WHAT'S COVERED

Allowable Procedures for the
North Dakota Colorectal Cancer Screening Initiative
and
Relevant 2021 CPT, HCPCS and APC Codes
and Reimbursement Rates per the January 2022 posting of the
North Dakota Medicare Part B Participating Provider Rates

CODE	RATE	PROCEDURE
		Fecal Tests
81528	$508.87	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
82272	$4.23	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82274	$15.92	Blood, Occult by fecal hemoglobin determination by immunoassay qualitative, feces, 1-3 simultaneous determinations (This code can be used for screening or diagnostic tests. G0328 is specifically for screenings and would be more appropriate for screening only initiatives.)
G0328	$18.05	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous
		Colonoscopy
44388	$410.63	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44389	$536.57	Colonoscopy through stoma; with biopsy, single or multiple
44390	$411.63	Colonoscopy through stoma; with removal of foreign body(s)
44391	$536.57	Colonoscopy through stoma; with control of bleeding, any method
44392	$536.57	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44394	$536.57	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44401	$536.57	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
44402	$3632.43	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
44403	$536.57	Colonoscopy through stoma; with endoscopic mucosal resection
44406	$536.57	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407	$536.57	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound

		examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44408	$410.63	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45378	$410.63	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)
45379	$536.57	Colonoscopy, flexible; with removal of foreign body(s)
45380	$536.57	Colonoscopy, flexible; with biopsy, single or multiple
45381	$536.57	Colonoscopy, flexible; with directed submucosal injections(s), any substance
45382	$536.57	Colonoscopy, flexible; with control of bleeding, any method
45384	$536.57	Colonoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	$536.57	Colonoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45386	$536.57	Colonoscopy, flexible; with transendoscopic balloon dilation
45388	$536.57	Colonoscopy, flexible; with ablation of tumor(s), polyp(s) or other lesion(s) (includes pre- and post- dilation and guidewire passage, when performed)
45389	$3502.31	Colonoscopy, flexible; with endoscopic stent placement (includes pre-and post-dilatation and guidewire passage, when performed)
45390	$1174.91	Colonoscopy, flexible; with endoscopic mucosal resection
45391	$536.57	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transvers, or ascending colon and cecum and adjacent structures
45392	$536.57	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45393	$536.57	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., Volvulus, megacolon), including placement of decompression tube, when performed
45398	$536.57	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
G0105	$410.63	Colorectal cancer screening; colonoscopy on individual at high risk
G0121	$410.63	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
Pathology		
88300	$15.18/unit	Surgical pathology, gross examination only (surgical specimen)
88300-TC	$10.88/unit	Technical Component: Surgical pathology, gross examination only (surgical specimen)
88300-26	$4.30/unit	Professional Component: Surgical pathology, gross examination only (surgical specimen)
88302	$31.79/unit	Surgical pathology, gross and microscopic examination (review level II)
88302-TC	$25.07/unit	Technical Component: Surgical pathology, gross and microscopic examination (review level II)
88302-26	$6.72/unit	Professional Component: Surgical pathology, gross and microscopic examination (review level II)
88304	$41.83/unit	Surgical pathology, gross and microscopic examination (review level III)

88304-TC	$30.60/unit	Technical Component: Surgical pathology, gross and microscopic examination (review level III)
88304-26	$11.22/unit	Professional Component: Surgical pathology, gross and microscopic examination (review level III)
88305	$71.59/unit	Surgical pathology, gross and microscopic examination, colon, colorectal polyp biopsy (review level IV)
88305-TC	$34.41/unit	Technical Component: Surgical pathology, gross and microscopic examination, colon, colorectal polyp biopsy (review level IV)
88305-26	$37.18/unit	Professional Component: Surgical pathology, gross and microscopic examination, colon, colorectal polyp biopsy (review level IV)
88307	$289.12/unit	Surgical pathology, gross and microscopic examination, colon, segmental resection other than for tumor (review level V)
88307-TC	$207.54/unit	Technical Component: Surgical pathology, gross and microscopic examination, colon, segmental resection other than for tumor (review level V)
88307-26	$81.58/unit	Professional Component: Surgical pathology, gross and microscopic examination, colon, segmental resection other than for tumor (review level V)
88309	$439.80/unit	Surgical pathology, gross and microscopic examination, colon, segmental resection for tumor or total resection (review level VI)
88309-TC	$296.13/unit	Technical Component: Surgical pathology, gross and microscopic examination, colon, segmental resection for tumor or total resection (review level VI)
88309-26	$143.67/unit	Professional Component: Surgical pathology, gross and microscopic examination, colon, segmental resection for tumor or total resection (review level VI)
88312	$114.15	Pathology, special stains
88312-TC	$88.05	Technical Component Pathology, special stains
88312-26	$26.10	Professional Component – Pathology, special stains
88341	$89.43/unit	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure) (Use 88341 in conjunction with 88342)
88341-TC	$61.60/unit	Technical Component: Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure) (Use 88341 in conjunction with 88342)
88341-26	$27.83/unit	Professional Component: Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure) (Use 88341 in conjunction with 88342)
88342	$102.04/unit	Pathology: Immunocytochemistry, each antibody
88342 TC	$67.63/unit	Technical Component - Pathology: Immunocytochemistry, each antibody
88342-26	$34.41/unit	Professional Component - Pathology: Immunocytochemistry, each antibody

Office Visits		
Initial, New Patients		
99202	$72.29	New patient; medically appropriate history/exam; straightforward decision making; 15-29 minutes
99203	$110.51	New patient; medically appropriate history/exam; low level decision making; 30-44 minutes

99204	$164.85	New patient; medically appropriate history/exam; moderate level decision making; 45-59 minutes
99205	$217.95	New patient; medically appropriate history/exam; high level decision making; 60-74 minutes (Patients who have chronic conditions, are on high toxicity drugs and require studies to support colonoscopy can be performed may result in a 99205)
99385	$110.51	Initial comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; 18 to 39 years of age (using reimbursement rate same as *Women's Way*)
99386	$110.51	Initial comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; 40 to 65 years of age (using reimbursement rate same as *Women's Way*)
99387	$110.51	Initial comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; 65 years and older (using reimbursement rate same as *Women's Way)*
87426	35.33	COVID-19 infectious agent detection by nuclei acid DNA or RNA: amplified probe technique
87635	51.31	COVID-19 infectious agent antigen detection by immunoassay technique; qualitative or semiquantitative
Established Patients		
99211	$23.34	Evaluation and management, may not require presence of Physician; 5 minutes
99212	$56.07	Problem focused history, exam, straightforward decision-making; 10 minutes
99213	$90.08	Expanded problem focused history, exam, and low complexity medial decision-making; 15 minutes
99214	$127.41	Detailed history, detailed exam and moderate complexity medical decision making; 25 minutes
99215	$178.93	Comprehensive history; comprehensive examination and medical decision making of high complexity; 60 minutes (Patients who have chronic conditions, are on high toxicity drugs and require studies to support colonoscopy can be performed may result in a 99215)
99395	$90.08	Periodic comprehensive preventive medicine evaluation and management; for 18 to 39 years of age (using reimbursement rate same as *Women's Way*)
99396	$90.08	Periodic comprehensive preventive medicine evaluation and management; for 40 to 64 years and older (using reimbursement rate same as *Women's Way*)
99397	$90.08	Periodic comprehensive preventive medicine evaluation and management; same as 99395 but 65 years and older (reimbursement rate same as *Women's Way*)
APC Codes (HOPPS Codes for Hospital Based Out-patient Facilities)		
44388	$810.48	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44389	$1059.06	Colonoscopy through stoma; with biopsy, single or multiple
44390	$810.48	Colonoscopy through stoma; with removal of foreign body(s)
44391	$1059.06	Colonoscopy through stoma; with control of bleeding, any method
44392	$1059.06	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps

44394	$1059.06	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44401	$1059.06	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
44402	$5140.85	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
44403	$1059.06	Colonoscopy through stoma; with endoscopic mucosal resection
44406	$1059.06	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407	$1059.06	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44408	$810.48	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45378	$810.48	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing (separate procedure)
45379	$1059.06	Colonoscopy, flexible; with removal of foreign body(s)
45380	$1059.06	Colonoscopy, flexible; with biopsy, single or multiple
45381	$1059.06	Colonoscopy, flexible; with directed submucosal injections(s), any substance
45382	$1059.06	Colonoscopy, flexible; with control of bleeding, any method
45384	$1059.06	Colonoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	$1059.06	Colonoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique
45386	$1059.06	Colonoscopy, flexible; with transendoscopic balloon dilation
45388	$1059.06	Colonoscopy, flexible; with ablation of tumor(s), polyp(s) or other lesion(s) (includes pre- and post-dilatation and guidewire passage, when performed)
45389	$5140.85	Colonoscopy, flexible; with endoscopic stent placement (includes pre-and post-dilatation and guidewire passage, when performed)
45390	$2495.04	Colonoscopy, flexible; with endoscopic mucosal resection
45391	$1059.06	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transvers, or ascending colon and cecum and adjacent structures
45392	$1059.06	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45393	$1059.06	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., Volvulus, megacolon), including placement of decompression tube, when performed
45398	$1059.06	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
ASC Codes		

44388	$410.63	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44389	$536.57	Colonoscopy through stoma; with biopsy, single or multiple
44390	$410.63	Colonoscopy through stoma; with removal of foreign body(s)
44391	$536.57	Colonoscopy through stoma; with control of bleeding, any method
44392	$536.57	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
44394	$536.57	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
44401	$536.57	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
44402	$3,632.43	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
44403	$536.57	Colonoscopy through stoma; with endoscopic mucosal resection
44406	$536.57	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44407	$536.57	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
44408	$410.63	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45378	$410.63	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	$536.57	Colonoscopy, flexible; with removal of foreign body(s)
45380	$536.57	Colonoscopy, flexible; with biopsy, single or multiple.
45381	$536.57	Colonoscopy, flexible; with directed submucosal injections(s), any substance.
45382	$536.57	Colonoscopy, flexible; with control of bleeding, any method.
45384	$536.57	Colonoscopy, flexible; with removal of tumor(s), polyp(s) or other lesion(s) by hot biopsy forceps or bipolar cautery.
45385	$536.57	Colonoscopy, flexible; with proximal to splenic flexure; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique.
45386	$536.57	Colonoscopy, flexible; with transendoscopic balloon dilatation.
45388	$536.57	Colonoscopy, flexible; with ablation of tumor(s), polyp(s) or other lesion(s) includes pre-and post-dilatation and guide-wire passage.
45389	$3502.31	Colonoscopy, flexible; with endoscopic stent placement (includes pre-and post-dilatation and guidewire passage, when performed).
45390	$524.00	Colonoscopy, flexible; with endoscopic mucosal resection.
45391	$536.57	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transvers, or ascending colon and cecum and adjacent structures.
45392	$536.57	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures.

45393	$536.57	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., Volvulus, megacolon), including placement of decompression tube, when performed.
45398	$536.57	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids).
Anesthesiology		
00811	$20.79/unit	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
00812	$20.79/unit	Anesthesia for lower intestinal endoscopic procedures, endoscopic introduced distal to duodenum; screening colonoscopy
CPT codes 00811-AA through 00811-QZ are allowable anesthesia codes with the relative value per unit of 4. CPT codes 00812-AA through 00812-QZ are allowable anesthesia codes with the relative value per unit of 3. Codes 00811-AA through QZ are calculated using the following formula. One unit of time (15-minute intervals/unit + the relative value of 4 x the conversion factor of CPT codes 00811at $20.79/unit. **Formula: RVU+ unit of time (15 min increment/unit) x Conversion factor** Example: Anesthesia services performed by an anesthesiologist (CPT code 00811-AA). The anesthesia was administered for 30 minutes which is 2 units of time. Example Equation for this scenario is as follows: 2+4 x 20.79 = $124.74 Codes 00812-AA through QZ are calculated using the following formula. One unit of time (15-minute intervals/unit + the relative value of 3 x the conversion factor of CPT codes 00812 at $20.79/unit. **Formula: RVU+ unit of time (15 min increment/unit) x Conversion factor** Example: Anesthesia services performed by an anesthesiologist (CPT code 00812-AA). The anesthesia was administered for 30 minutes which is 2 units of time. Example Equation for this scenario is as follows: 2+3 x 20.79 = $103.95		
See addendum to What's Covered on page 8 of this document for guidance regarding reimbursement for each of the anesthesia modifiers below based on provider type.		
00811-AA	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified, Anesthesia services performed by anesthesiologist
00811-QK	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified, Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
00811-QX	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified, CRNA service with medical direction by a Physician
00811-QY	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified, Anesthesiologist medically directs one CRNA
00811-QZ	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified, CRNA service without medical direction by a physician
00812-AA	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy, Anesthesia services performed by anesthesiologist
00812-QK	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy, Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

00812-QX	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy, CRNA service with medical direction by a Physician
00812-QY	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy, Anesthesiologist medically directs one CRNA
00812-QZ	Use Formula	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy, CRNA service without medical direction by a physician
As of January 1, 2017, the following CPT codes are to be used for moderate sedation. These codes will be reimbursed for colonoscopy procedures by this Initiative at Medicare Part B rates. Additional information regarding coding and billing of moderate sedation using the four codes below is included on page 14 of this document.		
99152	$51.47	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age five years and older.
99153	$10.68	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (list separately in addition to code for primary service).
99156	$73.63	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older.
99157	$60.82	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (list separately in addition to code for primary service).
G0500	$57.40	Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)
J2250	$0.11/mg	Injection, midazolam hydrochloride per 1 mg
J3010	$0.67/0.1mg	Injection, fentanyl citrate per 0.1 mg

The Following CPT Codes Are ONLY Allowed as Part of a Pre-op Physical Prior to Colonoscopy Procedure (if required)		
Electrocardiogram (billable only as pre-op procedure prior to colonoscopy)		
93000	$14.14	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	$6.03	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93010	$8.11	Electrocardiogram, routine ECG with at least 12 leads; tracing only, interpretation and report only
93040	$12.41	Rhythm ECG, one to three leads; with interpretation and report
93041	$5.69	Rhythm ECG, one to three leads; tracing only without interpretation and report
93042	$6.72	Rhythm ECG, one to here leads; interpretation and report only
Blood or other Lab Work (billable only as pre-op procedure prior to colonoscopy)		
80048	$8.46	Basic metabolic panel (Calcium total). This panel must include the following: Calcium (82310) Carbon dioxide (82374) Chloride (82423) Creatinine (82565) Glucose (82947) potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
80053	$10.56	Comprehensive metabolic panel. This panel must include the following; albumin (82040); bilirubin, total (82247); calcium (82310); carbon dioxide (bicarbonate) (82374); chloride (82435); creatinine (82565); glucose (82947); phosphatase, alkaline (84075); potassium (84132); protein, total (84155); sodium (84295); transferase, alanine amino (84460); transferase, aspartate amino (84450); urea nitrogen (84520)
85025	$7.77	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	$6.47	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85610	$4.29	Prothrombin time
85732	$6.47	Thromboplastin time, partial (PTT); plasma or whole blood
36415	$3.00	Venipuncture (allow one per day) (*FFS)
81000	$4.02	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
81001	$3.17	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, with microscopy
81002	$3.48	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
81003	$2.25	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, without microscopy
Chest X-ray (billable only as pre-op procedure prior to colonoscopy		
71046	$34.21	Chest x-ray two views (frontal and lateral)

71046-TC	$23.68	Chest x-ray two views (frontal and lateral)
71046-26	$10.53	Chest x-ray two views (frontal and lateral)
Modifiers (to be reported with appropriate CPT Codes)		
-53	A discontinued procedure due to extenuating circumstances or those that threatens the well-being of the patient. Not to be used to report elective cancellation.	
-73	Discontinued procedure prior to anesthesia	
-74	Discontinued procedure after anesthesia	
-26	Professional Component	
-TC	Technical Component	
-QW	Waived test under CLIA*	
- SG	The modifier indicates that the claim is for the facility fee ONLY.	
Note: A procedure can be split into its "professional" and "technical" components and each can be billed separately as noted; however, a provider cannot bill using both codes. The sum of the two components equals the rate if billed with one code.		
*The CPT codes for this test must have the modifier QW to be recognized as a waived test. These are tests approved by the Food and Drug Administration as waived tests under CLIA.		

- CPT codes and reimbursement rates are updated annually.

Record of Review/Revisions:

Date of Issue	Description of Review or Change	Page(s) Affected	Approved By
3/23/2022	Updated approved CPT code reimbursement amounts for 2022 Added new Cologuard code 81528	All pages Page 1	
3/24/2021	Updated approved CPT code reimbursement amounts for 2021 Removed CPT code 99201 as was no longer valid Added New COVID-19 codes: 87426 and 87635 Added new FOBT code 82272 Added new colonoscopy, ASC, APC codes 44388-44392, 44394, 44401-44403, 44406-44408 Added new anesthesia codes J2250 & J3010	All pages Page 3 Page 1 Pages 1-6 Page 8	
02/11/2020	Updated approved CPT code reimbursement amounts for 2020 Added codes G0328, G0105, G0121, G0500, 99205, 99215	All pages Pages 1-3, 6	
03/11/2019	Updated approved CPT code reimbursement amounts for 2019	All pages	Susan M. Mormann
7/16/2018	Removed CPT code 00810 as was no longer a valid code and replaced with codes 00811 and 00812	Page 4 and 5	Susan M. Mormann
7/16/2018	Updated approved CPT code reimbursement amounts for 2019	All pages	Susan M. Mormann
5/09/2018	Corrected chest x-ray CPT code to the new code for 2018 and it's corresponding reimbursement amount.	Page 6	Susan M. Mormann
3/01/2018	Updated approved CPT code reimbursement amounts for 2018	All pages	Susan M. Mormann
3/16/2017	Added CPT codes 99152, 99153, 99156 and 99157. Added information regarding coding and billing for moderate sedation. Corrected reimbursement amounts for CPT codes 71020-TC and 71020-26	Page 5 Page 10 Page 6	Susan M. Mormann
3/16/2017	Added CPT codes 99152, 99153, 99156 and 99157. Added information regarding coding and billing for moderate sedation. Corrected reimbursement amounts for CPT codes 71020-TC and 71020-26	Page 5 Page 10 Page 6	Susan M. Mormann

07/01/2016	Added 99396 and 99386 Effective back to original date of document (03/03/16)	Page 3	Susan M. Mormann
03/03/2016	Original What's Covered List approved	All	Susan M. Mormann

Acronyms

APC	Ambulatory Payment Classifications
ASC	Ambulatory Surgery Center
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
HCPCS	Healthcare Common Procedure Coding System
HOPPS	Hospital Outpatient Prospective Payment System
MS	Moderate Sedation

NORTH Dakota | Health
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North Dakota Colorectal Cancer Screening Initiative

Addendum to
WHAT'S COVERED
Allowable Procedures for the
North Dakota Colorectal Cancer Screening Initiative

Initiative Billing Details

Provider fee for multiple endoscopy codes per procedure:
The Initiative will follow CMS rules for provider fee billing of multiple endoscopy codes per procedure. Only codes listed on this document from 45378 through 45398 will be considered for reimbursement. Guidelines for billing of codes not within the same family include the following:

- When the same Physician performs more than one surgical service at the same session, the allowed amount is 100 percent of the surgical code listed in this document with the highest reimbursement rate. The allowed amount for the subsequent surgical codes is based on 50 percent of the allowed amount as listed in this document.

Guidelines for billing when the codes are within the same family include the following:

- Identify if the billed codes are the same Endoscopic Base Code (using the Physician Fee Schedule Payment Policy Indicator File).
- Pay the full value, as noted on this document, of the highest value endoscopy (if the same basis is shared), plus the difference between the next highest and the base endoscopy.

Billing APC and ASC codes when multiple codes per procedure occur:

- The Initiative will follow CMS guidelines for billing of APC codes when multiple codes per procedure occur. The CPT code with the highest reimbursement rate will be billed at 100% of the listed reimbursement rate on this document and 50% of the reimbursement rate thereafter for any additional codes.
- The Initiative will follow CMS guidelines for billing of ASC codes when multiple codes per procedure occur. The CPT code with the highest reimbursement rate will be billed at 100% of the listed reimbursement rate on this document and 50% of the reimbursement rate thereafter for any additional codes.

Monitored Anesthesia:

- Use of monitored anesthesia care is considered **not medically necessary** for colonoscopy procedures in patients of average risk related to use of anesthesia and sedation and will not be reimbursed by the Initiative.
- The Initiative will follow CMS guidelines for monitored anesthesia. Monitored anesthesia will be reimbursed by the Initiative only under specific circumstances as noted below:
    - Use of monitored anesthesia care may be considered medically necessary for colonoscopy procedures only when there is documentation by the Proceduralist and Anesthesiologist that one or more of the following specific risk factors or significant medical conditions are present:
        - Prolonged or therapeutic endoscopy procedure requiring deep sedation, or
        - Increased risk for complications due to severe comorbidity (ASA class III or greater), or
        - Morbid obesity (BMI >40), or
        - Documented sleep apnea, or
        - Inability to follow simple commands (cognitive dysfunction, intoxication, or psychological impairment), or

- Spasticity or movement disorder complicating procedure, or
- History of or anticipated intolerance to standard sedatives, such as
  - Chronic opioid use
  - Chronic benzodiazepine use, or
- Patients with active medical problems related to drug or alcohol abuse, or
- Acutely agitated uncooperative patients, or
- Patients with increased risk for airway obstruction due to anatomic variation, such as:
  - History of stridor
  - Dysmorphic facial features
  - Oral abnormalities (e.g., macroglossia)
  - Neck abnormalities (e.g., neck mass)
  - Jaw abnormalities (e.g., micrognathia)

- The QS modifier must be included on the claim when requesting reimbursement for monitored anesthesia.
- Use of monitored anesthesia for patients enrolled in the Initiative will be evaluated, post-procedure, to assess for appropriateness.

Billing of Anesthesia:

- The Initiative will follow CMS reimbursement guidelines for the administration of anesthesia by provider types (Anesthesiologists and CRNAs), associated with colonoscopy procedures. See table below.
- When billing for anesthesia services, the claim must also include the correct modifier, identifying the anesthesia provider type, for the procedure on pages 4 and 5 in the Anesthesiology section of WHAT'S COVERED.

Anesthesia CPT Code and Modifier with Reimbursement Rate for Physicians and CRNAs

Anesthesia Provider and Type of Reimbursement Request	CPT Code and Modifier	Physician Allowed Amount	CRNA/AA Allowed Amount
Anesthesia services personally performed by Anesthesiologist	00811-AA and 00812- AA	100 percent	NA
Medical direction of one of 2, 3, 4 concurrent anesthesia procedures	00811-QK and 00812-QK	50 percent	50 percent
CRNA services with medical direction by a Physician	00811-QX and 00812-QX	50 percent	50 percent
Anesthesiologist medically directs one CRNA	00811-QY and 00812-QY	50 percent	50 percent
CRNA service without medical direction by a Physician	00811-QZ and 00812-QZ	NA	100 percent

Moderate Sedation for Colonoscopies

See page eight of this document for the reimbursement amount and description of the moderate sedation codes used with colonoscopy procedures.
Billing of moderate sedation for colonoscopies has changed effective 01-01-2017.
CPT Code 99152 to be used where the physician or qualified health care professional preforming the colonoscopy is also providing the sedation for the procedure. CPT Code 99153 to be included as an add-on code for each additional 15-minute interval of time providing moderate sedation after the initial 10 to 22 minutes of intraservice time for the procedure. CPT Code 99156 to be used when the

physician or other qualified health care professional other than the physician or other qualified healthcare professional performing the colonoscopy is providing the sedation support. CPT Code 99157 to be included as an add-on code for each additional 15-minute interval of time providing moderated sedation after the initial 10 to 22 minutes of intra-service time for the procedure. See the table below for billing examples.

Moderate Sedation Coding and Billing Guidance

		Physician or other qualified health care professional providing Moderate sedation (MS) is the same person performing the colonoscopy procedure	MS provided by a different physician or qualified health care professional (not the same physician or qualified health care professional who is performing the colonoscopy procedure)
Total intraservice time for moderate sedation	Patient age	Code(s)	Codes(s)
Less than 10 minutes	Any age	Not separately reported	Not separately reported
10-22 minutes	5 years or older	99152 Billing amount = $52.29	99156 Billing Amount = $74.29
23-37 minutes	5 years or older	99152 + 99153 x 1 Billing Amount $52.29+ $10.62 = $62.91	99156 + 99157 x 1 Billing Amount $74.29 + $61.67= $135.96
38 – 52 minutes	5 years or older	99152 + 99153 x 2 Billing Amount $52.29 + $21.24 = $73.53	99156 + 99157 x 2 Billing Amount $74.29 + $123.34 = $197.63
53-67 minutes	5 years or older	99152 + 99153 x 3 Billing Amount $52.29 + $31.86 = $84.15	99156 + 99157 x 3 Billing Amount $74.29 + $185.01= $259.30
68-82 minutes	5 years or older	99152 + 99153 x 4 $52.29 + $42.48 = $94.77	99156 + 99157 x 4 $74.29 + $246.68= $320.97
83 minutes or longer	5 years or older	99152 + 99153 x 5 $52.29 + $53.10 = $105.39	99156 + 99157 x 5 $74.29 + $308.35= $382.64

Supply codes associated with colonoscopy procedures will not be reimbursed with Initiative funds.