IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201504 JANUARY 27, 2015

IHCP changes age restriction for J3262

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) will change the age restriction for Healthcare Common Procedure Coding System (HCPCS) code J3262 – *Tocilizumab injection, 1 mg*. The current age restriction of 18 years of age and older will be changed to an age restriction of 2 years of age and older. This change applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **September 1, 2014**.

Beginning March 1, 2015, providers may bill HCPCS code J3262 for individuals ages 2 years of age and older, as appropriate. Claims with DOS on or after September 1, 2014, that previously denied for explanation of benefits (EOB) 4034 – *Procedure code vs. age restriction* may be resubmitted for processing. Claims beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

System correction: Providers should continue to bill HCPCS code E0936 with RR modifier

Because of a system error, claims billed for Healthcare Common Procedure Coding System (HCPCS) code E0936 – *Continuous passive motion exercise device for use other than knee (rental)* with an RR modifier were denying for explanation of benefits (EOB) 4209 – *No pricing segment for procedure/modifier combination*. Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) has corrected the pricing error. This pricing correction applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **January 1, 2014**.

Beginning March 1, 2015, for reimbursement consideration, providers may bill HCPCS code E0936 RR, as appropriate. Claims with DOS on or after January 1, 2014, that previously denied for EOB 4209 may be resubmitted. Claims beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

This pricing correction will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com.

MORE IN THIS ISSUE

The IHCP to cover HCPCS A9564

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code A9564 – *Chromic phosphate P-32 suspension, therapeutic, per millicurie*. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies to dates of service (DOS) on or after March 1, 2015.

The following reimbursement information applies:

- **Pricing**: Maximum fee
- **Prior Authorization (PA)**: None
- **Billing Guidance**: See *Chapter 8: Billing Instructions* of the *IHCP Provider Manual*

These changes will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com. Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS-PA should be directed to ADVANTAGE Health Solutions[SM] at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the risk-based managed care (RBMC) delivery system. Questions about RBMC-PA should be directed to the MCE with which the member is enrolled.

The IHCP to cover CPT codes 15850, 93740, 94150, 97010, and 97602

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) will cover the Current Procedural Terminology (CPT®[1]) codes in Table 1 for outpatient services. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages, for dates of service (DOS) on or after March 1, 2015.

Table 1 – CPT codes covered for DOS on or after March 1, 2015

Procedure Code	Code Description
15850	*Removal of sutures under anesthesia (other than local), same surgeon*
93740	*Temperature gradient studies*
94150	*Vital capacity, total (separate procedure)*
97010	*Application of a modality to 1 or more areas; hot or cold packs*
97602	*Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet to moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.*

The following reimbursement information applies:

- **Pricing**: Maximum fee
- **Prior Authorization**: None
- **Billing Guidance**: Providers are instructed to bill these codes with appropriate revenue codes per the national coding guidelines. These codes remain noncovered for physicians. If billed by a physician, the claim detail line will show paid at zero dollars. For more detailed information, see *Chapter 8: Billing Instructions* of the *IHCP Provider Manual*.

continued

These changes will be reflected in the next monthly updates to the provider *Code Sets* and *Fee Schedule* at indianamedicaid.com. Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS-PA should be directed to ADVANTAGE Health Solutions at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the risk-based managed care (RBMC) delivery system. Questions about RBMC-PA should be directed to the MCE with which the member is enrolled.

CPT codes assigned maximum fee pricing

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) has assigned maximum fee pricing to the Current Procedural Terminology (CPT) codes listed in Table 2. For reimbursement consideration, providers may bill these CPT codes as outpatient services for dates of service (DOS) on or after March 1, 2015. The pricing changes will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com.

Table 2 – CPT codes assigned maximum fee pricing for DOS on or after March 1, 2015

Procedure Code	Code Description
15850	*Removal of sutures under anesthesia (other than local), same surgeon*
92921	*Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*
92925	*Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*
92929	*Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*
92934	*Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*
92938	*Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)*
92944	*Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)*
93740	*Temperature gradient studies*
94150	*Vital capacity, total (separate procedure)*
97010	*Application of a modality to 1 or more areas; hot or cold packs*
97602	*Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session*

Procedure codes linked to revenue codes and assigned maximum fee pricing

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) will link revenue codes and assign maximum fee pricing to the procedure codes indicated in *Table 3* in the attachment. The revenue code linkages and pricing changes apply retroactively to fee-for-service claims with dates of service (DOS) on or after **July 1, 2014**.

Where revenue code linkages have been established, beginning March 1, 2015, providers may bill the procedure codes and the revenue codes together, as appropriate, for reimbursement consideration. Claims with DOS on or after July 1, 2014, that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue codes and procedure code combination* may be resubmitted.

Beginning March 1, 2015, for reimbursement consideration, providers may bill the procedure codes assigned maximum fee pricing as outpatient services. Claims with DOS on or after July 1, 2014, that previously denied for EOB 4014 – *Claim being reviewed for pricing* may be resubmitted. The pricing changes will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com.

All claims beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

QUESTIONS?

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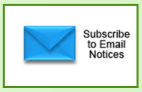

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TO PRINT

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Table 3 – Procedure codes linked to revenue codes and/or assigned maximum fee pricing for DOS on or after July 1, 2014

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
10022	Fine needle aspiration; with imaging guidance	• 320 – Radiology-Diagnostic-General • 341 – Nuclear Medicine-Diagnostic • 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans	Yes
19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	• 360 – Operating Room Services-General • 402 – Other Imaging Services-Ultrasound	
19281	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance		Yes
20555	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 333 – Radiology-Therapeutic and/or Chemotherapy Administration-Radiation Therapy • 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 402 – Other Imaging Services-Ultrasound • 610 – Magnetic Resonance Technology-General • 619 – Magnetic Resonance Technology-Other MRT	Yes
22520	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic	• 329 – Other Radiology-Diagnostic	Yes
22521	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar	• 329 – Other Radiology-Diagnostic	Yes
27093	Injection procedure for hip arthrography; without anesthesia	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 341 – Nuclear Medicine-Diagnostic • 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 610 – Magnetic Resonance Technology-General • 611 – Magnetic Resonance Technology-MRI-Brain/Brain Stem • 612 – Magnetic Resonance Technology-MRI-Spinal Cord/Spine • 619 – Magnetic Resonance Technology-Other MRT	

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
27095	Injection procedure for hip arthrography; with anesthesia	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 341 – Nuclear Medicine-Diagnostic • 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 610 – Magnetic Resonance Technology-General • 611 – Magnetic Resonance Technology-MRI-Brain/Brain Stem • 612 – Magnetic Resonance Technology-MRI-Spinal Cord/Spine • 619 – Magnetic Resonance Technology-Other MRT	
27370	Injection procedure for knee arthrography	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 341 – Nuclear Medicine-Diagnostic • 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 610 – Magnetic Resonance Technology-General • 611 – Magnetic Resonance Technology-MRI-Brain/Brain Stem • 612 – Magnetic Resonance Technology-MRI-Spinal Cord/Spine • 614 – Magnetic Resonance Technology-MRI-Other • 619 – Magnetic Resonance Technology-Other MRT	
29902	Arthroscopy, metacarpophalangeal joint, surgical; with reduction of displaced ulnar collateral ligament (eg, Stenar lesion)	• 490 – Ambulatory Surgical Care-General	
32557	Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance		Yes
36221	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	• 619 – Magnetic Resonance Technology-Other MRT	
36226	Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	• 619 – Magnetic Resonance Technology-Other MRT	

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
36251	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	• 360 – Operating Room Services-General	Yes
36252	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	• 320 – Radiology-Diagnostic-General	Yes
36253	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral		Yes
36254	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral		Yes
37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed		Yes
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed		Yes

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed		Yes
37197	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed	• 329 – Other Radiology-Diagnostic	Yes
37200	Transcatheter biopsy	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 341 – Nuclear Medicine-Diagnostic • 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 400 – Other Imaging Services-General • 402 – Other Imaging Services-Ultrasound • 610 – Magnetic Resonance Technology-General • 611 – Magnetic Resonance Technology-MRI-Brain/Brain Stem • 612 – Magnetic Resonance Technology-MRI-Spinal Cord/Spine • 619 – Magnetic Resonance Technology-Other MRT	
37202	Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 400 – Other Imaging Services-General • 402 – Other Imaging Services-Ultrasound • 610 – Magnetic Resonance Technology-General • 619 – Magnetic Resonance Technology-Other MRT	
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day		Yes
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day		Yes

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed		Yes
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method		Yes
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 333 – Radiology-Therapeutic and/or Chemotherapy Administration-Radiation Therapy • 351 – CT Scan-Head Scan • 359 – CT Scan-Other CT Scans • 402 – Other Imaging Services-Ultrasound • 610 – Magnetic Resonance Technology-General • 611 – Magnetic Resonance Technology-MRI-Brain/Brain Stem • 619 – Magnetic Resonance Technology-Other MRT	Yes
47560	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy	• 329 – Other Radiology-Diagnostic	Yes
47561	Laparoscopy, surgical; with guided transhepatic cholangiography with biopsy		Yes
47563	Laparoscopy, surgical; cholecystectomy with cholangiography		Yes
49084	Peritoneal lavage, including imaging guidance, when performed		Yes
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	• 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 402 – Other Imaging Services-Ultrasound • 610 – Magnetic Resonance Technology-General • 619 – Magnetic Resonance Technology-Other MRT	Yes
51725	Simple cystometrogram (CMG) (eg, spinal manometer)	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans	

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
51726	Complex cystometrogram (ie, calibrated electronic equipment);	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans	
51736	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	• 320 – Radiology-Diagnostic-General	
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans	
51785	Needle electromyography studies (EMG) of anal or urethral sphincter, any technique	• 922 – Other Diagnostic Services-Electromyogram	
51792	Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans	
51797	Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 341 – Nuclear Medicine-Diagnostic	
54240	Penile plethysmography	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic	
54250	Nocturnal penile tumescence and/or rigidity test	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic	
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic • 333 – Radiology-Therapeutic and/or Chemotherapy Administration-Radiation Therapy • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 402 – Other Imaging Services-Ultrasound • 610 – Magnetic Resonance Technology-General • 619 – Magnetic Resonance Technology-Other MRT	Yes
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	• 360 – Operating Room Services-General • 490 – Ambulatory Surgical Care-General	Yes

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
62310	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic	• 329 – Other Radiology-Diagnostic • 341 – Nuclear Medicine-Diagnostic • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 402 – Other Imaging Services-Ultrasound • 404 – Other Imaging Services-Positron Emission Tomography • 610 – Magnetic Resonance Technology-General • 619 – Magnetic Resonance Technology-Other MRT	Yes
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	• 329 – Other Radiology-Diagnostic • 341 – Nuclear Medicine-Diagnostic • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 402 – Other Imaging Services-Ultrasound • 404 – Other Imaging Services-Positron Emission Tomography • 610 – Magnetic Resonance Technology-General • 619 – Magnetic Resonance Technology-Other MRT	Yes
62318	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic	• 329 – Other Radiology-Diagnostic • 341 – Nuclear Medicine-Diagnostic • 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans • 402 – Other Imaging Services-Ultrasound • 404 – Other Imaging Services-Positron Emission Tomography • 610 – Magnetic Resonance Technology-General • 619 – Magnetic Resonance Technology-Other MRT	Yes
62319	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	• 402 – Other Imaging Services-Ultrasound • 404 – Other Imaging Services-Positron Emission Tomography • 610 – Magnetic Resonance Technology-General	Yes
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	• 359 – CT Scan-Other CT Scans	
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	• 359 – CT Scan-Other CT Scans	

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	• 611 – Magnetic Resonance Technology-MRI-Brain/Brain Stem	
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	• 359 – CT Scan-Other CT Scans	
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	• 359 – CT Scan-Other CT Scans	
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	• 352 – CT Scan-Body Scan	
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	• 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans	
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	• 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans	
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	• 352 – CT Scan-Body Scan • 359 – CT Scan-Other CT Scans	
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	• 359 – CT Scan-Other CT Scans	
75791	Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation	• 329 – Other Radiology-Diagnostic	
75901	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation	• 329 – Other Radiology-Diagnostic	

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	• 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan	
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	• 351 – CT Scan-Head Scan • 352 – CT Scan-Body Scan	
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	• 329 – Other Radiology-Diagnostic	
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	• 402 – Other Imaging Services-Ultrasound	
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	• 402 – Other Imaging Services-Ultrasound	
77011	Computed tomography guidance for stereotactic localization	• 352 – CT Scan-Body Scan	
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	• 352 – CT Scan-Body Scan	
77014	Computed tomography guidance for placement of radiation therapy fields	• 352 – CT Scan-Body Scan	
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	• 619 – Magnetic Resonance Technology-Other MRT	
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session		Yes
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine		Yes
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	• 341 – Nuclear Medicine-Diagnostic	
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	• 341 – Nuclear Medicine-Diagnostic	
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	• 360 – Operating Room Services-General	
92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited	• 360 – Operating Room Services-General	

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	• 424 – Physical Therapy-Evaluation or Reevaluation • 430 – Occupational Therapy-General • 431 – Occupational Therapy-Visit Charge • 432 – Occupational Therapy-Hourly Charge • 433 – Occupational Therapy-Group Rate • 434 – Occupational Therapy-Evaluation or Reevaluation • 439 – Occupational Therapy-Other Occupational Therapy	
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	• 400 – Other Imaging Services-General	Yes
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	• 400 – Other Imaging Services-General	Yes
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	• 400 - Other Imaging Services-General	Yes
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	• 400 – Other Imaging Services-General	Yes
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report	• 329 – Other Radiology-Diagnostic	
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report	• 320 – Radiology-Diagnostic-General • 329 – Other Radiology-Diagnostic	
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch		Yes
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)		Yes
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch		Yes
92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)		Yes

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel		Yes
92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)		Yes
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel		Yes
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel		Yes
92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)		Yes
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report		Yes
94799	Unlisted pulmonary service or procedure	• 360 – Operating Room Services-General	
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording		Yes
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	• 423 – Physical Therapy-Group Rate • 432 – Occupational Therapy-Hourly Charge • 433 – Occupational Therapy-Group Rate • 439 – Occupational Therapy-Other Occupational Therapy	

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
95832	Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side	• 423 – Physical Therapy-Group Rate • 432 – Occupational Therapy-Hourly Charge • 433 – Occupational Therapy-Group Rate • 439 – Occupational Therapy-Other Occupational Therapy	
95833	Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands	• 423 – Physical Therapy-Group Rate • 432 – Occupational Therapy-Hourly Charge • 433 – Occupational Therapy-Group Rate • 439 – Occupational Therapy-Other Occupational Therapy	
95834	Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands	• 423 – Physical Therapy-Group Rate • 432 – Occupational Therapy-Hourly Charge • 433 – Occupational Therapy-Group Rate • 439 – Occupational Therapy-Other Occupational Therapy	
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	• 423 – Physical Therapy-Group Rate • 432 – Occupational Therapy-Hourly Charge • 433 – Occupational Therapy-Group Rate • 439 – Occupational Therapy-Other Occupational Therapy	
95852	Range of motion measurements and report (separate procedure); hand, with or without comparison with normal side	• 423 – Physical Therapy-Group Rate • 432 – Occupational Therapy-Hourly Charge • 433 – Occupational Therapy-Group Rate • 439 – Occupational Therapy-Other Occupational Therapy	
95865	Needle electromyography; larynx		Yes
95866	Needle electromyography; hemidiaphragm		Yes
95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)		Yes
95970	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming		Yes

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
95971	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming		Yes
95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour		Yes
95974	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour		Yes
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming		Yes
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming		Yes
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)		Yes
A4641	Radiopharmaceutical, diagnostic, not otherwise classified	• 343 – Nuclear Medicine-Diagnostic Radiopharmaceuticals	

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch		Yes
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)		Yes
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch		Yes
C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)		Yes
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel		Yes
C9605	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)		Yes
C9606	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel		Yes
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel		Yes
C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)		Yes

Procedure Code	Description	Revenue Code Linkage	Assigned Maximum Fee Pricing
C9733	Nonophthalmic fluorescent vascular angiography	• 329 – Other Radiology-Diagnostic	
J9999	Not otherwise classified, antineoplastic drugs	• 250 – Pharmacy-General	