5. Payments for services billed by Physicians using Current Procedural Terminology (CPT) codes will be calculated using the April 1, 2002 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2002 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

   a. Surgical codes 10000 – 58999 and 60000 - 69999 will be reimbursed at 100% of the Medicare facility rate.
   b. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
   c. Medicine codes 90000 – 99199 and Evaluation and Management codes 99201 - 99499 will be reimbursed at 85% of the Medicare non-facility rate. Vaccine Products 90476 – 90749 will be reimbursed at 85% of the Medicare non-facility rate.
   d. Obstetrical service codes 59000 – 59999 will be reimbursed at 100% of the Medicare non-facility rate.
   e. Anesthesia codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2009 anesthesia conversion factor of $21.12. Anesthesia codes 01967 – 01969 are occurrence based codes that are paid a flat rate. Anesthesia codes 99100 – 99140 are not covered.
   f. Medicine codes 90281-90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.

   Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on our website: http://dhcfp.nv.gov/.