

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201252 DECEMBER 18, 2012



Coverage and billing information for the 2013 annual HCPCS codes update

The Indiana Health Coverage Programs (IHCP) has reviewed the 2013 annual Healthcare Common Procedure Coding System (HCPCS) update to determine coverage and billing guidelines. This bulletin serves as notice of the following information:

- **Table 1:** A list of the new alphanumeric and Current Procedural Terminology (CPT^{®1}) codes included in the 2013 annual HCPCS update, showing:
 - Procedure code
 - Description
 - Program coverage determination
 - Prior authorization (PA) requirements
 - National Drug Code (NDC) requirements
- **Table 2:** A list of the new modifier codes for the 2013 annual HCPCS update by modifier, description, type, and effective date.
- **Table 3:** A list of deleted codes included in the 2013 annual HCPCS update, along with any alternate code considerations.

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- **Table 4:** A list of deleted modifier codes for the 2013 annual HCPCS update by modifier, description, type, and end date.

IHCP coverage and billing information on the tables on the following pages is effective January 1, 2013. The 2013 annual HCPCS update also included modifications to descriptions for some existing HCPCS codes. These modifications have not been published in this bulletin but are available for download from the [Centers for Medicare & Medicaid Services \(CMS\) website](#) at cms.gov.

The 2013 annual HCPCS/CPT codes have been added to the IndianaAIM claims processing system and established pricing posted on the [Fee Schedule](#) at indianamedicaid.com. Providers should report using the appropriate modifiers by following CPT coding guidelines. Providers may report these codes for dates of service on or after January 1, 2013. The standard global billing procedures and edits apply when using the new codes.

QUESTIONS?

If you have questions about this information, contact the appropriate PA vendor or HP Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

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TO PRINT

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Table 1 – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
0309T	ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, WITH POSTERIOR INSTRUMENTATION, WITH IMAGE GUIDANCE, INCLUDES BONE GRAFT, WHEN PERFORMED, LUMBAR, L4-L5 INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRI)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0310T	MOTOR FUNCTION MAPPING USING NON-INVASIVE NAVIGATED TRANSCRANIAL MAGNETIC STIMULATION (NTMS) FOR THERAPEUTIC TREATMENT PLANNING, UPPER AND LOWER EXTREMITY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0311T	NON-INVASIVE CALCULATION AND ANALYSIS OF CENTRAL ARTERIAL PRESSURE WAVEFORMS WITH INTERPRETATION AND REPORT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0312T	VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); LAPAROSCOPIC IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, ANTERIOR AND POSTERIOR VAGAL TRUNKS ADJACENT TO ESOPHAGOGASTRIC JUNCTION (EGJ), WITH IMPLANTATION OF PULSE GENERATOR, INCLUDES PROGRAMMING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0313T	VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); LAPAROSCOPIC REVISION OR REPLACEMENT OF VAGAL TRUNK NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0314T	VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); LAPAROSCOPIC REMOVAL OF VAGAL TRUNK NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0315T	VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); REMOVAL OF PULSE GENERATOR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0316T	VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); REPLACEMENT OF PULSE GENERATOR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0317T	VAGUS NERVE BLOCKING THERAPY (MORBID OBESITY); NEUROSTIMULATOR PULSE GENERATOR ELECTRONIC ANALYSIS, INCLUDES REPROGRAMMING WHEN PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0318T	IMPLANTATION OF CATHETER-DELIVERED PROSTHETIC AORTIC HEART VALVE, OPEN THORACIC APPROACH, (EG, TRANSAPICAL, OTHER THAN TRANSAORTIC)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0319T	INSERTION OR REPLACEMENT OF SUBCUTANEOUS IMPLANTABLE DEFIBRILLATOR SYSTEM WITH SUBCUTANEOUS ELECTRODE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0320T	INSERTION OF SUBCUTANEOUS DEFIBRILLATOR ELECTRODE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
0321T	INSERTION OF SUBCUTANEOUS IMPLANTABLE DEFIBRILLATOR PULSE GENERATOR ONLY WITH EXISTING SUBCUTANEOUS ELECTRODE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0322T	REMOVAL OF SUBCUTANEOUS IMPLANTABLE DEFIBRILLATOR PULSE GENERATOR ONLY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0323T	REMOVAL OF SUBCUTANEOUS IMPLANTABLE DEFIBRILLATOR PULSE GENERATOR WITH REPLACEMENT OF SUBCUTANEOUS IMPLANTABLE DEFIBRILLATOR PULSE GENERATOR ONLY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0324T	REMOVAL OF SUBCUTANEOUS DEFIBRILLATOR ELECTRODE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0325T	REPOSITIONING OF SUBCUTANEOUS IMPLANTABLE DEFIBRILLATOR ELECTRODE AND/OR PULSE GENERATOR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0326T	ELECTROPHYSIOLOGIC EVALUATION OF SUBCUTANEOUS IMPLANTABLE DEFIBRILLATOR (INCLUDES DEFIBRILLATION THRESHOLD EVALUATION, INDUCTION OF ARRHYTHMIA, EVALUATION OF SENSING FOR ARRHYTHMIA TERMINATION, AND PROGRAMMING OR REPROGRAMMING OF SENSING OR THERAPEUT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0327T	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER; IMPLANTABLE SUBCUTANEOUS LEAD DEFIBRILLATOR SYSTEM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0328T	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH ANALYSIS; IMPLANTABLE SUBCUTANEOUS LEAD DEFIBRILLATOR SYSTEM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0580F	MULTIDISCIPLINARY CARE PLAN DEVELOPED OR UPDATED (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0581F	PATIENT TRANSFERRED DIRECTLY FROM ANESTHETIZING LOCATION TO CRITICAL CARE UNIT (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0582F	PATIENT NOT TRANSFERRED DIRECTLY FROM ANESTHETIZING LOCATION TO CRITICAL CARE UNIT (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0583F	TRANSFER OF CARE CHECKLIST USED (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
0584F	TRANSFER OF CARE CHECKLIST NOT USED (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
1500F	SYMPTOMS AND SIGNS OF DISTAL SYMMETRIC POLYNEUROPATHY REVIEWED AND DOCUMENTED (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
1501F	NOT INITIAL EVALUATION FOR CONDITION (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
1502F	PATIENT QUERIED ABOUT PAIN AND PAIN INTERFERENCE WITH FUNCTION USING A VALID AND RELIABLE INSTRUMENT (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
1503F	PATIENT QUERIED ABOUT SYMPTOMS OF RESPIRATORY INSUFFICIENCY (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
1504F	PATIENT HAS RESPIRATORY INSUFFICIENCY (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
1505F	PATIENT DOES NOT HAVE RESPIRATORY INSUFFICIENCY (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
22586	ARTHRODESIS, PRE-SACRAL INTERBODY TECHNIQUE, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, WITH POSTERIOR INSTRUMENTATION, WITH IMAGE GUIDANCE, INCLUDES BONE GRAFT WHEN PERFORMED, L5-S1 INTERSPACE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
23473	REVISION OF TOTAL SHOULDER ARTHROPLASTY, INCLUDING ALLOGRAFT WHEN PERFORMED; HUMERAL OR GLENOID COMPONENT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
23474	REVISION OF TOTAL SHOULDER ARTHROPLASTY, INCLUDING ALLOGRAFT WHEN PERFORMED; HUMERAL AND GLENOID COMPONENT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
24370	REVISION OF TOTAL ELBOW ARTHROPLASTY, INCLUDING ALLOGRAFT WHEN PERFORMED; HUMERAL OR ULNAR COMPONENT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
24371	REVISION OF TOTAL ELBOW ARTHROPLASTY, INCLUDING ALLOGRAFT WHEN PERFORMED; HUMERAL AND ULNAR COMPONENT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
31647	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BALLOON OCCLUSION, WHEN PERFORMED, ASSESSMENT OF AIR LEAK, AIRWAY SIZING, AND INSERTION OF BRONCHIAL VALVE(S), INITIAL LOBE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
31648	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH REMOVAL OF BRONCHIAL VALVE(S), INITIAL LOBE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
31649	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH REMOVAL OF BRONCHIAL VALVE(S), EACH ADDITIONAL LOBE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
31651	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BALLOON OCCLUSION, WHEN PERFORMED, ASSESSMENT OF AIR LEAK, AIRWAY SIZING, AND INSERTION OF BRONCHIAL VALVE(S), EACH ADDITIONAL LOBE (LIST SEPARATELY IN ADDITION TO	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
31660	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 1 LOBE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
31661	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 2 OR MORE LOBES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
32554	THORACENTESIS, NEEDLE OR CATHETER, ASPIRATION OF THE PLEURAL SPACE; WITHOUT IMAGING GUIDANCE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
32555	THORACENTESIS, NEEDLE OR CATHETER, ASPIRATION OF THE PLEURAL SPACE; WITH IMAGING GUIDANCE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
32556	PLEURAL DRAINAGE, PERCUTANEOUS, WITH INSERTION OF INDWELLING CATHETER; WITHOUT IMAGING GUIDANCE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
32557	PLEURAL DRAINAGE, PERCUTANEOUS, WITH INSERTION OF INDWELLING CATHETER; WITH IMAGING GUIDANCE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
32701	THORACIC TARGET(S) DELINEATION FOR STEREOTACTIC BODY RADIATION THERAPY (SRS/SBRT), (PHOTON OR PARTICLE BEAM), ENTIRE COURSE OF TREATMENT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
33361	TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR/TAVI) WITH PROSTHETIC VALVE; PERCUTANEOUS FEMORAL ARTERY APPROACH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
33362	TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR/TAVI) WITH PROSTHETIC VALVE; OPEN FEMORAL ARTERY APPROACH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
33363	TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR/TAVI) WITH PROSTHETIC VALVE; OPEN AXILLARY ARTERY APPROACH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
33364	TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR/TAVI) WITH PROSTHETIC VALVE; OPEN ILIAC ARTERY APPROACH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
33365	TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR/TAVI) WITH PROSTHETIC VALVE; TRANSAORTIC APPROACH (EG, MEDIAN STERNOTOMY, MEDIASTINOTOMY)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
33367	TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR/TAVI) WITH PROSTHETIC VALVE; CARDIOPULMONARY BYPASS SUPPORT WITH PERCUTANEOUS PERIPHERAL ARTERIAL AND VENOUS CANNULATION (EG, FEMORAL VESSELS) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
33368	TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR/TAVI) WITH PROSTHETIC VALVE; CARDIOPULMONARY BYPASS SUPPORT WITH OPEN PERIPHERAL ARTERIAL AND VENOUS CANNULATION (EG, FEMORAL, ILIAC, AXILLARY VESSELS) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROC)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
33369	TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR/TAVI) WITH PROSTHETIC VALVE; CARDIOPULMONARY BYPASS SUPPORT WITH CENTRAL ARTERIAL AND VENOUS CANNULATION (EG, AORTA, RIGHT ATRIUM, PULMONARY ARTERY) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDU	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
33990	INSERTION OF VENTRICULAR ASSIST DEVICE, PERCUTANEOUS INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; ARTERIAL ACCESS ONLY	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
33991	INSERTION OF VENTRICULAR ASSIST DEVICE, PERCUTANEOUS INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; BOTH ARTERIAL AND VENOUS ACCESS, WITH TRANSSEPTAL PUNCTURE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
33992	REMOVAL OF PERCUTANEOUS VENTRICULAR ASSIST DEVICE AT SEPARATE AND DISTINCT SESSION FROM INSERTION	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
33993	REPOSITIONING OF PERCUTANEOUS VENTRICULAR ASSIST DEVICE WITH IMAGING GUIDANCE AT SEPARATE AND DISTINCT SESSION FROM INSERTION	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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 T	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
36222	SELECTIVE CATHETER PLACEMENT, COMMON CAROTID OR INNOMINATE ARTERY, UNILATERAL, ANY APPROACH, WITH ANGIOGRAPHY OF THE IPSILATERAL EXTRACRANIAL CAROTID CIRCULATION AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDES ANGIOGRAPHY OF	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
36223	SELECTIVE CATHETER PLACEMENT, COMMON CAROTID OR INNOMINATE ARTERY, UNILATERAL, ANY APPROACH, WITH ANGIOGRAPHY OF THE IPSILATERAL INTRACRANIAL CAROTID CIRCULATION AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDES ANGIOGRAPHY OF	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
36224	SELECTIVE CATHETER PLACEMENT, INTERNAL CAROTID ARTERY, UNILATERAL, WITH ANGIOGRAPHY OF THE IPSILATERAL INTRACRANIAL CAROTID CIRCULATION AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDES ANGIOGRAPHY OF THE EXTRACRANIAL CAROTID A	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
36225	SELECTIVE CATHETER PLACEMENT, SUBCLAVIAN OR INNOMINATE ARTERY, UNILATERAL, WITH ANGIOGRAPHY OF THE IPSILATERAL VERTEBRAL CIRCULATION AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDES ANGIOGRAPHY OF THE CERVICOCEREBRAL ARCH, WHE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
36227	SELECTIVE CATHETER PLACEMENT, EXTERNAL CAROTID ARTERY, UNILATERAL, WITH ANGIOGRAPHY OF THE IPSILATERAL EXTERNAL CAROTID CIRCULATION AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCED	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
36228	SELECTIVE CATHETER PLACEMENT, EACH INTRACRANIAL BRANCH OF THE INTERNAL CAROTID OR VERTEBRAL ARTERIES, UNILATERAL, WITH ANGIOGRAPHY OF THE SELECTED VESSEL CIRCULATION AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION (EG, MIDDLE CEREBRAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
37211	TRANSCATHETER THERAPY, ARTERIAL INFUSION FOR THROMBOLYSIS OTHER THAN CORONARY, ANY METHOD, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION, INITIAL TREATMENT DAY	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
37212	TRANSCATHETER THERAPY, VENOUS INFUSION FOR THROMBOLYSIS, ANY METHOD, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION, INITIAL TREATMENT DAY	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
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-	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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-	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
3751F	ELECTRODIAGNOSTIC STUDIES FOR DISTAL SYMMETRIC POLYNEUROPATHY CONDUCTED (OR REQUESTED), DOCUMENTED, AND REVIEWED WITHIN 6 MONTHS OF INITIAL EVALUATION FOR CONDITION (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3752F	ELECTRODIAGNOSTIC STUDIES FOR DISTAL SYMMETRIC POLYNEUROPATHY NOT CONDUCTED (OR REQUESTED), DOCUMENTED, OR REVIEWED WITHIN 6 MONTHS OF INITIAL EVALUATION FOR CONDITION (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3753F	PATIENT HAS CLEAR CLINICAL SYMPTOMS AND SIGNS THAT ARE HIGHLY SUGGESTIVE OF NEUROPATHY AND CANNOT BE ATTRIBUTED TO ANOTHER CONDITION, AND HAS AN OBVIOUS CAUSE FOR THE NEUROPATHY (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3754F	SCREENING TESTS FOR DIABETES MELLITUS REVIEWED, REQUESTED, OR ORDERED (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3755F	COGNITIVE AND BEHAVIORAL IMPAIRMENT SCREENING PERFORMED (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3756F	PATIENT HAS PSEUDOBULBAR AFFECT, SIALORRHEA, OR ALS RELATED SYMPTOMS (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3757F	PATIENT DOES NOT HAVE PSEUDOBULBAR AFFECT, SIALORRHEA, OR ALS RELATED SYMPTOMS (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3758F	PATIENT REFERRED FOR PULMONARY FUNCTION TESTING OR PEAK COUGH EXPIRATORY FLOW (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3759F	PATIENT SCREENED FOR DYSPHAGIA, WEIGHT LOSS, AND IMPAIRED NUTRITION, AND RESULTS DOCUMENTED (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3760F	PATIENT EXHIBITS DYSPHAGIA, WEIGHT LOSS, OR IMPAIRED NUTRITION (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3761F	PATIENT DOES NOT EXHIBIT DYSPHAGIA, WEIGHT LOSS, OR IMPAIRED NUTRITION (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
3762F	PATIENT IS DYSARTHIC (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
3763F	PATIENT IS NOT DYSARTHIC (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
38243	HEMATOPOIETIC PROGENITOR CELL (HPC); HPC BOOST	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
43206	ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH OPTICAL ENDOMICROSCOPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
43252	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; WITH OPTICAL ENDOMICROSCOPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
44705	PREPARATION OF FECAL MICROBIOTA FOR INSTILLATION, INCLUDING ASSESSMENT OF DONOR SPECIMEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4540F	DISEASE MODIFYING PHARMACOTHERAPY DISCUSSED (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4541F	PATIENT OFFERED TREATMENT FOR PSEUDOBULBAR AFFECT, SIALORRHEA, OR ALS RELATED SYMPTOMS (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4550F	OPTIONS FOR NONINVASIVE RESPIRATORY SUPPORT DISCUSSED WITH PATIENT (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4551F	NUTRITIONAL SUPPORT OFFERED (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4552F	PATIENT OFFERED REFERRAL TO A SPEECH LANGUAGE PATHOLOGIST (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4553F	PATIENT OFFERED ASSISTANCE IN PLANNING FOR END OF LIFE ISSUES (DSP)8	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4554F	PATIENT RECEIVED INHALATIONAL ANESTHETIC AGENT (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4555F	PATIENT DID NOT RECEIVE INHALATIONAL ANESTHETIC AGENT (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4556F	PATIENT EXHIBITS 3 OR MORE RISK FACTORS FOR POST-OPERATIVE NAUSEA AND VOMITING (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4557F	PATIENT DOES NOT EXHIBIT 3 OR MORE RISK FACTORS FOR POST-OPERATIVE NAUSEA AND VOMITING (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4558F	PATIENT RECEIVED AT LEAST 2 PROPHYLACTIC PHARMACOLOGIC ANTI-EMETIC AGENTS OF DIFFERENT CLASSES PREOPERATIVELY AND INTRAOPERATIVELY (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
4559F	AT LEAST 1 BODY TEMPERATURE MEASUREMENT EQUAL TO OR GREATER THAN 35.5 DEGREES CELSIUS (OR 95.9 DEGREES FAHRENHEIT) RECORDED WITHIN THE 30 MINUTES IMMEDIATELY BEFORE OR THE 15 MINUTES IMMEDIATELY AFTER ANESTHESIA END TIME (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4560F	ANESTHESIA TECHNIQUE DID NOT INVOLVE GENERAL OR NEURAXIAL ANESTHESIA (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4561F	PATIENT HAS A CORONARY ARTERY STENT (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4562F	PATIENT DOES NOT HAVE A CORONARY ARTERY STENT (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
4563F	PATIENT RECEIVED ASPIRIN WITHIN 24 HOURS PRIOR TO ANESTHESIA START TIME (PERI2)11	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
52287	CYSTOURETHROSCOPY, WITH INJECTION(S) FOR CHEMODENERVATION OF THE BLADDER	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
64615	CHEMODENERVATION OF MUSCLE(S); MUSCLE(S) INNERVATED BY FACIAL, TRIGEMINAL, CERVICAL SPINAL AND ACCESSORY NERVES, BILATERAL (EG, FOR CHRONIC MIGRAINE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
78012	THYROID UPTAKE, SINGLE OR MULTIPLE QUANTITATIVE MEASUREMENT(S) (INCLUDING STIMULATION, SUPPRESSION, OR DISCHARGE, WHEN PERFORMED)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
78013	THYROID IMAGING (INCLUDING VASCULAR FLOW, WHEN PERFORMED);	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
78014	THYROID IMAGING (INCLUDING VASCULAR FLOW, WHEN PERFORMED); WITH SINGLE OR MULTIPLE UPTAKE(S) QUANTITATIVE MEASUREMENT(S) (INCLUDING STIMULATION, SUPPRESSION, OR DISCHARGE, WHEN PERFORMED)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
78071	PARATHYROID PLANAR IMAGING (INCLUDING SUBTRACTION, WHEN PERFORMED); WITH TOMOGRAPHIC (SPECT)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
78072	PARATHYROID PLANAR IMAGING (INCLUDING SUBTRACTION, WHEN PERFORMED); WITH TOMOGRAPHIC (SPECT), AND CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ANATOMICAL LOCALIZATION	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
81201	APC (ADENOMATOUS POLYPOSIS COLI) (EG, FAMILIAL ADENOMATOUS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; FULL GENE SEQUENCE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81202	APC (ADENOMATOUS POLYPOSIS COLI) (EG, FAMILIAL ADENOMATOUS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
81203	APC (ADENOMATOUS POLYPOSIS COLI) (EG, FAMILIAL ADENOMATOUS POLYPOSIS [FAP], ATTENUATED FAP) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81235	EGFR (EPIDERMAL GROWTH FACTOR RECEPTOR) (EG, NON-SMALL CELL LUNG CANCER) GENE ANALYSIS, COMMON VARIANTS (EG, EXON 19 LREA DELETION, L858R, T790M, G719A, G719S, L861Q)	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
81252	GJB2 (GAP JUNCTION PROTEIN, BETA 2, 26KDA; CONNEXIN 26) (EG, NONSYNDROMIC HEARING LOSS) GENE ANALYSIS; FULL GENE SEQUENCE	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
81253	GJB2 (GAP JUNCTION PROTEIN, BETA 2, 26KDA; KNOWN FAMILIAL VARIANTS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
81254	GJB6 (GAP JUNCTION PROTEIN, BETA 6, 30KDA, CONNEXIN 30) (EG, NONSYNDROMIC HEARING LOSS) GENE ANALYSIS, COMMON VARIANTS (EG, 309KB [DEL(GJB6-D13S1830)] AND 232KB [DEL(GJB6-D13S1854)])	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
81321	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
81322	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
81323	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANT	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
81324	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (EG, CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; DUPLICATION/DELETION ANALYSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81325	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (EG, CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81326	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (EG, CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81479	UNLISTED MOLECULAR PATHOLOGY PROCEDURE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81500	ONCOLOGY (OVARIAN), BIOCHEMICAL ASSAYS OF TWO PROTEINS (CA-125 AND HE4), UTILIZING SERUM, WITH MENOPAUSAL STATUS, ALGORITHM REPORTED AS A RISK SCORE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
81503	ONCOLOGY (OVARIAN), BIOCHEMICAL ASSAYS OF FIVE PROTEINS (CA-125, APOLIPROTEIN A1, BETA-2 MICROGLOBULIN, TRANSFERRIN, AND PRE-ALBUMIN), UTILIZING SERUM, ALGORITHM REPORTED AS A RISK SCORE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81506	ENDOCRINOLOGY (TYPE 2 DIABETES), BIOCHEMICAL ASSAYS OF SEVEN ANALYTES (GLUCOSE, HBA1C, INSULIN, HS-CRP, ADOPONECTIN, FERRITIN, INTERLEUKIN 2-RECEPTOR ALPHA), UTILIZING SERUM OR PLASMA, ALGORITHM REPORTING A RISK SCORE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81508	FETAL CONGENITAL ABNORMALITIES, BIOCHEMICAL ASSAYS OF TWO PROTEINS (PAPP-A, HCG [ANY FORM]), UTILIZING MATERNAL SERUM, ALGORITHM REPORTED AS A RISK SCORE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81509	FETAL CONGENITAL ABNORMALITIES, BIOCHEMICAL ASSAYS OF THREE PROTEINS (PAPP-A, HCG [ANY FORM], DIA), UTILIZING MATERNAL SERUM, ALGORITHM REPORTED AS A RISK SCORE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81510	FETAL CONGENITAL ABNORMALITIES, BIOCHEMICAL ASSAYS OF THREE ANALYTES (AFP, UE3, HCG [ANY FORM]), UTILIZING MATERNAL SERUM, ALGORITHM REPORTED AS A RISK SCORE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81511	FETAL CONGENITAL ABNORMALITIES, BIOCHEMICAL ASSAYS OF FOUR ANALYTES (AFP, UE3, HCG [ANY FORM], DIA) UTILIZING MATERNAL SERUM, ALGORITHM REPORTED AS A RISK SCORE (MAY INCLUDE ADDITIONAL RESULTS FROM PREVIOUS BIOCHEMICAL TESTING)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81512	FETAL CONGENITAL ABNORMALITIES, BIOCHEMICAL ASSAYS OF FIVE ANALYTES (AFP, UE3, TOTAL HCG, HYPERGLYCOSYLATED HCG, DIA) UTILIZING MATERNAL SERUM, ALGORITHM REPORTED AS A RISK SCORE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
81599	UNLISTED MULTIANALYTE ASSAY WITH ALGORITHMIC ANALYSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
82777	GALECTIN-3	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
86152	CELL ENUMERATION USING IMMUNOLOGIC SELECTION AND IDENTIFICATION IN FLUID SPECIMEN (EG, CIRCULATING TUMOR CELLS IN BLOOD);	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
86153	CELL ENUMERATION USING IMMUNOLOGIC SELECTION AND IDENTIFICATION IN FLUID SPECIMEN (EG, CIRCULATING TUMOR CELLS IN BLOOD); PHYSICIAN INTERPRETATION AND REPORT, WHEN REQUIRED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
86711	ANTIBODY; JC (JOHN CUNNINGHAM) VIRUS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
86828	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (EG, MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); QUALITATIVE ASSESSMENT OF THE PRESENCE OR ABSENCE OF ANTIBODY(IES) TO HLA CLASS I AND CLASS II HLA ANTIGENS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
86829	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (EG, MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); QUALITATIVE ASSESSMENT OF THE PRESENCE OR ABSENCE OF ANTIBODY(IES) TO HLA CLASS I OR CLASS II HLA ANTIGENS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
86830	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (EG, MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); ANTIBODY IDENTIFICATION BY QUALITATIVE PANEL USING COMPLETE HLA PHENOTYPES, HLA CLASS I	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
86831	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (EG, MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); ANTIBODY IDENTIFICATION BY QUALITATIVE PANEL USING COMPLETE HLA PHENOTYPES, HLA CLASS II	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
86832	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (EG, MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); HIGH DEFINITION QUALITATIVE PANEL FOR IDENTIFICATION OF ANTIBODY SPECIFICITIES (EG, INDIVIDUAL ANTIGEN PER BEAD METHODOLOGY), HLA CLASS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
86833	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (EG, MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); HIGH DEFINITION QUALITATIVE PANEL FOR IDENTIFICATION OF ANTIBODY SPECIFICITIES (EG, INDIVIDUAL ANTIGEN PER BEAD METHODOLOGY), HLA CLASS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
86834	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (EG, MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); SEMI-QUANTITATIVE PANEL (EG, TITER), HLA CLASS I	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
86835	ANTIBODY TO HUMAN LEUKOCYTE ANTIGENS (HLA), SOLID PHASE ASSAYS (EG, MICROSPHERES OR BEADS, ELISA, FLOW CYTOMETRY); SEMI-QUANTITATIVE PANEL (EG, TITER), HLA CLASS II	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
87631	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); RESPIRATORY VIRUS (EG, ADENOVIRUS, INFLUENZA VIRUS, CORONAVIRUS, METAPNEUMOVIRUS, PARAINFLUENZA VIRUS, RESPIRATORY SYNCYTIAL VIRUS, RHINOVIRUS), MULTIPLEX REVERSE TRANSCRIPTION AND AMPLIFIED PR	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
87632	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); RESPIRATORY VIRUS (EG, ADENOVIRUS, INFLUENZA VIRUS, CORONAVIRUS, METAPNEUMOVIRUS, PARAINFLUENZA VIRUS, RESPIRATORY SYNCYTIAL VIRUS, RHINOVIRUS), MULTIPLEX REVERSE TRANSCRIPTION AND AMPLIFIED PR	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
87633	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); RESPIRATORY VIRUS (EG, ADENOVIRUS, INFLUENZA VIRUS, CORONAVIRUS, METAPNEUMOVIRUS, PARAINFLUENZA VIRUS, RESPIRATORY SYNCYTIAL VIRUS, RHINOVIRUS), MULTIPLEX REVERSE TRANSCRIPTION AND AMPLIFIED PR	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
87910	INFECTIOUS AGENT GENOTYPE ANALYSIS BY NUCLEIC ACID (DNA OR RNA); CYTOMEGALOVIRUS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
87912	INFECTIOUS AGENT GENOTYPE ANALYSIS BY NUCLEIC ACID (DNA OR RNA); HEPATITIS B VIRUS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
88375	OPTICAL ENDOMICROSCOPIC IMAGE(S), INTERPRETATION AND REPORT, REAL-TIME OR REFERRED, EACH ENDOSCOPIC SESSION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
90653	INFLUENZA VACCINE, INACTIVATED, SUBUNIT, ADJUVANTED, FOR INTRAMUSCULAR USE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
90672	INFLUENZA VIRUS VACCINE, QUADRIVALENT, LIVE, FOR INTRANASAL USE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90685	INFLUENZA VIRUS VACCINE, QUADRIVALENT, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
90686	INFLUENZA VIRUS VACCINE, QUADRIVALENT, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
90687	INFLUENZA VIRUS VACCINE, QUADRIVALENT, SPLIT VIRUS, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
90688	INFLUENZA VIRUS VACCINE, QUADRIVALENT, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
90739	HEPATITIS B VACCINE, ADULT DOSAGE (2 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90785	INTERACTIVE COMPLEXITY (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	Covered	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES	Covered	No for All Programs, No for Package C	NO
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90833	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90836	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90838	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90840	PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
90863	PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION AND REVIEW OF MEDICATION, WHEN PERFORMED WITH PSYCHOTHERAPY SERVICES (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
91112	GASTROINTESTINAL TRANSIT AND PRESSURE MEASUREMENT, STOMACH THROUGH COLON, WIRELESS CAPSULE, WITH INTERPRETATION AND REPORT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
92920	PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY; SINGLE MAJOR CORONARY ARTERY OR BRANCH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
92921	PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY; EACH ADDITIONAL BRANCH OF A MAJOR CORONARY ARTERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
92924	PERCUTANEOUS TRANSLUMINAL CORONARY ATHERECTOMY, WITH CORONARY ANGIOPLASTY WHEN PERFORMED; SINGLE MAJOR CORONARY ARTERY OR BRANCH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
92928	PERCUTANEOUS TRANSCATHETER PLACEMENT OF INTRACORONARY STENT(S), WITH CORONARY ANGIOPLASTY WHEN PERFORMED; SINGLE MAJOR CORONARY ARTERY OR BRANCH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
92933	PERCUTANEOUS TRANSLUMINAL CORONARY ATHERECTOMY, WITH INTRACORONARY STENT, WITH CORONARY ANGIOPLASTY WHEN PERFORMED; SINGLE MAJOR CORONARY ARTERY OR BRANCH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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 AD	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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 ASPIRAT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
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	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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, CO	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
93653	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS WITH INDUCTION OR ATTEMPTED INDUCTION OF AN ARRHYTHMIA WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, H	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
93654	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS WITH INDUCTION OR ATTEMPTED INDUCTION OF AN ARRHYTHMIA WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, H	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
93655	INTRACARDIAC CATHETER ABLATION OF A DISCRETE MECHANISM OF ARRHYTHMIA WHICH IS DISTINCT FROM THE PRIMARY ABLATED MECHANISM, INCLUDING REPEAT DIAGNOSTIC MANEUVERS, TO TREAT A SPONTANEOUS OR INDUCED ARRHYTHMIA (LIST SEPARATELY IN ADDITION TO CODE FOR PR	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
93656	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION INCLUDING TRANSSEPTAL CATHETERIZATIONS, INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS WITH INDUCTION OR ATTEMPTED INDUCTION OF AN ARRHYTHMIA WITH ATRIAL RECORDING AND PACING, WHEN POSSIBLE, RI	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
93657	ADDITIONAL LINEAR OR FOCAL INTRACARDIAC CATHETER ABLATION OF THE LEFT OR RIGHT ATRIUM FOR TREATMENT OF ATRIAL FIBRILLATION REMAINING AFTER COMPLETION OF PULMONARY VEIN ISOLATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95017	ALLERGY TESTING, ANY COMBINATION OF PERCUTANEOUS (SCRATCH, PUNCTURE, PRICK) AND INTRACUTANEOUS (INTRADERMAL), SEQUENTIAL AND INCREMENTAL, WITH VENOMS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT, SPECIFY NUMBER OF TESTS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
95018	ALLERGY TESTING, ANY COMBINATION OF PERCUTANEOUS (SCRATCH, PUNCTURE, PRICK) AND INTRACUTANEOUS (INTRADERMAL), SEQUENTIAL AND INCREMENTAL, WITH DRUGS OR BIOLOGICALS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT, SPECIFY NUMBER OF	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95076	INGESTION CHALLENGE TEST (SEQUENTIAL AND INCREMENTAL INGESTION OF TEST ITEMS, EG, FOOD, DRUG OR OTHER SUBSTANCE); INITIAL 120 MINUTES OF TESTING	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95079	INGESTION CHALLENGE TEST (SEQUENTIAL AND INCREMENTAL INGESTION OF TEST ITEMS, EG, FOOD, DRUG OR OTHER SUBSTANCE); EACH ADDITIONAL 60 MINUTES OF TESTING (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95782	POLYSOMNOGRAPHY; YOUNGER THAN 6 YEARS, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95783	POLYSOMNOGRAPHY; YOUNGER THAN 6 YEARS, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, WITH INITIATION OF CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY OR BI-LEVEL VENTILATION, ATTENDED BY A TECHNOLOGIST	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95907	NERVE CONDUCTION STUDIES; 1-2 STUDIES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95908	NERVE CONDUCTION STUDIES; 3-4 STUDIES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95909	NERVE CONDUCTION STUDIES; 5-6 STUDIES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95910	NERVE CONDUCTION STUDIES; 7-8 STUDIES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95911	NERVE CONDUCTION STUDIES; 9-10 STUDIES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95912	NERVE CONDUCTION STUDIES; 11-12 STUDIES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95913	NERVE CONDUCTION STUDIES; 13 OR MORE STUDIES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95924	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; COMBINED PARASYMPATHETIC AND SYMPATHETIC ADRENERGIC FUNCTION TESTING WITH AT LEAST 5 MINUTES OF PASSIVE TILT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
95940	CONTINUOUS INTRAOPERATIVE NEUROPHYSIOLOGY MONITORING IN THE OPERATING ROOM, ONE ON ONE MONITORING REQUIRING PERSONAL ATTENDANCE, EACH 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
95941	CONTINUOUS INTRAOPERATIVE NEUROPHYSIOLOGY MONITORING, FROM OUTSIDE THE OPERATING ROOM (REMOTE OR NEARBY) OR FOR MONITORING OF MORE THAN ONE CASE WHILE IN THE OPERATING ROOM, PER HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
95943	SIMULTANEOUS, INDEPENDENT, QUANTITATIVE MEASURES OF BOTH PARASYMPATHETIC FUNCTION AND SYMPATHETIC FUNCTION, BASED ON TIME-FREQUENCY ANALYSIS OF HEART RATE VARIABILITY CONCURRENT WITH TIME-FREQUENCY ANALYSIS OF CONTINUOUS RESPIRATORY ACTIVITY, WITH ME	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
99485	SUPERVISION BY A CONTROL PHYSICIAN OF INTERFACILITY TRANSPORT CARE OF THE CRITICALLY ILL OR CRITICALLY INJURED PEDIATRIC PATIENT, 24 MONTHS OF AGE OR YOUNGER, INCLUDES TWO-WAY COMMUNICATION WITH TRANSPORT TEAM BEFORE TRANSPORT, AT THE REFERRING FACIL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
99486	SUPERVISION BY A CONTROL PHYSICIAN OF INTERFACILITY TRANSPORT CARE OF THE CRITICALLY ILL OR CRITICALLY INJURED PEDIATRIC PATIENT, 24 MONTHS OF AGE OR YOUNGER, INCLUDES TWO-WAY COMMUNICATION WITH TRANSPORT TEAM BEFORE TRANSPORT, AT THE REFERRING FACIL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
99487	COMPLEX CHRONIC CARE COORDINATION SERVICES; FIRST HOUR OF CLINICAL STAFF TIME DIRECTED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH NO FACE-TO-FACE VISIT, PER CALENDAR MONTH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
99488	COMPLEX CHRONIC CARE COORDINATION SERVICES; FIRST HOUR OF CLINICAL STAFF TIME DIRECTED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH ONE FACE-TO-FACE VISIT, PER CALENDAR MONTH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
99489	COMPLEX CHRONIC CARE COORDINATION SERVICES; EACH ADDITIONAL 30 MINUTES OF CLINICAL STAFF TIME DIRECTED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, PER CALENDAR MONTH (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
99495	TRANSITIONAL CARE MANAGEMENT SERVICES WITH THE FOLLOWING REQUIRED ELEMENTS: COMMUNICATION (DIRECT CONTACT, TELEPHONE, ELECTRONIC) WITH THE PATIENT AND/OR CAREGIVER WITHIN 2 BUSINESS DAYS OF DISCHARGE MEDICAL DECISION MAKING OF AT LEAST MODERATE COMPL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
99496	TRANSITIONAL CARE MANAGEMENT SERVICES WITH THE FOLLOWING REQUIRED ELEMENTS: COMMUNICATION (DIRECT CONTACT, TELEPHONE, ELECTRONIC) WITH THE PATIENT AND/OR CAREGIVER WITHIN 2 BUSINESS DAYS OF DISCHARGE MEDICAL DECISION MAKING OF HIGH COMPLEXITY DURING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
A4435	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, WITH EXTENDED WEAR BARRIER (ONE-PIECE SYSTEM), WITH OR WITHOUT FILTER, EACH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
A9586	FLORBETAPIR F18, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
C9294	INJECTION, TALIGLUCERASE ALFA, 10 UNITS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
C9295	INJECTION, CARFILZOMIB, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
C9296	INJECTION, ZIV-AFLIBERCEPT, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
C9600	PERCUTANEOUS TRANSCATHETER PLACEMENT OF DRUG ELUTING INTRACORONARY STENT(S), WITH CORONARY ANGIOPLASTY WHEN PERFORMED; SINGLE MAJOR CORONARY ARTERY OR BRANCH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
C9602	PERCUTANEOUS TRANSLUMINAL CORONARY ATHERECTOMY, WITH DRUG ELUTING INTRACORONARY STENT, WITH CORONARY ANGIOPLASTY WHEN PERFORMED; SINGLE MAJOR CORONARY ARTERY OR BRANCH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
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 PERFO	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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 PERFO	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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, INCLU	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
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 CORON	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
D0190	SCREENING OF A PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0191	ASSESSMENT OF A PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0364	CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW - LESS THAN ONE WHOLE JAW	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0365	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MANDIBLE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0366	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MAXILLA, WITH OR WITHOUT CRANIUM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
D0368	CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0369	MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0370	MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0371	SIALOENDOSCOPY CAPTURE AND INTERPRETATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0380	CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW - LESS THAN ONE WHOLE JAW	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0381	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MANDIBLE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0382	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MAXILLA, WITH OR WITHOUT CRANIUM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0383	CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0384	CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0385	MAXILLOFACIAL MRI IMAGE CAPTURE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0386	MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE BY A PRACTITIONER NOT ASSOCIATED WITH CAPTURE OF THE IMAGE, INCLUDING REPORT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D1208	TOPICAL APPLICATION OF FLUORIDE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
D2929	PREFABRICATED PORCELAIN/CERAMIC CROWN - PRIMARY TOOTH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D2981	INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D2982	ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
D2983	VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D2990	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
D4212	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), FIRST TOOTH OR EDENTULOUS TOOTH POSITION IN GRAFT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), EACH ADDITIONAL CONTIGUOUS TOOTH OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D6051	INTERIM ABUTMENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D6101	DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D6102	DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D6103	BONE GRAFT FOR REPAIR OF PERIIMPLANT DEFECT - NOT INCLUDING FLAP ENTRY AND CLOSURE OR, WHEN INDICATED, PLACEMENT OF A BARRIER MEMBRANE OR BIOLOGIC MATERIALS TO AID IN OSSEOUS REGENERATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D7921	COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D7952	SINUS AUGMENTATION VIA A VERTICAL APPROACH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
D9975	EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH; INCLUDES MATERIALS AND FABRICATION OF CUSTOM TRAYS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
E0670	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL LEGS AND TRUNK	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
E2378	POWER WHEELCHAIR COMPONENT, ACTUATOR, REPLACEMENT ONLY	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NO
G0452	MOLECULAR PATHOLOGY PROCEDURE; PHYSICIAN INTERPRETATION AND REPORT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
G0453	CONTINUOUS INTRAOPERATIVE NEUROPHYSIOLOGY MONITORING, FROM OUTSIDE THE OPERATING ROOM (REMOTE OR NEARBY), PER PATIENT, (ATTENTION DIRECTED EXCLUSIVELY TO ONE PATIENT) EACH 15 MINUTES (LIST IN ADDITION TO PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G0454	PHYSICIAN DOCUMENTATION OF FACE-TO-FACE VISIT FOR DURABLE MEDICAL EQUIPMENT DETERMINATION PERFORMED BY NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR CLINICAL NURSE SPECIALIST	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G0455	PREPARATION WITH INSTILLATION OF FECAL MICROBIOTA BY ANY METHOD, INCLUDING ASSESSMENT OF DONOR SPECIMEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G0456	NEGATIVE PRESSURE WOUND THERAPY, (E.G. VACUUM ASSISTED DRAINAGE COLLECTION) USING A MECHANICALLY-POWERED DEVICE, NOT DURABLE MEDICAL EQUIPMENT, INCLUDING PROVISION OF CARTRIDGE AND DRESSING(S), TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTIO	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G0457	NEGATIVE PRESSURE WOUND THERAPY, (E.G. VACUUM ASSISTED DRAINAGE COLLECTION) USING A MECHANICALLY-POWERED DEVICE, NOT DURABLE MEDICAL EQUIPMENT, INCLUDING PROVISION OF CARTRIDGE AND DRESSING(S), TOPICAL APPLICATION(S), WOUND ASSESSMENT, AND INSTRUCTIO	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G0458	LOW DOSE RATE (LDR) PROSTATE BRACHYTHERAPY SERVICES, COMPOSITE RATE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8907	PATIENT DOCUMENTED NOT TO HAVE EXPERIENCED ANY OF THE FOLLOWING EVENTS: A BURN PRIOR TO DISCHARGE; A FALL WITHIN THE FACILITY; WRONG SITE/SIDE/PATIENT/PROCEDURE/IMPLANT EVENT; OR A HOSPITAL TRANSFER OR HOSPITAL ADMISSION UPON DISCHARGE FROM THE FACIL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8908	PATIENT DOCUMENTED TO HAVE RECEIVED A BURN PRIOR TO DISCHARGE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8909	PATIENT DOCUMENTED NOT TO HAVE RECEIVED A BURN PRIOR TO DISCHARGE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8910	PATIENT DOCUMENTED TO HAVE EXPERIENCED A FALL WITHIN ASC	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G8911	PATIENT DOCUMENTED NOT TO HAVE EXPERIENCED A FALL WITHIN AMBULATORY SURGICAL CENTER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8912	PATIENT DOCUMENTED TO HAVE EXPERIENCED A WRONG SITE, WRONG SIDE, WRONG PATIENT, WRONG PROCEDURE OR WRONG IMPLANT EVENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8913	PATIENT DOCUMENTED NOT TO HAVE EXPERIENCED A WRONG SITE, WRONG SIDE, WRONG PATIENT, WRONG PROCEDURE OR WRONG IMPLANT EVENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8914	PATIENT DOCUMENTED TO HAVE EXPERIENCED A HOSPITAL TRANSFER OR HOSPITAL ADMISSION UPON DISCHARGE FROM ASC	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8915	PATIENT DOCUMENTED NOT TO HAVE EXPERIENCED A HOSPITAL TRANSFER OR HOSPITAL ADMISSION UPON DISCHARGE FROM ASC	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8916	PATIENT WITH PREOPERATIVE ORDER FOR IV ANTIBIOTIC SURGICAL SITE INFECTION (SSI) PROPHYLAXIS, ANTIBIOTIC INITIATED ON TIME	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8917	PATIENT WITH PREOPERATIVE ORDER FOR IV ANTIBIOTIC SURGICAL SITE INFECTION (SSI) PROPHYLAXIS, ANTIBIOTIC NOT INITIATED ON TIME	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8918	PATIENT WITHOUT PREOPERATIVE ORDER FOR IV ANTIBIOTIC SURGICAL SITE INFECTION (SSI) PROPHYLAXIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8919	MOST RECENT SYSTOLIC BLOOD PRESSURE < 140 MMHG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8920	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140 MMHG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8921	MOST RECENT DIASTOLIC BLOOD PRESSURE < 90 MMHG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8922	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90 MMHG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8923	LEFT VENTRICULAR EJECTION FRACTION (LVEF) < 40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8924	SPIROMETRY TEST RESULTS DEMONSTRATE FEV1/FVC <60% WITH COPD SYMPTOMS (E.G., DYSPNEA, COUGH/SPUTUM, WHEEZING)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8925	SPIROMETRY TEST RESULTS DEMONSTRATE FEV1/FVC >=60% OR PATIENT DOES NOT HAVE COPD SYMPTOMS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8926	SPIROMETRY TEST NOT PERFORMED OR DOCUMENTED, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G8927	ADJUVANT CHEMOTHERAPY REFERRED, PRESCRIBED OR PREVIOUSLY RECEIVED FOR AJCC STAGE III, COLON CANCER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8928	ADJUVANT CHEMOTHERAPY NOT PRESCRIBED OR PREVIOUSLY RECEIVED, REASON GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8929	ADJUVANT CHEMOTHERAPY NOT PRESCRIBED OR PREVIOUSLY RECEIVED, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8930	ASSESSMENT OF DEPRESSION SEVERITY NOT DOCUMENTED, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8931	ASSESSMENT OF DEPRESSION SEVERITY NOT DOCUMENTED, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8932	SUICIDE RISK ASSESSED AT THE INITIAL EVALUATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8933	SUICIDE RISK NOT ASSESSED AT THE INITIAL EVALUATION, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8934	LEFT VENTRICULAR EJECTION FRACTION (LVEF) <40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8935	CLINICIAN PRESCRIBED ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8936	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8937	CLINICIAN DID NOT PRESCRIBE ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8938	BMI IS CALCULATED, BUT PATIENT NOT ELIGIBLE FOR FOLLOW-UP PLAN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8939	PAIN ASSESSMENT DOCUMENTED, FOLLOW-UP PLAN NOT DOCUMENTED, PATIENT NOT ELIGIBLE/APPROPRIATE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8940	SCREENING FOR CLINICAL DEPRESSION DOCUMENTED, FOLLOW-UP PLAN NOT DOCUMENTED, PATIENT NOT ELIGIBLE/APPROPRIATE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8941	ELDER MALTREATMENT SCREEN DOCUMENTED, PATIENT NOT ELIGIBLE FOR FOLLOW-UP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G8942	DOCUMENTED FUNCTIONAL OUTCOMES ASSESSMENT AND CARE PLAN WITHIN THE PREVIOUS 30 DAYS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8943	LDL-C RESULT NOT PRESENT OR NOT WITHIN 12 MONTHS PRIOR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8944	AJCC MELANOMA CANCER STAGE 0 THROUGH IIC MELANOMA	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8945	ANEURYSM MINOR DIAMETER <= 6 CM FOR MEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8946	MINIMALLY INVASIVE BIOPSY METHOD ATTEMPTED BUT NOT DIAGNOSTIC OF BREAST CANCER (E.G., HIGH RISK LESION OF BREAST SUCH AS ATYPICAL DUCTAL HYPERPLASIA, LOBULAR NEOPLASIA, ATYPICAL LOBULAR CARCINOMA IN SITU, ATYPICAL COLUMNAR HYPERPLASIA, FLAT EPITHELI	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8947	ONE OR MORE NEUROPSYCHIATRIC SYMPTOMS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8948	NO NEUROPSYCHIATRIC SYMPTOMS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8949	DOCUMENTATION OF PATIENT REASON(S) FOR PATIENT NOT RECEIVING COUNSELING FOR DIET AND PHYSICAL ACTIVITY (E.G., PATIENT IS NOT WILLING TO DISCUSS DIET OR EXERCISE INTERVENTIONS TO HELP CONTROL BLOOD PRESSURE, OR THE PATIENT SAID HE/SHE REFUSED TO MAKE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8950	PRE-HYPERTENSIVE OR HYPERTENSIVE BLOOD PRESSURE READING DOCUMENTED, INDICATED FOLLOW-UP DOCUMENTED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8951	PRE-HYPERTENSIVE OR HYPERTENSIVE BLOOD PRESSURE READING DOCUMENTED, INDICATED FOLLOW-UP NOT DOCUMENTED, PATIENT NOT ELIGIBLE/NOT APPROPRIATE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8952	PRE-HYPERTENSIVE OR HYPERTENSIVE BLOOD PRESSURE READING DOCUMENTED, INDICATED FOLLOW-UP NOT DOCUMENTED, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8953	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE ONCOLOGY MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8954	COMPLETE AND APPROPRIATE PATIENT DATA WERE REPORTED TO A QUALIFIED CLINICAL DATABASE REGISTRY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8955	MOST RECENT ASSESSMENT OF ADEQUACY OF VOLUME MANAGEMENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G8956	PATIENT RECEIVING MAINTENANCE HEMODIALYSIS IN AN OUTPATIENT DIALYSIS FACILITY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8957	PATIENT NOT RECEIVING MAINTENANCE HEMODIALYSIS IN AN OUTPATIENT DIALYSIS FACILITY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8958	ASSESSMENT OF ADEQUACY OF VOLUME MANAGEMENT NOT DOCUMENTED, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8959	CLINICIAN TREATING MAJOR DEPRESSIVE DISORDER COMMUNICATES TO CLINICIAN TREATING COMORBID CONDITION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8960	CLINICIAN TREATING MAJOR DEPRESSIVE DISORDER DID NOT COMMUNICATE TO CLINICIAN TREATING COMORBID CONDITION, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8961	CARDIAC STRESS IMAGING TEST PRIMARILY PERFORMED ON LOW-RISK SURGERY PATIENT FOR PREOPERATIVE EVALUATION WITHIN 30 DAYS PRECEDING THIS SURGERY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8962	CARDIAC STRESS IMAGING TEST PERFORMED ON PATIENT FOR ANY REASON INCLUDING THOSE WHO DID NOT HAVE LOW RISK SURGERY OR TEST THAT WAS PERFORMED MORE THAN 30 DAYS PRECEDING LOW RISK SURGERY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8963	CARDIAC STRESS IMAGING PERFORMED PRIMARILY FOR MONITORING OF ASYMPTOMATIC PATIENT WHO HAD PCI WITHIN 2 YEARS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8964	CARDIAC STRESS IMAGING TEST PERFORMED PRIMARILY FOR ANY OTHER REASON THAN MONITORING OF ASYMPTOMATIC PATIENT WHO HAD PCI WITHIN 2 YEARS (E.G., SYMPTOMATIC PATIENT, PATIENT GREATER THAN 2 YEARS SINCE PCI, INITIAL EVALUATION, ETC)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8965	CARDIAC STRESS IMAGING TEST PRIMARILY PERFORMED ON LOW CHD RISK PATIENT FOR INITIAL DETECTION AND RISK ASSESSMENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8966	CARDIAC STRESS IMAGING TEST PERFORMED ON SYMPTOMATIC OR HIGHER THAN LOW CHD RISK PATIENT OR FOR ANY REASON OTHER THAN INITIAL DETECTION AND RISK ASSESSMENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8967	WARFARIN OR ANOTHER ORAL ANTICOAGULANT THAT IS FDA APPROVED PRESCRIBED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8968	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT PRESCRIBING WARFARIN OR ANOTHER ORAL ANTICOAGULANT THAT IS FDA APPROVED NOT PRESCRIBED (E.G., ALLERGY, RISK OF BLEEDING, TRANSIENT OR REVERSIBLE CAUSES OF ATRIAL FIBRILLATION, OTHER MEDICAL REASONS INCLUDING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G8969	DOCUMENTATION OF PATIENT REASON(S) FOR NOT PRESCRIBING WARFARIN OR ANOTHER ORAL ANTICOAGULANT THAT IS FDA APPROVED (E.G., ECONOMIC, SOCIAL, AND/OR RELIGIOUS IMPEDIMENTS, NONCOMPLIANCE OR PATIENT REFUSAL, OTHER PATIENT REASONS)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8970	NO RISK FACTORS OR ONE MODERATE RISK FACTOR FOR THROMBOEMBOLISM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8971	WARFARIN OR ANOTHER ORAL ANTICOAGULANT THAT IS FDA APPROVED NOT PRESCRIBED, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8972	ONE OR MORE HIGH RISK FACTORS FOR THROMBOEMBOLISM OR MORE THAN ONE MODERATE RISK FACTOR FOR THROMBOEMBOLISM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8973	MOST RECENT HEMOGLOBIN (HGB) LEVEL < 10 G/DL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8974	HEMOGLOBIN LEVEL MEASUREMENT NOT DOCUMENTED, REASON NOT GIVEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8975	DOCUMENTATION OF MEDICAL REASON(S) FOR PATIENT HAVING A HEMOGLOBIN LEVEL < 10 G/DL (E.G., PATIENTS WHO HAVE NON-RENAL ETIOLOGIES OF ANEMIA [E.G., SICKLE CELL ANEMIA OR OTHER HEMOGLOBINOPATHIES, HYPERSPLENISM, PRIMARY BONE MARROW DISEASE, ANEMIA RELAT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8976	MOST RECENT HEMOGLOBIN (HGB) LEVEL >= 10 G/DL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8977	I INTEND TO REPORT THE ONCOLOGY MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8978	MOBILITY: WALKING & MOVING AROUND FUNCTIONAL LIMITATION, CURRENT STATUS, AT THERAPY EPISODE OUTSET AND AT REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8979	MOBILITY: WALKING & MOVING AROUND FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS, AT THERAPY EPISODE OUTSET, AT REPORTING INTERVALS, AND AT DISCHARGE OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8980	MOBILITY: WALKING & MOVING AROUND FUNCTIONAL LIMITATION, DISCHARGE STATUS, AT DISCHARGE FROM THERAPY OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8981	CHANGING & MAINTAINING BODY POSITION FUNCTIONAL LIMITATION, CURRENT STATUS, AT THERAPY EPISODE OUTSET AND AT REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8982	CHANGING & MAINTAINING BODY POSITION FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS, AT THERAPY EPISODE OUTSET, AT REPORTING INTERVALS, AND AT DISCHARGE OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G8983	CHANGING & MAINTAINING BODY POSITION FUNCTIONAL LIMITATION, DISCHARGE STATUS, AT DISCHARGE FROM THERAPY OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8984	CARRYING, MOVING & HANDLING OBJECTS FUNCTIONAL LIMITATION, CURRENT STATUS, AT THERAPY EPISODE OUTSET AND AT REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8985	CARRYING, MOVING & HANDLING OBJECTS FUNCTIONAL LIMITATION, CURRENT STATUS, AT THERAPY EPISODE OUTSET AND AT REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8986	CARRYING, MOVING & HANDLING OBJECTS FUNCTIONAL LIMITATION, DISCHARGE STATUS, AT DISCHARGE FROM THERAPY OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8987	SELF CARE FUNCTIONAL LIMITATION, CURRENT STATUS, AT THERAPY EPISODE OUTSET AND AT REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8988	SELF CARE FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS, AT THERAPY EPISODE OUTSET, AT REPORTING INTERVALS, AND AT DISCHARGE OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8989	SELF CARE FUNCTIONAL LIMITATION, DISCHARGE STATUS, AT DISCHARGE FROM THERAPY OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8990	OTHER PHYSICAL OR OCCUPATIONAL PRIMARY FUNCTIONAL LIMITATION, CURRENT STATUS, AT THERAPY EPISODE OUTSET AND AT REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8991	OTHER PHYSICAL OR OCCUPATIONAL PRIMARY FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS, AT THERAPY EPISODE OUTSET, AT REPORTING INTERVALS, AND AT DISCHARGE OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8992	OTHER PHYSICAL OR OCCUPATIONAL PRIMARY FUNCTIONAL LIMITATION, DISCHARGE STATUS, AT DISCHARGE FROM THERAPY OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8993	OTHER PHYSICAL OR OCCUPATIONAL SUBSEQUENT FUNCTIONAL LIMITATION, CURRENT STATUS, AT THERAPY EPISODE OUTSET AND AT REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8994	OTHER PHYSICAL OR OCCUPATIONAL SUBSEQUENT FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS, AT THERAPY EPISODE OUTSET, AT REPORTING INTERVALS, AND AT DISCHARGE OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8995	OTHER PHYSICAL OR OCCUPATIONAL SUBSEQUENT FUNCTIONAL LIMITATION, DISCHARGE STATUS, AT DISCHARGE FROM THERAPY OR TO END REPORTING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8996	SWALLOWING FUNCTIONAL LIMITATION, CURRENT STATUS AT TIME OF INITIAL THERAPY TREATMENT/EPISODE OUTSET AND REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G8997	SWALLOWING FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS, AT INITIAL THERAPY TREATMENT/OUTSET AND AT DISCHARGE FROM THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8998	SWALLOWING FUNCTIONAL LIMITATION, DISCHARGE STATUS, AT DISCHARGE FROM THERAPY/END OF REPORTING ON LIMITATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G8999	MOTOR SPEECH FUNCTIONAL LIMITATION, CURRENT STATUS AT TIME OF INITIAL THERAPY TREATMENT/EPISODE OUTSET AND REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9148	NATIONAL COMMITTEE FOR QUALITY ASSURANCE - LEVEL 1 MEDICAL HOME	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9149	NATIONAL COMMITTEE FOR QUALITY ASSURANCE - LEVEL 2 MEDICAL HOME	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9150	NATIONAL COMMITTEE FOR QUALITY ASSURANCE - LEVEL 3 MEDICAL HOME	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9151	MAPCP DEMONSTRATION - STATE PROVIDED SERVICES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9152	MAPCP DEMONSTRATION - COMMUNITY HEALTH TEAMS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9153	MAPCP DEMONSTRATION - PHYSICIAN INCENTIVE POOL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9157	TRANSESOPHAGEAL DOPPLER USE FOR CARDIAC MONITORING	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
G9158	MOTOR SPEECH FUNCTIONAL LIMITATION, DISCHARGE STATUS AT DISCHARGE FROM THERAPY/END OF REPORTING ON LIMITATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9159	SPOKEN LANGUAGE COMPREHENSION FUNCTIONAL LIMITATION, CURRENT STATUS AT TIME OF INITIAL THERAPY TREATMENT/EPISODE OUTSET AND REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9160	SPOKEN LANGUAGE COMPREHENSION FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS AT INITIAL THERAPY TREATMENT/OUTSET AND AT DISCHARGE FROM THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9161	SPOKEN LANGUAGE COMPREHENSION FUNCTIONAL LIMITATION, DISCHARGE STATUS AT DISCHARGE FROM THERAPY/END OF REPORTING ON LIMITATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9162	SPOKEN LANGUAGE EXPRESSION FUNCTIONAL LIMITATION, CURRENT STATUS AT TIME OF INITIAL THERAPY TREATMENT/EPISODE OUTSET AND REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G9163	SPOKEN LANGUAGE EXPRESSION FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS AT INITIAL THERAPY TREATMENT/OUTSET AND AT DISCHARGE FROM THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9164	SPOKEN LANGUAGE EXPRESSION FUNCTIONAL LIMITATION, DISCHARGE STATUS AT DISCHARGE FROM THERAPY/END OF REPORTING ON LIMITATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9165	ATTENTION FUNCTIONAL LIMITATION, CURRENT STATUS AT TIME OF INITIAL THERAPY TREATMENT/EPISODE OUTSET AND REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9166	ATTENTION FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS AT INITIAL THERAPY TREATMENT/OUTSET AND AT DISCHARGE FROM THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9167	ATTENTION FUNCTIONAL LIMITATION, DISCHARGE STATUS AT DISCHARGE FROM THERAPY/END OF REPORTING ON LIMITATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9168	MEMORY FUNCTIONAL LIMITATION, CURRENT STATUS AT TIME OF INITIAL THERAPY TREATMENT/EPISODE OUTSET AND REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9169	MEMORY FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS AT INITIAL THERAPY TREATMENT/OUTSET AND AT DISCHARGE FROM THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9170	MEMORY FUNCTIONAL LIMITATION, DISCHARGE STATUS AT DISCHARGE FROM THERAPY/END OF REPORTING ON LIMITATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9171	VOICE FUNCTIONAL LIMITATION, CURRENT STATUS AT TIME OF INITIAL THERAPY TREATMENT/EPISODE OUTSET AND REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9172	VOICE FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS AT INITIAL THERAPY TREATMENT/OUTSET AND AT DISCHARGE FROM THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9173	VOICE FUNCTIONAL LIMITATION, DISCHARGE STATUS AT DISCHARGE FROM THERAPY/END OF REPORTING ON LIMITATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9174	OTHER SPEECH LANGUAGE PATHOLOGY FUNCTIONAL LIMITATION, CURRENT STATUS AT TIME OF INITIAL THERAPY TREATMENT/EPISODE OUTSET AND REPORTING INTERVALS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9175	OTHER SPEECH LANGUAGE PATHOLOGY FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS AT INITIAL THERAPY TREATMENT/OUTSET AND AT DISCHARGE FROM THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
G9176	OTHER SPEECH LANGUAGE PATHOLOGY FUNCTIONAL LIMITATION, DISCHARGE STATUS AT DISCHARGE FROM THERAPY/END OF REPORTING ON LIMITATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
G9186	MOTOR SPEECH FUNCTIONAL LIMITATION, PROJECTED GOAL STATUS AT INITIAL THERAPY TREATMENT/OUTSET AND AT DISCHARGE FROM THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
J0178	INJECTION, AFLIBERCEPT, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J0485	INJECTION, BELATACEPT, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J0716	INJECTION, CENTRUROIDES IMMUNE F(AB)2, UP TO 120 MILLIGRAMS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
J0890	INJECTION, PEGINESATIDE, 0.1 MG (FOR ESRD ON DIALYSIS)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J1050	INJECTION, MEDROXYPROGESTERONE ACETATE, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J1741	INJECTION, IBUPROFEN, 100 MG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
J1744	INJECTION, ICATIBANT, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J2212	INJECTION, METHYLNALTREXONE, 0.1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J7178	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J7315	MITOMYCIN, OPHTHALMIC, 0.2 MG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
J7527	EVEROLIMUS, ORAL, 0.25 MG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
J9002	INJECTION, DOXORUBICIN HYDROCHLORIDE, LIPOSOMAL, DOXIL, 10 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J9019	INJECTION, ASPARAGINASE (ERWINAZE), 1,000 IU	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
J9042	INJECTION, BRENTUXIMAB VEDOTIN, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	YES
L5859	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION/EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO
L7902	TENSION RING, FOR VACUUM ERECTION DEVICE, ANY TYPE, REPLACEMENT ONLY, EACH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
L8605	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, ANAL CANAL, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
Q4131	EPIFIX, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
Q4132	GRAFIX CORE, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
Q4133	GRAFIX PRIME, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
Q4134	HMATRIX, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
Q4135	MEDISKIN, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
Q4136	EZ-DERM, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
Q9969	TC-99M FROM NON-HIGHLY ENRICHED URANIUM SOURCE, FULL COST RECOVERY ADD-ON, PER STUDY DOSE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
S9110	TELEMONITORING OF PATIENT IN THEIR HOME, INCLUDING ALL NECESSARY EQUIPMENT; COMPUTER SYSTEM, CONNECTIONS, AND SOFTWARE; MAINTENANCE; PATIENT EDUCATION AND SUPPORT; PER MONTH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5281	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM SYSTEM, MONAURAL, (1 RECEIVER, TRANSMITTER, MICROPHONE), ANY TYPE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5282	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM SYSTEM, BINAURAL, (2 RECEIVERS, TRANSMITTER, MICROPHONE), ANY TYPE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5283	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM NECK, LOOP INDUCTION RECEIVER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5284	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM, EAR LEVEL RECEIVER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5285	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM, DIRECT AUDIO INPUT RECEIVER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5286	ASSISTIVE LISTENING DEVICE, PERSONAL BLUE TOOTH FM/DM RECEIVER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5287	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM RECEIVER, NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 1 (continued) – New 2013 Annual HCPCS Codes, effective January 1, 2013

Procedure code	Description	Program coverage	PA requirements	NDC required
V5288	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM TRANSMITTER ASSISTIVE LISTENING DEVICE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5289	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM ADAPTER/BOOT COUPLING DEVICE FOR RECEIVER, ANY TYPE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA
V5290	ASSISTIVE LISTENING DEVICE, TRANSMITTER MICROPHONE, ANY TYPE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA

Table 2 – New modifier codes for the 2013 annual HCPCS update

Modifier code	Description	Type	Date effective
CH	0 PERCENT IMPAIRED, LIMITED OR RESTRICTED	Informational	January 1, 2013
CI	AT LEAST 1 PERCENT BUT LESS THAN 20 PERCENT IMPAIRED, LIMITED OR RESTRICTED	Informational	January 1, 2013
CJ	AT LEAST 20 PERCENT BUT LESS THAN 40 PERCENT IMPAIRED, LIMITED OR RESTRICTED	Informational	January 1, 2013
CK	AT LEAST 40 PERCENT BUT LESS THAN 60 PERCENT IMPAIRED, LIMITED OR RESTRICTED	Informational	January 1, 2013
CL	AT LEAST 60 PERCENT BUT LESS THAN 80 PERCENT IMPAIRED, LIMITED OR RESTRICTED	Informational	January 1, 2013
CM	AT LEAST 80 PERCENT BUT LESS THAN 100 PERCENT IMPAIRED, LIMITED OR RESTRICTED	Informational	January 1, 2013
CN	100 PERCENT IMPAIRED, LIMITED OR RESTRICTED	Informational	January 1, 2013
LM	LEFT MAIN CORONARY ARTERY	Informational	January 1, 2013
RI	RAMUS INTERMEDIUS CORONARY ARTERY	Informational	January 1, 2013

Table 3 – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
0030T	ANTIPROTHROMBIN (PHOSPHOLIPID COFACTOR ANTIBODY, EACH IG CLASS)	86849
0048T	IMPLANTATION OF A VENTRICULAR ASSIST DEVICE, EXTRACORPOREAL, PERCUTANEOUS TRANSSEPTAL ACCESS, SINGLE OR DUAL CANNULATION	33991
0050T	REMOVAL OF A VENTRICULAR ASSIST DEVICE, EXTRACORPOREAL, PERCUTANEOUS TRANSSEPTAL ACCESS, SINGLE OR DUAL CANNULATION	33990-33993
0173T	MONITORING OF INTRAOCULAR PRESSURE DURING VITRECTOMY SURGERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NA

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
0242T	GASTROINTESTINAL TRACT TRANSIT AND PRESSURE MEASUREMENT, STOMACH THROUGH COLON, WIRELESS CAPSULE, WITH INTERPRETATION AND REPORT	91112
0250T	AIRWAY SIZING AND INSERTION OF BRONCHIAL VALVE(S), EACH LOBE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	31647-31649
0251T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH REMOVAL OF BRONCHIAL VALVE(S), INITIAL LOBE	31647-31649
0252T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH REMOVAL OF BRONCHIAL VALVE(S), EACH ADDITIONAL LOBE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	31647-31649
0256T	IMPLANTATION OF CATHETER-DELIVERED PROSTHETIC AORTIC HEART VALVE; ENDOVASCULAR APPROACH	33361-33364
0257T	IMPLANTATION OF CATHETER-DELIVERED PROSTHETIC AORTIC HEART VALVE; OPEN THORACIC APPROACH (EG, TRANSAPICAL, TRANSVENTRICULAR)	33365, 0318T
0258T	TRANSTHORACIC CARDIAC EXPOSURE (EG, STERNOTOMY, THORACOTOMY, SUBXIPHOID FOR CATHETER-DELIVERED AORTIC VALVE REPLACEMENT; WITHOUT CARDIOPULMONARY BYPASS	33365, 33366
0259T	TRANSTHORACIC CARDIAC EXPOSURE (EG, STERNOTOMY, THORACOTOMY, SUBXIPHOID FOR CATHETER-DELIVERED AORTIC VALVE REPLACEMENT; WITH CARDIOPULMONARY BYPASS	33365-33369
0276T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 1 LOBE	31660, 31661
0277T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 2 OR MORE LOBES	31660, 31661
0279T	CELL ENUMERATION USING IMMUNOLOGIC SELECTION AND IDENTIFICATION IN FLUID SPECIMEN (EG, CIRCULATING TUMOR CELLS IN BLOOD ;	86152, 86153
0280T	CELL ENUMERATION USING IMMUNOLOGIC SELECTION AND IDENTIFICATION IN FLUID SPECIMEN (EG, CIRCULATING TUMOR CELLS IN BLOOD ; INTERPRETATION AND REPORT	86152, 86153
29590	DENIS-BROWNE SPLINT STRAPPING	NA
31656	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH INJECTION OF CONTRAST MATERIAL FOR SEGMENTAL BRONCHOGRAPHY (FIBERSCOPE ONLY	31899
31715	TRANSTRACHEAL INJECTION FOR BRONCHOGRAPHY	31899
32420	PNEUMOCENTESIS, PUNCTURE OF LUNG FOR ASPIRATION	32405

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
32421	THORACENTESIS, PUNCTURE OF PLEURAL CAVITY FOR ASPIRATION, INITIAL OR SUBSEQUENT	32554, 32555
32422	THORACENTESIS WITH INSERTION OF TUBE, INCLUDES WATER SEAL (EG, FOR PNEUMOTHORAX , WHEN PERFORMED (SEPARATE PROCEDURE	32554, 32555
37201	TRANSCATHETER THERAPY, INFUSION FOR THROMBOLYSIS OTHER THAN CORONARY	37211-37214
37203	TRANSCATHETER RETRIEVAL, PERCUTANEOUS, OF INTRAVASCULAR FOREIGN BODY (EG, FRACTURED VENOUS OR ARTERIAL CATHETER	37197
37209	EXCHANGE OF A PREVIOUSLY PLACED INTRAVASCULAR CATHETER DURING THROMBOLYTIC THERAPY	37211-37214
43234	UPPER GASTROINTESTINAL ENDOSCOPY, SIMPLE PRIMARY EXAMINATION (EG, WITH SMALL DIAMETER FLEXIBLE ENDOSCOPE (SEPARATE PROCEDURE	43235
65805	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE ; WITH THERAPEUTIC RELEASE OF AQUEOUS	65800
71040	BRONCHOGRAPHY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	76499
71060	BRONCHOGRAPHY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	76499
75650	ANGIOGRAPHY, CERVICOCEREBRAL, CATHETER, INCLUDING VESSEL ORIGIN, RADIOLOGICAL SUPERVISION AND INTERPRETATION	36221-36226
75660	ANGIOGRAPHY, EXTERNAL CAROTID, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION	36227
75662	ANGIOGRAPHY, EXTERNAL CAROTID, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION	36227
75665	ANGIOGRAPHY, CAROTID, CEREBRAL, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	36223, 36224
75671	ANGIOGRAPHY, CAROTID, CEREBRAL, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	36223, 36224
75676	ANGIOGRAPHY, CAROTID, CERVICAL, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	36222-36224
75680	ANGIOGRAPHY, CAROTID, CERVICAL, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	36222-36224
75685	ANGIOGRAPHY, VERTEBRAL, CERVICAL, AND/OR INTRACRANIAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	36225, 36226
75900	EXCHANGE OF A PREVIOUSLY PLACED INTRAVASCULAR CATHETER DURING THROMBOLYTIC THERAPY WITH CONTRAST MONITORING, RADIOLOGICAL SUPERVISION AND INTERPRETATION	37211-37214

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
75961	TRANSCATHETER RETRIEVAL, PERCUTANEOUS, OF INTRAVASCULAR FOREIGN BODY (EG, FRACTURED VENOUS OR ARTERIAL CATHETER , RADIOLOGICAL SUPERVISION AND INTERPRETATION	37197
78000	THYROID UPTAKE; SINGLE DETERMINATION	78012-78014
78001	THYROID UPTAKE; MULTIPLE DETERMINATIONS	78012-78014
78003	THYROID UPTAKE; STIMULATION, SUPPRESSION OR DISCHARGE (NOT INCLUDING INITIAL UPTAKE STUDIES	78012-78014
78006	THYROID IMAGING, WITH UPTAKE; SINGLE DETERMINATION	78012-78014
78007	THYROID IMAGING, WITH UPTAKE; MULTIPLE DETERMINATIONS	78012-78014
78010	THYROID IMAGING; ONLY	78012-78014
78011	THYROID IMAGING; WITH VASCULAR FLOW	78012-78014
83890	MOLECULAR DIAGNOSTICS; MOLECULAR ISOLATION OR EXTRACTION, EACH NUCLEIC ACID TYPE (IE, DNA OR RNA	81200-81479
83891	MOLECULAR DIAGNOSTICS; ISOLATION OR EXTRACTION OF HIGHLY PURIFIED NUCLEIC ACID, EACH NUCLEIC ACID TYPE (IE, DNA OR RNA	81200-81479
83892	MOLECULAR DIAGNOSTICS; ENZYMATIC DIGESTION, EACH ENZYME TREATMENT	81200-81479
83893	MOLECULAR DIAGNOSTICS; DOT/SLOT BLOT PRODUCTION, EACH NUCLEIC ACID PREPARATION	81200-81479
83894	MOLECULAR DIAGNOSTICS; SEPARATION BY GEL ELECTROPHORESIS (EG, AGAROSE, POLYACRYLAMIDE , EACH NUCLEIC ACID PREPARATION	81200-81479
83896	MOLECULAR DIAGNOSTICS; NUCLEIC ACID PROBE, EACH	81200-81479
83897	MOLECULAR DIAGNOSTICS; NUCLEIC ACID TRANSFER (EG, SOUTHERN, NORTHERN , EACH NUCLEIC ACID PREPARATION	81200-81479
83898	MOLECULAR DIAGNOSTICS; AMPLIFICATION, TARGET, EACH NUCLEIC ACID SEQUENCE	81200-81479
83900	MOLECULAR DIAGNOSTICS; AMPLIFICATION, TARGET, MULTIPLEX, FIRST 2 NUCLEIC ACID SEQUENCES	81200-81479
83901	MOLECULAR DIAGNOSTICS; AMPLIFICATION, TARGET, MULTIPLEX, EACH ADDITIONAL NUCLEIC ACID SEQUENCE BEYOND 2 (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE	81200-81479
83902	MOLECULAR DIAGNOSTICS; REVERSE TRANSCRIPTION	81200-81479
83903	MOLECULAR DIAGNOSTICS; MUTATION SCANNING, BY PHYSICAL PROPERTIES (EG, SINGLE STRAND CONFORMATIONAL POLYMORPHISMS [SSCP], HETERODUPLEX, DENATURING GRADIENT GEL ELECTROPHORESIS [DGGE], RNA'ASE A , SINGLE SEGMENT, EACH	81200-81479

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
83904	MOLECULAR DIAGNOSTICS; MUTATION IDENTIFICATION BY SEQUENCING, SINGLE SEGMENT, EACH SEGMENT	81200-81479
83905	MOLECULAR DIAGNOSTICS; MUTATION IDENTIFICATION BY ALLELE SPECIFIC TRANSCRIPTION, SINGLE SEGMENT, EACH SEGMENT	81200-81479
83906	MOLECULAR DIAGNOSTICS; MUTATION IDENTIFICATION BY ALLELE SPECIFIC TRANSLATION, SINGLE SEGMENT, EACH SEGMENT	81200-81479
83907	MOLECULAR DIAGNOSTICS; LYSIS OF CELLS PRIOR TO NUCLEIC ACID EXTRACTION (EG, STOOL SPECIMENS, PARAFFIN EMBEDDED TISSUE , EACH SPECIMEN	81200-81479
83908	MOLECULAR DIAGNOSTICS; AMPLIFICATION, SIGNAL, EACH NUCLEIC ACID SEQUENCE	81200-81479
83909	MOLECULAR DIAGNOSTICS; SEPARATION AND IDENTIFICATION BY HIGH RESOLUTION TECHNIQUE (EG, CAPILLARY ELECTROPHORESIS , EACH NUCLEIC ACID PREPARATION	81200-81479
83912	MOLECULAR DIAGNOSTICS; INTERPRETATION AND REPORT	81200-81479
83913	MOLECULAR DIAGNOSTICS; RNA ST ILIZATION	81200-81479
83914	MUTATION IDENTIFICATION BY ENZYMATIC LIGATION OR PRIMER EXTENSION, SINGLE SEGMENT, EACH SEGMENT (EG, OLIGONUCLEOTIDE LIGATION ASSAY [OLA], SINGLE BASE CHAIN EXTENSION [SBCE], OR ALLELE-SPECIFIC PRIMER EXTENSION [ASPE]	81200-81479
88384	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 11 THROUGH 50 PROBES	81200-81479
88385	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 51 THROUGH 250 PROBES	81200-81479
88386	ARRAY-BASED EVALUATION OF MULTIPLE MOLECULAR PROBES; 251 THROUGH 500 PROBES	81200-81479
90665	LYME DISEASE VACCINE, ADULT DOSAGE, FOR INTRAMUSCULAR USE	NA
90701	DIPHThERIA, TETANUS TOXOIDS, AND WHOLE CELL PERTUSSIS VACCINE (DTP , FOR INTRAMUSCULAR USE	NA
90718	TETANUS AND DIPHThERIA TOXOIDS (TD ADSORBED WHEN ADMINISTERED TO INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	NA
90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION	90791, 90792
90802	INTERACTIVE PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF COMMUNICATION	90791, 90792

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
90804	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90805	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90806	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90807	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90808	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
90809	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90810	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90811	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; W	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90812	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
90813	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; W	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90814	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90815	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; W	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90816	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
90817	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGE	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90818	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90819	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGE	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90821	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90822	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGE	90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
90823	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 20 TO 30 MINUT	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90824	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 20 TO 30 MINUT	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90826	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 45 TO 50 MINUT	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90827	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 45 TO 50 MINUT	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
90828	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 75 TO 80 MINUT	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90829	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 75 TO 80 MINUT	90785 IN CONJUNCTION WITH PSYCHOTHERAPY CODES 90832, 90834, 90837 OR PSYCHOTHERAPY ADD-ON CODES WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350]
90857	INTERACTIVE GROUP PSYCHOTHERAPY	90785 IN CONJUNCTION WITH 90853
90862	PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION, USE, AND REVIEW OF MEDICATION WITH NO MORE THAN MINIMAL MEDICAL PSYCHOTHERAPY	EVALUATION AND MANAGEMENT SERVICES CODES 99201-99255, 99281-99285, 99304-99337, 99341-99350
92980	TRANSCATHETER PLACEMENT OF AN INTRACORONARY STENT(S , PERCUTANEOUS, WITH OR WITHOUT OTHER THERAPEUTIC INTERVENTION, ANY METHOD; SINGLE VESSEL	92920-92944
92981	TRANSCATHETER PLACEMENT OF AN INTRACORONARY STENT(S , PERCUTANEOUS, WITH OR WITHOUT OTHER THERAPEUTIC INTERVENTION, ANY METHOD; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE	92920-92944
92982	PERCUTANEOUS TRANSLUMINAL CORONARY BALLOON ANGIOPLASTY; SINGLE VESSEL	92920-92944
92984	PERCUTANEOUS TRANSLUMINAL CORONARY BALLOON ANGIOPLASTY; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE	92920-92944
92995	PERCUTANEOUS TRANSLUMINAL CORONARY ATHERECTOMY, BY MECHANICAL OR OTHER METHOD, WITH OR WITHOUT BALLOON ANGIOPLASTY; SINGLE VESSEL	92924, 92925, 92933-92944)

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
92996	PERCUTANEOUS TRANSLUMINAL CORONARY ATHERECTOMY, BY MECHANICAL OR OTHER METHOD, WITH OR WITHOUT BALLOON ANGIOPLASTY; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE	92924, 92925, 92933-92944
93651	INTRACARDIAC CATHETER LATION OF ARRHYTHMOGENIC FOCUS; FOR TREATMENT OF SUPRAVENTRICULAR TACHYCARDIA BY LATION OF FAST OR SLOW ATRIOVENTRICULAR PATHWAYS, ACCESSORY ATRIOVENTRICULAR CONNECTIONS OR OTHER ATRIAL FOCI, SINGLY OR IN COMBINATION	93653-93657
93652	INTRACARDIAC CATHETER LATION OF ARRHYTHMOGENIC FOCUS; FOR TREATMENT OF VENTRICULAR TACHYCARDIA	93653-93657
95010	PERCUTANEOUS TESTS (SCRATCH, PUNCTURE, PRICK SEQUENTIAL AND INCREMENTAL, WITH DRUGS, BIOLOGICALS OR VENOMS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT BY A PHYSICIAN, SPECIFY NUMBER OF TESTS	95017,95018
95015	INTRACUTANEOUS (INTRADERMAL TESTS, SEQUENTIAL AND INCREMENTAL, WITH DRUGS, BIOLOGICALS, OR VENOMS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT BY A PHYSICIAN, SPECIFY NUMBER OF TESTS	95017,95018
95075	INGESTION CHALLENGE TEST (SEQUENTIAL AND INCREMENTAL INGESTION OF TEST ITEMS, EG, FOOD, DRUG OR OTHER SUBSTANCE SUCH AS MET ISULFITE	95076, 95079
95900	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE; MOTOR, WITHOUT F-WAVE STUDY	95907-95913
95903	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE; MOTOR, WITH F-WAVE STUDY	95907-95913
95904	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE; SENSORY	95907-95913
95920	INTRAOPERATIVE NEUROPHYSIOLOGY TESTING, PER HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE	95940, 95941
95934	H-REFLEX, AMPLITUDE AND LATENCY STUDY; RECORD GASTROCNEMIUS/SOLEUS MUSCLE	95907-95913
95936	H-REFLEX, AMPLITUDE AND LATENCY STUDY; RECORD MUSCLE OTHER THAN GASTROCNEMIUS/SOLEUS MUSCLE	95907-95913
C9279	INJECTION, IBUPROFEN, 100 MG	J1741
C9286	INJECTION, BELATACEPT, 1 MG	J0485
C9287	INJECTION, BRENTUXIM VEDOTIN, 1 MG	J9042
C9288	INJECTION, CENTRUROIDES (SCORPION IMMUNE F (2 (EQUINE , 1 VIAL	J0716
C9289	INJECTION, ASPARAGINASE ERWINIA CHRYSANTHEMI, 1,000 INTERNATIONAL UNITS (I U	J9019

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
C9291	INJECTION, AFLIBERCEPT, 2 MG VIAL	J0178
C9366	EPIFIX, PER SQUARE CENTIMETER	NA
C9368	GRAFIX CORE, PER SQUARE CENTIMETER	NA
C9369	GRAFIX PRIME, PER SQUARE CENTIMETER	NA
C9732	INSERTION OF OCULAR TELESCOPE PROSTHESIS INCLUDING REMOVAL OF CRYSTALLINE LENS	NA
D0360	CONE BEAM CT - CRANIOFACIAL DATA CAPTURE	NA
D0362	CONE BEAM - TWO-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES	NA
D1203	TOPICAL APPLICATION OF FLUORIDE - CHILD	D1206
D1204	TOPICAL APPLICATION OF FLUORIDE - ADULT	D1206
D4271	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY	NA
D6254	INTERIM PONTIC	NA
D6795	INTERIM RETAINER CROWN	NA
D6970	POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER, INDIRECTLY F RICATED	NA
D6972	PREF RICATED POST AND CORE IN ADDITION TO BRIDGE RETAINER	NA
D6973	CORE BUILD UP FOR RETAINER, INCLUDING ANY PINS	NA
D6976	EACH ADDITIONAL INDIRECTLY F RICATED POST - SAME TOOTH	NA
D6977	EACH ADDITIONAL PREF RICATED POST - SAME TOOTH	NA
G0290	TRANSCATHETER PLACEMENT OF A DRUG ELUTING INTRACORONARY STENT(S , PERCUTANEOUS, WITH OR WITHOUT OTHER THERAPEUTIC INTERVENTION, ANY METHOD; SINGLE VESSEL	C9600, C9601, C9602, C9603, C9604
G0291	TRANSCATHETER PLACEMENT OF A DRUG ELUTING INTRACORONARY STENT(S , PERCUTANEOUS, WITH OR WITHOUT OTHER THERAPEUTIC INTERVENTION, ANY METHOD; EACH ADDITIONAL VESSEL	C9605, C9606, C9607, C9608
G0911	ASSESSED LEVEL OF ACTIVITY AND SYMPTOMS	NA
G0912	LEVEL OF ACTIVITY AND SYMPTOMS NOT ASSESSED	NA
G8447	PATIENT ENCOUNTER WAS DOCUMENTED USING AN EHR SYSTEM THAT HAS BEEN CERTIFIED BY AN AUTHORIZED TESTING AND CERTIFICATION BODY (ATCB	NA
G8448	PATIENT ENCOUNTER WAS DOCUMENTED USING A PQRI QUALIFIED EHR OR OTHER ACCEPT LE SYSTEMS	NA

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
G8468	ANGIOTENSIN CONVERTING ENZYME (ACE INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB THERAPY PRESCRIBED FOR PATIENTS WITH A LEFT VENTRICULAR EJECTION FRACTION (LVEF <40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC F	NA
G8469	CLINICIAN DOCUMENTED THAT PATIENT WITH A LEFT VENTRICULAR EJECTION FRACTION (LVEF <40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION WAS NOT AN ELIGIBLE CANDIDATE FOR ANGIOTENSIN CONVERTING ENZYME (ACE INHI	NA
G8470	PATIENT WITH LEFT VENTRICULAR EJECTION FRACTION (LVEF >=40% OR DOCUMENTATION AS NORMAL OR MILDLY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	NA
G8471	LEFT VENTRICULAR EJECTION FRACTION (LVEF WAS NOT PERFORMED OR DOCUMENTED	NA
G8472	ANGIOTENSIN CONVERTING ENZYME (ACE INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB THERAPY NOT PRESCRIBED FOR PATIENTS WITH A LEFT VENTRICULAR EJECTION FRACTION (LVEF <40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOL	NA
G8524	PATCH CLOSURE USED FOR PATIENT UNDERGOING CONVENTIONAL CEA	NA
G8525	CLINICIAN DOCUMENTED THAT PATIENT DID NOT RECEIVE CONVENTIONAL CEA	NA
G8526	PATCH CLOSURE NOT USED FOR PATIENT UNDERGOING CONVENTIONAL CEA, REASON NOT SPECIFIED	NA
G8546	I INTEND TO REPORT THE COMMUNITY-ACQUIRED PNEUMONIA (CAP MEASURES GROUP	NA
G8550	ALL QUALITY ACTIONS FOR THE APPLIC LE MEASURES IN THE COMMUNITY-ACQUIRED PNEUMONIA (CAP MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	NA
G8675	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140 MM HG	NA
G8676	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90 MM HG	NA
G8677	MOST RECENT SYSTOLIC BLOOD PRESSURE < 130 MM HG	NA
G8678	MOST RECENT SYSTOLIC BLOOD PRESSURE 130 TO 139 MM HG	NA
G8679	MOST RECENT DIASTOLIC BLOOD PRESSURE < 80 MM HG	NA
G8680	MOST RECENT DIASTOLIC BLOOD PRESSURE 80 - 89 MM HG	NA
G8695	LEFT VENTRICULAR EJECTION FRACTION (LVEF >= 40% OR DOCUMENTATION AS MILDLY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION OR NORMAL	NA
G8715	HEMODIALYSIS TREATMENT PERFORMED LESS THAN THREE TIMES PER WEEK OR GREATER THAN THREE TIMES PER WEEK	NA

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
G8716	DOCUMENTATION OF REASON(S FOR PATIENT NOT HAVING GREATER THAN OR EQUAL TO 1 2 (SINGLE-POOL CLEARANCE OF UREA [KT] / VOLUME [V]	NA
G8727	PATIENT RECEIVING HEMODIALYSIS, PERITONEAL DIALYSIS OR KIDNEY TRANSPLANTATION	NA
G8750	PRESENCE OF SIGNS OF MELANOMA (COUGH, DYSPNEA, TENDERNESS, LOCALIZED NEUROLOGIC SIGNS SUCH AS WEAKNESS, JAUNDICE OR ANY OTHER SIGN SUGGESTING SYSTEMIC SPREAD OR PRESENCE OF SYMPTOMS OF MELANOMA (PAIN, PARESTHESIA, OR ANY OTHER SYMPTOM SUGGESTING THE	NA
G8760	ALL QUALITY ACTIONS FOR THE APPLIC LE MEASURES IN THE EPILEPSY MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	NA
G8786	SEVERITY OF ANGINA ASSESSED ACCORDING TO LEVEL OF ACTIVITY	NA
G8787	ANGINA ASSESSED AS PRESENT	NA
G8788	ANGINA ASSESSED AS SENT	NA
G8789	SEVERITY OF ANGINA NOT ASSESSED ACCORDING TO LEVEL OF ACTIVITY	NA
G8802	PREGNANCY TEST (URINE OR SERUM ORDERED	NA
G8803	PREGNANCY TEST (URINE OR SERUM NOT ORDERED FOR REASONS DOCUMENTED BY CLINICIAN	NA
G8805	PREGNANCY TEST (URINE OR SERUM WAS NOT ORDERED, REASON NOT SPECIFIED	NA
G8819	ANEURYSM MINOR DIAMETER <= 5 5 CM	NA
G8820	ANEURYSM MINOR DIAMETER 5 6-6 0 CM	NA
G8821	DOMINAL AORTIC ANEURYSM IS NOT INFARENAL	NA
G8822	MALE PATIENTS WITH ANEURYSMS MINOR DIAMETER >6 CM	NA
G8823	FEMALE PATIENTS WITH ANEURYSM MINOR DIAMETER >6CM	NA
G8824	FEMALE PATIENTS WITH ANEURYSM MINOR DIAMETER 5 6-6 0 CM	NA
G8828	ANEURYSM MINOR DIAMETER <= 5 5 CM FOR MEN	NA
G8829	ANEURYSM MINOR DIAMETER 5 6-6 0 CM FOR MEN	NA
G8830	ANEURYSM MINOR DIAMETER >6CM FOR MEN	NA
G8831	ANEURYSM MINOR DIAMETER >6CM FOR WOMEN	NA
G8832	ANEURYSM MINOR DIAMETER 5 6-6 0 CM FOR WOMEN	NA
G8836	SYMPTOMATIC PATIENT WITH IPSILATERAL STROKE OR TIA WITHIN 120 DAYS PRIOR TO CEA	NA

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
G8837	OTHER SYMPTOMATIC PATIENT WITH IPSILATERAL CAROTID TERRITORY TIA OR STROKE > 120 DAYS PRIOR TO CEA, OR CONTRALATERAL CAROTID TERRITORY TIA OR STROKE OR VERTEBROBASILAR TIA OR STROKE	NA
G8847	POSITIVE AIRWAY PRESSURE THERAPY NOT PRESCRIBED	NA
G8901	I INTEND TO REPORT THE EPILEPSY MEASURES GROUP	NA
G9141	INFLUENZA A (H1N1 IMMUNIZATION ADMINISTRATION (INCLUDES THE PHYSICIAN COUNSELING THE PATIENT/FAMILY	NA
G9142	INFLUENZA A (H1N1 VACCINE, ANY ROUTE OF ADMINISTRATION	NA
J1051	INJECTION, MEDROXYPROGESTERONE ACETATE, 50 MG	J1050
J1055	INJECTION, MEDROXYPROGESTERONE ACETATE FOR CONTRACEPTIVE USE, 150 MG	NA
J1056	INJECTION, MEDROXYPROGESTERONE ACETATE / ESTRADIOL CYPIONATE, 5MG / 25MG	NA
J1680	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 100 MG	J7178
J8561	EVEROLIMUS, ORAL, 0 25 MG	J7527
J9001	INJECTION, DOXORUBICIN HYDROCHLORIDE, ALL LIPID FORMULATIONS, 10 MG	NA
K0741	PORT LE GASEOUS OXYGEN SYSTEM, RENTAL, INCLUDES PORT LE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING, FOR CLUSTER HEADACHES	NA
K0742	PORT LE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT, FOR CLUSTER HEADACHES, FOR INITIAL MONTHS SUPPLY OR TO REPLACE USED CONTENTS	NA
Q2045	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 1 MG	J7178
Q2046	INJECTION, AFLIBERCEPT, 1 MG	J0178
Q2047	INJECTION, PEGINESATIDE, 0 1 MG (FOR ESRD ON DIALYSIS	J0890
Q2048	INJECTION, DOXORUBICIN HYDROCHLORIDE, LIPOSOMAL, DOXIL, 10 MG	J9002
S3711	CIRCULATING TUMOR CELL TEST	NA
S3713	KRAS MUTATION ANALYSIS TESTING	NA
S3818	COMPLETE GENE SEQUENCE ANALYSIS; BRCA1 GENE	NA
S3819	COMPLETE GENE SEQUENCE ANALYSIS; BRCA2 GENE	NA
S3820	COMPLETE BRCA1 AND BRCA2 GENE SEQUENCE ANALYSIS FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER	NA

Table 3 (continued) – Deleted HCPCS codes, effective January 1, 2013

Procedure code	Description	Alternate codes for consideration
S3822	SINGLE MUTATION ANALYSIS (IN INDIVIDUAL WITH A KNOWN BRCA1 OR BRCA2 MUTATION IN THE FAMILY FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER	NA
S3823	THREE-MUTATION BRCA1 AND BRCA2 ANALYSIS FOR SUSCEPTIBILITY TO BREAST AND OVARIAN CANCER IN ASHKENAZI INDIVIDUALS	NA
S3828	COMPLETE GENE SEQUENCE ANALYSIS; MLH1 GENE	NA
S3829	COMPLETE GENE SEQUENCE ANALYSIS; MSH2 GENE	NA
S3830	COMPLETE MLH1 AND MSH2 GENE SEQUENCE ANALYSIS FOR HEREDITARY NONPOLYPOSIS COLORECTAL CANCER (HNPCC GENETIC TESTING	NA
S3831	SINGLE-MUTATION ANALYSIS (IN INDIVIDUAL WITH A KNOWN MLH1 AND MSH2 MUTATION IN THE FAMILY FOR HEREDITARY NONPOLYPOSIS COLORECTAL CANCER (HNPCC GENETIC TESTING	NA
S3835	COMPLETE GENE SEQUENCE ANALYSIS FOR CYSTIC FIBROSIS GENETIC TESTING	NA
S3837	COMPLETE GENE SEQUENCE ANALYSIS FOR HEMOCHROMATOSIS GENETIC TESTING	NA
S3843	DNA ANALYSIS OF THE F5 GENE FOR SUSCEPTIBILITY TO FACTOR V LEIDEN THROMBOPHILIA	NA
S3847	GENETIC TESTING FOR TAY-SACHS DISEASE	NA
S3848	GENETIC TESTING FOR GAUCHER DISEASE	NA
S3851	GENETIC TESTING FOR CANAVAN DISEASE	NA
S3860	GENETIC TESTING, COMPREHENSIVE CARDIAC ION CHANNEL ANALYSIS, FOR VARIANTS IN 5 MAJOR CARDIAC ION CHANNEL GENES FOR INDIVIDUALS WITH HIGH INDEX OF SUSPICION FOR FAMILIAL LONG QT SYNDROME (LQTS OR RELATED SYNDROMES	NA
S3862	GENETIC TESTING, FAMILY-SPECIFIC ION CHANNEL ANALYSIS, FOR BLOOD-RELATIVES OF INDIVIDUALS (INDEX CASE WHO HAVE PREVIOUSLY TESTED POSITIVE FOR A GENETIC VARIANT OF A CARDIAC ION CHANNEL SYNDROME USING EITHER ONE OF THE OVE TEST CONFIGURATIONS OR CO	NA
S8049	INTRAOPERATIVE RADIATION THERAPY (SINGLE ADMINISTRATION	NA
S9109	CONGESTIVE HEART FAILURE TELEMONITORING, EQUIPMENT RENTAL, INCLUDING TELESCALE, COMPUTER SYSTEM AND SOFTWARE, TELEPHONE CONNECTIONS, AND MAINTENANCE, PER MONTH	NA

Table 4 – Deleted modifier codes for the 2013 annual HCPCS update

Modifier code	Description	Type	End date
V8	INFECTION PRESENT	Informational	December 31, 2012
V9	NO INFECTION PRESENT	Informational	December 31, 2012