Ohio BWC

This document contains updated data elements related to the January 1, 2011 implementation of BWC's new hospital outpatient reimbursement methodology:

- **Covered and non-covered revenue codes for all hospital services**
- **Revenue codes requiring CPT® codes for hospital outpatient services**
- **Valid modifiers for hospital outpatient services**

COVERED AND NON-COVERED REVENUE CODES

All Inclusive Rate

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
100	All INCL R&B	Covered	Not covered	Not covered
101	All INCL R&B	Covered	Not covered	Not covered

Room and Board-Private Medical or General

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
110	R&B - private	Covered	Not covered	Not covered
111	Medical/Surgical/Gyn	Covered	Not covered	Not covered
112	OB	Not covered	Not covered	Not covered
113	Pediatric	Not covered	Not covered	Not covered
114	Psychiatric	Covered	Not covered	Not covered
115	Hospice	Not covered	Not covered	Not covered
116	Detoxification	Covered	Not covered	Not covered
117	Oncology	Covered	Not covered	Not covered
118	Rehabilitation	Covered	Not covered	Not covered
119	Other	Not covered	Not covered	Not covered

Room & Board-Semi Prvt 2 Bed Medical/General

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
120	R&B semi private 2 bed	Covered	Not covered	Not covered
121	Medical/Surgical/Gyn	Covered	Not covered	Not covered
122	OB	Not covered	Not covered	Not covered
123	Pediatric	Not covered	Not covered	Not covered

124	Psychiatric	Covered	Not covered	Not covered
125	Hospice	Not covered	Not covered	Not covered
126	Detoxification	Covered	Not covered	Not covered
127	Oncology	Covered	Not covered	Not covered
128	Rehabilitation	Covered	Not covered	Not covered
129	Other	Not covered	Not covered	Not covered

Semi-Private-3/4 Beds

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
130	Semi private (3-4 bed)	Covered	Not covered	Not covered
131	Medical/Surgical/Gyn	Covered	Not covered	Not covered
132	OB	Not covered	Not covered	Not covered
133	Pediatric	Not covered	Not covered	Not covered
134	Psychiatric	Covered	Not covered	Not covered
135	Hospice	Not covered	Not covered	Not covered
136	Detoxification	Covered	Not covered	Not covered
137	Oncology	Covered	Not covered	Not covered
138	Rehabilitation	Covered	Not covered	Not covered
139	Other	Not covered	Not covered	Not covered

Private (Deluxe)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
140	Private (deluxe)	Not covered	Not covered	Not covered
141	Medical/Surgical/Gyn	Not covered	Not covered	Not covered
142	OB	Not covered	Not covered	Not covered
143	Pediatric	Not covered	Not covered	Not covered
144	Psychiatric	Not covered	Not covered	Not covered
145	Hospice	Not covered	Not covered	Not covered
146	Detoxification	Not covered	Not covered	Not covered
147	Oncology	Not covered	Not covered	Not covered
148	Rehabilitation	Not covered	Not covered	Not covered
149	Other	Not covered	Not covered	Not covered

Room & Board-Ward

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service	Outpatient - Dates of service on or

			prior to 01/01/2011	after 01/01/2011
150	R&B (ward)	Covered	Not covered	Not covered
151	Medical/Surgical/Gyn	Covered	Not covered	Not covered
152	OB	Not covered	Not covered	Not covered
153	Pediatric	Not covered	Not covered	Not covered
154	Psychiatric	Covered	Not covered	Not covered
155	Hospice	Not covered	Not covered	Not covered
156	Detoxification	Covered	Not covered	Not covered
157	Oncology	Covered	Not covered	Not covered
158	Rehabilitation	Covered	Not covered	Not covered
159	Other	Not covered	Not covered	Not covered

Other Room & Board

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
160	Other R&B (general class)	Not covered	Not covered	Not covered
164	Sterile Environment	Covered	Not covered	Not covered
167	Self Care	Not covered	Not covered	Not covered
169	Other	Not covered	Not covered	Not covered

Nursery

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
170	Nursery	Not covered	Not covered	Not covered
171	Newborn-Level I	Not covered	Not covered	Not covered
172	Newborn-Level II	Not covered	Not covered	Not covered
173	Newborn-Level III	Not covered	Not covered	Not covered
174	Newborn-Level IV	Not covered	Not covered	Not covered
179	Other	Not covered	Not covered	Not covered

Leave of Absence

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
180	Leave of absence	Not covered	Not covered	Not covered
182	Patient Convenience	Not covered	Not covered	Not covered

183	Therapeutic Leave	Covered	Not covered	Not covered
184	ICF/MR -any reason	Not covered	Not covered	Not covered
185	Nursing home	Not covered	Not covered	Not covered
189	Other Leave of absence	Not covered	Not covered	Not covered

Subacute Care

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
190	Subacute Care	Not covered	Not covered	Not covered
191	Subacute Care Level I	Not covered	Not covered	Not covered
192	Subacute Care Level II	Not covered	Not covered	Not covered
193	Subacute Care Level III	Not covered	Not covered	Not covered
194	Subacute Care Level IV	Not covered	Not covered	Not covered
199	Other Subacute Care	Not covered	Not covered	Not covered

Intensive Care

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
200	Intensive care	Covered	Not covered	Not covered
201	Surgical	Covered	Not covered	Not covered
202	Medical	Covered	Not covered	Not covered
203	Pediatric	Not covered	Not covered	Not covered
204	Psychiatric	Covered	Not covered	Not covered
206	Intermediate ICU	Covered	Not covered	Not covered
207	Burn Care	Covered	Not covered	Not covered
208	Trauma	Covered	Not covered	Not covered
209	Other Intensive Care	Not covered	Not covered	Not covered

Coronary Care

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
210	Coronary care	Covered	Not covered	Not covered
211	Myocardial Infarction	Covered	Not covered	Not covered
212	Pulmonary Care	Covered	Not covered	Not covered
213	Heart Transplant	Covered	Not covered	Not covered
214	Intermediate CCU	Covered	Not covered	Not covered

219	Other Coronary Care	Not covered	Not covered	Not covered

Special Charges

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
220	Special Charges	Not covered	Not covered	Not covered
221	Admission Charge	Not covered	Not covered	Not covered
222	Technical Support Charge	Not covered	Not covered	Not covered
223	U.R. Service Charge	Not covered	Not covered	Not covered
224	Late Discharge/MED NEC	Not covered	Not covered	Not covered
229	Other special charges	Not covered	Not covered	Not covered

Incremental Nursing Charge Rate

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
230	Incremental NUR charge	Covered	Not covered	Not covered
231	Nursery	Not covered	Not covered	Not covered
232	OB	Not covered	Not covered	Not covered
233	ICU	Covered	Not covered	Not covered
234	CCU	Covered	Not covered	Not covered
235	Hospice	Not covered	Not covered	Not covered
239	Other	Not covered	Not covered	Not covered

All Inclusive Ancillary

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
240	All inclusive ANCIL	Covered	Not covered	Not covered
241	Basic	Not covered	Not covered	Not covered
242	Comprehensive	Not covered	Not covered	Not covered
243	Specialty	Not covered	Not covered	Not covered
249	All INCL ANCIL/OTHER	Not covered	Not covered	Not covered

Pharmacy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
250	Pharmacy	Covered	Covered	Covered
251	Generic Drugs	Covered	Covered	Covered
252	Non-generic Drugs	Covered	Covered	Covered
253	Take Home Drugs	Covered	Covered	Covered
254	Drugs/INCIDENT ODX	Covered	Covered	Covered
255	Drugs/INCIDENT RAD	Covered	Covered	Covered
256	Experimental Drugs	Not covered	Not covered	Not covered
257	Non-prescription	Covered	Covered	Covered
258	IV Solutions	Covered	Covered	Covered
259	Other Pharmacy	Not covered	Not covered	Covered

IV Therapy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
260	IV Therapy	Covered	Covered	Covered
261	Infusion pump	Covered	Covered	Covered
262	IV THER/PHARM/ SVC	Covered	Covered	Covered
263	IV THER/DRUG/SUPPLY	Covered	Covered	Covered
264	IV THER/SUPPLIES	Covered	Covered	Covered
269	IV Therapy/Other	Not covered	Not covered	Covered

Medical/Surgical Supplies and Devices

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
270	MED-SUR SUPPLIES	Covered	Covered	Covered
271	Non Sterile Supply	Covered	Covered	Covered
272	Sterile supply	Covered	Covered	Covered
273	Take home supplies	Covered	Covered	Covered
274	Prosthetic/Orthotic DV	Covered	Covered	Covered
275	Pace maker	Covered	Covered	Covered
276	Intraocular Lens	Covered	Covered	Covered
277	Oxygen- Take Home	Covered	Covered	Covered
278	Other Implants	Covered	Covered	Covered

279	Other Supplies/Devices	Not covered	Not covered	Covered

Oncology

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
280	Oncology	Covered	Covered	Covered
289	Other oncology	Not covered	Not covered	Covered

Durable Medical Equipment (No Rental)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
290	DME (no rental)	Covered	Covered	Covered
291	Rental	Covered	Covered	Covered
292	Purchase	Covered	Covered	Covered
293	Purchase of used DME	Covered	Covered	Covered
294	Supplies/Drugs for DME effectiveness (HHA only)	Not covered	Not covered	Not covered
299	Other equipment	Not covered	Not covered	Covered

Laboratory

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
300	Laboratory	Covered	Covered	Covered
301	Chemistry	Covered	Covered	Covered
302	Immunology	Covered	Covered	Covered
303	Renal patient (home)	Covered	Covered	Covered
304	Non-routine Dialysis	Covered	Covered	Covered
305	Hematology	Covered	Covered	Covered
306	Bacteriology Microbiology	Covered	Covered	Covered
307	Urology	Covered	Covered	Covered
309	Other laboratory	Not covered	Not covered	Covered

Laboratory Pathological

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to	Outpatient - Dates of service on or after

			01/01/2011	01/01/2011
310	Laboratory-Pathology	Covered	Covered	Covered
311	Cytology	Covered	Covered	Covered
312	Histology	Covered	Covered	Covered
314	Biopsy	Covered	Covered	Covered
319	Other	Not covered	Not covered	Covered

Radiology-Diagnostic

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
320	Radiology-Diagnostic	Covered	Covered	Covered
321	Angiocardiography	Covered	Covered	Covered
322	Arthrography	Covered	Covered	Covered
323	Arteriography	Covered	Covered	Covered
324	Chest x-ray	Covered	Covered	Covered
329	Other	Not covered	Not covered	Covered

Radiology-Therapeutic

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
330	Radiology-Therapeutic	Covered	Covered	Covered
331	Chemotherapy-Injected	Covered	Covered	Covered
332	Chemotherapy-Oral	Covered	Covered	Covered
333	Radiation Therapy	Covered	Covered	Covered
335	Chemotherapy-IV	Covered	Covered	Covered
339	Other	Not covered	Not covered	Covered

Nuclear Medicine

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
340	Nuclear medicine	Covered	Covered	Covered
341	Diagnostic	Covered	Covered	Covered
342	Therapeutic	Covered	Covered	Covered
343	Diagnostic Radiopharmaceuticals	Covered	Covered	Covered
344	Therapeutic Radiopharmaceuticals	Covered	Covered	Covered

349	Other	Not covered	Not covered	Covered

CT Scan

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
350	CT scan	Covered	Covered	Covered
351	Head Scan	Covered	Covered	Covered
352	Body Scan	Covered	Covered	Covered
359	Other CT Scans	Not covered	Not covered	Covered

Operating Room Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
360	Operating Room Services	Covered	Covered	Covered
361	Minor Surgery	Covered	Covered	Covered
362	Organ Transplant (not Kidney)	Covered	Not covered	Not covered
367	Kidney Transplant	Covered	Not covered	Not covered
369	OR/Other	Not covered	Not covered	Covered

Anesthesia

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
370	Anesthesia	Covered	Covered	Covered
371	Incident to Radiology	Covered	Covered	Covered
372	Anesthesia Incident to Other Diagnostic Services	Covered	Covered	Covered
374	Acupuncture	Covered	Covered	Covered
379	Other Anesthesia	Not covered	Not covered	Covered

Blood

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
380	Blood	Covered	Covered	Covered

381	Packed Red Cells	Covered	Covered	Covered
382	Whole Blood	Covered	Covered	Covered
383	Plasma	Covered	Covered	Covered
384	Platelets	Covered	Covered	Covered
385	Leucocytes	Covered	Covered	Covered
386	Other components	Covered	Covered	Covered
387	Other Derivatives	Covered	Covered	Covered
389	Other Blood	Not covered	Not covered	Covered

Blood Storage and Processing

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
390	Blood/ Storage/Processing	Covered	Covered	Covered
391	Blood Administration	Covered	Covered	Covered
399	Blood/Other Storage	Not covered	Not covered	Covered

Other Imaging Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
400	Other Imaging Services	Covered	Covered	Covered
401	Diagnostic Mammography	Not covered	Not covered	Not covered
402	Ultrasound	Covered	Covered	Covered
403	Screening Mammography	Not covered	Not covered	Not covered
404	PET Scan	Covered	Covered	Covered
409	Other Imaging Services	Not covered	Not covered	Covered

Respiratory Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
410	Respiratory Services	Covered	Covered	Covered
412	Inhalation Services	Covered	Covered	Covered
413	Hyperbaric O2 Therapy	Covered	Covered	Covered
419	Other RESPIR SVS	Not covered	Not covered	Covered

Physical Therapy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
420	Physical Therapy	Covered	Covered	Covered
421	Visit Charge	Covered	Covered	Covered
422	Hourly Charge	Covered	Covered	Covered
423	Group Rate	Covered	Covered	Covered
424	Evaluation or Re-Eval	Covered	Covered	Covered
429	Other Physical Therapy	Not covered	Not covered	Covered

Occupational Therapy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
430	Occupational Therapy	Covered	Covered	Covered
431	Visit Charge	Covered	Covered	Covered
432	Hourly Charge	Covered	Covered	Covered
433	Group Rate	Covered	Covered	Covered
434	Evaluation or Re-Eval	Covered	Covered	Covered
439	Other Occup Therapy	Not covered	Not covered	Covered

Speech-Language Pathology

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
440	Speech Language Path	Covered	Covered	Covered
441	Speech-Visit charge	Covered	Covered	Covered
442	Speech-Hourly charge	Covered	Covered	Covered
443	Speech-Group rate	Covered	Covered	Covered
444	Speech-Evaluation	Covered	Covered	Covered
449	Other Speech-Language	Not covered	Not covered	Covered

Emergency Room

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
450	Emergency Room	Covered	Covered	Covered
451	EMTALA Emergency Medical Screening	Not covered	Not covered	Covered

	Services			
452	ER Beyond EMTALA Screening	Not covered	Not covered	Covered
456	Urgent Care	Covered	Covered	Covered
459	Other Emergency Room	Not covered	Not covered	Covered

Pulmonary Function

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
460	Pulmonary Function Diag.	Covered	Covered	Covered
469	Other Pulmonary Function	Not covered	Not covered	Covered

Audiology

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
470	Audiology	Covered	Covered	Covered
471	Diagnostic	Covered	Covered	Covered
472	Treatment	Covered	Covered	Covered
479	Other Audiology	Not covered	Not covered	Covered

Cardioloy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
480	Cardiology	Covered	Covered	Covered
481	Cardiac Cath Lab	Covered	Covered	Covered
482	Stress test	Covered	Covered	Covered
483	Echocardiology	Covered	Covered	Covered
489	Other cardiology	Not covered	Not covered	Covered

Ambulatory Surgical Care

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
490	Ambulatory Surgical Care	Not covered	Not covered	Covered

499	Other Ambulatory Surg.	Not covered	Not covered	Covered

Outpatient Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
500	Outpatient services	Not covered	Not covered	Not covered
509	Other outpatient services	Not covered	Not covered	Not covered

Clinic

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
510	Clinic	Covered	Covered	Covered
511	Chronic pain Center	Covered	Covered	Covered
512	Dental Clinic	Covered	Covered	Covered
513	Psychiatric Clinic	Covered	Covered	Covered
514	OB/GYN Clinic	Not covered	Not covered	Not covered
515	Pediatric Clinic	Not covered	Not covered	Not covered
516	Urgent care Clinic	Covered	Covered	Covered
517	Family Practice Clinic	Covered	Covered	Covered
519	Other Clinic	Not covered	Not covered	Covered

Free-Standing Clinic

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
520	Free-Standing Clinic	Not covered	Not covered	Not covered
521	Rural Health-Clinic	Not covered	Not covered	Not covered
522	Rural Health-Home	Not covered	Not covered	Not covered
523	Family Practice Clinic	Not covered	Not covered	Not covered
526	Urgent Care Clinic	Not covered	Not covered	Not covered
529	Other Free Standing Clinic	Not covered	Not covered	Not covered

Osteopathic Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
530	Osteopathic Services	Not covered	Not covered	Not covered
531	Osteopathic Therapy	Not covered	Not covered	Not covered

539	Other Osteopathic Services	Not covered	Not covered	Not covered

Ambulance

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
540	Ambulance	Not covered	Not covered	Not covered
541	Supplies	Not covered	Not covered	Not covered
542	Medical Transport	Not covered	Not covered	Not covered
543	Heart Mobile	Not covered	Not covered	Not covered
544	Oxygen	Not covered	Not covered	Not covered
545	Air Ambulance	Not covered	Not covered	Not covered
546	Neonatal	Not covered	Not covered	Not covered
547	Ambulance/pharmacy	Not covered	Not covered	Not covered
548	Ambulance telephone EKG	Not covered	Not covered	Not covered
549	Other ambulance	Not covered	Not covered	Not covered

Skilled Nursing

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
550	Skilled Nursing	Not covered	Not covered	Not covered
551	Visit Charges	Not covered	Not covered	Not covered
552	Hourly Charges	Not covered	Not covered	Not covered
559	Other Skilled Nursing	Not covered	Not covered	Not covered

Medical Social Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
560	Medical Social Services	Not covered	Not covered	Not covered
561	Visit Charges	Not covered	Not covered	Not covered
562	Hourly Charges	Not covered	Not covered	Not covered
569	Other Med/Social Services	Not covered	Not covered	Not covered

Home Health Aide (HH)

CODE	DESCRIPTION	Inpatient	Outpatient	Outpatient -

			- Dates of service prior to 01/01/2011	Dates of service on or after 01/01/2011
570	Home Health Aide	Not covered	Not covered	Not covered
571	Visit Charge	Not covered	Not covered	Not covered
572	Hourly Charge	Not covered	Not covered	Not covered
579	Other HH Aide	Not covered	Not covered	Not covered

Other Visits (Home Health)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
580	Other Visits (HH)	Not covered	Not covered	Not covered
581	Visit Charge	Not covered	Not covered	Not covered
582	Hourly Charge	Not covered	Not covered	Not covered
583	Home Health Assessment	Not covered	Not covered	Not covered
589	Other Home Health Visit	Not covered	Not covered	Not covered

Units of Service (Home Health)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
590	Units of service (HH)	Not covered	Not covered	Not covered
599	Home health other units	Not covered	Not covered	Not covered

Home Health – Oxygen

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
600	Oxygen (HH)	Not covered	Not covered	Not covered
601	O2-state/equip/supply/cont	Not covered	Not covered	Not covered
602	O2 supply under 1 LPM	Not covered	Not covered	Not covered
603	O2 supply over 4 LPM	Not covered	Not covered	Not covered
604	O2 portable add-on	Not covered	Not covered	Not covered
609	Other Oxygen	Not covered	Not covered	Not covered

MRI and MRA

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of	Outpatient - Dates of

			service prior to 01/01/2011	service on or after 01/01/2011
610	MRI General	Covered	Covered	Covered
611	MRI Brain	Covered	Covered	Covered
612	MRI Spinal Cord	Covered	Covered	Covered
614	MRI Other	Not covered	Not covered	Covered
615	MRA Head and Neck	Covered	Covered	Covered
616	MRA Lower Extremities	Covered	Covered	Covered
618	MRA Other	Not covered	Not covered	Covered
619	MRT Other	Not covered	Not covered	Covered

Medical Surgical Supplies (Extension of 270)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
621	Supplies Incident to RAD	Covered	Covered	Covered
622	Sup Incident to Other DX	Covered	Covered	Covered
623	Surgical Dressings	Covered	Covered	Covered
624	FDA Investigational DEV	Not covered	Not covered	Not covered

Pharmacy-(Extension of 250)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
631	Single Source Drug	Covered	Covered	Covered
632	Multiple Source Drug	Covered	Covered	Covered
633	Restrictive Prescription	Covered	Covered	Covered
634	EPO less than 10,000	Covered	Covered	Covered
635	EPO 10,000 or more	Covered	Covered	Covered
636	Drugs Requir detail coding	Covered	Covered	Covered
637	Self-administered drugs	Not covered	Covered	Covered

Home IV Therapy Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
640	Home IV Therapy Services	Not covered	Not covered	Not covered

641	Nonroutine Nursing central	Not covered	Not covered	Not covered
642	IV Site Care, Central Line	Not covered	Not covered	Not covered
643	IV Start/Chng/Periphal	Not covered	Not covered	Not covered
644	Nonroutine Nursing Periph	Not covered	Not covered	Not covered
645	TRNG PT/Caregvr/Centrl	Not covered	Not covered	Not covered
646	TRNG DSBLPT/Central	Not covered	Not covered	Not covered
647	TRNG PT/Caregvr/Periph	Not covered	Not covered	Not covered
648	TRNG/DSBLPT/Periph	Not covered	Not covered	Not covered
649	Other IV Therapy Services	Not covered	Not covered	Not covered

Hospice Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
650	Hospice Services	Not covered	Not covered	Not covered
651	Routine Home Care	Not covered	Not covered	Not covered
652	Continuous Home Care	Not covered	Not covered	Not covered
655	Inpatient Respite Care	Not covered	Not covered	Not covered
656	General Inpatient Care	Not covered	Not covered	Not covered
657	Physician Services	Not covered	Not covered	Not covered
658	Hospice Room and Board Nursing Facility	Not covered	Not covered	Not covered
659	Other Hospice	Not covered	Not covered	Not covered

Respite Care (HHA Only)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
660	Respite Care	Not covered	Not covered	Not covered
661	Hourly Charge/Skilled Nsg	Not covered	Not covered	Not covered
662	Hourly Charge/HH aide	Not covered	Not covered	Not covered
663	Daily respite charge	Not covered	Not covered	Not covered
669	Other respite charge	Not covered	Not covered	Not covered

Outpatient Special Residence Charges

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of	Outpatient - Dates of

			service prior to 01/01/2011	service on or after 01/01/2011
670	OP SPEC RES	Not covered	Not covered	Not covered
671	Hospital Based	Not covered	Not covered	Not covered
672	Contracted	Not covered	Not covered	Not covered
679	OP SPEC RES/Other	Not covered	Not covered	Not covered

Trauma Response

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
681	Trauma response Level I	Covered	Covered	Covered
682	Trauma response Level II	Covered	Covered	Covered
683	Trauma response Level III	Covered	Covered	Covered
684	Trauma response Level IV	Covered	Covered	Covered
689	Other trauma response	Not covered	Not covered	Covered

Cast Room

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
700	Cast Room	Covered	Covered	Covered
709	Other Cast Room	Not covered	Not covered	Covered

Recovery Room

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
710	Recovery room	Covered	Covered	Covered
719	Other recovery room	Not covered	Not covered	Not covered

Labor Room/Delivery

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
720	Labor Room/Delivery	Not covered	Not covered	Not covered

721	Labor	Not covered	Not covered	Not covered
722	Delivery	Not covered	Not covered	Not covered
723	Circumcision	Not covered	Not covered	Not covered
724	Birthing Center	Not covered	Not covered	Not covered
729	Other Labor room/delivery	Not covered	Not covered	Not covered

EKG/ECG (Electrocardiogram)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
730	EKG/ECG	Covered	Covered	Covered
731	Holter Monitor	Covered	Covered	Covered
732	Telemetry	Covered	Covered	Covered
739	Other EKG/ECG	Not covered	Not covered	Covered

EEG (Electroencepalogram)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
740	EEG	Covered	Covered	Covered
749	Other EEG	Not covered	Not covered	Covered

Gastro Intestinal Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
750	Gastro Intestinal Services	Covered	Covered	Covered
759	Other Gastro-Intestinal	Not covered	Not covered	Covered

Treatment/Observation Room

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
760	Treatment/Observation	Not covered	Not covered	Covered
761	Treatment Room	Covered	Covered	Covered
762	Observation Room	Covered	Covered	Covered
769	Other Treatment or Observation Room	Not covered	Not covered	Covered

Preventive Care Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
770	Prevent Care Services	Not covered	Not covered	Not covered
771	Vaccine Administration	Not covered	Not covered	Not covered
779	Other Preventive	Not covered	Not covered	Not covered

Telemedicine

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
780	Telemedicine	Not covered	Not covered	Not covered
789	Other Telemedicine	Not covered	Not covered	Not covered

Lithotripsy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
790	Lithotripsy General Class	Covered	Covered	Covered
799	Lithotripsy Other	Not covered	Not covered	Covered

Inpatient Renal Dialysis

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
800	Inpatient Renal Dialysis	Covered	Not covered	Not covered
801	Inpatient Hemodialysis	Covered	Not covered	Not covered
802	IP Peritoneal (Non-CAPD)	Covered	Not covered	Not covered
803	Inpatient CAPD	Covered	Not covered	Not covered
804	Inpatient CCPD	Covered	Not covered	Not covered
809	Other Inpatient Dialysis	Not covered	Not covered	Not covered

Organ Acquisition

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to	Outpatient - Dates of service on or after

			01/01/2011	01/01/2011
810	Organ Acquisition	Covered	Not covered	Covered
811	Living Donor	Covered	Not covered	Covered
812	Cadaver Donor	Covered	Not covered	Covered
813	Unknown donor	Covered	Not covered	Covered
814	Unsuccessful Search	Covered	Covered	Covered
819	Other Donor	Not covered	Not covered	Covered

Hemodialysis (Outpatient or Home)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
820	Hemodialysis (op/home)	Not covered	Covered	Covered
821	Hemo/Composite	Not covered	Covered	Covered
822	Home Supplies	Not covered	Covered	Covered
823	Home Equipment	Not covered	Covered	Covered
824	Maintenance / 100%	Not covered	Covered	Covered
825	Support Services	Not covered	Covered	Covered
829	Other Outpatient Hemo	Not covered	Not covered	Covered

Peritoneal Dialysis (Outpatient or Home)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
830	Peritoneal Dialysis (OP)	Not covered	Covered	Covered
831	Peritoneal/Composite	Not covered	Covered	Covered
832	Home Supplies	Not covered	Covered	Covered
833	Home Equipment	Not covered	Covered	Covered
834	Maintenance / 100%	Not covered	Covered	Covered
835	Support Services	Not covered	Covered	Covered
839	Other Peritoneal Dialysis	Not covered	Not covered	Covered

CAPD (Outpatient or Home)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
840	CAPD (OP)	Not covered	Covered	Covered
841	CAPD-composite	Not covered	Covered	Covered
842	Home Supplies	Not covered	Covered	Covered

843	Home Equipment	Not covered	Covered	Covered
844	Maintenance / 100%	Not covered	Covered	Covered
845	Support Services	Not covered	Covered	Covered
849	Other OP CAPD	Not covered	Not covered	Covered

CCPD (Outpatient or Home)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
850	CCPD, general class	Not covered	Covered	Covered
851	CCPD, composite	Not covered	Covered	Covered
852	Home Supplies	Not covered	Covered	Covered
853	Home Equipment	Not covered	Covered	Covered
854	Maintenance / 100%	Not covered	Covered	Covered
855	Support Services	Not covered	Covered	Covered
859	Other Outpatient CCPD	Not covered	Not covered	Covered

Miscellaneous Dialysis

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
880	Miscellaneous Dialysis	Covered	Covered	Covered
881	Ultrafiltration	Covered	Covered	Covered
882	Home Dialysis Aid Visit	Not covered	Covered	Covered
889	Misc. Dialysis Other	Not covered	Not covered	Covered

Behavioral Health Treatments/Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
900	Psychiatric/Psychological Treatments	Not covered	Not covered	Covered
901	Electroshock Treatments	Not covered	Not covered	Covered
902	Milieu Therapy	Not covered	Not covered	Not covered
903	Play Therapy	Not covered	Not covered	Not covered
904	Activity Therapy	Not covered	Not covered	Not covered
905	Intensive Outpatient Services Psychiatric	Not covered	Covered	Covered
906	Intensive Outpatient Services Chemical Dependency	Not covered	Covered	Covered

907	Community Behavioral Health Program Day Treatment	Not covered	Not covered	Covered

Behavioral Health Treatments/Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
910	Psychiatric/Psychological	Covered	Covered	Covered
911	Rehabilitation	Covered	Covered	Covered
912	Partial Hospitalization less Intensive	Covered	Covered	Covered
913	Partial Hospitalization Intensive	Covered	Covered	Covered
914	Individual Therapy	Covered	Covered	Covered
915	Group Therapy	Covered	Covered	Covered
916	Family Therapy	Covered	Covered	Covered
917	Bio Feedback	Covered	Covered	Covered
918	Testing	Covered	Covered	Covered
919	Other	Not covered	Not covered	Covered

Other Diagnostic Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
920	Other Diagnostic Services	Covered	Covered	Covered
921	Peripheral Vascular Lab	Covered	Covered	Covered
922	Electromyelogram	Covered	Covered	Covered
923	Pap Smear	Covered	Covered	Covered
924	Allergy Test	Covered	Covered	Covered
925	Pregnancy Test	Covered	Covered	Covered
929	Other Diagnostic Services	Not covered	Not covered	Covered

Medical Rehabilitation Day Program

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
931	Half day	Not covered	Not covered	Not covered
932	Full day	Not covered	Not covered	Not covered

Other Therapeutic Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
940	Other Therapeutic Services	Covered	Covered	Covered
941	Recreational Therapy	Covered	Covered	Covered
942	Education/Training	Covered	Covered	Covered
943	Cardiac Rehab	Covered	Covered	Covered
944	Drug Rehab	Covered	Covered	Covered
945	Alcohol Rehab	Covered	Covered	Covered
946	Complex Med Equip-Rout	Covered	Covered	Covered
947	Complex Med Equip-Anc	Covered	Covered	Covered
949	Other Therapeutic Services	Not covered	Not covered	Covered

Other Therapeutic Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
952	Kinesiotherapy	Not covered	Not covered	Not covered

Professional Fees

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
960	Professional Fees	Not covered	Not covered	Not covered
961	Psychiatric	Not covered	Not covered	Not covered
962	Ophthalmology	Not covered	Not covered	Not covered
963	Anesthesiologist (MD)	Not covered	Not covered	Not covered
964	Anesthetist (CRNA)	Not covered	Not covered	Not covered
969	Other Professional Fees	Not covered	Not covered	Not covered

Professional Fees (Extension of 960)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011

971	Laboratory	Not covered	Not covered	Not covered
972	Radiology-Diagnostic	Not covered	Not covered	Not covered
973	Radiology-Therapeutic	Not covered	Not covered	Not covered
974	Radiology-NUC MED	Not covered	Not covered	Not covered
975	Operating Room	Not covered	Not covered	Not covered
976	Respiratory Therapy	Not covered	Not covered	Not covered
977	Physical Therapy	Not covered	Not covered	Not covered
978	Occupational Therapy	Not covered	Not covered	Not covered
979	Speech Pathology	Not covered	Not covered	Not covered

Professional Fees (Extension of 960 & 970)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
981	Emergency Room	Not covered	Not covered	Not covered
982	Outpatient Services	Not covered	Not covered	Not covered
983	Clinic	Not covered	Not covered	Not covered
984	Medical Social Services	Not covered	Not covered	Not covered
985	EKG	Not covered	Not covered	Not covered
986	EEG	Not covered	Not covered	Not covered
987	Hospital Visit	Not covered	Not covered	Not covered
988	Consultation	Not covered	Not covered	Not covered
989	Private Duty Nurse	Not covered	Not covered	Not covered

Patient Convenience Items

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
990	Patient convenience Items	Not covered	Not covered	Not covered
991	Cafeteria/Guest Tray	Not covered	Not covered	Not covered
992	Private Linen Service	Not covered	Not covered	Not covered
993	Telephone/Telegraph	Not covered	Not covered	Not covered
994	TV/Radio	Not covered	Not covered	Not covered
995	Nonpatient Room Rentals	Not covered	Not covered	Not covered
996	Late Discharge Charge	Not covered	Not covered	Not covered
997	Admission Kits	Not covered	Not covered	Not covered
998	Beauty Shop/Barber	Not covered	Not covered	Not covered
999	Other PT Convenience	Not covered	Not covered	Not covered

REVENUE CODES REQUIRING CPT® CODES FOR HOSPITAL OUTPATIENT SERVICES

IV Therapy

CODE	Revenue Center Description
261	Infusion Pump

 # Items Medical/Surgical Supplies and Devices (see also 062X)

CODE	Revenue Center Description
274	Prosthetic/orthotic devices

Laboratory

CODE	Revenue Center Description
300	Laboratory - General
301	Chemistry
302	Immunology
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology & Microbiology
307	Urology
309	Other laboratory

Laboratory Pathological

CODE	Revenue Center Description
310	Laboratory Pathological - Gen
311	Cytology
312	Histology
314	Biopsy
319	Other laboratory pathology

Radiology Diagnostic

CODE	Revenue Center Description
320	Radiology Diagnostic - General
321	Angiocardiography
322	Arthrography
323	Arteriographty
324	Chest X-ray
329	Other Radiology Diagnostic

Radiology Therapeutic

CODE	Revenue Center Description
330	Radiology Therapeutic - General
331	Chemotherapy injected
332	Chemotherapy oral
333	Radiation therapy
335	Chemotherapy IV
339	Other Radiology Therapeutic

* Not required by Medicare under OPPS. Required by BWC.

* Not required by Medicare under OPPS. Required by BWC.

Nuclear Medicine

CODE	Revenue Center Description
340	Nuclear Medicine - General
341	Diagnostic
342	Therapeutic
343	Diagnostic radiopharmaceuticals
344	Therapeutic radiopharmaceuticals
349	Other Nuclear Medicine

CT Scan

CODE	Revenue Center Description
350	CT Scan - General
351	CT Scan-head
352	CT Scan-body
359	Other CT scans

Operating Room Services

CODE	Revenue Center Description
360	Operating Room Services-General
361	Minor Surgery
369	Other OR services

Blood and Blood Components

CODE	Revenue Center Description
380	General
381	Packed Red Cells
382	Whole blood
383	Plasma
384	Platelets
385	Leukocytes
386	Other components
387	Other derivatives
389	Other blood

Administration, Processing and Storage for Blood and Blood Components

391	Administration

Other Imaging Services

CODE	Revenue Center Description
400	Other Imaging services - General
401	Diagnostic mammography
402	Ultrasound
403	Screening mammography
404	PET Scan
409	Other Imaging services

* Not required by Medicare under OPPS. Required by BWC.

Respiratory Services

CODE	Revenue Center Description
410	Respiratory Serv-General
412	Inhalation Services
413	Hyperbaric oxygen
419	Other Respiratory services

Physical Therapy

CODE	Revenue Center Description
420	Physical Therapy - General
421	PT-Visit charge
422	PT-Hourly charge
423	PT-Group rate
424	PT-Evaluation
429	Other Physical Therapy

Occupational Therapy

CODE	Revenue Center Description
430	Occupational Therapy - General
431	OT-Visit charge
432	OT-Hourly charge
433	OT-Group rate
434	OT-Evaluation or re-evaluation
439	OT-Other occupational therapy (may include restorative therapy)

Speech Therapy

CODE	Revenue Center Description
440	Speech Pathology - General
441	Speech-Visit charge
442	Speech-Hourly charge
443	Speech-Group rate
444	Speech-Evaluation or re-evaluation
449	Other speech-language pathology

Emergency Room Services

CODE	Revenue Center Description
450	Emergency Room
451	EMTALA emergency medical screening services
452	ER beyond EMTALA screening
456	Urgent Care
459	Other ER

Pulmonary Function

CODE	Revenue Center Description
460	Pulmonary Function - General
469	Other Pulmonary Function

Audiology

CODE	Revenue Center Description
470	Audiology - General
471	Audiology - Diagnostic
472	Audiology - Treatment
479	Other Audiology

Cardiology

CODE	Revenue Center Description
480	Cardiology - General
481	Cardiology - Cardiac Cath Lab
482	Cardiology - Stress Test
483	Cardiology - Echocardiology
489	Other Cardiology

Ambulatory Surgical Care

CODE	Revenue Center Description
490	Ambulatory Surgical Care - General
499	Other Ambulatory Surgical Care

Clinic

CODE	Revenue Center Description
510	Clinic - General
511	Chronic Pain Center
512	Dental Clinic
513	Psychiatric Clinic
516	Urgent Care Clinic
517	Family Practice Clinic
519	Other Clinic

Magnetic Resonance Imaging

CODE	Revenue Center Description
610	Magnetic Resonance Imaging
611	MRI-Brain
612	MRI-Spinal Cord
614	MRI- Other
615	MRI-Head and Neck
616	MRI-Lower Extremities
618	MRA-Other
619	Other MRT

Medical/Surgical Supplies Extension of 27X

CODE	Revenue Center Description
623	Surgical dressings

Pharmacy-Extension of 25X

CODE	Revenue Center Description
636	Drugs requiring detailed coding
637	Self-Administrable Drugs

EKG/ECG (Electrocardiogram)

CODE	Revenue Center Description
730	EKG/ECG - General
731	Holter monitor
739	Other EKG/ECG

* Not required by Medicare under OPPS. Required by BWC.

EEG (Electroencephalogram)

CODE	Revenue Center Description
740	EEG - General
749	Other EEG

Gastrointestinal Services

CODE	Revenue Center Description
750	Gastrointestinal Services - Gen
759	Other General Gastrointestinal Services

Treatment and Observation Room

CODE	Revenue Center Description
761	Treatment Room
769	Other Treatment/Observation

Extra-Corporeal Shock Wave Therapy-formerly Lithotripsy

CODE	Revenue Center Description
790	Extra-Corporeal Shock Wave Therapy
799	Extra-Corporeal Shock Wave Therapy-Other

Acquisition of Body Components

CODE	Revenue Center Description
810	Organ Acquisition
811	Acquisition of body components-living donor
812	Acquisition of body components-cadaver donor
813	Acquisition of body components-unknown donor
814	Donor bank charges for an unsuccessful search
819	Other Donor

* Not required by Medicare under OPPS. Required by BWC.

* Not required by Medicare under OPPS. Required by BWC.

Behavioral Health Treatments/Services

CODE	Revenue Center Description
900	Psychiatric Services - General
901	Electroshock Treatment
902	Milieu therapy
903	Play therapy
904	Activity therapy
907	Community behavior health program-day treatment

* Not required by Medicare under OPPS. Required by BWC.

Behavioral Health Treatments/Services-Extension of 90X

CODE	Revenue Center Description
911	Psych - Rehab
914	Psych - Indiv Therapy
915	Psych - Group Therapy

916	Psych - Family Therapy
917	Biofeedback
918	Psych - Testing
919	Other Behavioral health treatments

Other Diagnostic Services

CODE	Revenue Center Description
920	Other Diagnostic Services - Gen
921	Peripheral Vasc Lab
922	Electromyelogram
924	Allergy Test
929	Other Diagnostic Services

Other therapeutic services

CODE	Revenue Center Description
941	Recreational Therapy
943	Cardiac Rehab
949	Other therapeutic services -

Other therapeutic services

CODE	Revenue Center Description
951	Athletic training
952	Kinesiotherapy

VALID MODIFIERS FOR HOSPITAL OUTPATIENT SERVICES

Modifier	Description
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.
50	Bilateral procedure
52	Reduced services
58	Staged or related procedure or service by the same physician during the postoperative period
59	Distinct procedural service
73	Discontinued outpatient hospital/ambulatory surgery center procedure prior to the administration on anesthesia
74	Discontinued outpatient hospital/ambulatory surgery center procedure after the administration on anesthesia
76	Repeat procedure or service by same physician
77	Repeat procedure by another physician
78	Unplanned return to the operating/procedure room by the same physician following initial procedures for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician during the postoperative period
91	Repeat clinical diagnostic laboratory test
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
E1	Upper left, eyelid
E2	Lower left, eyelid

E3	Upper right, eyelid
E4	Lower right, eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
GN	OP speech language service
GO	OP occupational therapy service
GP	OP physical therapy services
LC	Left circumflex coronary artery
LD	Left descending coronary artery
LT	Left side
RC	Right coronary artery
RT	Right side
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit