Colorectal Cancer Procedure	CPT Code	Medicare Reimbursement Rates, 2010 for Region 1 In-Facility	Not In-Facility
Office Visit			
Initial, New Patient			
LEVEL 1: Problem focused history & examination with straightforward medical decision	**99201**	**$22.57**	**$40.44**
LEVEL 2: Expanded problem focused history & examination with straightforward medical decision	**99202**	**$49.66**	**$69.88**
LEVEL 3: Detailed history & examination requiring low complexity medical decision	**99203**	**$74.84**	**$101.16**
Established Patient			
LEVEL 1: Problem focused history & examination with straightforward medical decision	**99211**	**$9.25**	**$19.93**
LEVEL 2: Expanded problem focused history & examination with straightforward medical decision	**99212**	**$25.19**	**$40.44**
LEVEL 3: Detailed history & examination requiring low complexity medical decision	**99213**	**$49.59**	**$67.89**
Office Consultation for a New or Established Patient:			
Problem focused history & examination with straightforward medical decision	**99241**		
Expanded problem focused history & examination with straightforward medical decision	**99242**		
Detailed history & examination requiring low complexity medical decision	**99243**		
Screening and Diagnosis **FOBT**			
Fecal Occult Blood Test--guaiac-based, qualitiative, 1 - 3 simultaneous determinations performed for other than colorectal neoplasm screening	**82272**	**$4.66**	**$4.66**
Fecal Occult Blood Test--guaiac-based, consecutive collected specimens with single determination (i.e., patient was provided three cards or single triple card for consecutive collection)	**82270**	**$4.66**	**$4.66**
Blood, occult, fecal hemoglobin immunoassay (FIT)	**82274**	**$22.78**	**$22.78**
Sigmoidoscopy			
Screening Sigmoidoscopy	**G0104**	**$61.06**	**$131.62**
Facility Fee for Screening Sigmoidoscopy	**G0104**	**$90.08**	
Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing	**45330**	**$63.02**	**$133.58**
^^Facility Fee for Sigmoidoscopy, flexible; diagnostic, with or without collection…	**45330**	**$90.08**	
Sigmoidoscopy, flexible; with biopsy, single or multiple	**45331**	**$76.46**	**$168.00**
^^Facility Fee for sigmoidoscopy, flexible; with biopsy, single or multiple	**45331**	**$247.69**	
Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	**45333**	**$11.36**	**$280.70**

Colorectal Cancer

Procedure	CPT Code	Medicare Reimbursement Rates, 2010 for Region 1	
		In-Facility	Not In-Facility
^^Facility Fee for sigmoidoscopy, flexible; with removal of tumor(s)…by hot biopsy forceps or bipolar cautery	45333	$361.24	
Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) with control of bleeding, any method	45334	$167.51	$167.51
^^Facility Fee for sigmoidoscopy, flexible;	45334	$361.24	
Sigmoidoscopy, flexible; diagnostic, with directed submucosal injection(s), any substance	45335	$92.77	$241.90
^^Facility Fee for sigmoidoscopy, flexible; with submucosal injection	45335	$247.69	
Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare techniques	45338	$143.69	$310.37
^^Facility Fee for sigmoidoscopy, flexible; with removal of tumor(s)...by snare technique	45338	$361.24	
Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	45339	$189.78	$325.18
^^ Facility Fee for sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	45339	$361.24	

Colonoscopy

Screening Colonoscopy on average risk individual	G0121	$213.96	$383.31
^^Facility Fee for Screening Colonoscopy	G0121	$353.51	
Screening Colonoscopy on high risk individual	G0105	$213.57	$382.92
^^Facility Fee for Screening Colonoscopy	G0105	$353.51	
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression [&]	45378	$220.63	$389.97
^^ [&&] Facility Fee for colonoscopy, flexible, proximal to splenic flexure; diagnostic…	45378	$384.30	
Discontinued procedure (see last page - modifier explanations)	45378-53	$63.02	$133.58
Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple [&]	45380	$264.88	$466.64
^^ [&&] Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with biopsy…	45380	$384.30	
-59 Modifier	45380-59	See Modifier note at the end	
Colonoscopy, flexible, proximal to splenic flexure; with direct submucosal injection(s), any substance [&]	45381	$251.12	$454.03
^^ [&&] Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with injection	45381	$384.30	
-59 Modifier	45381-59	See Modifier note at the end	
Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding, any method [&]	45382	$338.50	$613.12
^^ [&&] Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with control of bleeding	45382	$384.30	
Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique [&]	45383	$341.69	$559.10

Colorectal Cancer Procedure	CPT Code	Medicare Reimbursement Rates, 2010 for Region 1 In-Facility	Not In-Facility
^^ &&Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s)...	45383	$384.30	
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery &	45384	$276.72	$461.71
^^ &&Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with removal of tumors(s)…by hot biopsy forceps or bipolar cautery	45384	$384.30	
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique &	45385	$314.68	$526.36
^^ && Facility Fee for colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s)...by snare technique	45385	$384.30	
Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (exploratory)	44388	$168.94	$340.19
^^Facility Fee for colonoscopy through stoma….	44388	$356.99	
Barium Enema			
Colorectal screening barium enema; as an alternative to G0104; screening sigmoidoscopy	G0106	$205.92	$205.92
-26 Modifier	G0106-26	$51.06	$51.06
-TC Modifier	G0106-TC	$154.86	$154.86
Colorectal screening barium enema; as an alternative to G0105; screening colonoscopy	G0120	$140.32	$140.32
-26 Modifier	G0120-26	$51.06	$51.06
-TC Modifier	G0120-TC	$89.26	$89.26
Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	G0121	$213.96	$383.31
-53 Modifier	G0121-53	$61.84	$132.40
Colorectal cancer screening; barium enema	G0122	$128.60	$128.60
Barium Enema, radiologic examination, colon; with or without KUB	74270	$128.60	$128.60
-26 Modifier	74270-26	$35.91	$35.91
-TC Modifier	74270-TC	$92.69	$92.69
Barium Enema, air contrast with specific high density barium, with or without glucagon	74280	$200.98	$200.98
-26 Modifier	74280-26	$51.45	$51.45
-TC Modifier	74280-TC	$149.52	$149.52
Usual Charges That Might Be Associated With Colonoscopy Work-Up			
Supplies and Materials provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	99070		**
Surgical Tray	A4550	Not Covered	Not Covered
Sedation with or without analgesia (conscious sedation); intravenous, intramuscular, or inhalation	99141	Not Covered	Not Covered
Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal	99142	Not Covered	Not Covered

Colorectal Cancer Procedure	CPT Code	Medicare Reimbursement Rates, 2010 for Region 1 In-Facility	Not In-Facility
Laboratory, Pathology			
Pathology review; comprehensive, for a complex diagnostic problem, with review of patients history and medical records	**80502**	**$65.03**	**$66.94**
Surgical Pathology , gross examination only &&&	**88300**	**$24.68**	**$24.68**
-26 Modifier	**88300-26**	**$4.46**	**$4.46**
-TC Modifier	**88300-TC**	**$20.23**	**$20.23**
Surgical Pathology Review Level II, surgical pathology, gross and microscopic examination &&&	**88302**	**$50.92**	**$50.92**
-26 Modifier	**88302-26**	**$6.66**	**$6.66**
TC Modifier	**88302-TC**	**$44.25**	**$44.25**
Surgical Pathology Review Level III, surgical pathology, gross and microscopic examination &&&	**88304**	**$64.12**	**$64.12**
-26 Modifier	**88304-26**	**$11.10**	**$11.10**
-TC Modifier	**88304-TC**	**$53.03**	**$53.03**
Surgical Pathology Review-Level IV, gross and microscopic examination, colon, colorectal polyp biopsy &&&	**88305**	**$106.36**	**$106.36**
-26 Modifier	**88305-26**	**$37.70**	**$37.70**
-TC Modifier	**88305-TC**	**$68.67**	**$68.67**
Surgical Pathology Review-Level V, gross and microscopic examination, colon, segmental resection other than for tumor &&&	**88307**	**$217.92**	**$217.92**
-26 Modifier	**88307-26**	**$80.60**	**$80.60**
-TC Modifier	**88307-TC**	**$137.32**	**$137.32**
Surgical Pathology Review-Level VI, gross and microscopic examination, colon, segmental resection for tumor or total resection &&&	**88309**	**$330.42**	**$330.42**
-26 Modifier	**88309-26**	**$140.83**	**$140.83**
-TC Modifier	**88309-TC**	**$189.58**	**$189.58**
Pathology: Special stains (list separately in addition to code for surgical pathology examination); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each	**88312**	**$102.89**	**$102.89**
-26 Modifier	**88312-26**	**$26.60**	**$26.60**
-TC Modifier	**88312-TC**	**$76.29**	**$76.29**
Pathology: Immunocytochemistry, each antibody	**88342**	**$102.40**	**$102.40**
-26 Modifier	**88342-26**	**$42.12**	**$42.12**
-TC Modifier	**88342-TC**	**$60.27**	**$60.27**
Blood Count; blood smear, micro exam with manual diff WBC count	**85007**	**$4.93**	**$4.93**
Electrolyte Panel - includes bicarbonate, chloride, potassium, sodium	**80051**	**$10.05**	**$10.05**
Renal Function Panel - includes albumin, calcium, bicarbonate, chloride, creatinine, glucose, phosphate, potassium, sodium, urea nitrogen (BUN)	**80069**	**$12.43**	**$12.43**
Thromboplastin (PTT) time, partial, plasma or whole blood	**85730**	**$6.93**	**$6.93**
Prothrombin (PT), specific clotting factor II	**85210**	**$5.88**	**$5.88**
Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	**81000**	**$4.54**	**$4.54**

Colorectal Cancer Procedure	CPT Code	Medicare Reimbursement Rates, 2010 for Region 1 In-Facility	Not In-Facility
Pharmacy			
Fentanyl Citrate, up to 0.1mg	**J3010**	**$0.34**	**$0.34**
Diazepam, up to 5 mg	**J3360**	**$1.02**	**$1.02**
Propofol for 10 mg		**$0.06**	**$0.06**

Anesthesia***

Diagnosis and Treatment:

Codes for Medical Assistance: Use CPT code for procedure being performed and add -30 Modifier
(except you can use 00857, and 00955. Time units are not recognized for anesthesia procedure code 01996.)

Screening:		
Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum	**00810**	5 Base Units

Anesthesia Formula: (Time Units + Base Units) x Conversion Factor= Allowance

Divide time of procedure in minutes by 15 to equal number of **Time Units**. Add Base Units (known as Uniform Relative Value Units [RVUs]) (base units (or RVU) for 00810 - anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum - is 5).

Multiply by Local/Region specific conversion factor (**Region 1 - $21.58)**

Examples of Reimbursement for 00810 using Anesthesia Formula A	**In-Facility**	**Not In-Facility**
1 Unit (=15 Minutes) + 5 Base Units	**$129.48**	**$129.48**
4 Units (=1 Hour) + 5 Base Units	**$194.22**	**$194.22**
8.7 Units (= 2 Hours 10 Minutes = 130 Minutes) + 5 Base Units	**$295.64**	**$295.64**

NOTES:

* Providers may be eligible for additional reimbursement for both physician fees and/or hospital or Ambulatory Surgical Center facility fees.

@Maryland Medicare reimburses dependent on location. There are 3 regions for the state and are broken-down below:

Region 1 includes: Anne Arundel, Baltimore, Carroll, Harford, Howard, and Baltimore City.

@The Medicare reimbursements given are for:

In-facility (when service performed in a facility setting: inpatient hospital, outpatient hospital, inpatient psychiatric facility, comprehensive inpatient rehabilitation facility, comprehensive outpatient rehabilitation facility, ambulatory surgical center, skilled nursing facility, and community mental health center) and

Not In-facility (when service performed in a physician's office, in the patient's home, facility, or institution other than the places of service listed under "in-facility")

For HSCRC-regulated facilities, reimburse using HSCRC rates.

***Medicare reimburses for anesthesia using a formula based on Uniform Relative Value Unit (RVU) (also referred to as 'base unit') for the procedure, time unit, conversion factor, and if special procedure. RVUs for anesthesia procedures are set by Medicare. Anesthesiologists submit the length of time of procedure: Medicare converts the time to units, then applies the formula. Anesthesiologists are reimbursed at 100%; however, if using a CRNA, the anesthesiologist receives 50%, and the CRNA receives 50%.

^^ **Facility Fees:** Ambulatory Surgical Center (ASC) Fee. Medicare and Medicaid reimburse facility fees if procedure is performed in an Ambulatory Surgical Center. If done in an HSCRC-regulated clinic or hospital, the rates will be set by HSCRC. Physician offices are not reimbursable. Note: In Maryland, each locality has a different rate. For simplification, we chose to use a singe (high) rate for all localities in Maryland, so our rate may differ from the rate an ASC may have on their fee schedule.

Colorectal Cancer	CPT Code	Medicare Reimbursement Rates, 2010 for Region 1	
Procedure		In-Facility	Not In-Facility

&& **Reimbursement for Facility Fees billed using multiple Colonoscopy CPTs:** A facility may submit more than one colonoscopy code if multiple techniques were used (for example 45383, 45384, and 45385 if ablation, snare and hot biopsy forceps were used to obtain or remove lesions). Local CRF programs may reimburse the facility fee as 100% for the allowable Medicare facility fee for the highest amount, then 50% of the allowable Medicare facility fee for each subsequent technique. For example, CPT code 45383, 45384, and 45385 would be reimbursable as $363.71 for the first technique plus up to 50% of the allowable Medicare facility fee for each additional technique.

& **Reimbursement for Providers when Multiple Biopsies Taken During Colonoscopy:** A provider may submit more than one colonoscopy CPTcode when billing for one procedure if multiple biopsy/removal techniques were used (for example 45383 and 45384 if both snare and hot biopsy forceps were used to obtain biopsies or remove lesions). If more than one CPT code is billed for different techniques used during the same colonoscopy procedure, local CRF programs may reimburse as 100% for the allowable Medicare reimbursement for the CPT code for the highest amount, then 50% of the allowable Medicare reimbursement amount for the second technique's CPT Code, and 25% of the allowable Medicare reimbursement amount for the third technique, etc.

&&& **Reimbursement for a Laboratory when Multiple Biopsies Taken During Colonoscopy:** A laboratory and pathologist may submit for reimbursement for processing and reading each individual specimen (e.g., each polyp or biopsy sent for analysis). For example, a laboratory might bill four times for CPT code 88305--once for each of four polyps processed. Local CRF programs may reimburse the lab at the Medicare rate for each of the four specimens.

Modifiers:

-26Modifier: Professional Component

-TC Modifier: Technical Component

A procedure can be split into its "professional" and "technical" components and each can be billed separately as noted; though, a provider cannot bill using both codes. The sum of the two components equals the rate if billed with one code.

-51 Modifier: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier "51" to the additional procedure or service code(s).
Please see Program Manual 9E1 and 9E2 for information on paying invoices with multiple procedures as indicated by this modifier.

-53 Modifier: A discontinued procedure due to extenuating circumstances or those that threaten the well being of the patient. Not to be used to report elective cancellation.

-59 Modifier: Distinct procedural service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day, eg, a separate lesion or different site. Please see Program Manual 9E1 and 9E2 for information on paying invoices with multiple procedures as indicated by this modifier.

-73 Modifier: A discontinued out-patient/ambulatory surgery procedure subsequent to patient's surgical preparation but prior to administration of anesthesia due to extenuating circumstances as with modifier -53.

-74 Modifier: A discontinued out-patient/ambulatory surgery center procedure after the administration of anesthesia due to extenuating circumstances as with modifier -53.

-80 Modifier: Assistant surgeon. Maximum payment is 20% of the listed fee for the primary procedure. The minimum allowance is $25.00. Assistant must be a physician. This may not be used to report physician assistant or nurse practitioner assistant surgical services.