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April 21, 2010

Table I-3.(a) 2010 CPT [1] Fee Schedule for Direct Entry Midwife Services

Code	Short Description	Maximum Allowable
36415	ROUTINE VENIPUNCTURE	$3.00
59400	OBSTETRICAL CARE	$2,398.54
59409	OBSTETRICAL CARE	$1,051.80
59410	OBSTETRICAL CARE	$1,225.14
59414	DELIVER PLACENTA	$125.93
59430	CARE AFTER DELIVERY	$185.84
81000	URINALYSIS, NONAUTO W/	$4.54
81002	URINALYSIS NONAUTO W/	$3.66
81003	URINALYSIS, AUTO, W/O S	$3.22
81005	URINALYSIS	$3.10
81015	MICROSCOPIC EXAM OF U	$4.35
81025	URINE PREGNANCY TEST	$9.06
81050	URINALYSIS, VOLUME ME	$4.29
82947	ASSAY, GLUCOSE, BLOOD	$5.62
82948	REAGENT STRIP/BLOOD G	$4.54
82950	GLUCOSE TEST	$6.80
82951	GLUCOSE TOLERANCE TE	$14.53
82952	GTT-ADDED SAMPLES	$5.61
82962	GLUCOSE BLOOD TEST	$2.59
83026	HEMOGLOBIN, COPPER S	$3.38
84030	ASSAY OF BLOOD PKU	$7.88
84702	CHORIONIC GONADOTRO	$21.56
84703	CHORIONIC GONADOTRO	$10.76
85009	MANUAL DIFF WBC COUNT	$5.33
85013	SPUN MICROHEMATOCRIT	$3.39
85014	HEMATOCRIT	$3.39
85018	HEMOGLOBIN	$3.39
85048	AUTOMATED LEUKOCYTE	$3.64
85651	RBC SED RATE, NONAUTO	$5.08

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* = PA Required

** = Medical Justification or Written Report Required

Table I-3.(a) 2010 CPT [1] Fee Schedule for Direct Entry Midwife Services

Code		Short Description	Maximum Allowable
86704		HEP B CORE ANTIBODY, T	$17.26
86705		HEP B CORE ANTIBODY, I	$16.86
86706		HEP B SURFACE ANTIBOD	$15.38
86707		HEP BE ANTIBODY	$16.57
86708		HEP A ANTIBODY, TOTAL	$17.75
86709		HEP A ANTIBODY, IGM	$16.12
86803		HEPATITIS C AB TEST	$20.44
86804		HEP C AB TEST, CONFIRM	$22.19
86880		COOMBS TEST, DIRECT	$7.70
87210		SMEAR, WET MOUNT, SALI	$6.11
88141		CYTOPATH, C/V, INTERPR	$38.69
88142		CYTOPATH, C/V, THIN LAY	$29.02
88152		CYTOPATH, C/V, AUTO RE	$15.13
99050	**	MEDICAL SERVICES AFTE	$24.91
99201		OFFICE/OUTPATIENT VISIT	$53.09
99202		OFFICE/OUTPATIENT VISIT	$93.36
99203		OFFICE/OUTPATIENT VISIT	$136.23
99204		OFFICE/OUTPATIENT VISIT	$214.71
99211		OFFICE/OUTPATIENT VISIT	$25.25
99212		OFFICE/OUTPATIENT VISIT	$53.09
99213		OFFICE/OUTPATIENT VISIT	$92.05
99214		OFFICE/OUTPATIENT VISIT	$138.70
99341		HOME VISIT, NEW PATIEN	$79.76
99342		HOME VISIT, NEW PATIEN	$116.06
99343		HOME VISIT, NEW PATIEN	$190.03
99347		HOME VISIT, EST PATIENT	$78.50
99348		HOME VISIT, EST PATIENT	$119.26
99349		HOME VISIT, EST PATIENT	$175.70
99461		INIT NB EM PER DAY, NON	$142.56

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Table I-3.(b) 2010 HCPC Fee Schedule for Direct Entry Midwife Services

Code	Description	Maximum Allowable
J2210	INJECTION, METHYLERGONOVINE MALEATE, UP TO 0.2 MG	By Report
J2590	INJECTION, OXYTOCIN, UP TO 10 UNITS	By Report
J2700	INJECTION, OXACILLIN SODIUM, UP TO 250 MG	By Report
J2790	INJECTION, RHO D IMMUNE GLOBULIN, HUMAN, FULL DOSE, 300 MICROGRAMS (1500 I.U.)	By Report
J3420	INJECTION, VITAMIN B-12 CYANOCOBALAMIN, UP TO 1000 MCG	By Report
J3430	INJECTION, PHYTONADIONE (VITAMIN K), PER 1 MG	By Report
J7030	INFUSION, NORMAL SALINE SOLUTION , 1000 CC	By Report
J7040	INFUSION, NORMAL SALINE SOLUTION, STERILE (500 ML=1 UNIT)	By Report
J7042	5% DEXTROSE/NORMAL SALINE (500 ML = 1 UNIT)	By Report
J7050	INFUSION, NORMAL SALINE SOLUTION , 250 CC	By Report
J7060	5% DEXTROSE/WATER (500 ML = 1 UNIT)	By Report
J7120	RINGERS LACTATE INFUSION, UP TO 1000 CC	By Report
Q0091	SCREENING PAPANICOLAOU SMEAR; OBTAINING, PREPARING AND CONVEYANCE OF CERVICAL OR VAGINAL SMEAR TO LABORATORY	$53.63
S3620	NEWBORN METABOLIC SCREENING PANEL, INCLUDES TEST KIT, POSTAGE AND THE LABORATORY TESTS SPECIFIED BY THE STATE FOR INCLUSION IN THIS PANEL (E.G. GALACTOSE; HEMOGLOBIN, ELECTROPHORESIS; HYDROXYPROGESTERONE, 17-D; PHENYLANINE (PKU); AND THYROXINE, TOTAL)	$79.97