	\$96.95
	99205 *	\$69.56
Established Patient; history, exam, straightforward decision-making; (5 min. face-to-face)	99211	\$18.24
	99211 *	\$8.70
Established Patient <i>expanded</i> history, exam, straightforward decision-making; (10 min. face-to-face)	99212	\$39.24
	99212 *	\$23.55
Established Patient <i>detailed</i> history, exam, straightforward decision-making; (15 min. face-to-face)	99213	\$65.48
	99213 *	\$46.71
Established Patient <i>detailed</i> history, exam, decision-making of moderate complexity; (25 min. face-to-face) (Program allowed limit same as 99213)	99214	\$65.48
	99214 *	\$46.71
Established Patient; <i>comprehensive</i> history, exam, decision-making of high complexity; (40 min. face-to-face) (Program allowed limit same as 99213)	99215	\$65.48
	99215 *	\$46.71
Consultation; history, exam, straightforward decision-making; (15 min. face-to-face)	99241	\$53.00
	99241 *	\$35.37
Consultation; Patient <i>expanded</i> history, exam, straightforward decision-making; (30 min. face-to-face)	99242	\$96.68
	99242 *	\$70.08
Consultation; <i>detailed</i> history, exam, decision-making of low complexity; (40 min. face-to-face)	99243	\$122.76
	99243 *	\$94.40
Consultation; <i>comprehensive</i> history, exam, decision-making of moderate complexity; (60 min. face-to-face)	99244	\$185.89
	99244 *	\$153.21
New Patient; <i>Initial</i> comp. prev. med. evaluation & management; history, exam, counseling/guidance, risk factor reduction, ordering of appropriate lab procedures, etc. (Age 50-64) (Program allowed limit same as 99203)	99386	\$96.95
	99386 *	\$69.56
New Patient Comprehensive (Age 65 & Older) (Program allowed limit same as 99203)	99387	\$96.95
	99387 *	\$69.59
Established Comprehensive Preventive Medicine (Age 50-64) (Program allowed limit same as 99213)	99396	\$65.48
	99396 *	\$46.71
Established Comprehensive Preventive Medicine (Age 65 and Older) (Program allowed limit same as 99213)	99397	\$65.48
	99397 *	\$46.71
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) (ASC Group 2)	45378	\$364.38
	45378 *	\$199.76
Colonoscopy-Discontinued Procedure (ASC Group 2)	45378-53	\$129.60
	45378-53 *	\$58.52
Colonoscopy, with or without biopsy, single or multiple (ASC Group 2)	45380	\$435.68
	45380 *	\$239.67
Colonoscopy, with removal of tumor(s), polyp(s), or other lesions(s), by hot biopsy forceps or bipolar cautery (ASC Group 2)	45384	\$431.95
	45384 *	\$249.49
Colonoscopy, with removal or tumor(s), polyp(s), or other lesion(s) by snare technique (ASC Group 2)	45385	\$490.41
	45385 *	\$284.25
Hemorrhoidectomy, by simple ligature	46221	\$238.98
	46221 *	\$170.98

*THESE AMOUNTS APPLY WHEN SERVICE IS PERFORMED IN A FACILITY SETTING – for the purpose of this program, “Facility” includes hospitals and ambulatory surgical centers (ASCs). Rates listed for services include all incidental charges related to the procedure; additional amounts may not be billed to the client.

TC = Technical Component 26 = Professional Component

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Level IV – Surgical Pathology (colon when procedure is a covered procedure) (RULE: This is an allowable charge only when the procedure to obtain sample is a covered procedure)	88305	\$97.75
	88305-TC	\$62.88
	88305-26	\$34.87
Level V – Surgical Pathology (colon when procedure is a covered procedure) (RULE: This is an allowable charge only when the procedure to obtain sample is a covered procedure)	88307	\$216.21
	88307-TC	\$140.42
	88307-26	\$75.79
Pathology consultation during surgery (colon only)	88329	\$49.40
	88329 *	\$32.47
Pathology consultation during surgery (colon only); first tissue block, with frozen sections(s) single specimen	88331	\$87.19
	88331-TC	\$30.26
	88331-26	\$56.92
Immunohistochemistry (including tissue immunoperoxidase), each antibody (colon only)	88342	\$97.37
	88342-TC	\$58.26
	88342-26	\$39.11
Hospital Fees related to approved Colon Procedures	00300	Medicaid % Rate
Anesthesia Fees related to approved Colon Procedures	00800	Attachment 1
Ambulatory Surgery Centers related to approved Colon Cancer Screening Procedures (NOTE: Refer to Procedure Code for ASC Group Assignment)	Group 1	\$336
	Group 2	\$449
	Group 3	\$518

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Attachment 1: Anesthesia Rates effective 7/1/2012 through 6/30/2013

Fee Schedule for Anesthesia is based on Medicaid Reimbursement system with unit values rounded to nearest cent. Rates are adjusted annually with the Program’s Fiscal Year which runs July 1 through June 30.

Anesthesia Claims Modifiers:

Healthcare providers report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised. All claims for anesthesia services must include:

- CPT Code **with Modifier** (see list below)
- Start & Stop Times
- Explanation of Benefits from Primary Insurance (where applicable)

When a physician bills for anesthesia services, the correct procedure code AND modifiers indicate:

- The Physician personally provided services to the individual patient
- The physician provided medical direction for CRNA services and the number of concurrent services directed.

The following modifiers MUST be used by when submitting claims for anesthesia services:

- AA** – Anesthesia Services performed personally by the anesthesiologist
- AD** – Medical Supervision by a physician; more than 4 concurrent anesthesia procedures
- QK** – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QX** – RNA service; with medical direction by a physician
- QY** – Medical direction of one certified registered nurse anesthetist by an anesthesiologist
- QZ** – CRNA service; without medical direction by a physician

Fee Schedule:

To determine the allowable rate for anesthesia services, add the unit value for the procedure to the number of minutes for the procedure and multiply by the appropriate conversion factor.

$$(\text{Unit Value} + \text{Minutes}) \times \text{Conversion Factor} = \text{Allowable Rate}$$

Unit Value:

CPT Code	AA/QY	QK	QX	QZ
00800*	\$44.88	\$67.87	\$44.58	\$44.79
00810*	\$74.80	\$113.12	\$74.30	\$74.65

*Anesthesia only covered when the surgical procedure performed is determined to be payable by NCP.

Minutes:

Anesthesia claims must include Start and Stop Times of the Procedure.

Conversion Factors:	AA = \$1.74	QX = \$0.82
	QY = \$1.74	QZ = \$1.45
	QK = \$0.87	

(EXAMPLE: CPT 00800-QZ – 68minutes ... (\$44.79 + 68) x \$1.45 = \$163.55)

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