A Message to

Business Office Managers

North NJ: 485 Route 1 South, Building C, Iselin, NJ 08830
South NJ: ***8000 Midlantic Drive, Suite 333, Mount Laurel NJ 08054***

MEMORANDUM

TO: **AmeriHealth Participating Ambulatory Surgery Centers in New Jersey**

FROM: **Kathleen Sullivan R.N.**
Director, Hospital & Ancillary contracting

DATE: **September 9, 2004**

SUBJECT: **BILLING REQUIREMENTS FOR CATEGORY NINE PROCEDURES**

This is a follow-up to a bulletin dated February 6, 2004, entitled "Updates to Outpatient Surgery Fee Schedule." Fee schedule changes, which were effective January 1, 2004, included the reclassification of several procedures to category nine.

PLEASE NOTE: All procedures in category nine are to be billed with revenue code 499 or 481, as appropriate. Inaccurate claim payments may result if the correct revenue code is not reported.

A copy of the current baseline Outpatient Surgery Fee Schedule is attached for your reference. Please refer to your AmeriHealth ancillary service agreement for specific reference to your facilities' rates.

If you have any questions about this bulletin, please call your ancillary service coordinator at 732-726-6700 (north, central and shore counties) or 856-778-6500 (south-western NJ counties).

Attachment

AmeriHealth HMO and PPO
Outpatient Surgery Fee Schedule
Effective Date: January 1, 2004

Payment by Category

Category	Base Fee*
M	$125
1	$300
2	$550
3	$650
4	$800
5	$950
6	$1,050
7	$1,200
8	$1,400
9	Individually priced

Individually Priced

CPT	Base Fee	Description
15342	$2,000	Application of bilaminate skin substitute/neodermis, 25 sq cm
15343	$2,000	Application of bilaminate skin substitute/neodermis, ea addl 25 sq cm
19240	$2,000	Mastectomy, modified radical w axillary lymph nodes wo pectoralis major
33282	$3,600	Implantation of patient-activated cardiac event recorder
36260	$2,000	Insertion of implantable intra-arterial infusion pump
37620	$2,400	Interruption of inferior vena cava by suture/ligation/plication/clip
38380	$2,000	Suture/ligation of thoracic duct, cervical approach
47562	$2,400	Laparoscopic cholecystectomy (previously code 56340)
47563	$2,400	Laparoscopic cholecystectomy w cholangiography (previously code 56341)
50590	$2,500	Lithotripsy, ESWL
56340	$2,400	Laparoscopic cholecystectomy (deleted 1-1-2000)
56431	$2,400	Laparoscopic cholecystectomy w cholangiography (deleted 1-1-2000)
67036	$1,800	Vitrectomy, mechanical, pars plana approach
67038	$1,800	Vitrectomy, mechanical, w epiretinal membrane stripping
67039	$1,800	Vitrectomy, mechanical, w focal endolaser photocoagulation
67040	$1,800	Vitrectomy, mechanical, w endolaser panretinal photocoagulation
67107	$1,800	Repair of retinal detachment, scleral buckling
67108	$1,800	Repair of retinal detachment, with vitrectomy
67112	$1,800	Repair of retinal detachment, by scleral buckling or vitrectomy, on patient with previous repair
67221	$1,700	Destruction of localized lesion of choroid, photodynamic therapy
67225	$1,700	Destruction of localized lesion of choroid, photodynamic therapy-2nd Eye
92980	$2,000	Transcatheter placement of intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
92981	$2,000	Transcatheter placement of intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each addtl
92982	$2,000	Percutaneous transluminal coronary balloon angioplasty; single vessel
93501	$1,800	Right heart catheterization
93508	$2,000	Catheter placement in coronary artery for angiography wo left heart cath
93510	$2,000	Left heart catheterization, via brachial/axillary/femoral artery, percutaneous
93511	$2,000	Left heart catheterization, via brachial/axillary/femoral artery, by cutdown
93514	$2,000	Left heart catheterization, via left ventricular punch
93524	$2,000	Left heart catheterization, combined transeptal and retrograde
93526	$2,200	Combined right and retrograde left heart catheterization
93527	$2,200	Combined right and transeptal left heart catheterization
93528	$2,200	Combined right heart catheterization w left ventricular puncture
93529	$2,200	Combined right and left heart catheterization via existing septal opening
93530	$1,800	Right heart catheterization for congenital cardiac anomalies
93531	$2,200	Combined right and retrograde left heart cath for congenital cardiac anomalies
93532	$2,200	Combined right and transeptal left heart cath for congenital cardiac anomalies
93533	$2,200	Combined right/transeptal left heart cath via septal opening for congenital cardiac anml
93631	$2,000	Intra-operative eipcardial and endocardial pacing and mapping
93650	$2,000	Intracardiac catheter ablation of atrioventricular node function
93651	$2,000	Intracardiac catheter ablation of arrhythmogenic focus
93652	$2,000	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia
G0183	$1,700	Destruction of localized lesion of choroid, photodynamic therapy
G0290	$2,000	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
G0291	$2,000	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each addtl

Inclusions and Exclusions

The categories and fees represent an all-inclusive per case payment with the exception of the specific implantable devices listed below:

- AV grafts (L8670)
- Brachytherapy Yttrium 90 (SIR-spheres) (C2616)
- Breast implants (L8600)
- Cochlear implants (L8614)
- Corneal tissue transplants (V2785)
- Cruciate ligaments (L8699)
- Fallopian Tube Microinserts for sterilization (L8699)
- ICD generators (L8699)
- Infusion pumps (E0782)
- Intravascular stents (L8699)
- Intravitreal implants (J7310)
- Neurostimulator generators (E0756)
- Neurostimulator leads (E0752)
- Pacemaker pulse generators (L8699)
- Pacemaker leads (L8699)
- Penile prostheses (L8699)
- Radioactive prostate seeds (Q3001)
- Tissue expanders (L8699)
- Vascular access reservoirs (A4301)
- Vascular Catheter (A4300)

These devices will be reimbursed separately at the provider's cost, not to exceed the maximum payment allowance