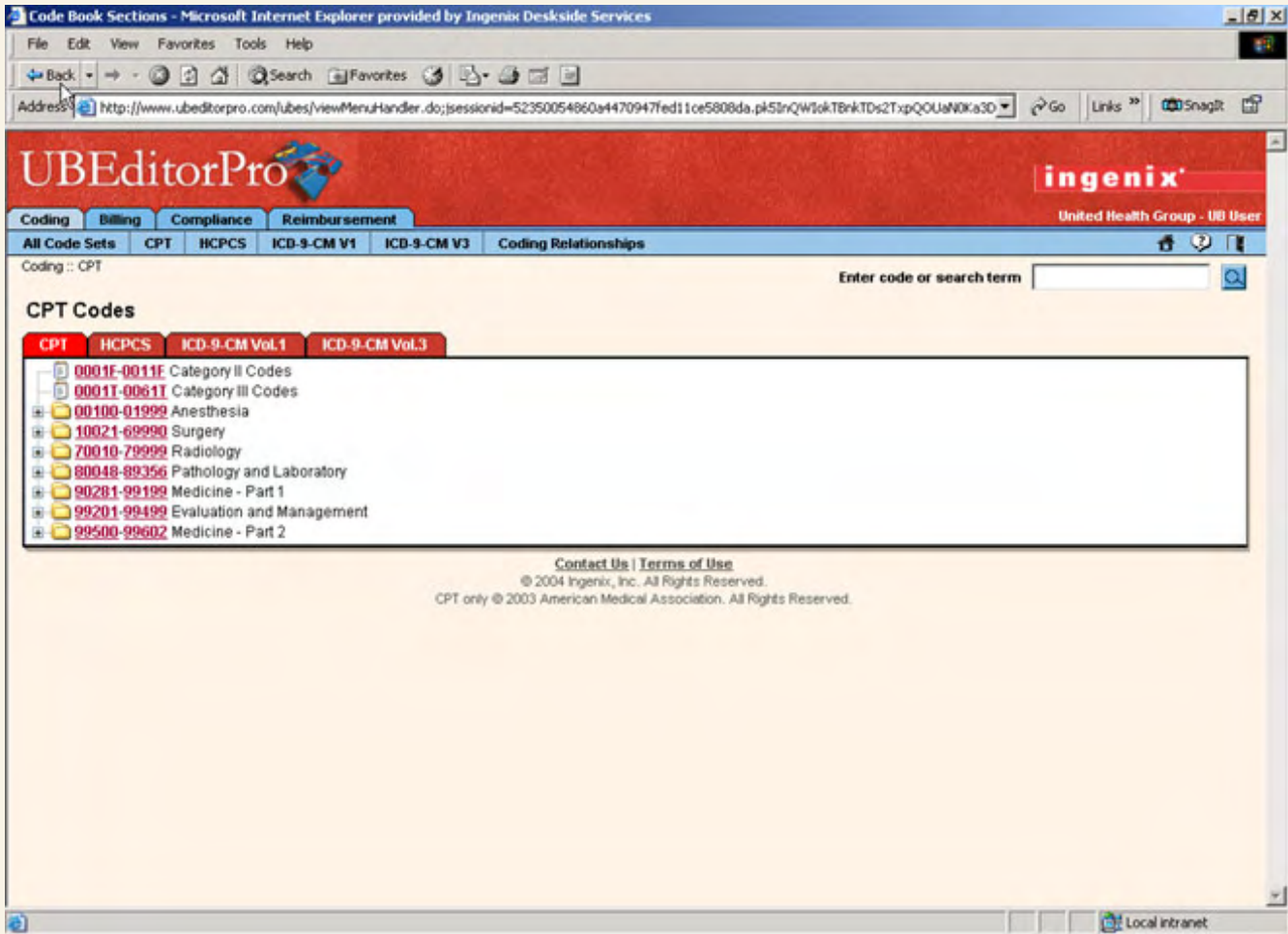


## All Code Sets

This screen shows all codes from which you can do a medical terminology or code search. You can look up codes by entering key search terms or a specific code number. You can specify that the search results display matches for all code sets or a specific code set (e.g. CPT® code set, ICD-9 Vol. 1, ICD-9 Vol. 3, and HCPCS Level II). If you choose to search on all code sets, the search results are presented under the tab that represents the specific code set, for example ICD-9-CM codes, CPT® codes or HCPCS Level II codes.

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## Interventional Radiology Procedure Codes

**Last Feature**

This screen shot provides a listing of all interventional radiology procedure codes. Each of these CPT® codes is linked to the corresponding surgical intervention procedures that may be billed to Medicare in addition to the radiology code.

**Next Feature**

The screenshot shows a web browser window displaying the UBEditorPro interface. The browser address bar shows the URL: [http://www.ubeditorpro.com/ubes/radiologyCodeHandler.do?\\_a=list](http://www.ubeditorpro.com/ubes/radiologyCodeHandler.do?_a=list). The page title is "Interventional Radiology Procedure Codes".

Below the title, there is a text box with the following text:

Interventional radiology procedures are an advance in medicine that replace open surgical procedures. An interventional radiology procedure is one that involves a surgical intervention of the patient that is greater than an injection of simple contrast media.

For proper reimbursement under Medicare, the supervision and interpretation (S&I) codes to describe the imaging component of the procedure, and a surgical procedure code (or codes) to reflect the surgical intervention must be reported on the bill to accurately reflect all aspects of the procedure performed in the hospital setting.

Below this text is a table titled "Interventional Radiology Procedure Codes":

Code	Description
<a href="#">00071</a>	Transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous, radiological supervision and interpretation, each vessel
<a href="#">00381</a>	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection involving coverage of left subclavian artery origin, initial endoprosthesis, radiological supervision and interpretation
<a href="#">00391</a>	Endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection not involving coverage of left subclavian artery origin, initial endoprosthesis, radiological supervision and interpretation
<a href="#">00401</a>	Placement of proximal or distal extension prosthesis for endovascular repair of descending thoracic aortic aneurysm, pseudoaneurysm or dissection, each extension, radiological supervision and interpretation
<a href="#">70010</a>	Myelography, posterior fossa, radiological supervision and interpretation
<a href="#">70015</a>	Cisternography, positive contrast, radiological supervision and interpretation
<a href="#">70170</a>	Dacryocystography, nasolacrimal duct, radiological supervision and interpretation
<a href="#">70332</a>	Temporomandibular joint arthrography, radiological supervision and interpretation

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## Revenue Codes

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This screen shot provides you with an example of the detailed revenue code information. It provides access to revenue codes and descriptions, abbreviations, and other relevant fields that may be necessary for accurate billing. Detailed billing and coding tips are provided for each revenue code. Each FL and clinical code that is referenced in the text is also hot-linked to provide more detailed information about each.

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The screenshot shows the UBEditorPro interface for revenue code 0332. The page is titled "Revenue Code: 0332" and includes a search bar with the text "Enter revenue code or search term". The main content area is divided into several sections:

- Revenue Code: 0332**: A table with columns for "0332 : RADIOLOGY-THERAPEUTIC AND/OR CHEMOTHERAPY ADMINISTRATION", "CHEMOTHER,ORAL", and "Ancillary Services Revenue Codes". The description is "Chemotherapy Administration-Oral" and it is noted as "Required CPT/HCPCS codes".
- Relevant Fields**: A table with two columns, both labeled "FL 44".
- Billing Tips**: A list of tips including:
  - HCPCS codes are required in [FL 44](#), HCPCS/Rates, for this RC with TOB code [\(FL 4\)](#) 13X or 71X.
  - This RC requires a HCPCS code for TOB codes [\(FL 4\)](#) 22X and 23X effective for SNF claims received on or after January 1, 2002, for dates of services on or after April 1, 2001.
  - RC 0636 (drugs requiring detailed coding) or RC 0250 (pharmacy) also must be reported whenever this RC is billed. Check with the FI to determine the appropriate RC to use for reporting J codes.
- Coding Tips**: A list of tips including:
  - In addition to reporting this RC, RC 0636 also must appear on the bill with one or more of the following valid HCPCS Level II J codes, which describe the drugs administered during chemotherapy. (See the Medicare Pub. 100-04, Chap. 25, sec. 60; Federal Register, 2003 OPPS final rule, November 1, 2002): [J8520](#), [J8560](#), [J8700](#). HHAs and SNFs submit the drug charges to the Medicare DMERC, if appropriate. Prior to April 1, 2003, J codes were used to identify the drugs on the claim to the

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## Coverage Policy Search Results

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This screen shot provides an example of the Medicare coverage data that will be accessible by search term or clinical code search. From this view you can access information from the Medicare Coverage Issues Manual (CIM), national coverage decisions, local medical review policies (LMRPs) for the specific fiscal intermediary serving your area, and the coverage data associated with the LMRPs involving medical necessity.

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CIM Number	NCD Title	NCD Section
<a href="#">30-1</a>	ROUTINE COSTS IN CLINICAL TRIALS	310.1
<a href="#">35-1</a>	COLONIC IRRIGATION--NOT COVERED	100.7
<a href="#">35-2</a>	MANIPULATION	150.1
<a href="#">35-3</a>	HEAT TREATMENT, INCLUDING THE USE OF DIATHERMY AND ULTRA-SOUND FOR PULMONARY CONDITIONS--NOT COVERED	240.3
<a href="#">35-4</a>	ULTRASONIC SURGERY	50.8
<a href="#">35-5</a>	CELLULAR THERAPY--NOT COVERED	30.8
<a href="#">35-6</a>	THERMOGENIC THERAPY--NOT COVERED	30.2
<a href="#">35-7</a>	CAROTID BODY RESECTION/CAROTID BODY DENERVATION	20.18
<a href="#">35-8</a>	ACUPUNCTURE--NOT COVERED	30.3
<a href="#">35-9</a>	HYDROPHILIC CONTACT LENS FOR CORNEAL BANDAGE	80.1
<a href="#">35-10</a>	HYPERBARIC OXYGEN THERAPY	20.29
<a href="#">35-11</a>	STERILIZATION	230.3
<a href="#">35-12</a>	PLASTIC SURGERY TO CORRECT "MOON FACE"--NOT COVERED	140.4

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## OCE Edits

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This screen shot depicts detailed information specific to one of 60 OCE edits and provides the claim disposition and tips on what you should do to correct and resolve the claim edit.

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The screenshot shows a web browser window displaying the UBEditorPro interface. The main content area is titled 'Type of Bill OCE Edit' and shows a specific edit: 'TOB 12X or 14X without condition code 41 reported in FLS 24-30'. Below this, there is a table with the following data:

Edit Number	Edit Description	Edit Result/Claim Disposition	Provider Action/Response
1	Invalid diagnosis code	This edit occurs when the first listed diagnosis field is blank or the diagnosis code is not valid for this version of the OCE. Return claim to provider (RTP).	The provider should resubmit the claim once the problem (s) is/are corrected.
2	Diagnosis and age conflict	This edit occurs when the diagnosis code includes an age range, and the age reported is outside the range. Return claim to provider (RTP).	The provider should resubmit the claim once the problem (s) is/are corrected.
3	Diagnosis and sex conflict	This edit occurs when the diagnosis code includes a sex designation and the sex reported for the patient does not match. Return claim to provider (RTP).	The provider should resubmit the claim once the problem (s) is/are corrected.
4	Medicare secondary payer alert (V1.0 and V1.1 only)	This edit occurs when the procedure code reported has an MSP warning indicator associated with it. The claim will be suspended. Not applicable for admitting diagnosis.	A suspended claim is not returned to the provider but will not be processed for payment until the FI makes a determination or obtains further information.
5	E diagnosis code cannot be used as principal diagnosis	This edit occurs when the first diagnosis code reported is an E code. Return claim to provider (RTP). Not applicable for admitting diagnosis.	The provider should resubmit the claim once the problem (s) is/are corrected.
Z	Procedure and age conflict (not activated)	This edit occurs when the procedure code reported has an age range associated with it and the age of the patient is outside that range. Return claim to provider (RTP).	The provider should resubmit the claim once the problem (s) is/are corrected.

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## Outpatient Calculator

This screen shot provides an example of the Medicare fee schedule or APC payment information that will be available for a specific CPT® code or HCPCS Level II code. It provides detailed reimbursement information, payment and copayment amounts (as applicable under APCs) based on the fiscal intermediary, wage index area, OPSI code and reimbursement formula. There are payment views for other code sets and schedules, such as DRG Payment and APC Payment. For information related to the DRG payment, for instance, you would be provided detailed payment information for a specific ICD-9-CM code, which DRGs it groups to, and the payment associated with the DRG, etc.

**Last Feature**

[Click here](#) to return to the **UBEditorPro.com**® product page where you can access more information about this product and view your purchasing options.

Reimbursement :: Outpatient Calculator

Enter APC code or search term

**Outpatient Calculator**

Enter a CPT/HCPCS code and select the preference you would like to use for the calculation.

CPT/HCPCS Code:  Preference:

Reimbursement Information	
Code Description	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours
OPSI Code	S
OPSI Description	Significant Procedure, Not Discounted When Multiple
APC	0209
Relative Weight	11.617
National Pay Rate	\$661.97
National Unadjusted Copay	\$280.58
Minimum Unadjusted Copay	\$132.39
Medicare Fee Schedule Carrier	00903 - 01 DC + MDVA Suburbs
Wage Index	Alexandria City, VA - Urban (1.0904) 2004
Payment Status	Paid under OPPS; Separate APC
Calculation	$[(APC * 60\%) * W] + (APC * 40\%) = \text{full adjusted APC payment}$
Medicare Reimbursement	<b>\$697.88</b>
Patient Adjusted Copay	<b>\$293.11</b>
Comments	APC=APC payment rate, W=wage index specific to the hospital, full payment includes the patient coinsurance

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