CMS RIF REPORT
AS OF: 10/28/2010

NAME	LENGTH	BEG	END	CONTENTS
*** HCPCS Contractor Record - 2011	320	1	320	REC
				2011 Healthcare Common Procedure Coding System (HCPCS) Contractor record description.
				STANDARD ALIAS : HCPCS_CNTRCTR_11_REC SYSTEM ALIAS : HCPCS11C
1. Healthcare Common Procedure Coding System Code	5	1	5	CHAR
				The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into two levels, or groups, as described Below: Level I Codes and descriptors copyrighted by the American Medical Association's current procedural terminology, fourth edition (CPT-4). These are 5 position numeric codes representing physician and non-physician services. **** NOTE: **** CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright. Level II Includes codes and descriptors copyrighted by the American Dental Association's current dental terminology, eighth edition (CDT-2011/12). These are 5 position alpha-numeric codes comprising the d series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel

(consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha- numeric codes representing primarily items and non-physician services that are not represented in the level I codes.

DB2 ALIAS : UNDEFINED
SAS ALIAS : HCPCS_CD
STANDARD ALIAS : HCPCS_CD
TITLE ALIAS : HCPCS_CD

LENGTH : 5

2. HCPCS Code Redefinition Group

5	1	5	GRP

REDEFINE : HCPCS_CD

3. FILLER

3	1	3	CHAR

DB2 ALIAS : FILLER

LENGTH : 3

4. HCPCS Modifier Code

2	4	5	CHAR

A modifier provides the means by which the reporting physician or provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:
> A service or procedure has both a professional and technical component.
> A service or procedure was performed by more than one physician and/or in more than one location.
> A service or procedure has been increased or reduced.
> Only part of a service was performed.
> An adjunctive service was performed.

> A bilateral procedure was performed.
> A service or procedure was provided more than once.
> Unusual events occurred.

HCPCS modifier codes are divided into two levels, or groups, as described below:

Level I
Codes and descriptors copyrighted by the American Medical Association's current procedural terminology, fourth edition (CPT-4). These are 2 position numeric codes.

**** NOTE: ****
CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright.

Level II
Codes and descriptors approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 2 position alpha-numeric codes.

DB2 ALIAS : UNDEFINED
SAS ALIAS : MDFR
STANDARD ALIAS : HCPCS_MDFR_CD

LENGTH : 2

SOURCE : CMS

5. HCPCS Sequence Number

5 6 10 NUM

Sequence number by 100s. Used to group procedure or modifier codes together.

DB2 ALIAS : UNDEFINED
STANDARD ALIAS : HCPCS_SQNC_NUM

LENGTH : 5 SIGNED : N

6. HCPCS Record Identification Code

	1	11	11	CHAR

Code to identify record type

DB2 ALIAS : UNDEFINED
SAS ALIAS : RIC
STANDARD ALIAS : HCPCS_REC_IDENT_CD

LENGTH : 1

CODES :
- 3 = First line of procedure record also contains detail information in positions 92-275
- 4 = Second, third, fourth, etc., Description of procedure record. No detail information in positions 92-275
- 7 = First line of modifier record also contains detail information in positions 92-275
- 8 = Second, third, fourth, etc., Description of modifier record. No detail information in positions 92-275

7. HCPCS Long Description

80	12	91	CHAR

Contains all text of procedure or modifier long descriptions.

The AMA owns the copyright on the CPT codes and descriptions; CPT codes and descriptions are not public property and must always be used in compliance with copyright law.

DB2 ALIAS : UNDEFINED
SAS ALIAS : DESC_TXT
STANDARD ALIAS : HCPCS_LONG_DESC_TXT

LENGTH : 80

8. HCPCS Short Description

28	92	119	CHAR

Short descriptive text of procedure or modifier code

(28 characters or less).

The AMA owns the copyright on the CPT codes and descriptions; CPT codes and descriptions are not public property and must always be used in compliance with copyright law.

DB2 ALIAS : UNDEFINED
SAS ALIAS : SHRTDESC
STANDARD ALIAS : HCPCS_SHRT_DESC_TXT
TITLE ALIAS : HCPCS_SHORT_DESC_TEXT

LENGTH : 28

9. HCPCS Pricing Indicator Code

2	120	121	CHAR

Code used to identify the appropriate methodology for developing unique pricing amounts under part B. A procedure may have one to four pricing codes.

DB2 ALIAS : UNDEFINED
SAS ALIAS : PRCNGCD
STANDARD ALIAS : HCPCS_PRCNG_IND_CD

LENGTH : 2

CODES :

00 = Service not separately priced by part B (e.g., services not covered, bundled, used by part a only, etc.)

Physician Fee Schedule And Non-Physician Practitioners

Linked To The Physician Fee Schedule

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11 = Price established using national RVU's
12 = Price established using national anesthesia base units
13 = Price established by carriers (e.g., not otherwise classified, individual determination, carrier discretion)

Clinical Lab Fee Schedule

---

21 = Price subject to national limitation amount

22 = Price established by carriers (e.g.,
gap-fills, carrier established panels)
Durable Medical Equipment, Prosthetics, Orthotics,

Supplies And Surgical Dressings
---
31 = Frequently serviced DME (price
subject to floors and ceilings)
32 = Inexpensive & routinely purchased
DME (price subject to floors and
ceilings)
33 = Oxygen and oxygen equipment (price
subject to floors and ceilings)
34 = DME supplies (price subject to floors
and ceilings)
35 = Surgical dressings (price subject to
floors and ceilings)
36 = Capped rental DME (price subject to
floors and ceilings)
37 = Ostomy, tracheostomy and urological
supplies (price subject to floors and
ceilings)
38 = Orthotics, prosthetics, prosthetic
devices & vision services (price subject
to floors and ceilings)
39 = Parenteral and Enteral Nutrition
45 = Customized DME items
46 = Carrier priced (e.g., not otherwise classified,
individual determination, carrier discretion,
gap-filled amounts)
Other
---
51 = Drugs
52 = Reasonable charge
53 = Statute
54 = Vaccinations
55 = Priced by carriers under clinical psychologist
fee schedule (not applicable as of January 1, 1998)
56 = Priced by carriers under clinical
social worker fee schedule (not applicable as of
January 1, 1998)
57 = Other carrier priced
99 = Value not established

OCCURS MIN: 4 OCCURS MAX: 0

10. HCPCS Multiple Pricing Indicator Code

1	128	128	CHAR

Code used to identify instances where a procedure could be priced under multiple methodologies.

DB2 ALIAS : UNDEFINED
SAS ALIAS : MULTCD
STANDARD ALIAS : HCPCS_MLTPL_PRCNG_IND_CD

LENGTH : 1

CODES :

- 9 = Not applicable as HCPCS not priced separately by part B (pricing indicator is 00) or value is not established (pricing indicator is '99')
- A = Not applicable as HCPCS priced under one methodology
- B = Professional component of HCPCS priced using RVU's, while technical component and global service priced by Medicare part B carriers
- C = Physician interpretation of clinical lab service is priced under physician fee schedule using RVU's, while pricing of lab service is paid under clinical lab fee schedule
- D = Service performed by physician is priced under physician fee schedule using RVU's, while service performed by clinical psychologist is priced under clinical psychologist fee schedule (not applicable as of January 1, 1998)
- E = Service performed by physician is priced under physician fee schedule using RVU's, service performed by clinical psychologist is priced under clinical psychologist's fee schedule and service performed by clinical social worker is priced under clinical social worker fee schedule (not applicable as of January 1, 1998)
- F = Service performed by physician is priced under physician fee schedule by carriers, service performed by clinical psychologist is priced under clinical psychologist's fee schedule and service performed by clinical social worker is priced under clinical social worker fee schedule (not applicable as of January 1, 1998)

G = Clinical lab service priced under reasonable charge when service is submitted on claim with blood products, while service is priced under clinical lab fee schedule when there are no blood products on claim.

11. HCPCS Coverage Issues Manual Reference Section Number

6	129	134	CHAR

Number identifying the reference section of the coverage issues manual.

DB2 ALIAS : UNDEFINED
SAS ALIAS : CIM
STANDARD ALIAS : HCPCS_CIM_RFRNC_SECT_NUM

LENGTH : 6

OCCURS MIN: 3 OCCURS MAX: 0

12. HCPCS Medicare Carriers Manual Reference Section Number

8	147	154	CHAR

Number identifying a section of the Medicare carriers manual.

DB2 ALIAS : UNDEFINED
SAS ALIAS : MCM
STANDARD ALIAS : HCPCS_MCM_RFRNC_SECT_NUM

LENGTH : 8

OCCURS MIN: 3 OCCURS MAX: 0

13. HCPCS Statute Number

10	171	180	CHAR

Number identifying statute reference for coverage or non-coverage of procedure or service.

DB2 ALIAS : UNDEFINED
SAS ALIAS : STATUTE
STANDARD ALIAS : HCPCS_STATUTE_NUM

LENGTH : 10

14. HCPCS Lab Certification Code

3	181	183	CHAR

Code used to classify laboratory procedures according to the specialty certification categories listed by CMS. Any generally certified laboratory (e.g., 100) may perform any of the tests in its subgroups (e.g., 110, 120, etc.).

DB2 ALIAS : UNDEFINED
SAS ALIAS : LABCERT
STANDARD ALIAS : HCPCS_LAB_CRTFCTN_CD

LENGTH : 3

CODES :

- 010 = Histocompatibility testing
- 100 = Microbiology
  - 110 = Bacteriology
  - 115 = Mycobacteriology
  - 120 = Mycology
  - 130 = Parasitology
  - 140 = Virology
  - 150 = Other microbiology
- 200 = Diagnostic immunology
  - 210 = Syphilis serology
  - 220 = General immunology
- 300 = Chemistry
  - 310 = Routine chemistry
  - 320 = Urinalysis
  - 330 = Endocrinology
  - 340 = Toxicology
  - 350 = Other chemistry
- 400 = Hematology
- 500 = Immunohematology
  - 510 = Abo group & RH type
  - 520 = Antibody detection (transfusion)
  - 530 = Antibody detection (nontransfusion)
  - 540 = Antibody identification
  - 550 = Compatibility testing
  - 560 = Other immunohematology
- 600 = Pathology
  - 610 = Histopathology
  - 620 = Oral pathology

630 = Cytology
800 = Radiobioassay
900 = Clinical cytogenetics

OCCURS MIN: 8 OCCURS MAX: 0

15. HCPCS Cross Reference Code

5	205	209	CHAR

An explicit reference crosswalking a deleted code or a code that is not valid for Medicare to a valid current code (or range of codes).

DB2 ALIAS : UNDEFINED
SAS ALIAS : XREF
STANDARD ALIAS : HCPCS_XREF_CD

LENGTH : 5

OCCURS MIN: 5 OCCURS MAX: 0

16. HCPCS Coverage Code

1	230	230	CHAR

A code denoting Medicare coverage status.

DB2 ALIAS : UNDEFINED
SAS ALIAS : CVRG_CD
STANDARD ALIAS : HCPCS_CVRG_CD

LENGTH : 1

CODES :
D = Special coverage instructions apply
I = Not payable by Medicare
M = Non-covered by Medicare
S = Non-covered by Medicare statute
C = Carrier judgment

17. HCPCS ASC Payment Group Code

2	231	232	GRP CHAR

The 'YY' indicator represents that this procedure is approved to be performed in an ambulatory surgical center. You must

access the ASC tables on the mainframe or CMS website to get the dollar amounts. Payment group rates, which are updated annually, (most recently on April 1, 2004), are as follows: Group 1 - $333; Group 2 - $446; Group 3 - $510; Group 4 – $630; Group 5 - $717; Group 6 - $826 ($676 for intraocular lenses IOLS); Group 7 - $995; Group 8 - $973 ($823+$150 for IOLS); Group 9 - $1339. The $150 payment allowance in groups 6 and 8 is for intraocular lenses.

DB2 ALIAS : UNDEFINED
SAS ALIAS : ASCIND
STANDARD ALIAS : HCPCS_ASC_PMT_GRP_CD

LENGTH : 2

EDIT RULES :
CODE: YY
BLANK = Not Approved For ASC

18. HCPCS ASC Payment Group Effective Date

8	233	240	GRP NUM

The date the procedure is assigned to the ASC payment group.

DB2 ALIAS : UNDEFINED
SAS ALIAS : ASCGRP
STANDARD ALIAS : HCPCS_ASC_PMT_GRP_EFCTV_DT
TITLE ALIAS : HCPCS_ASC_PMT_GROUP_EFCTV_DT

LENGTH : 8 SIGNED : N

EDIT RULES :
YYYYMMDD

19. HCPCS MOG Payment Group Code

3	241	243	GRP CHAR

Medicare outpatient groups (MOG) payment group code

DB2 ALIAS : UNDEFINED
SAS ALIAS : MOGGRP
STANDARD ALIAS : HCPCS_MOG_PMT_GRP_CD

LENGTH : 3

COMMENTS :
1St digit indicates the body system
2nd digit is sequential numbering within the body system
3rd digit is the level of intensity where:
'1', '2', '3' or '4' represents levels
for a given group type
'0' and '9' represent single level
for a given group type

CODES :

No MOG applies

000 = No MOG applies

Integumentary

102 = Level II needle biopsy/aspiration
112 = Level II incision and drainage
132 = Level II debridement/destruction
142 = Level II excision/biopsy
143 = Level III excision/biopsy
151 = Level I skin repair
152 = Level II skin repair
153 = Level III skin repair
160 = Incision/excision breast
169 = Breast reconstruction/mastectomy

Musculoskeletal

201 = Level I skull and facial bone procedures
202 = Level II skull and facial bone procedures
211 = Level I hand musculoskeletal procedures
212 = Level II hand musculoskeletal procedures
221 = Level I foot musculoskeletal procedures
222 = Level II foot musculoskeletal procedures
231 = Level I musculoskeletal procedures
232 = Level II musculoskeletal procedures
233 = Level III musculoskeletal procedures
241 = Level I arthroscopy
242 = Level II arthroscopy
260 = Closed treatment fracture finger/toe/trunk
269 = Closed treatment fracture/dislocation/except

finger/toe/trunk
270 = Open/percutaneous treatment fracture or dislocation
279 = Bone/joint manipulation under anesthesia
280 = Bunion procedures
289 = Arthroplasty
290 = Arthroplasty with prosthesis

ENT/Respiratory/Cardiovascular/Lymphatic/Endocrine

302 = Level II ENT procedures
303 = Level III ENT procedures
304 = Level IV ENT procedures
309 = Implantation of cochlear device (ASC rate does not include cost of implant)
310 = Nasal cauterization/packing
319 = Tonsil/adenoid procedures
322 = Level II endoscopy upper airway
323 = Level III endoscopy upper airway
329 = Endoscopy lower airway
330 = Thoracentesis/lavage procedures
350 = Placement transvenous caths/cutdown
359 = Removal/revision, pacemaker/vascular device
360 = Vascular ligation
369 = Vascular repair/fistula construction
370 = Lymph node excisions
379 = Thyroid/lymphadenectomy procedures

Digestive

400 = Esophageal dilation without endoscopy
410 = Esophagoscopy
421 = Level I upper GI endoscopy/intubation
422 = Level II upper GI endoscopy/intubation
429 = Lower GI endoscopy
430 = Anoscopy and diagnostic sigmoidoscopy
439 = Therapeutic proctosigmoidoscopy
440 = Small intestine endoscopy
449 = Percutaneous biliary endoscopic procedures
450 = Endoscopic retrograde cholangio-pancreatography (ERCP)
460 = Hernia/hydrocele procedures
472 = Level II anal/rectal procedures
473 = Level III anal/rectal procedures
480 = Peritoneal and abdominal procedures
490 = Tube procedures

Urinary/Genital

501 = Level I laparoscopy
502 = Level II laparoscopy
509 = Lithotripsy
511 = Level I cystourethroscopy and other genitourinary procedures
512 = Level II cystourethroscopy and other genitourinary procedures
513 = Level III cystourethroscopy and other genitourinary procedures
521 = Level I urethral procedures
522 = Level II urethral procedures
530 = Circumcision
539 = Penile procedures
540 = Insertion of penile prosthesis (ASC rate does include cost of implant)
549 = Testes/epididymis procedures
550 = Prostrate biopsy
562 = Level II female reproductive procedures
563 = Level III female reproductive procedures
570 = Surgical hysteroscopy
579 = D & C
580 = Spontaneous abortion
589 = Therapeutic abortion

Nervous/Eye

602 = Level II nervous system injections
609 = Revision/removal neurological device
610 = Implantation of neurostimulator electrodes (ASC rate does not include cost of implant)
619 = Implantation of neurological devices (ASC rate does not include cost of implant)
621 = Level I nerve procedures
622 = Level II nerve procedures
629 = Spinal tap
639 = Laser eye procedures except retinal
640 = Cataract procedures
649 = Cataract procedures with IOL insert (includes $150 insert)
651 = Level I anterior segment eye procedures
652 = Level II anterior segment eye procedures
659 = Corneal transplant (ASC rate includes price

of transplant)
660 = Posterior segment eye procedures
669 = Strabismus/muscle procedures
673 = Level III eye procedure
674 = Level IV eye procedure
680 = Vitrectomy
689 = Implantation/replacement of intraitreal drug

20. HCPCS MOG Payment Policy Indicator

1	244	244	CHAR

Indicator identifying whether a HCPCS code is subject to payment of an ASC facility fee, to a separate fee under another provision of Medicare, or to no fee at all.

DB2 ALIAS : UNDEFINED
SAS ALIAS : MOGIND
STANDARD ALIAS : HCPCS_MOG_PMT_PLCY_IND_CD

LENGTH : 1

CODES :
1 = ASC covered procedure
2 = Bundled service/no separate payment
3 = Excluded from ASC list
4 = Invalid code/90 day grace period
6 = Separate payment when furnished in an ASC
7 = ASC restricted coverage procedure
9 = ASC payment not applicable

21. HCPCS MOG Effective Date

8	245	252	GRP NUM

The date the procedure is assigned to the Medicare outpatient group (MOG) payment group.

DB2 ALIAS : UNDEFINED
SAS ALIAS : MOGDTE
STANDARD ALIAS : HCPCS_MOG_PMT_GRP_EFCTV_DT

LENGTH : 8 SIGNED : N

EDIT RULES :

22. HCPCS Processing Note Number

4	253	256	CHAR

Number identifying the processing note contained in Appendix A of the HCPCS manual.

DB2 ALIAS : UNDEFINED
SAS ALIAS : PROCNOTE
STANDARD ALIAS : HCPCS_PRCSG_NOTE_NUM

LENGTH : 4

23. HCPCS Berenson-Eggers Type Of Service Code

3	257	259	CHAR

This field is valid beginning with 2003 data.
The Berenson-Eggers Type of Service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services.

DB2 ALIAS : UNDEFINED
SAS ALIAS : BETOS
STANDARD ALIAS : HCPCS_BETOS_CD
TITLE ALIAS : BETOS_CD

LENGTH : 3

CODE TABLE : BETOS_TB

24. FILLER

1	260	260	CHAR

DB2 ALIAS : FILLER

LENGTH : 1

25. HCPCS Type Of Service Code

1	261	261	CHAR

The carrier assigned CMS type of service which describes the particular kind(s) of service represented by the procedure code.

DB2 ALIAS : UNDEFINED

SAS ALIAS : TYPESRVC
STANDARD ALIAS : HCPCS_TYPE_SRVC_CD

LENGTH : 1

CODE TABLE : CMS_TYPE_SRVC_TB

OCCURS MIN: 5 OCCURS MAX: 0

26. HCPCS Anesthesia Base Unit Quantity

3 266 268 NUM

The base unit represents the level of intensity for anesthesia procedure services that reflects all activities except time. These activities include usual preoperative and post-operative visits, the administration of fluids and/or blood incident to anesthesia care, and monitoring procedures. (Note: the payment amount for anesthesia services is based on a calculation using base unit, time units, and the conversion factor.)

DB2 ALIAS : UNDEFINED
SAS ALIAS : BASEUNIT
STANDARD ALIAS : HCPCS_ANSTHSA_BASE_UNIT_QTY
TITLE ALIAS : HCPCS_ANESTHESIA_BASE_UNIT_QTY

LENGTH : 3 SIGNED : N

27. HCPCS Code Added Date

8 269 276 NUM

The year the HCPCS code was added to the Healthcare common procedure coding system.

DB2 ALIAS : HCPCS_CD_ADD_DT
SAS ALIAS : ADD_DT
STANDARD ALIAS : HCPCS_CD_ADD_DT

LENGTH : 8 SIGNED : N

EDIT RULES :
YYYYMMDD

28. HCPCS Action Effective Date

8 277 284 NUM

Effective date of action to a procedure or modifier code

DB2 ALIAS : UNDEFINED
SAS ALIAS : EFCTV_DT
STANDARD ALIAS : HCPCS_ACTN_EFCTV_DT

LENGTH : 8 SIGNED : N

EDIT RULES :
YYYYMMDD

29. HCPCS Termination Date

8 285 292 NUM

Last date for which a procedure or modifier code may be used by Medicare providers.

DB2 ALIAS : UNDEFINED
SAS ALIAS : TERM_DT
STANDARD ALIAS : HCPCS_TRMNTN_DT
TITLE ALIAS : HCPCS_TERMINATION_DT

LENGTH : 8 SIGNED : N

EDIT RULES :
YYYYMMDD

30. HCPCS Action Code

1 293 293 CHAR

A code denoting the change made to a procedure or modifier code within the HCPCS system.

DB2 ALIAS : UNDEFINED
SAS ALIAS : ACTN_CD
STANDARD ALIAS : HCPCS_ACTN_CD

LENGTH : 1

CODES :
A = Add procedure or modifier code
B = Change in both administrative data field

and long description of procedure or
modifier code
C = Change in long description of procedure or
modifier code
D = Discontinue procedure or modifier code
F = Change in administrative data field of
procedure or modifier code
N = No maintenance for this code
P = Payment change (MOG, pricing indicator codes,
anesthesia base units, Ambulatory Surgical Centers)
R = Re-activate discontinued/deleted procedure
or modifier code
S = Change in short description of procedure code
T = Miscellaneous change (BETOS, type of service)

31. FILLER 27 294 320 CHAR

DB2 ALIAS : FILLER

LENGTH : 27

****

H3PM.R_RIF_MAIN_Q,Q1,F
1
TABLE OF CODES APPENDIX HCPCS_CNTRCTR_10_REC
FROM CA REPOSITORY RIF REPORT

BETOS_TB BETOS Table

M1A = Office visits - new
M1B = Office visits - established
M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit
M4B = Nursing home visit
M5A = Specialist - pathology

M5B = Specialist - psychiatry
M5C = Specialist - opthamology
M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterectomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment of retinal lesions
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy
P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy

P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services (medicare fee schedule)
P9B = Dialysis services (non-medicare fee schedule)
I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck
I2B = Advanced imaging - CAT/CT/CTA: other
I2C = Advanced imaging - MRI/MRA: brain/head/neck
I2D = Advanced imaging - MRI/MRA: other
I3A = Echography/ultrasonography - eye
I3B = Echography/ultrasonography - abdomen/pelvis
I3C = Echography/ultrasonography - heart
I3D = Echography/ultrasonography - carotid arteries
I3E = Echography/ultrasonography - prostate, transrectal
I3F = Echography/ultrasonography - other
I4A = Imaging/procedure - heart including cardiac
catheterization
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare
fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)
T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Prosthetic/Orthotic devices
D1G = Drugs Administered through DME
O1A = Ambulance
O1B = Chiropractic

O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Hearing and speech services
O1G = Immunizations/Vaccinations
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

CMS_TYPE_SRVC_TB CMS Type of Service Table

1 = Medical care
2 = Surgery
3 = Consultation
4 = Diagnostic radiology
5 = Diagnostic laboratory
6 = Therapeutic radiology
7 = Anesthesia
8 = Assistant at surgery
9 = Other medical items or services
0 = Whole blood only eff 01/96,
whole blood or packed red cells before 01/96
A = Used durable medical equipment (DME)
B = High risk screening mammography
(obsolete 1/1/98)
C = Low risk screening mammography
(obsolete 1/1/98)
D = Ambulance (eff 04/95)
E = Enteral/parenteral nutrients/supplies
(eff 04/95)
F = Ambulatory surgical center (facility
usage for surgical services)
G = Immunosuppressive drugs
H = Hospice services (discontinued 01/95)
I = Purchase of DME (installment basis)
(discontinued 04/95)
J = Diabetic shoes (eff 04/95)
K = Hearing items and services (eff 04/95)
L = ESRD supplies (eff 04/95)
(renal supplier in the home before 04/95)
M = Monthly capitation payment for dialysis
N = Kidney donor

P = Lump sum purchase of DME, prosthetics,
orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies
(eff 04/95)
T = Psychological therapy (term. 12/31/97)
outpatient mental health limitation (eff. 1/1/98)
U = Occupational therapy
V = Pneumococcal/flu vaccine (eff 01/96),
Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
Pneumococcal only before 04/95
W = Physical therapy
Y = Second opinion on elective surgery
(obsolete 1/97)
Z = Third opinion on elective surgery
(obsolete 1/97)