FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
30110	Excision, nasal polyp(s), simple	00	00	20	4/1/1989	$45.00	
30110	Excision, nasal polyp(s), simple	00	00	40	4/1/1989	$23.50	
30115	Excision, nasal polyp(s), extensive	00	00	20	4/1/1989	$169.00	
30115	Excision, nasal polyp(s), extensive	00	00	40	4/1/1989	$55.00	
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)	00	00	25	1/1/1998	$166.00	
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)	00	00	40	1/1/1998	$147.50	
36000	Introduction of needle or intracatheter, vein	00	00	25	7/1/1998	$38.50	
36000	Introduction of needle or intracatheter, vein	00	00	40	7/1/1998	$19.50	
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	00	00	54	4/1/1989	$37.50	
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	00	00	57	4/1/1989	$15.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	00	00	RD	4/1/1989	$22.50	
71010	Radiologic examination, chest; single view, frontal	00	00	54	4/1/1989	$19.00	
71010	Radiologic examination, chest; single view, frontal	00	00	57	4/1/1989	$7.50	
71010	Radiologic examination, chest; single view, frontal	00	00	RD	4/1/1989	$11.50	
71020	Radiologic examination, chest, 2 views, frontal and lateral;	00	00	54	4/1/1989	$30.00	
71020	Radiologic examination, chest, 2 views, frontal and lateral;	00	00	57	4/1/1989	$15.00	
71020	Radiologic examination, chest, 2 views, frontal and lateral;	00	00	RD	4/1/1989	$15.00	
71030	Radiologic examination, chest, complete, minimum of 4 views;	00	00	54	4/1/1989	$37.50	
71030	Radiologic examination, chest, complete, minimum of 4 views;	00	00	57	4/1/1989	$15.00	
71030	Radiologic examination, chest, complete, minimum of 4 views;	00	00	RD	4/1/1989	$22.50	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	00	00	54	4/1/1989	$65.00	
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	00	00	57	4/1/1989	$26.00	
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	00	00	RD	4/1/1989	$39.00	
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	00	00	54	7/1/1999	$96.50	
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	00	00	57	7/1/1999	$39.00	
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	00	00	RD	7/1/1999	$57.50	
80049	BASIC MATEBOLIC PANEL WHICH INCLUDES CARBON DIOXIDE (82374); CHLORIDE (82435); CREATININE (82565); GLUCOSE (82947); POTASSIUM (84132); SODIUM (84295); UREA NITROGEN (BUN) (84520).	00	00	86	7/1/1999	$8.00	
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374) Chloride (82435) Potassium (84132) Sodium (84295)	00	00	86	7/1/1999	$7.00	
80054	COMP METABOLIC PANEL WHICH INCL ALBU(82040); BILIRU, TOTAL OR DIRECT(82250); CALC(82310); CHLOR(82435); CREAT(82565); GLUC(82947); PHOS, ALKALINE(84075); POTASS(84132); PROT, TOTAL(84155); SODIUM(84295); TRANSFERASE, ASPARTATE AMINO(AST)(SGOT)(84450); UREA NITRO (BUN)(84520)	00	00	86	7/1/1999	$8.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
80058	HEPATIC FUNCTION PANEL WHICH INCLUDES: ALBUMIN (82040); BILIRUBIN, TOTAL AND DIRECT (82251); PHOSPHATASE, ALKALINE (84075); TRANSFERASE, ALANINE AMINO (ALT) (SGPT) (84460); TRANSFERASE, ASPARTATE AMINO (AST) (SGOT) (84450).	00	00	86	7/1/1999	$8.00	
80059	HEPATITIS PANEL WHICH INCLUDES: HEPATITIS B SURFACE ANTIGEN (HBSAG) (87340); HEPATITIS B SURFACE ANTIBODY (HBSAB) (86706); HEPATITIS B CORE ANTIBODY (HBCAB), IGG AND IGM (86704); HEPATITIS A ANTIBODY (HAAB), IGG AND IGM (86708); HEPATITIS C ANTIBODY (86803).	00	00	86	7/1/1999	$41.00	
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)	00	00	86	7/1/1999	$14.00	
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)	00	00	86	1/1/1998	$14.00	
80170	Gentamicin	00	00	86	1/1/1998	$12.00	
80178	Lithium	00	00	86	1/1/1998	$8.00	
80198	Theophylline	00	00	86	1/1/1998	$11.00	
80299	Quantitation of drug, not elsewhere specified	00	00	86	7/1/1999	$4.50	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
81000	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	00	00	86	1/1/1998	$4.37	
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy	00	00	86	1/1/1998	$3.10	
82150	Amylase	00	00	86	4/1/1989	$5.00	
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)	00	00	86	1/1/1998	$3.47	
82550	Creatine kinase (CK), (CPK); total	00	00	86	7/1/1999	$7.19	
82575	Creatinine; clearance	00	00	86	4/1/1989	$10.00	
82803	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation);	00	00	86	1/1/1998	$26.74	
82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)	00	00	86	1/1/1998	$12.50	
82952	Glucose; tolerance test, each additional beyond 3 specimens	00	00	86	1/1/1998	$3.27	6 SPECIMENS

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
82977	Glutamyltransferase, gamma (GGT)	00	00	86	7/1/1999	$9.70	
83020	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)	00	00	86	4/1/1989	$11.00	
83491	Hydroxycorticosteroids, 17- (17-OHCS)	00	00	86	1/1/1998	$7.00	
83540	Iron	00	00	86	7/1/1999	$8.45	
83550	Iron binding capacity	00	00	86	4/1/1989	$5.00	
83586	Ketosteroids, 17- (17-KS); total	00	00	86	1/1/1998	$17.69	
83655	Lead	00	00	86	4/1/1989	$10.00	
83690	Lipase	00	00	86	4/1/1989	$5.00	
83715	LIPOPROTEIN,BLOOD;ELECTROPHORETIC SEPARATION AND QUANTITATION	00	00	86	4/1/1989	$10.00	
83986	pH, body fluid, except blood	00	00	86	1/1/1998	$2.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
84165	Protein; electrophoretic fractionation and quantitation, serum	00	00	86	1/1/1998	$14.87	
84436	Thyroxine; total	00	00	86	1/1/1998	$9.50	
84446	Tocopherol alpha (Vitamin E)	00	00	86	1/1/1998	$10.00	
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)	00	00	86	1/1/1998	$8.95	
84490	Trypsin; feces, quantitative, 24-hour collection	00	00	86	1/1/1998	$10.52	
85002	Bleeding time	00	00	86	1/1/1998	$5.00	
85013	Blood count; spun microhematocrit	00	00	86	1/1/1998	$3.27	
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	00	00	86	1/1/1998	$6.00	
85044	Blood count; reticulocyte, manual	00	00	86	1/1/1998	$4.00	
85097	Bone marrow, smear interpretation	00	00	89	1/1/1998	$19.20	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
85345	Coagulation time; Lee and White	00	00	86	4/1/1989	$4.00	
85590	PLATELET;MANUAL COUNT	00	00	86	1/1/1998	$3.00	
85610	Prothrombin time;	00	00	86	4/1/1989	$4.00	
85651	Sedimentation rate, erythrocyte; non-automated	00	00	86	1/1/1998	$3.00	
85730	Thromboplastin time, partial (PTT); plasma or whole blood	00	00	86	4/1/1989	$7.50	
86038	Antinuclear antibodies (ANA);	00	00	86	1/1/1998	$15.00	
86039	Antinuclear antibodies (ANA); titer	00	00	86	1/1/1998	$15.00	
86060	Antistreptolysin 0; titer	00	00	86	4/1/1989	$7.00	
86140	C-reactive protein;	00	00	86	4/1/1989	$3.00	
86308	Heterophile antibodies; screening	00	00	86	1/1/1998	$7.15	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
86329	Immunodiffusion; not elsewhere specified	00	00	86	1/1/1998	$17.00	
86430	Rheumatoid factor; qualitative	00	00	86	1/1/1998	$7.00	
86431	Rheumatoid factor; quantitative	00	00	86	1/1/1998	$7.73	
86631	Antibody; Chlamydia	00	00	86	1/1/1998	$11.44	
86762	Antibody; rubella	00	00	86	1/1/1998	$19.83	
86777	Antibody; Toxoplasma	00	00	86	1/1/1998	$19.83	
86781	Antibody; Treponema pallidum, confirmatory test (eg, FTA-abs)	00	00	86	1/1/1998	$18.30	
86790	Antibody; virus, not elsewhere specified	00	00	00	7/1/1999	$9.15	
86850	Antibody screen, RBC, each serum technique	00	00	86	1/1/1998	$8.45	
86880	Antihuman globulin test (Coombs test); direct, each antiserum	00	00	86	1/1/1998	$7.43	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
86885	Antihuman globulin test (Coombs test); indirect, qualitative, each reagent red cell	00	00	86	1/1/1998	$7.90	
86900	Blood typing; ABO	00	00	86	1/1/1998	$4.12	
86901	Blood typing; Rh (D)	00	00	86	1/1/1998	$6.05	
87015	Concentration (any type), for infectious agents	00	00	86	4/1/1989	$7.50	
87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)	00	00	86	1/1/1998	$14.00	
87060	CULTURE, BACTERIAL, DEFINITIVE;THROAT OR NOSE	00	00	86	1/1/1998	$6.90	
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates	00	00	86	1/1/1998	$6.90	
87164	Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection	00	00	86	1/1/1998	$8.00	
87166	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection	00	00	86	1/1/1998	$8.00	
87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)	00	00	86	1/1/1998	$6.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	00	00	86	1/1/1998	$4.50	
87210	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)	00	00	86	1/1/1998	$5.90	
87340	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)	00	00	86	7/1/1999	$14.27	
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision	00	00	86	1/1/1998	$6.20	
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologi	00	00	86	4/1/1989	$23.00	
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologi	00	00	89	4/1/1989	$16.50	
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologi	00	00	LT	4/1/1989	$6.50	
89050	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood;	00	00	86	4/1/1989	$4.50	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
89310	Semen analysis; motility and count (not including Huhner test)	00	00	86	1/1/1998	$5.50	
89360	SWEAT COLLECTION BY IONTOPHORESIS	00	00	86	4/1/1989	$10.00	
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	00	00	80	4/1/1989	$21.50	
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	00	00	AY	4/1/1989	$7.50	
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	00	00	80	4/1/1989	$15.00	
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	00	00	AY	4/1/1989	$6.00	
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	00	00	AZ	4/1/1989	$9.00	
94150	Vital capacity, total (separate procedure)	00	00	80	1/1/1998	$4.00	
94150	Vital capacity, total (separate procedure)	00	00	AY	1/1/1998	$1.60	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
94150	Vital capacity, total (separate procedure)	00	00	AZ	1/1/1998	$2.40	
94200	Maximum breathing capacity, maximal voluntary ventilation	00	00	80	1/1/1998	$9.00	
94200	Maximum breathing capacity, maximal voluntary ventilation	00	00	AY	1/1/1998	$3.60	
94200	Maximum breathing capacity, maximal voluntary ventilation	00	00	AZ	1/1/1998	$5.40	
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	00	00	00	7/1/1998	$20.00	
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	00	00	80	1/1/1998	$5.00	
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling	00	00	60	1/1/1998	$20.00	
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of	00	00	60	1/1/1998	$42.00	
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or o	00	00	60	1/1/1998	$17.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers	00	00	90	1/1/1998	$30.00	
99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies	00	00	90	1/1/1998	$30.00	
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers	00	00	90	1/1/1998	$49.00	
99272	CONFIRM CONSULT FOR NEW OR ESTAB PT. PROBLEM OF LOW SEVERITY	00	00	90	1/1/1998	$30.00	
99274	CONFIRMATORY CONSULT FOR PT. PROBLEM OF MODERATE TO HIGH SEVERITY	00	00	90	1/1/1998	$49.00	
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensi	00	00	60	1/1/1998	$50.00	
A4615	Cannula, nasal	00	00	AE	1/1/1998	$5.00	
A4620	Variable concentration mask	00	00	AE	1/1/1998	$5.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
ADJ	ADJUSTMENT FOR PRIOR CLAIM (FOR DEPT OF HEALTH USE ONLY)	00	00	00	4/1/1989	$1,000.00	
DRG	INPATIENT HOSPITAL COSTS (FOR DEPT OF HEALTH USE ONLY)	00	00	00	10/1/1997	50,000.00	
E0416	OXYGEN REFILL FOR PORTABLE GASEOUS SYSTEM ONLY, (UP TO 23 CUBIC FEET)	00	00	9P	7/1/1998	$15.00	
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	00	00	9R	1/1/1998	$65.52	MONTHLY RENTAL FEE
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing	00	00	9R	1/1/1998	$65.52	MONTHLY RENTAL FEE
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	00	00	9P	7/1/1998	$50.00	
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	00	00	9R	7/1/1998	$24.00	
E0443	Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), 1 month's supply = 1 unit	00	00	9P	7/1/1998	$24.62	
E0444	Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), 1 month's supply = 1 unit	00	00	9P	1/1/1998	$24.62	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
E0480	Percussor, electric or pneumatic, home model	00	00	9P	1/1/1998	$265.00	
E0480	Percussor, electric or pneumatic, home model	00	00	9R	1/1/1998	$55.90	MONTHLY RENTAL FEE
E0500	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	00	00	9P	1/1/1998	$575.00	
E0500	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	00	00	9R	1/1/1998	$75.00	MONTHLY RENTAL FEE
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	00	00	9P	7/1/1998	$42.50	
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	00	00	9R	7/1/1998	$15.00	MONTHLY RENTAL FEE
E0570	Nebulizer, with compressor	00	00	9P	11/1/2002	$202.83	
E0570	Nebulizer, with compressor	00	00	9R	11/1/2002	$18.82	MONTHLY RENTAL FEE
E0575	Nebulizer, ultrasonic, large volume	00	00	9P	1/1/1998	$625.00	
E0575	Nebulizer, ultrasonic, large volume	00	00	9R	1/1/1998	$70.00	MONTHLY RENTAL FEE

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
E0600	Respiratory suction pump, home model, portable or stationary, electric	00	00	9P	1/1/1998	$212.00	
E0600	Respiratory suction pump, home model, portable or stationary, electric	00	00	9R	1/1/1998	$50.00	MONTHLY RENTAL FEE
E0605	Vaporizer, room type	00	00	9P	1/1/1998	$12.00	
E0608	APNEA MONITOR	00	00	9R	1/1/1998	$200.00	MONTHLY RENTAL FEE
E1353	Regulator	00	00	9R	7/1/1998	$33.00	MONTHLY RENTAL FEE
E1400	OXYGEN CONCENTRATOR,FLOW RATE NOT TO EXCEED 2 LITERS PER MIN,85% GDT CONC	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE
E1401	OXYGEN CONCENTRATOR,FLO >2 LITERS PER MIN, NOT EXCE 3 LITERS, 85% GRTER CONC	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE
E1402	OXYGEN CONCENTRATOR,FLOW RATE >3 LITERS PER MINUTE,NOT EXC 4 LITERS 85%/GREATER	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE
E1403	OXYGEN CONCENTRATOR,MAX FLOW RATE >4 LTSPER MIN,NOT EXCEED 5, 85% >CONCENTRATION	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE
E1404	OXYGEN CONCENTRATOR,MAX FLOW RATE >5 LITERS PER MIN,85% OR GREATER CONSETRAT	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
J1550	Injection, gamma globulin, intramuscular, 10 cc	00	00	00	7/1/1998	$53.00	
K0180	AEROSOL MASK, USED W/DME NEBULIZER	00	00	9P	7/1/1998	$1.45	
K0269	AEROSOL COMPRESSOR, ADJUSTABLE PRESSURE, LIGHT DUTY FOR INTERMITTENT USE	00	00	9P	7/1/1998	$160.00	
K0269	AEROSOL COMPRESSOR, ADJUSTABLE PRESSURE, LIGHT DUTY FOR INTERMITTENT USE	00	00	9R	7/1/1998	$40.00	MONTHLY RENTAL FEE
SN257	ALL VITAMINS MUST BE LISTED IN RED BOOK & DIRECTLY RELATED TO THE SPEC COND FOR WHICH THE INDIV IS ENROLLED TO REC SERVICES	00	00	00	1/1/1998	$1,000.00	REIMBURSED AT AWP-10%; NO DISP FEE
SN701	ALL PRESCR DRUGS MUST BE LISTED IN THE CURR ISSUE OF THE PHAR FUNDAM REF (RED BOOK); DRUGS MUST BE DIRECTLY RELATED TO SPECIFIC CONDITION FOR WHICH THE INDIV IS ENROLLED TO RECEIVE SVCS; GENERIC SUBSTITUTIONS ARE PERMITTED	00	00	00	7/1/1998	$3,000.00	APPROVED DRUG FORMULARY REIMBURSED AT AWP-10%+$3.50 DISP FEE FOLLOWS THIS SECTION
SN722	NUTRITIONAL SUPPLEMENTS (ENTERAL); MUST BE DIRECTLY RELATED TO THE SPECIFIC CONDITION FOR WHICH THE INDIV IS ENROLLED TO RECEIVE SERVICES	00	00	00	1/1/1998	$800.00	MAX FEE/MONTH; APPROVED FORMULARY FOLLOWS THIS SECTION; REIMBURSED AT AWP-10%+$3.50 DISP FEE
SN723	NUTRITIONAL SUPPLEMENTS (ORAL);MUST BE DIRECTLY RELATED TO SPECIFIC COND FOR WHICH THE INDIV IS ENROLLED TO RECEIVE SVCS; MED JUSTIFICATION, INCL DOSAGE & QUAN, SIGNED & DATED BY PRESCR PHYSICIAN MUST ACCOMPANY INV	00	00	00	1/1/1998	$100.00	MAX FEE/MONTH; APPROVED FORMULARY FOLLOWS THIS SECTION; REIMBURSED AT AWP-10%, NO DISP FEE

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
SN730	HOME IV THERAPY, ONE MEDICATION FROM DRUG FORMULARY REIMBURSED AT AWP-10%+$3.50 DISP FEE; INVOICE MUST INCL MEDICATIONS, SUPPLIES, START AND END DATE OF THERAPY	00	00	00	1/1/1998	$250.00	MAX FEE/DAY
SN731	HOME IV THERAPY, TWO MEDICATIONS FROM DRUG FORMULARY REIMBURSED AT AWP-10%+$3.50 DISP FEE; INVOICE MUST INCL MEDICATIONS, SUPPLIES, START AND END DATE OF THERAPY	00	00	00	1/1/1998	$350.00	MAX FEE/DAY
SN732	HOME IV THERAPY, THREE OR MORE MEDICATIONS FROM DRUG FORMULARY REIMBURSED AT AWP-10%+$3.50 DISP FEE; INVOICE MUST INCL MEDICATIONS, SUPPLIES, START & END DATE OF THERAPY	00	00	00	1/1/1998	$450.00	MAX FEE/DAY
W9416	PEAK EXPIRATORY FLOW RATE (PERF)	00	00	80	7/1/1998	$9.70	
W9416	PEAK EXPIRATORY FLOW RATE (PERF)	00	00	AY	7/1/1998	$3.88	
W9416	PEAK EXPIRATORY FLOW RATE (PERF)	00	00	AZ	7/1/1998	$5.82	
Z0404	OXYGEN 87 TO 128 CUBIC FEET	00	00	9P	7/1/1998	$20.00	
Z0405	OXYGEN 129 TO 150 CUBIC FEET	00	00	9P	7/1/1998	$20.00	
Z0406	OXYGEN 151 TO 250 CUBIC FEET	00	00	9P	7/1/1998	$27.50	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
Z0407	OXYGEN 251 TO 281 CUBIC FEET	00	00	9P	7/1/1998	$30.00	
30110	Excision, nasal polyp(s), simple	00	00	20	4/1/1989	$45.00	
30110	Excision, nasal polyp(s), simple	00	00	40	4/1/1989	$23.50	
30115	Excision, nasal polyp(s), extensive	00	00	20	4/1/1989	$169.00	
30115	Excision, nasal polyp(s), extensive	00	00	40	4/1/1989	$55.00	
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)	00	00	25	1/1/1998	$166.00	
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)	00	00	40	1/1/1998	$147.50	
36000	Introduction of needle or intracatheter, vein	00	00	25	7/1/1998	$38.50	
36000	Introduction of needle or intracatheter, vein	00	00	40	7/1/1998	$19.50	
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	00	00	54	4/1/1989	$37.50	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	00	00	57	4/1/1989	$15.00	
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	00	00	RD	4/1/1989	$22.50	
71010	Radiologic examination, chest; single view, frontal	00	00	54	4/1/1989	$19.00	
71010	Radiologic examination, chest; single view, frontal	00	00	57	4/1/1989	$7.50	
71010	Radiologic examination, chest; single view, frontal	00	00	RD	4/1/1989	$11.50	
71020	Radiologic examination, chest, 2 views, frontal and lateral;	00	00	54	4/1/1989	$30.00	
71020	Radiologic examination, chest, 2 views, frontal and lateral;	00	00	57	4/1/1989	$15.00	
71020	Radiologic examination, chest, 2 views, frontal and lateral;	00	00	RD	4/1/1989	$15.00	
71030	Radiologic examination, chest, complete, minimum of 4 views;	00	00	54	4/1/1989	$37.50	
71030	Radiologic examination, chest, complete, minimum of 4 views;	00	00	57	4/1/1989	$15.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
71030	Radiologic examination, chest, complete, minimum of 4 views;	00	00	RD	4/1/1989	$22.50	
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	00	00	54	4/1/1989	$65.00	
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	00	00	57	4/1/1989	$26.00	
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	00	00	RD	4/1/1989	$39.00	
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	00	00	54	7/1/1999	$96.50	
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	00	00	57	7/1/1999	$39.00	
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	00	00	RD	7/1/1999	$57.50	
80049	BASIC MATEBOLIC PANEL WHICH INCLUDES CARBON DIOXIDE (82374); CHLORIDE (82435); CREATININE (82565); GLUCOSE (82947); POTASSIUM (84132); SODIUM (84295); UREA NITROGEN (BUN) (84520).	00	00	86	7/1/1999	$8.00	
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374) Chloride (82435) Potassium (84132) Sodium (84295)	00	00	86	7/1/1999	$7.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
80054	COMP METABOLIC PANEL WHICH INCL ALBU(82040); BILIRU, TOTAL OR DIRECT(82250); CALC(82310); CHLOR(82435); CREAT(82565); GLUC(82947); PHOS, ALKALINE(84075); POTASS(84132); PROT, TOTAL(84155); SODIUM(84295); TRANSFERASE, ASPARTATE AMINO(AST)(SGOT)(84450); UREA NITRO (BUN)(84520)	00	00	86	7/1/1999	$8.00	
80058	HEPATIC FUNCTION PANEL WHICH INCLUDES: ALBUMIN (82040); BILIRUBIN, TOTAL AND DIRECT (82251); PHOSPHATASE, ALKALINE (84075); TRANSFERASE, ALANINE AMINO (ALT) (SGPT) (84460); TRANSFERASE, ASPARTATE AMINO (AST) (SGOT) (84450).	00	00	86	7/1/1999	$8.00	
80059	HEPATITIS PANEL WHICH INCLUDES: HEPATITIS B SURFACE ANTIGEN (HBSAG) (87340); HEPATITIS B SURFACE ANTIBODY (HBSAB) (86706); HEPATITIS B CORE ANTIBODY (HBCAB), IGG AND IGM (86704); HEPATITIS A ANTIBODY (HAAB), IGG AND IGM (86708); HEPATITIS C ANTIBODY (86803).	00	00	86	7/1/1999	$41.00	
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)	00	00	86	7/1/1999	$14.00	
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)	00	00	86	1/1/1998	$14.00	
80170	Gentamicin	00	00	86	1/1/1998	$12.00	
80178	Lithium	00	00	86	1/1/1998	$8.00	
80198	Theophylline	00	00	86	1/1/1998	$11.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
80299	Quantitation of drug, not elsewhere specified	00	00	86	7/1/1999	$4.50	
81000	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	00	00	86	1/1/1998	$4.37	
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy	00	00	86	1/1/1998	$3.10	
82150	Amylase	00	00	86	4/1/1989	$5.00	
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)	00	00	86	1/1/1998	$3.47	
82550	Creatine kinase (CK), (CPK); total	00	00	86	7/1/1999	$7.19	
82575	Creatinine; clearance	00	00	86	4/1/1989	$10.00	
82803	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation);	00	00	86	1/1/1998	$26.74	
82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)	00	00	86	1/1/1998	$12.50	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
82952	Glucose; tolerance test, each additional beyond 3 specimens	00	00	86	1/1/1998	$3.27	6 SPECIMENS
82977	Glutamyltransferase, gamma (GGT)	00	00	86	7/1/1999	$9.70	
83020	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)	00	00	86	4/1/1989	$11.00	
83491	Hydroxycorticosteroids, 17- (17-OHCS)	00	00	86	1/1/1998	$7.00	
83540	Iron	00	00	86	7/1/1999	$8.45	
83550	Iron binding capacity	00	00	86	4/1/1989	$5.00	
83586	Ketosteroids, 17- (17-KS); total	00	00	86	1/1/1998	$17.69	
83655	Lead	00	00	86	4/1/1989	$10.00	
83690	Lipase	00	00	86	4/1/1989	$5.00	
83715	LIPOPROTEIN,BLOOD;ELECTROPHORETIC SEPARATION AND QUANTITATION	00	00	86	4/1/1989	$10.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
83986	pH, body fluid, except blood	00	00	86	1/1/1998	$2.00	
84165	Protein; electrophoretic fractionation and quantitation, serum	00	00	86	1/1/1998	$14.87	
84436	Thyroxine; total	00	00	86	1/1/1998	$9.50	
84446	Tocopherol alpha (Vitamin E)	00	00	86	1/1/1998	$10.00	
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)	00	00	86	1/1/1998	$8.95	
84490	Trypsin; feces, quantitative, 24-hour collection	00	00	86	1/1/1998	$10.52	
85002	Bleeding time	00	00	86	1/1/1998	$5.00	
85013	Blood count; spun microhematocrit	00	00	86	1/1/1998	$3.27	
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	00	00	86	1/1/1998	$6.00	
85044	Blood count; reticulocyte, manual	00	00	86	1/1/1998	$4.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
85097	Bone marrow, smear interpretation	00	00	89	1/1/1998	$19.20	
85345	Coagulation time; Lee and White	00	00	86	4/1/1989	$4.00	
85590	PLATELET;MANUAL COUNT	00	00	86	1/1/1998	$3.00	
85610	Prothrombin time;	00	00	86	4/1/1989	$4.00	
85651	Sedimentation rate, erythrocyte; non-automated	00	00	86	1/1/1998	$3.00	
85730	Thromboplastin time, partial (PTT); plasma or whole blood	00	00	86	4/1/1989	$7.50	
86038	Antinuclear antibodies (ANA);	00	00	86	1/1/1998	$15.00	
86039	Antinuclear antibodies (ANA); titer	00	00	86	1/1/1998	$15.00	
86060	Antistreptolysin 0; titer	00	00	86	4/1/1989	$7.00	
86140	C-reactive protein;	00	00	86	4/1/1989	$3.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
86308	Heterophile antibodies; screening	00	00	86	1/1/1998	$7.15	
86329	Immunodiffusion; not elsewhere specified	00	00	86	1/1/1998	$17.00	
86430	Rheumatoid factor; qualitative	00	00	86	1/1/1998	$7.00	
86431	Rheumatoid factor; quantitative	00	00	86	1/1/1998	$7.73	
86631	Antibody; Chlamydia	00	00	86	1/1/1998	$11.44	
86762	Antibody; rubella	00	00	86	1/1/1998	$19.83	
86777	Antibody; Toxoplasma	00	00	86	1/1/1998	$19.83	
86781	Antibody; Treponema pallidum, confirmatory test (eg, FTA-abs)	00	00	86	1/1/1998	$18.30	
86790	Antibody; virus, not elsewhere specified	00	00	00	7/1/1999	$9.15	
86850	Antibody screen, RBC, each serum technique	00	00	86	1/1/1998	$8.45	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
86880	Antihuman globulin test (Coombs test); direct, each antiserum	00	00	86	1/1/1998	$7.43	
86885	Antihuman globulin test (Coombs test); indirect, qualitative, each reagent red cell	00	00	86	1/1/1998	$7.90	
86900	Blood typing; ABO	00	00	86	1/1/1998	$4.12	
86901	Blood typing; Rh (D)	00	00	86	1/1/1998	$6.05	
87015	Concentration (any type), for infectious agents	00	00	86	4/1/1989	$7.50	
87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)	00	00	86	1/1/1998	$14.00	
87060	CULTURE, BACTERIAL, DEFINITIVE;THROAT OR NOSE	00	00	86	1/1/1998	$6.90	
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates	00	00	86	1/1/1998	$6.90	
87164	Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection	00	00	86	1/1/1998	$8.00	
87166	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection	00	00	86	1/1/1998	$8.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)	00	00	86	1/1/1998	$6.00	
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	00	00	86	1/1/1998	$4.50	
87210	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)	00	00	86	1/1/1998	$5.90	
87340	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)	00	00	86	7/1/1999	$14.27	
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision	00	00	86	1/1/1998	$6.20	
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologi	00	00	86	4/1/1989	$23.00	
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologi	00	00	89	4/1/1989	$16.50	
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologi	00	00	LT	4/1/1989	$6.50	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
89050	Cell count, miscellaneous body fluids (eg, cerebrospinal fluid, joint fluid), except blood;	00	00	86	4/1/1989	$4.50	
89310	Semen analysis; motility and count (not including Huhner test)	00	00	86	1/1/1998	$5.50	
89360	SWEAT COLLECTION BY IONTOPHORESIS	00	00	86	4/1/1989	$10.00	
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	00	00	80	4/1/1989	$21.50	
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	00	00	AY	4/1/1989	$7.50	
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	00	00	80	4/1/1989	$15.00	
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	00	00	AY	4/1/1989	$6.00	
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	00	00	AZ	4/1/1989	$9.00	
94150	Vital capacity, total (separate procedure)	00	00	80	1/1/1998	$4.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
94150	Vital capacity, total (separate procedure)	00	00	AY	1/1/1998	$1.60	
94150	Vital capacity, total (separate procedure)	00	00	AZ	1/1/1998	$2.40	
94200	Maximum breathing capacity, maximal voluntary ventilation	00	00	80	1/1/1998	$9.00	
94200	Maximum breathing capacity, maximal voluntary ventilation	00	00	AY	1/1/1998	$3.60	
94200	Maximum breathing capacity, maximal voluntary ventilation	00	00	AZ	1/1/1998	$5.40	
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	00	00	00	7/1/1998	$20.00	
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination	00	00	80	1/1/1998	$5.00	
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling	00	00	60	1/1/1998	$20.00	
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of	00	00	60	1/1/1998	$42.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or o	00	00	60	1/1/1998	$17.00	
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers	00	00	90	1/1/1998	$30.00	
99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies	00	00	90	1/1/1998	$30.00	
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers	00	00	90	1/1/1998	$49.00	
99272	CONFIRM CONSULT FOR NEW OR ESTAB PT. PROBLEM OF LOW SEVERITY	00	00	90	1/1/1998	$30.00	
99274	CONFIRMATORY CONSULT FOR PT. PROBLEM OF MODERATE TO HIGH SEVERITY	00	00	90	1/1/1998	$49.00	
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensi	00	00	60	1/1/1998	$50.00	
A4615	Cannula, nasal	00	00	AE	1/1/1998	$5.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
A4620	Variable concentration mask	00	00	AE	1/1/1998	$5.00	
ADJ	ADJUSTMENT FOR PRIOR CLAIM (FOR DEPT OF HEALTH USE ONLY)	00	00	00	4/1/1989	$1,000.00	
DRG	INPATIENT HOSPITAL COSTS (FOR DEPT OF HEALTH USE ONLY)	00	00	00	10/1/1997	50,000.00	
E0416	OXYGEN REFILL FOR PORTABLE GASEOUS SYSTEM ONLY, (UP TO 23 CUBIC FEET)	00	00	9P	7/1/1998	$15.00	
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	00	00	9R	1/1/1998	$65.52	MONTHLY RENTAL FEE
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing	00	00	9R	1/1/1998	$65.52	MONTHLY RENTAL FEE
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	00	00	9P	7/1/1998	$50.00	
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	00	00	9R	7/1/1998	$24.00	MONTHLY RENTAL FEE
E0443	Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), 1 month's supply = 1 unit	00	00	9P	7/1/1998	$24.62	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
E0444	Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), 1 month's supply = 1 unit	00	00	9P	1/1/1998	$24.62	
E0480	Percussor, electric or pneumatic, home model	00	00	9P	1/1/1998	$265.00	
E0480	Percussor, electric or pneumatic, home model	00	00	9R	1/1/1998	$55.90	MONTHLY RENTAL FEE
E0500	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	00	00	9P	1/1/1998	$575.00	
E0500	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	00	00	9R	1/1/1998	$75.00	MONTHLY RENTAL FEE
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	00	00	9P	7/1/1998	$42.50	
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter	00	00	9R	7/1/1998	$15.00	MONTHLY RENTAL FEE
E0570	Nebulizer, with compressor	00	00	9P	11/1/2002	$202.83	
E0570	Nebulizer, with compressor	00	00	9R	11/1/2002	$18.82	MONTHLY RENTAL FEE
E0575	Nebulizer, ultrasonic, large volume	00	00	9P	1/1/1998	$625.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
E0575	Nebulizer, ultrasonic, large volume	00	00	9R	1/1/1998	$70.00	MONTHLY RENTAL FEE
E0600	Respiratory suction pump, home model, portable or stationary, electric	00	00	9P	1/1/1998	$212.00	
E0600	Respiratory suction pump, home model, portable or stationary, electric	00	00	9R	1/1/1998	$50.00	MONTHLY RENTAL FEE
E0605	Vaporizer, room type	00	00	9P	1/1/1998	$12.00	
E0608	APNEA MONITOR	00	00	9R	1/1/1998	$200.00	MONTHLY RENTAL FEE
E1353	Regulator	00	00	9R	7/1/1998	$33.00	MONTHLY RENTAL FEE
E1400	OXYGEN CONCENTRATOR,FLOW RATE NOT TO EXCEED 2 LITERS PER MIN,85% GDT CONC	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE
E1401	OXYGEN CONCENTRATOR,FLO >2 LITERS PER MIN, NOT EXCE 3 LITERS, 85% GRTER CONC	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE
E1402	OXYGEN CONCENTRATOR,FLOW RATE >3 LITERS PER MINUTE,NOT EXC 4 LITERS 85%/GREATER	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE
E1403	OXYGEN CONCENTRATOR,MAX FLOW RATE >4 LTSPER MIN,NOT EXCEED 5, 85% >CONCENTRATION	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
E1404	OXYGEN CONCENTRATOR,MAX FLOW RATE >5 LITERS PER MIN,85% OR GREATER CONSETRAT	00	00	9R	1/1/1998	$299.15	MONTHLY RENTAL FEE
J1550	Injection, gamma globulin, intramuscular, 10 cc	00	00	00	7/1/1998	$53.00	
K0180	AEROSOL MASK, USED W/DME NEBULIZER	00	00	9P	7/1/1998	$1.45	
K0269	AEROSOL COMPRESSOR, ADJUSTABLE PRESSURE, LIGHT DUTY FOR INTERMITTENT USE	00	00	9P	7/1/1998	$160.00	
K0269	AEROSOL COMPRESSOR, ADJUSTABLE PRESSURE, LIGHT DUTY FOR INTERMITTENT USE	00	00	9R	7/1/1998	$40.00	MONTHLY RENTAL FEE
SN257	ALL VITAMINS MUST BE LISTED IN RED BOOK & DIRECTLY RELATED TO THE SPEC COND FOR WHICH THE INDIV IS ENROLLED TO REC SERVICES	00	00	00	1/1/1998	$1,000.00	REIMBURSED AT AWP-10%; NO DISP FEE
SN701	ALL PRESCR DRUGS MUST BE LISTED IN THE CURR ISSUE OF THE PHAR FUNDAM REF (RED BOOK); DRUGS MUST BE DIRECTLY RELATED TO SPECIFIC CONDITION FOR WHICH THE INDIV IS ENROLLED TO RECEIVE SVCS; GENERIC SUBSTITUTIONS ARE PERMITTED	00	00	00	7/1/1998	$3,000.00	APPROVED DRUG FORMULARY REIMBURSED AT AWP-10%+$3.50 DISP FEE FOLLOWS THIS SECTION
SN722	NUTRITIONAL SUPPLEMENTS (ENTERAL); MUST BE DIRECTLY RELATED TO THE SPECIFIC CONDITION FOR WHICH THE INDIV IS ENROLLED TO RECEIVE SERVICES	00	00	00	1/1/1998	$800.00	MAX FEE/MONTH; APPROVED FORMULARY FOLLOWS THIS SECTION; REIMBURSED AT AWP-10%+$3.50 DISP FEE

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
SN723	NUTRITIONAL SUPPLEMENTS (ORAL);MUST BE DIRECTLY RELATED TO SPECIFIC COND FOR WHICH THE INDIV IS ENROLLED TO RECEIVE SVCS; MED JUSTIFICATION, INCL DOSAGE & QUAN, SIGNED & DATED BY PRESCR PHYSICIAN MUST ACCOMPANY INV	00	00	00	1/1/1998	$100.00	MAX FEE/MONTH; APPROVED FORMULARY FOLLOWS THIS SECTION; REIMBURSED AT AWP-10%, NO DISP FEE
SN730	HOME IV THERAPY, ONE MEDICATION FROM DRUG FORMULARY REIMBURSED AT AWP-10%+$3.50 DISP FEE; INVOICE MUST INCL MEDICATIONS, SUPPLIES, START AND END DATE OF THERAPY	00	00	00	1/1/1998	$250.00	MAX FEE/DAY
SN731	HOME IV THERAPY, TWO MEDICATIONS FROM DRUG FORMULARY REIMBURSED AT AWP-10%+$3.50 DISP FEE; INVOICE MUST INCL MEDICATIONS, SUPPLIES, START AND END DATE OF THERAPY	00	00	00	1/1/1998	$350.00	MAX FEE/DAY
SN732	HOME IV THERAPY, THREE OR MORE MEDICATIONS FROM DRUG FORMULARY REIMBURSED AT AWP-10%+$3.50 DISP FEE; INVOICE MUST INCL MEDICATIONS, SUPPLIES, START & END DATE OF THERAPY	00	00	00	1/1/1998	$450.00	MAX FEE/DAY
W9416	PEAK EXPIRATORY FLOW RATE (PERF)	00	00	80	7/1/1998	$9.70	
W9416	PEAK EXPIRATORY FLOW RATE (PERF)	00	00	AY	7/1/1998	$3.88	
W9416	PEAK EXPIRATORY FLOW RATE (PERF)	00	00	AZ	7/1/1998	$5.82	
Z0404	OXYGEN 87 TO 128 CUBIC FEET	00	00	9P	7/1/1998	$20.00	

FEE SCHEDULES FOR CYSTIC FIBROSIS AND ADULT CYSTIC FIBROSIS PROGRAM

Service Code	Service Description	Provider Type	Service Place	Service Type	Effective Date End Date	Fee	Limit Description
Z0405	OXYGEN 129 TO 150 CUBIC FEET	00	00	9P	7/1/1998	$20.00	
Z0406	OXYGEN 151 TO 250 CUBIC FEET	00	00	9P	7/1/1998	$27.50	
Z0407	OXYGEN 251 TO 281 CUBIC FEET	00	00	9P	7/1/1998	$30.00	
H2000	Comprehensive multidisciplinary evaluation	00	00	00	7/1/2006	$1,300.00	