

Fee Schedule Legend

The following is a description of the fields that appear on the results page for Procedure Code Search.

Procedure Code – the five-character procedure code as listed in the CPT or HCPCS manual; OR the four-digit revenue code listed in the UB-04 manual.

Code Type – describes the type of code displayed. Value values are:

- HCPCS Procedure Code
- DME Rental Procedure Code
- Home Health Revenue Code
- Outpatient Revenue Code
- Inpatient Revenue Code

Description – an abbreviated description of the service (please check the appropriate coding manual for the complete description).

Fee Schedule – EqualityCare services are priced differently according to which fee schedule they have been assigned. A service may be assigned to more than one fee schedule. Valid values are:

- M01 – the primary EqualityCare fee schedule
- B01 – fee schedule for clients on the Breast and Cervical Plan
- D01 – fee schedule for clients on the Marginal Dental Plan
- D02 – fee schedule for clients on the Maternal Dental Care Services Plan
- W01 – fee schedule for children on the Developmentally Disabled Waiver Plan
- W02 – fee schedule for adults on the Developmentally Disabled Waiver Plan
- W03 – fee schedule for clients on the Acquired Brain Injury Plan

Rate Begin Date – the date that the new pricing began or that a prior authorization was/was not required.

Factor Code – the pricing methodology used for the service. Value values are:

- A – Anesthesia Units
- B – Billed Charge
- C – Maximum fee before suspension
- D – Injection pricing
- E – Encounter rate
- F – Fee schedule
- G – Fee professional component
- H – Fee technical component
- I – Percent of billed charges
- J – Relative value units
- K – Relative value professional component
- L – Relative value technical component
- M – Manual pricing usually requires invoice
- N – Not allowed
- O – Suspend for review
- P – Price off procedure code (applies only to revenue codes)
- Q – Maximum fee for emergency
- S – APC-based fee schedule (NOTE: procedures assigned this factor code can only be billed by outpatient hospitals.)
- T – CPT or HCPCS code was deleted from its respective coding manual and is no longer valid
- U – Priced by National Drug Code (NDC)

Rate – the reimbursement rate for the service.

Conversion Factor Amount – a number determined by EqualityCare which when multiplied by the relative value unit determines the fee for the service.

RVU (Relative Value Unit) – based on McGraw Hill or Medicare relative value guide.

Prior Authorization – indicates whether or not a prior authorization is required for the service. Please see the General Provider Manual for details on how to apply for a prior authorization.

Min Age – the youngest age allowed for the service.

Max Units of Service – the maximum number of units EqualityCare will pay for the service.

OPPS Status Indicator – This indicator only applies to outpatient hospital services. The status indicator is assigned by the Outpatient Code Editor (OCE) to each line item on an outpatient hospital claim. The status indicator directs payment of the line item. The status indicators used by EqualityCare are based on the indicators used by Medicare, with additional EqualityCare-specific indicators. Valid values are:

- B – Non-allowed item or service for OPSS that is not paid under OPSS
- C – Inpatient procedure that is not paid under OPSS
- F – Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines that is paid APC by report
- G – Drugs and biological pass-through that is paid by APC
- H – Pass-through device categories, brachytherapy sources, and radiopharmaceutical agents that is paid APC by report
- K – Non pass-through drugs and biologicals, and blood and blood products that is paid by APC
- L – Flu/PPV vaccines that is paid APC by report
- N – Services packaged into another service or APC
- Q – Packaged services subject to separate payment under OPSS payment criteria
- S – Significant procedure not subject to multiple procedure discounting that is paid by APC
- T – Significant procedure subject to multiple procedure discounting that is paid by APC
- V – Medical visit to clinic or emergency department that is paid by APC
- X – Ancillary service that is paid by APC
- Y – Non-implantable durable medical equipment (DME), therapeutic shoes that is not paid under OPSS
- 1 – Procedure or service that is not covered (e.g., a service that cannot be provided in an outpatient hospital setting or that is not a covered benefit)
- 2 – Procedure is paid at the provider specific EqualityCare cost to charge ratio
- 3 – Procedure is excluded from the APC-based methodology (e.g., radiology, laboratory, therapy, VFC program and screening mammography)

Medicare Covered – indicates whether the service is covered by Medicare. If a service is covered by Medicare and the client has appropriate Medicare coverage, the claim must be billed to Medicare first. Valid values are Y (yes) and N (no).

Valid Sex – indicates for which gender the service is valid. Valid values are:

- M – Male
- F – Female
- B – Both

Follow Up Days – the number of days in which follow up office visits are included in the surgical procedure reimbursement.

Max Age – the oldest age allowed for the service.

ASC (Ambulatory Surgical Center) Group – reimbursement is based on the ASC payment group assigned to the surgical procedure code. Payment is an all-inclusive rate based on all services related to the surgery. Payment is the lesser of total billed charges versus the ASC all-inclusive rate. Below are the fees for freestanding Ambulatory Surgery Centers. These fees DO NOT apply to clients on the Breast and Cervical Plan.

ASC Group	Fee
1	300.00
2	401.00
3	459.00
4	567.00
5	645.00
6	743.00
7	896.00
8	876.00

Multiple Surgery – indicates whether an operation report is required when one or more surgical procedures is performed on the same date of service. An operation report is required regardless of whether the multiple surgical procedures are billed on the same or different claims.

Nursing Home Covered – indicates whether EqualityCare covers the service for a client in a nursing home. Valid values are Y (yes) and N (no).

Referral Indicator – indicates whether the referring provider’s NPI must appear on the claim. Valid values are Y (yes) and N (no).

Fee Schedule Notes

Modifiers

EqualityCare recognizes the following list of modifiers when used in conjunction with CPT surgical procedure codes:

Modifier	Description	Notes
22	Unusual Procedural Services	An operative report is required. Reimbursed at allowed fee plus 20-percent.
50	Bilateral Procedures	Reimbursed at 75-percent of allowed fee.
51	Multiple Procedure	Reimbursed at 50-percent of allowed fee.
62	Two Surgeons	Under certain circumstances, two surgeons may be required in the management of a specific surgical procedure. Under such circumstances the separate services may be identified by adding the modifier “-62” to the procedure number reported by each surgeon for the services. An operative report is required. Reimbursed at 100-percent of allowed fee.
80	Assistant Surgeons	Reimbursed at 20-percent of allowed fee.
AS	Physician Assistant or Registered Nurse	Surgical assistant services. Reimbursed at 15percent of allowed fee.

When a radiology facility does not specify they are billing a global fee by billing both the 26 and TC modifiers used for the technical and professional components, they will be reimbursed for the technical component only.

Injections

Reimbursement for therapeutic injections INCLUDES the cost of administration. The only exception is when the patient supplies the medication, which must be documented on the claim.

If multiple drugs are included in a single injection, separate codes may be billed for the drugs, however, the administration fee should be included with only one code.

Anesthesia

CPT codes 00100-01999 are reimbursed based on the units of the anesthesia procedure and the time units allowed. Submit claim for anesthesia time as the total number of minutes of anesthesia time for the surgery(ies) performed. Minutes are automatically converted by EqualityCare’s payment system to reflect one unit for each 15-minute period. The total units (base units and time units) are multiplied by a conversion factor to determine the allowed amount. Medical supervision is not reimbursed.