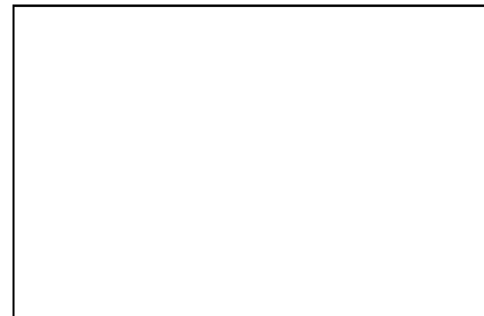
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201501 JANUARY 6, 2015

Coverage and billing information for the 2015 annual HCPCS codes update

The Indiana Health Coverage Programs (IHCP) has reviewed the 2015 annual Healthcare Common Procedure Coding System (HCPCS) update to determine coverage and billing guidelines. IHCP coverage and billing information provided in this bulletin is effective January 1, 2015. This bulletin serves as notice of the following information:

- **Table 1**: New alphanumeric and Current Procedural Terminology (CPT®[1]) codes included in the 2015 annual HCPCS update, showing:
  - Procedure code
  - Description
  - Program coverage determination
  - Prior authorization (PA) requirement
  - National Drug Code (NDC) requirement



- **Table 2**: New modifiers included in the 2015 annual HCPCS update showing the modifier code, description, and type. Providers should follow CPT coding guidelines for reporting services using appropriate modifiers.
- **Table 3**: Pricing percentages for newly covered codes from Table 1 that are manually priced codes.
- **Table 4**: Newly covered codes from Table 1 for which separate reimbursement is allowed under revenue code (RC) 636 – *Drugs requiring detailed coding for separate reimbursement in an outpatient setting*. For reimbursement consideration, providers may bill these procedure codes and the RC together, as appropriate, for dates of service (DOS) on or after January 1, 2015.
- **Table 5**: Newly covered codes from Table 1 payable only when billed as a *CMS-1500* claim.
- **Table 6**: Newly covered codes from Table 1 payable only when billed as a *UB-04* claim.
- **Table 7**: Existing IHCP-covered codes with updated pricing based on modified descriptions effective January 1, 2015. Codes are payable only when billed as *UB-04* claims effective January 1, 2015.

The 2015 annual HCPCS and CPT codes will be added to the Indiana*AIM* claims processing system. Established pricing will be posted on the *Fee Schedule* and codes added to the provider *Code Sets* page and to the list of *Procedure Codes that Require NDCs* at indianamedicaid.com. Providers may report these codes for DOS on or after January 1, 2015. The standard global billing procedures and edits apply when using the new codes.

The 2015 annual HCPCS update also included modifications to descriptions for some existing HCPCS codes. There were three IHCP-covered codes for which the description modification affected reimbursement. These codes along with their

[1] *CPT copyright 2013 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

modified descriptions are listed on Table 7. Updated pricing information will be posted in the next monthly update to the *Fee Schedule* at indianamedicaid.com. These codes will continue to be covered; however, effective for DOS on or after January 1, 2015, the codes will be payable only when billed as *UB-04* claims. Upon evaluation, it was determined that other description modifications resulted in no substantive change in meaning or intent and therefore are not addressed in this bulletin. These modifications are available for reference or download from the Centers for Medicare & Medicaid Services (CMS) website at cms.gov.

The 2015 annual HCPCS update also included a list of deleted codes. These codes are available for reference or download from the CMS website at cms.gov. CMS has not yet published the alternative codes associated with the deleted codes. Once announced by CMS, the IHCP will issue a publication listing any IHCP-covered codes that were deleted and for which there are associated alternative codes effective January 1, 2015.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	Covered for all programs	No	No	No
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	Covered for all programs	No	No	No
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	Covered for all programs	No	No	No
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Covered for all programs	No	No	See Table 3 for manual pricing percentage
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	Covered for all programs	No	No	No
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	Covered for all programs	No	No	No
21813	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs	Covered for all programs	No	No	No
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	Covered for all programs	No	No	No
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance	Covered for all programs	No	No	No
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance	Covered for all programs	No	No	No
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance	Covered for all programs	No	No	See Table 3 for manual pricing percentage
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedures)	Noncovered for all programs	NA	NA	NA
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Noncovered for all programs	NA	NA	NA
33271	Insertion of subcutaneous implantable defibrillator electrode	Noncovered for all programs	NA	NA	NA
33272	Removal of subcutaneous implantable defibrillator electrode	Noncovered for all programs	NA	NA	NA
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	Noncovered for all programs	NA	NA	NA
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Covered for all programs	No	No	No
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	Covered for all programs	No	No	No
33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	Covered for all programs	No	No	No
33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	Covered for all programs	No	No	No
33949	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
33951	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Covered for all programs	No	No	No
33952	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Covered for all programs	No	No	No
33953	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Covered for all programs	No	No	No
33954	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Covered for all programs	No	No	No
33955	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Covered for all programs	No	No	No
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Covered for all programs	No	No	No
33957	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
33958	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Covered for all programs	No	No	No
33959	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Covered for all programs	No	No	No
33962	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	Covered for all programs	No	No	No
33963	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Covered for all programs	No	No	No
33964	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	Covered for all programs	No	No	No
33965	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
33966	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	Covered for all programs	No	No	No
33969	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Covered for all programs	No	No	No
33984	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Covered for all programs	No	No	No
33985	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Covered for all programs	No	No	No
33986	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Covered for all programs	No	No	No
33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Covered for all programs	No	No	No
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Covered for all programs	No	No	No
34839	Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	Covered for all programs	No	No	No
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed	Covered for all programs	No	No	No
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	Covered for all programs	No	No	See Table 3 for manual pricing percentage
44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
44401	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
44403	Colonoscopy through stoma; with endoscopic mucosal resection	Covered for all programs	No	No	See Table 3 for manual pricing percentage
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	Covered for all programs	No	No	See Table 3 for manual pricing percentage
44405	Colonoscopy through stoma; with transendoscopic balloon dilation	Covered for all programs	No	No	See Table 3 for manual pricing percentage
44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	Covered for all programs	No	No	See Table 3 for manual pricing percentage

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	Covered for all programs	No	No	See Table 3 for manual pricing percentage
44408	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45390	Colonoscopy, flexible; with endoscopic mucosal resection	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	Covered for all programs	No	No	See Table 3 for manual pricing percentage

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
45399	Unlisted procedure, colon	Covered for all programs	No	No	See Table 3 for manual pricing percentage
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	Covered for all programs	No	No	See Table 3 for manual pricing percentage
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	Covered for all programs	No	No	See Table 3 for manual pricing percentage
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Covered for all programs	No	No	See Table 3 for manual pricing percentage
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Covered for all programs	Yes	No	No
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Covered for all programs	Yes	No	No
62302	Myelography via lumbar injection, including radiological supervision and interpretation; cervical	Covered for all programs	No	No	No
62303	Myelography via lumbar injection, including radiological supervision and interpretation; thoracic	Covered for all programs	No	No	No
62304	Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral	Covered for all programs	No	No	No
62305	Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)	Covered for all programs	No	No	No
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
64487	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)	Covered for all programs	No	No	No
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)	Covered for all programs	No	No	No
64489	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)	Covered for all programs	No	No	No
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	Covered for all programs	No	No	No
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	Covered for all programs	No	No	No
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Covered for all programs	No	No	No
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Covered for all programs	No	No	No
77061	Digital breast tomosynthesis; unilateral	Covered for all programs	No	No	See Table 3 for manual pricing percentage
77062	Digital breast tomosynthesis; bilateral	Covered for all programs	No	No	See Table 3 for manual pricing percentage
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	Covered for all programs	No	No	No
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)	Covered for all programs	No	No	No
77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)	Covered for all programs	No	No	No
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote after loading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	Covered for all programs	No	No	No
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote after loading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)	Covered for all programs	No	No	No
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote after loading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	Covered for all programs	No	No	No
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Covered for all programs	No	No	See Table 6-payable only as *UB-04* claim
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	Covered for all programs	No	No	See Table 6 – payable only as *UB-04* claim
77387	Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed	Noncovered for all programs	NA	NA	NA
80163	Digoxin; free	Covered for all programs	No	No	No
80165	Valproic acid (dipropylacetic acid); free	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
80300	Drug screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures, (eg, immunoassay) capable of being read by direct optical observation, including instrumented-assisted when performed (eg, dipsticks, cups, cards, cartridges) per date of service	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80301	Drug screen, any number of drug classes from Drug Class List A; single drug class method, by instrumented test systems (eg, discrete multichannel chemistry analyzers utilizing immunoassay or enzyme assay), per date of service	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80302	Drug screen, presumptive, single drug class from Drug Class List B, by immunoassay (eg, ELISA) or non-TLC chromatography without mass spectrometry (eg, GC, HPLC), each procedure	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80303	Drug screen, any number of drug classes, presumptive, single or multiple drug class method; thin layer chromatography procedure(s) (TLC) (eg, acid, neutral, alkaloid plate), per date of service	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80304	Drug screen, any number of drug classes, presumptive, single or multiple drug class method; not otherwise specified presumptive procedure (eg, TOF, MALDI, LDTD, DESI, DART), each procedure	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80320	Alcohols	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80321	Alcohol biomarkers; 1 or 2	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80322	Alcohol biomarkers; 3 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80323	Alkaloids, not otherwise specified	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80324	Amphetamines; 1 or 2	Covered for all programs	No	No	See Table 3 for manual pricing percentage

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
80325	Amphetamines; 3 or 4	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80326	Amphetamines; 5 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80327	Anabolic steroids; 1 or 2	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80328	Anabolic steroids; 3 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80329	Analgesics, non-opioid; 1 or 2	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80330	Analgesics, non-opioid; 3-5	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80331	Analgesics, non-opioid; 6 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80332	Antidepressants, serotonergic class; 1 or 2	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80333	Antidepressants, serotonergic class; 3-5	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80334	Antidepressants, serotonergic class; 6 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80336	Antidepressants, tricyclic and other cyclicals; 3-5	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80337	Antidepressants, tricyclic and other cyclicals; 6 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80338	Antidepressants, not otherwise specified	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80339	Antiepileptics, not otherwise specified; 1-3	Covered for all programs	No	No	See Table 3 for manual pricing percentage

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
80340	Antiepileptics, not otherwise specified; 4-6	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80341	Antiepileptics, not otherwise specified; 7 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80342	Antipsychotics, not otherwise specified; 1-3	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80343	Antipsychotics, not otherwise specified; 4-6	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80344	Antipsychotics, not otherwise specified; 7 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80345	Barbiturates	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80346	Benzodiazepines; 1-12	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80347	Benzodiazepines; 13 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80348	Buprenorphine	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80349	Cannabinoids, natural	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80350	Cannabinoids, synthetic; 1-3	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80351	Cannabinoids, synthetic; 4-6	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80352	Cannabinoids, synthetic; 7 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80353	Cocaine	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80354	Fentanyl	Covered for all programs	No	No	See Table 3 for manual pricing percentage

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
80355	Gabapentin, non-blood	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80356	Heroin metabolite	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80357	Ketamine and norketamine	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80358	Methadone	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80360	Methylphenidate	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80361	Opiates, 1 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80362	Opioids and opiate analogs; 1 or 2	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80363	Opioids and Opiate analogs; 3 or 4	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80364	Opioids and Opiate analogs; 5 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80365	Oxycodone	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80366	Pregabalin	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80367	Propoxyphene	Noncovered for all programs	NA	NA	NA
80368	Sedative hypnotics (non-benzodiazepines)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80369	Skeletal muscle relaxants; 1 or 2	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80370	Skeletal muscle relaxants; 3 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
80371	Stimulants, synthetic	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80372	Tapentadol	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80373	Tramadol	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80374	Stereoisomer (enantiomer) analysis, single drug class	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	Covered for all programs	No	No	See Table 3 for manual pricing percentage
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	Covered for all programs	No	No	See Table 3 for manual pricing percentage
81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	Covered for all programs	Yes	No	See Table 3 for manual pricing percentage
81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis	Covered for all programs	Yes	No	See Table 3 for manual pricing percentage
81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/ kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)	Noncovered for all programs	NA	NA	NA
81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFBR1, TGFBR2, COL3A1, , MYH11, ACTA2, SLC2A10, SMAD3, and MYLK	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK	Noncovered for all programs	NA	NA	NA
81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Noncovered for all programs	NA	NA	NA
81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)	Noncovered for all programs	NA	NA	NA
81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)	Noncovered for all programs	NA	NA	NA
81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	Noncovered for all programs	NA	NA	NA
81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Noncovered for all programs	NA	NA	NA
81426	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)	Noncovered for all programs	NA	NA	NA
81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3	Noncovered for all programs	NA	NA	NA
81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes	Noncovered for all programs	NA	NA	NA
81435	Hereditary colon cancer syndromes (eg, Lynch syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include analysis of at least 7 genes, including APC, CHEK2, MLH1, MSH2, MSH6, MUTYH, and PMS2	Noncovered for all programs	NA	NA	NA
81436	Hereditary colon cancer syndromes (eg, Lynch syndrome, familial adenomatosis polyposis); duplication/deletion gene analysis panel, must include analysis of at least 8 genes, including APC, MLH1, MSH2, MSH6, PMS2, EPCAM, CHEK2, and MUTYH	Noncovered for all programs	NA	NA	NA
81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SULCG1, TAZ, TK2, and TYMP	Noncovered for all programs	NA	NA	NA
81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
81450	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, DNA and RNA analysis when performed, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), interrogation for sequence variants	Noncovered for all programs	NA	NA	NA
81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA and RNA analysis when performed, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET) interrogation for sequence variants and copy number variants or rearrangements, if performed	Noncovered for all programs	NA	NA	NA
81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with hertoplasmy detection	Noncovered for all programs	NA	NA	NA
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed	Noncovered for all programs	NA	NA	NA
81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, PRS6KA3, SLC16A2	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
81471	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, PRS6KA3, SLC16A2,	Noncovered for all programs	NA	NA	NA
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score	Covered for all programs	No	No	See Table 3 for manual pricing percentage
83006	Growth stimulation expressed gene 2 (ST2, Interleukin 1 receptor like-1)	Covered for all programs	No	No	No
87505	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes	Covered for all programs	No	No	No
87506	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes	Covered for all programs	No	No	No
87507	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes	Covered for all programs	No	No	No
87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)	Noncovered for all programs	NA	NA	NA
87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	Covered for all programs	No	No	No
87806	Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	Covered for all programs	No	No	No
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
88344	Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure	Covered for all programs	No	No	No
88364	In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
88366	In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure	Covered for all programs	No	No	No
88369	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
88373	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
88374	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
88377	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure	Covered for all programs	No	No	No
89337	Cryopreservation, mature oocyte(s)	Noncovered for all programs	NA	NA	NA
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	Covered for all programs	No	No	See Table 4 – Linked to RC 636
90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use	Noncovered for all programs	NA	NA	NA
90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-HibHepB), for intramuscular use	Noncovered for all programs	NA	NA	NA
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	Noncovered for all programs	NA	NA	NA
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	Noncovered for all programs	NA	NA	NA
93260	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, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	Noncovered for all programs	NA	NA	NA
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
93355	Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (eg, TAVR, transcathether pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri- and intraprocedural), real time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D	Covered for all programs	No	No	No
93644	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 therapeutic parameters	Noncovered for all programs	NA	NA	NA
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	Noncovered for all programs	NA	NA	NA
93895	Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral	Noncovered for all programs	NA	NA	NA
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	Covered for all programs	No	No	No
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Covered for all programs	No	No	See Table 3 for manual pricing percentage

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Covered for all programs	No	No	See Table 3 for manual pricing percentage
99184	Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude	Covered for all programs	No	No	No
99188	Application of topical fluoride varnish by a physician or other qualified health care professional	Noncovered for all programs	NA	NA	NA
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected	Noncovered for all programs	NA	NA	NA
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with patient, family, or designated surrogate	Noncovered for all programs	NA	NA	NA
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	Noncovered for all programs	NA	NA	NA
A4459	Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type	Covered for all programs	No	No	See Table 3 for manual pricing percentage

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
A4602	Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each	Covered for all programs	No	No	See Table 3 for manual pricing percentage
A7048	Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each	Covered for all programs	No	No	No
A9606	Radium ra-223 dichloride, therapeutic, per microcurie	Covered for all programs	No	Yes	No
C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	Noncovered for all programs	NA	NA	NA
C9027	Injection, pembrolizumab, 1 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
C9136	Injection, factor viii, fc fusion protein, (recombinant), per i.u.	Covered for all programs	No	No	See Table 4 – Linked to RC 636
C9349	Fortaderm, and fortaderm antimicrobial, any type, per square centimeter	Noncovered for all programs	NA	NA	NA
C9442	Injection, belinostat, 10 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
C9443	Injection, dalbavancin, 10 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
C9444	Injection, oritavancin, 10 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
C9446	Injection, tedizolid phosphate, 1 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	Noncovered for all programs	NA	NA	NA
C9742	Laryngoscopy, flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed	Covered for all programs	No	No	No
D0171	Re-evaluation - post-operative office visit	Noncovered for all programs	NA	NA	NA
D0351	3D photographic image	Noncovered for all programs	NA	NA	NA
D1353	Sealant repair - per tooth	Noncovered for all programs	NA	NA	NA
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	Noncovered for all programs	NA	NA	NA
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	Noncovered for all programs	NA	NA	NA
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	Noncovered for all programs	NA	NA	NA
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	Noncovered for all programs	NA	NA	NA
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	Noncovered for all programs	NA	NA	NA
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	Noncovered for all programs	NA	NA	NA
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	Noncovered for all programs	NA	NA	NA
D6549	Resin retainer - for resin bonded fixed prosthesis	Noncovered for all programs	NA	NA	NA
D9219	Evaluation for deep sedation or general anesthesia	Noncovered for all programs	NA	NA	NA
D9931	Cleaning and inspection of a removable appliance	Noncovered for all programs	NA	NA	NA
D9986	Missed appointment	Noncovered for all programs	NA	NA	NA
D9987	Cancelled appointment	Noncovered for all programs	NA	NA	NA
G0276	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control, performed in an approved coverage with evidence development (CED) clinical trial	Noncovered for all programs	NA	NA	NA
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	Covered for all programs	No	No	No
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206)	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G0464	Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., kras, ndrg4 and bmp3)	Noncovered for all programs	NA	NA	NA
G0472	Hepatitis C antibody screening, for individual at high risk and other covered indication(s)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes	Noncovered for all programs	NA	NA	NA
G6001	Ultrasonic guidance for placement of radiation therapy fields	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6002	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6004	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6005	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6006	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6008	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6009	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6010	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G6011	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6012	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6013	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6014	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session	Covered for all programs	No	No	See Table 5 – payable only as *CMS-1500* claim
G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg,3d positional tracking, gating, 3d surface tracking), each fraction of treatment	Noncovered for all programs	NA	NA	NA
G6018	Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)	Covered for all programs	No	No	No
G6019	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G6020	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)	Covered for all programs	No	No	No
G6021	Unlisted procedure, intestine	Covered for all programs	No	No	See Table 3 for manual pricing percentage
G6022	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesions(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	Covered for all programs	No	No	No
G6023	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)	Covered for all programs	No	No	No
G6024	Colonoscopy, flexible; proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	Covered for all programs	No	No	No
G6025	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)	Covered for all programs	No	No	No
G6027	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	Covered for all programs	No	No	See Table 3 for manual pricing percentage
G6028	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	Covered for all programs	No	No	See Table 3 for manual pricing percentage
G6030	Amitriptyline	Covered for all programs	No	No	No
G6031	Benzodiazepines	Covered for all programs	No	No	No
G6032	Desipramine	Covered for all programs	No	No	No
G6034	Doxepin	Covered for all programs	No	No	No
G6035	Gold	Covered for all programs	No	No	No
G6036	Assay of imipramine	Covered for all programs	No	No	No
G6037	Nortriptyline	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G6038	Salicylate	Covered for all programs	No	No	No
G6039	Acetaminophen	Covered for all programs	No	No	No
G6040	Alcohol (ethanol); any specimen except breath	Covered for all programs	No	No	No
G6041	Alkaloids, urine, quantitative	Covered for all programs	No	No	No
G6042	Amphetamine or methamphetamine	Covered for all programs	No	No	No
G6043	Barbiturates, not elsewhere specified	Covered for all programs	No	No	No
G6044	Cocaine or metabolite	Covered for all programs	No	No	No
G6045	Dihydrocodeinone	Covered for all programs	No	No	No
G6046	Dihydromorphinone	Covered for all programs	No	No	No
G6047	Dihydrotestosterone	Covered for all programs	No	No	No
G6048	Dimethadione	Covered for all programs	No	No	No
G6049	Epiandrosterone	Covered for all programs	No	No	No
G6050	Ethchlorvynol	Covered for all programs	No	No	No
G6051	Flurazepam	Covered for all programs	No	No	No
G6052	Meprobamate	Covered for all programs	No	No	No
G6053	Methadone	Covered for all programs	No	No	No
G6054	Methsuximide	Covered for all programs	No	No	No
G6055	Nicotine	Covered for all programs	No	No	No
G6056	Opiate(s), drug and metabolites, each procedure	Covered for all programs	No	No	No
G6057	Phenothiazine	Covered for all programs	No	No	No
G6058	Drug confirmation, each procedure	Covered for all programs	No	No	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9362	Duration of monitored anesthesia care (MAC) or peripheral nerve block (PNB) without the use of general anesthesia during an applicable procedure 60 minutes or longer, as documented in the anesthesia record	Noncovered for all programs	NA	NA	NA
G9363	Duration of monitored anesthesia care (MAC) or peripheral nerve block (PNB) without the use of general anesthesia during an applicable procedure or general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record	Noncovered for all programs	NA	NA	NA
G9364	Sinusitis caused by, or presumed to be caused by, bacterial infection	Noncovered for all programs	NA	NA	NA
G9365	One high-risk medication ordered	Noncovered for all programs	NA	NA	NA
G9366	One high-risk medication not ordered	Noncovered for all programs	NA	NA	NA
G9367	At least two different high-risk medications ordered	Noncovered for all programs	NA	NA	NA
G9368	At least two different high-risk medications not ordered	Noncovered for all programs	NA	NA	NA
G9369	Individual filled at least two prescriptions for any antipsychotic medication and had a PDC of 0.8 or greater	Noncovered for all programs	NA	NA	NA
G9370	Individual who did not fill at least two prescriptions for any antipsychotic medication or did not have a PDC of 0.8 or greater	Noncovered for all programs	NA	NA	NA
G9376	Patient continued to have the retina attached at the 6 months follow up visit (+/- 1 month) following only one surgery	Noncovered for all programs	NA	NA	NA
G9377	Patient did not have the retina attached after 6 months following only one surgery	Noncovered for all programs	NA	NA	NA
G9378	Patient continued to have the retina attached at the 6 months follow up visit (+/- 1 month)	Noncovered for all programs	NA	NA	NA
G9379	Patient did not achieve flat retinas six months post surgery	Noncovered for all programs	NA	NA	NA
G9380	Patient offered assistance with end of life issues during the measurement period	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9381	Documentation of medical reason(s) for not offering assistance with end of life issues (eg, patient in hospice and in terminal phase) during the measurement period	Noncovered for all programs	NA	NA	NA
G9382	Patient not offered assistance with end of life issues during the measurement period	Noncovered for all programs	NA	NA	NA
G9383	Patient received screening for HCV infection within the 12 month reporting period	Noncovered for all programs	NA	NA	NA
G9384	Documentation of medical reason(s) for not receiving screening for HCV infection within the 12 month reporting period (e.g., decompensated cirrhosis including advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, or waitlist for organ transplant, limited life expectancy, other medical reasons)	Noncovered for all programs	NA	NA	NA
G9385	Documentation of patient reason(s) for not receiving screening for HCV infection within the 12 month reporting period (e.g., patient declined, other patient reasons)	Noncovered for all programs	NA	NA	NA
G9386	Screening for HCV infection not received within the 12 month reporting period, reason not given	Noncovered for all programs	NA	NA	NA
G9389	Unplanned rupture of the posterior capsule requiring vitrectomy	Noncovered for all programs	NA	NA	NA
G9390	No unplanned rupture of the posterior capsule requiring vitrectomy	Noncovered for all programs	NA	NA	NA
G9391	Patient achieves refraction +-1 d for the eye that underwent cataract surgery, measured at the one month follow up visit	Noncovered for all programs	NA	NA	NA
G9392	Patient does not achieve refraction +-1 d for the eye that underwent cataract surgery, measured at the one month follow up visit	Noncovered for all programs	NA	NA	NA
G9393	Patient with an initial phgPHG-9 score greater than nine who achieves remission at twelve months as demonstrated by a twelve month (+/- 30 days) phg-9 score of less than five	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9394	Patient who had a diagnosis of bipolar disorder or personality disorder, death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement or assessment period	Noncovered for all programs	NA	NA	NA
G9395	Patient with an initial phq-9 score greater than nine who did not achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) phq-9 score greater than or equal to five	Noncovered for all programs	NA	NA	NA
G9396	Patient with an initial phq-9 score greater than nine who was not assessed for remission at twelve months (+/- 30 days)	Noncovered for all programs	NA	NA	NA
G9399	Documentation in the patient record of a discussion between the physician/clinician and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward the outcome of the treatment	Noncovered for all programs	NA	NA	NA
G9400	Documentation of medical or patient reason(s) for not discussing treatment options; medical reasons: patient is not a candidate for treatment due to advanced physical or mental health comorbidity (including active substance use); currently receiving antiviral treatment; successful antiviral treatment (with sustained virologic response) prior to reporting period; other documented medical reasons; patient reasons: patient unable or unwilling to participate in the discussion or other patient reasons	Noncovered for all programs	NA	NA	NA
G9401	No documentation of a discussion in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9402	Patient received follow-up on the date of discharge or within 30 days after discharge	Noncovered for all programs	NA	NA	NA
G9403	Clinician documented reason patient was not able to complete 30 day follow-up from acute inpatient setting discharge (e.g., patient death prior to follow-up visit, patient non-compliant for visit follow-up)	Noncovered for all programs	NA	NA	NA
G9404	Patient did not receive follow-up on the date of discharge or within 30 days after discharge	Noncovered for all programs	NA	NA	NA
G9405	Patient received follow-up within 7 days from discharge	Noncovered for all programs	NA	NA	NA
G9406	Clinician documented reason patient was not able to complete 7 day follow-up from acute inpatient setting discharge (i.e patient death prior to follow-up visit, patient non-compliance for visit follow-up)	Noncovered for all programs	NA	NA	NA
G9407	Patient did not receive follow-up on or within 7 days after discharge	Noncovered for all programs	NA	NA	NA
G9408	Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days	Noncovered for all programs	NA	NA	NA
G9409	Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days	Noncovered for all programs	NA	NA	NA
G9410	Patient admitted within 180 days, status post CIED implantation, replacement, or revision with an infection requiring device removal or surgical revision	Noncovered for all programs	NA	NA	NA
G9411	Patient not admitted within 180 days, status post CIED implantation, replacement, or revision with an infection requiring device removal or surgical revision	Noncovered for all programs	NA	NA	NA
G9412	Patient admitted within 180 days, status post CIED implantation, replacement, or revision with an infection requiring device removal or surgical revision	Noncovered for all programs	NA	NA	NA
G9413	Patient not admitted within 180 days, status post CIED implantation, replacement, or revision with an infection requiring device removal or surgical revision	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9414	Patient had one dose of meningococcal vaccine on or between the patient's 11th and 13th birthdays	Noncovered for all programs	NA	NA	NA
G9415	Patient did not have one dose of meningococcal vaccine on or between the patient's 11th and 13th birthdays	Noncovered for all programs	NA	NA	NA
G9416	Patient had one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the patient's 10th and 13th birthdays or one tetanus and one diphtheria vaccine on or between the patient's 10th and 13th birthdays	Noncovered for all programs	NA	NA	NA
G9417	Patient did not have one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the patient's 10th and 13th birthdays or one tetanus and one diphtheria vaccine on or between the patient's 10th and 13th birthdays	Noncovered for all programs	NA	NA	NA
G9418	Primary non-small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type or classified as NSCLC-NOS with an explanation	Noncovered for all programs	NA	NA	NA
G9419	Documentation of medical reason(s) for not reporting the histological type or NSCLC-NOS classification with an explanation (e.g., biopsy taken for other purposes in a patient with a history of primary non-small cell lung cancer or other documented medical reasons)	Noncovered for all programs	NA	NA	NA
G9420	Specimen site other than anatomic location of lung or is not classified as primary non-small cell lung cancer	Noncovered for all programs	NA	NA	NA
G9421	Primary non-small cell lung cancer biopsy and cytology specimen report does not document classification into specific histologic type or classified as NSCLC-NOS with an explanation	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9422	Non-small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type or classified as NSCLC-NOS with an explanation	Noncovered for all programs	NA	NA	NA
G9423	Documentation of medical reason(s) for not reporting the histological type or NSCLC-NOS classification with an explanation (e.g., a solitary fibrous tumor in a person with a history of non-small cell carcinoma or other documented medical reasons)	Noncovered for all programs	NA	NA	NA
G9424	Specimen site other than anatomic location of lung, is not classified as non-small cell lung cancer or classified as NSCLC-NOS	Noncovered for all programs	NA	NA	NA
G9425	Non small cell lung cancer biopsy and cytology specimen report does not document classification into specific histologic type or classified as NSCLC-NOS with an explanation	Noncovered for all programs	NA	NA	NA
G9426	Improvement in median time from ED arrival to initial ED oral or parenteral pain medication administration performed for ED admitted patients	Noncovered for all programs	NA	NA	NA
G9427	Improvement in median time from ED arrival to initial ED oral or parenteral pain medication administration not performed for ED admitted patients	Noncovered for all programs	NA	NA	NA
G9428	Pathology report includes the pt category and a statement on thickness and ulceration and for pt1, mitotic rate	Noncovered for all programs	NA	NA	NA
G9429	Documentation of medical reason(s) for not reporting pt category and a statement on thickness and ulceration and for pt1, mitotic rate (e.g., negative skin biopsies in a patient with a history of melanoma or other documented medical reasons)	Noncovered for all programs	NA	NA	NA
G9430	Specimen site other than anatomic cutaneous location	Noncovered for all programs	NA	NA	NA
G9431	Pathology report does not include the pt category and a statement on thickness and ulceration and for pt1, mitotic rate	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9432	Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score and results documented	Noncovered for all programs	NA	NA	NA
G9433	Death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9434	Asthma not well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score, or specified asthma control tool not used, reason not given	Noncovered for all programs	NA	NA	NA
G9435	Aspirin prescribed at discharge	Noncovered for all programs	NA	NA	NA
G9436	Aspirin not prescribed for documented reasons (e.g., allergy, medical intolerance, history of bleed)	Noncovered for all programs	NA	NA	NA
G9437	Aspirin not prescribed at discharge	Noncovered for all programs	NA	NA	NA
G9438	P2y inhibitor prescribed at discharge	Noncovered for all programs	NA	NA	NA
G9439	P2y inhibitor not prescribed for documented reasons (e.g., allergy, medical intolerance, history of bleed)	Noncovered for all programs	NA	NA	NA
G9440	P2y inhibitor not prescribed at discharge	Noncovered for all programs	NA	NA	NA
G9441	Statin prescribed at discharge	Noncovered for all programs	NA	NA	NA
G9442	Statin not prescribed for documented reasons (e.g., allergy, medical intolerance)	Noncovered for all programs	NA	NA	NA
G9443	Statin not prescribed at discharge	Noncovered for all programs	NA	NA	NA
G9448	Patients who were born in the years 1945-1965	Noncovered for all programs	NA	NA	NA
G9449	History of receiving blood transfusions prior to 1992	Noncovered for all programs	NA	NA	NA
G9450	History of injection drug use	Noncovered for all programs	NA	NA	NA
G9451	Patient received one-time screening for HCV infection	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9452	Documentation of medical reason(s) for not receiving one-time screening for HCV infection (e.g., decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons)	Noncovered for all programs	NA	NA	NA
G9453	Documentation of patient reason(s) for not receiving one-time screening for HCV infection (e.g., patient declined, other patient reasons)	Noncovered for all programs	NA	NA	NA
G9454	One-time screening for HCV infection not received within 12 month reporting period and no documentation of prior screening for HCV infection, reason not given	Noncovered for all programs	NA	NA	NA
G9455	Patient underwent abdominal imaging with ultrasound, contrast enhanced CT or contrast MRI for HCC	Noncovered for all programs	NA	NA	NA
G9456	Documentation of medical or patient reason(s) for not ordering or performing screening for HCC; medical reason: comorbid medical conditions with expected survival < 5 years, hepatic decompensation and not a candidate for liver transplantation, or other medical reasons; patient reasons: patient declined or other patient reasons (e.g., cost of tests, time related to accessing testing equipment)	Noncovered for all programs	NA	NA	NA
G9457	Patient did not undergo abdominal imaging and did not have a documented reason for not undergoing abdominal imaging in the reporting period	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9458	Patient documented as tobacco user and received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user	Noncovered for all programs	NA	NA	NA
G9459	Currently a tobacco non-user	Noncovered for all programs	NA	NA	NA
G9460	Tobacco assessment or tobacco cessation intervention not performed, reason not otherwise specified	Noncovered for all programs	NA	NA	NA
G9463	I intend to report the sinusitis measures group	Noncovered for all programs	NA	NA	NA
G9464	All quality actions for the applicable measures in the sinusitis measures group have been performed for this patient	Noncovered for all programs	NA	NA	NA
G9465	I intend to report the acute otitis externa (AOE) measures group	Noncovered for all programs	NA	NA	NA
G9466	All quality actions for the applicable measures in the AOE measures group have been performed for this patient	Noncovered for all programs	NA	NA	NA
G9467	Patients who have received or are receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills	Noncovered for all programs	NA	NA	NA
G9468	Patient not receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills	Noncovered for all programs	NA	NA	NA
G9469	Patients who have received or are receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9470	Patients not receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills	Noncovered for all programs	NA	NA	NA
G9471	Within the past 2 years, central dual-energy X-ray absorptiometry (DXA) not ordered or documented	Noncovered for all programs	NA	NA	NA
G9472	Within the past 2 years, central dual-energy X-ray absorptiometry (DXA) not ordered and documented, no review of systems and no medication history or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	Noncovered for all programs	NA	NA	NA
J0153	Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds)	Covered for all programs	No	Yes	No
J0571	Buprenorphine, oral, 1 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	Noncovered for all programs	NA	NA	NA
J0888	Injection, epoetin beta, 1 microgram, (for non ESRD use)	Noncovered for all programs	NA	NA	NA
J1071	Injection, testosterone cypionate, 1mg	Covered for all programs	Yes	Yes	Limited to 400 units
J1322	Injection, elosulfase alfa, 1mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J1439	Injection, ferric carboxymaltose, 1mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg	Covered for all programs	No	Yes	No
J2704	Injection, propofol, 10 mg	Covered for all programs	No	Yes	No

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
J3121	Injection, testosterone enanthate, 1 mg	Covered for all programs	Yes	Yes	Limited to 400 units
J3145	Injection, testosterone undecanoate, 1 mg	Covered for all programs	Yes	Yes	Limited to 750 units
J7181	Injection, factor XIII a-subunit, (recombinant), per iu	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J7182	Injection, factor viii, (antihemophilic factor, recombinant), (novoeight), per iu	Noncovered for all programs	NA	NA	NA
J7200	Injection, factor ix, (antihemophilic factor, recombinant), rixubis, per iu	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J7201	Injection, factor ix, fc fusion protein (recombinant), per iu	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J7327	Hyaluronan or derivative, monovisc, for intra-articular injection, per dose	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J7336	Capsaicin 8% patch, per square centimeter	Noncovered for all programs	NA	NA	NA
J9267	Injection, paclitaxel, 1 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
J9301	Injection, obinutuzumab, 10 mg	Covered for all programs	No	Yes	See Table 4 – Linked to RC 636
L3981	Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments	Covered for all programs	No	No	No
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)	Covered for all programs	No	No	No
L7259	Electronic wrist rotator, any type	Covered for all programs	No	No	No
L8696	Antenna (external) for use with implantable diaphragmatic/phrenic nerve stimulation device, replacement, each	Covered for all programs	No	No	No
Q4150	AlloWrap DS or dry, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4151	Amnioband or guardian, per square centimeter	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
Q4152	Dermapure, per square centimeter	Covered for all programs	No	No	See Table 3 for manual pricing percentage
Q4153	Dermavest, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4154	Biovance, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4155	Neoxflo or clarixflo, 1 mg	Noncovered for all programs	NA	NA	NA
Q4156	Neox 100, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4157	Revitalon, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4158	Marigen, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4159	Affinity, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4160	Nushield, per square centimeter	Noncovered for all programs	NA	NA	NA
S8032	Low-dose computer tomography for lung cancer screening	Covered for all programs	No	No	See Table 3 for manual pricing percentage (Note: Noncovered in October 1, 2014, HCPCS update; covered effective January 1, 2015. Providers must follow US Preventative Services Taskforce guidelines)
S9901	Services by a journal-listed Christian Science nurse, per hour	Noncovered for all programs	NA	NA	NA
3126F	Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite, and if present, contains appropriate grading) (PATH)	Noncovered for all programs	NA	NA	NA
0357T	Cryopreservation; immature oocyte(s)	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0375T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, three or more levels	Noncovered for all programs	NA	NA	NA
0376T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)	Noncovered for all programs	NA	NA	NA
0377T	Anoscopy with directed submucosal injection of bulking agent for fecal incontinence	Noncovered for all programs	NA	NA	NA
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified healthcare professional	Noncovered for all programs	NA	NA	NA
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified healthcare professional	Noncovered for all programs	NA	NA	NA
0380T	Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report	Noncovered for all programs	NA	NA	NA
0381T	External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0382T	External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	Noncovered for all programs	NA	NA	NA
0383T	External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	Noncovered for all programs	NA	NA	NA
0384T	External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	Noncovered for all programs	NA	NA	NA
0385T	External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	Noncovered for all programs	NA	NA	NA
0386T	External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; review and interpretation only	Noncovered for all programs	NA	NA	NA
0387T	Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular	Noncovered for all programs	NA	NA	NA
0388T	Transcatheter removal of permanent leadless pacemaker, ventricular	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 1 − New codes included in the 2015 annual HCPCS update, effective for DOS on or after January 1, 2015

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0389T	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, review and report, leadless pacemaker system	Noncovered for all programs	NA	NA	NA
0390T	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure or test with analysis, review and report, leadless pacemaker system	Noncovered for all programs	NA	NA	NA
0391T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system	Noncovered for all programs	NA	NA	NA

* "Covered" indicates the service described for the code is covered, subject to the limitations of the member's benefit package. "Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 2 − New modifiers included in the 2015 annual HCPCS update effective January 1, 2015

Modifier code	Description	Type
PO	Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments	Informational
SZ	Habilitative services	Informational
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter	Informational
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner	Informational
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	Informational
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	Informational

Table 3 − Pricing percentages for newly covered codes that are manually priced

Procedure Code	Description	Amount reimbursed as % of billed charges when billed on a *CMS-1500* claim	Amount reimbursed as % of billed charges when billed on a *UB-04* claim
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	20%	15%
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance	90%	90%
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	20%	15%
44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	20%	15%
44401	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)	20%	15%
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)	20%	15%
44403	Colonoscopy through stoma; with endoscopic mucosal resection	20%	15%
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	20%	15%

Table 3 − Pricing percentages for newly covered codes that are manually priced

Procedure Code	Description	Amount reimbursed as % of billed charges when billed on a *CMS-1500* claim	Amount reimbursed as % of billed charges when billed on a *UB-04* claim
44405	Colonoscopy through stoma; with transendoscopic balloon dilation	20%	15%
44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	20%	15%
44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	20%	15%
44408	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	20%	15%
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	20%	15%
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	20%	15%
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	20%	15%
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	20%	15%
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	20%	15%
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	20%	15%
45390	Colonoscopy, flexible; with endoscopic mucosal resection	20%	15%
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	20%	15%
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	20%	15%
45399	Unlisted procedure, colon	20%	15%

Table 3 − Pricing percentages for newly covered codes that are manually priced

Procedure Code	Description	Amount reimbursed as % of billed charges when billed on a *CMS-1500* claim	Amount reimbursed as % of billed charges when billed on a *UB-04* claim
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	20%	15%
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	20%	15%
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	20%	15%
77061	Digital breast tomosynthesis; unilateral	25%	15%
77062	Digital breast tomosynthesis; bilateral	25%	15%
80300	Drug screen, any number of drug classes from Drug Class List A; any number of non-TLC devices or procedures, (eg, immunoassay) capable of being read by direct optical observation, including instrumented-assisted when performed (eg, dipsticks, cups, cards, cartridges) per date of service	30%	15%
80301	Drug screen, any number of drug classes from Drug Class List A; single drug class method, by instrumented test systems (eg, discrete multichannel chemistry analyzers utilizing immunoassay or enzyme assay), per date of service	30%	15%
80302	Drug screen, presumptive, single drug class from Drug Class List B, by immunoassay (eg, ELISA) or non-TLC chromatography without mass spectrometry (eg, GC, HPLC), each procedure	30%	15%
80303	Drug screen, any number of drug classes, presumptive, single or multiple drug class method; thin layer chromatography procedure(s) (TLC) (eg, acid, neutral, alkaloid plate), per date of service	30%	15%
80304	Drug screen, any number of drug classes, presumptive, single or multiple drug class method; not otherwise specified presumptive procedure (eg, TOF, MALDI, LDTD, DESI, DART), each procedure	30%	15%
80320	Alcohols	30%	15%
80321	Alcohol biomarkers; 1 or 2	30%	15%
80322	Alcohol biomarkers; 3 or more	30%	15%
80323	Alkaloids, not otherwise specified	30%	15%
80324	Amphetamines; 1 or 2	30%	15%
80325	Amphetamines; 3 or 4	30%	15%
80326	Amphetamines; 5 or more	30%	15%

Table 3 − Pricing percentages for newly covered codes that are manually priced

Procedure Code	Description	Amount reimbursed as % of billed charges when billed on a *CMS-1500* claim	Amount reimbursed as % of billed charges when billed on a *UB-04* claim
80327	Anabolic steroids; 1 or 2	30%	15%
80328	Anabolic steroids; 3 or more	30%	15%
80329	Analgesics, non-opioid; 1 or 2	30%	15%
80330	Analgesics, non-opioid; 3-5	30%	15%
80331	Analgesics, non-opioid; 6 or more	30%	15%
80332	Antidepressants, serotonergic class; 1 or 2	30%	15%
80333	Antidepressants, serotonergic class; 3-5	30%	15%
80334	Antidepressants, serotonergic class; 6 or more	30%	15%
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2	30%	15%
80336	Antidepressants, tricyclic and other cyclicals; 3-5	30%	15%
80337	Antidepressants, tricyclic and other cyclicals; 6 or more	30%	15%
80338	Antidepressants, not otherwise specified	30%	15%
80339	Antiepileptics, not otherwise specified; 1-3	30%	15%
80340	Antiepileptics, not otherwise specified; 4-6	30%	15%
80341	Antiepileptics, not otherwise specified; 7 or more	30%	15%
80342	Antipsychotics, not otherwise specified; 1-3	30%	15%
80343	Antipsychotics, not otherwise specified; 4-6	30%	15%
80344	Antipsychotics, not otherwise specified; 7 or more	30%	15%
80345	Barbiturates	30%	15%
80346	Benzodiazepines; 1-12	30%	15%
80347	Benzodiazepines; 13 or more	30%	15%
80348	Buprenorphine	30%	15%
80349	Cannabinoids, natural	30%	15%
80350	Cannabinoids, synthetic; 1-3	30%	15%
80351	Cannabinoids, synthetic; 4-6	30%	15%
80352	Cannabinoids, synthetic; 7 or more	30%	15%
80353	Cocaine	30%	15%
80354	Fentanyl	30%	15%
80355	Gabapentin, non-blood	30%	15%
80356	Heroin metabolite	30%	15%
80357	Ketamine and norketamine	30%	15%
80358	Methadone	30%	15%

Table 3 − Pricing percentages for newly covered codes that are manually priced

Procedure Code	Description	Amount reimbursed as % of billed charges when billed on a *CMS-1500* claim	Amount reimbursed as % of billed charges when billed on a *UB-04* claim
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)	30%	15%
80360	Methylphenidate	30%	15%
80361	Opiates, 1 or more	30%	15%
80362	Opioids and opiate analogs; 1 or 2	30%	15%
80363	Opioids and Opiate analogs; 3 or 4	30%	15%
80364	Opioids and Opiate analogs; 5 or more	30%	15%
80365	Oxycodone	30%	15%
80366	Pregabalin	30%	15%
80368	Sedative hypnotics (non-benzodiazepines)	30%	15%
80369	Skeletal muscle relaxants; 1 or 2	30%	15%
80370	Skeletal muscle relaxants; 3 or more	30%	15%
80371	Stimulants, synthetic	30%	15%
80372	Tapentadol	30%	15%
80373	Tramadol	30%	15%
80374	Stereoisomer (enantiomer) analysis, single drug class	30%	15%
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3	30%	15%
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6	30%	15%
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	30%	15%
81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	90%	90%
81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis	90%	90%
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score	90%	90%
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	90%	90%

Table 3 − Pricing percentages for newly covered codes that are manually priced

Procedure Code	Description	Amount reimbursed as % of billed charges when billed on a *CMS-1500* claim	Amount reimbursed as % of billed charges when billed on a *UB-04* claim
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	90%	90%
A4459	Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type	75% of manufacturer's suggested retail price (MSRP) or 120% of cost invoice	75% of MSRP or 120% of cost
A4602	Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each	75% of MSRP or 120% of cost	75% of MSRP or 120% of cost
G0472	Hepatitis C antibody screening, for individual at high risk and other covered indication(s)	90%	90%
G6021	Unlisted procedure, intestine	90%	90%
G6027	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	90%	90%
G6028	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	90%	90%
Q4152	Dermapure, per square centimeter	90%	90%
S8032	Low-dose computer tomography for lung cancer screening	90%	90%

Table 4 – Newly covered codes for which separate reimbursement is allowed under RC 636

Procedure Code	Description
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
C9027	Injection, pembrolizumab, 1 mg
C9136	Injection, factor viii, fc fusion protein, (recombinant), per i.u.
C9442	Injection, belinostat, 10 mg
C9443	Injection, dalbavancin, 10 mg
C9444	Injection, oritavancin, 10 mg
C9446	Injection, tedizolid phosphate, 1 mg
J0571	Buprenorphine, oral, 1 mg

Table 4 – Newly covered codes for which separate reimbursement is allowed under RC 636

Procedure Code	Description
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg
J0575	Buprenorphine/naloxone, oral, greater than 10 mg
J1322	Injection, elosulfase alfa, 1mg
J1439	Injection, ferric carboxymaltose, 1mg
J7181	Injection, factor xiii a-subunit, (recombinant), per iu
J7200	Injection, factor ix, (antihemophilic factor, recombinant), rixubis, per iu
J7201	Injection, factor ix, fc fusion protein (recombinant), per iu
J7327	Hyaluronan or derivative, monovisc, for intra-articular injection, per dose
J9267	Injection, paclitaxel, 1 mg
J9301	Injection, obinutuzumab, 10 mg

Table 5 − Newly covered **codes** *payable only when billed as a CMS-1500 claim*

Procedure Code	Description
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206)
G6001	Ultrasonic guidance for placement of radiation therapy fields
G6002	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy
G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev
G6004	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev
G6005	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev
G6006	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater
G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5 mev
G6008	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10 mev
G6009	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19 mev
G6010	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater
G6011	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev

Table 5 − Newly covered **codes** *payable only when billed as a CMS-1500 claim*

Procedure Code	Description
G6012	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev
G6013	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev
G6014	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session
G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session

Table 6 − Newly covered codes payable only when billed as a UB-04 claim

Procedure Code	Description
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex

Table 7 – IHCP-covered codes with updated pricing based on modified descriptions payable only as a UB-04 claim for DOS on or after January 1, 2015

Procedure code	Current description	New description
77402	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 mev	Radiation treatment delivery, >= 1 mev; simple
77407	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 mev	Radiation treatment delivery, >= 1 mev; intermediate
77412	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev	Radiation treatment delivery, >= 1 mev; complex