IHCP bulletin

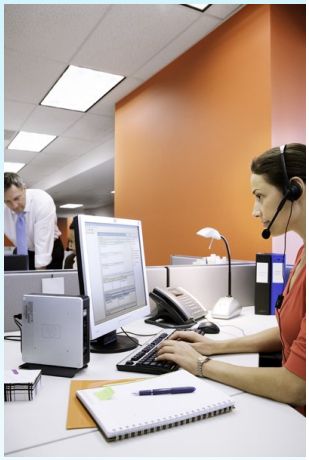
INDIANA HEALTH COVERAGE PROGRAMS BT201515 MARCH 17, 2015

Updates to the 2015 annual Healthcare Common Procedure Coding System code information

This bulletin updates information published in *Indiana Health Coverage Programs (IHCP) Bulletin* BT201501, dated January 6, 2015, regarding the 2015 Annual Healthcare Common Procedure Coding System (HCPCS) codes. The updates included are as follows:

- Table 1 provides revisions to the IHCP coverage and billing information originally published in *BT201501*. The prior authorization (PA) requirement for code 81519 is effective immediately. The coverage change for code 90651 is retroactive to dates of service (DOS) on or after **January 1, 2015**. Claims filed beyond the original one-year filing limit must include a copy of this bulletin as an attachment and must be filed within one year of the publication date.
- Table 2 provides coverage and billing information for additional codes included in the 2015 annual HCPCS update that were not included in *BT201501*, showing:
  - Procedure code
  - Description
  - Program coverage determination
  - PA requirements
  - National Drug Code (NDC) requirements

  Coverage and billing information for these codes applies retroactively to DOS on or after **February 1, 2015**. Claims filed beyond the original one-year filing limit must include a copy of this bulletin as an attachment and must be filed within one year of the publication date.



- Table 3 provides a list of deleted codes included in the 2015 annual HCPCS update, along with any alternate code considerations. Inclusion of an alternate code on this table does not indicate IHCP coverage of the alternate code. Consult the Fee Schedule at indianamedicaid.com for coverage information.

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

Revenue codes linked to covered codes in the 2015 annual HCPCS update were not immediately available to enter into the IHCP claims processing system. Therefore, claims submitted for covered codes with DOS on or after January 1, 2015, that denied for explanation of benefits (EOB) code 0520 – *Invalid revenue code and procedure code combination – please verify and resubmit* will be reprocessed. Adjustments will begin appearing on Remittance Advices (RAs) on or after April 1, 2015, and will be identified with internal control numbers (ICNs) that begin with region code 80.

Table 1 – Revised information for 2015 HCPCS codes effective for DOS on or after January 1, 2015

Procedure code	Description	Information published in ***BT201501***	Revised coverage and billing information*
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; PA not required; NDC not required	Covered for all programs; **PA required**; NDC not required
90651	Nonavalent HPV vaccine	Noncovered for all programs	Covered for all programs; PA not required; NDC not required; separate reimbursement allowed under revenue code 636

* "Covered" indicates the service described for the code is covered, subject to limitations established for certain benefit packages.
"Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 2 − New 2015 HCPCS codes, effective for DOS on or after February 1, 2015

Procedure code	Description	Program Coverage*	Prior Authorization Requirements	NDC Required	Special billing instructions
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intramuscular	Covered for all programs	No	No	Separate reimbursement allowed under revenue code 636
90621	Meningococcal recombinant lipoprotein vaccine, Serogroup B, 2 or 3 dose schedule, for intramuscular use	Covered for all programs	No	No	Separate reimbursement allowed under revenue code 636

* "Covered" indicates the service described for the code is covered, subject to limitations established for certain benefit packages.

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations

Procedure code	Description	Alternate code considerations
3125F	Esogageal biopsy report with statement about dysplasia (present, absent, or indefinite) (PATH)	NA
0059T	Cryopreservation; oocyte(s)	89337, 0357T
0073T	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	77385

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
0092T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), each additional interspace, cervical (List separately in addition to code for primary procedure)	0375T
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy	NA
0181T	Corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report	92145
0197T	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	77387
0199T	Physiologic recording of tremor using accelerometer(s) and/or gyroscope(s) (including frequency and amplitude), including interpretation and report	95999
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	46601
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	46607
0239T	Bioimpedance spectroscopy (BIS), measuring 100 frequencies or greater, direct measurement of extracellular fluid differences between the limbs	93702
0245T	Open treatment of rib fracture requiring internal fixation, unilateral; 1-2 ribs	21811
0246T	Open treatment of rib fracture requiring internal fixation, unilateral; 3-4 ribs	21811, 21812
0247T	Open treatment of rib fracture requiring internal fixation, unilateral; 5-6 ribs	21812
0248T	Open treatment of rib fracture requiring internal fixation, unilateral; 7 or more ribs	21813
0319T	Insertion or replacement of subcutaneous implantable defibrillator system with subcutaneous electrode	33270
0320T	Insertion of subcutaneous defibrillator electrode	33271
0321T	Insertion of subcutaneous implantable defibrillator pulse generator only with existing subcutaneous electrode	33240
0322T	Removal of subcutaneous implantable defibrillator pulse generator only	33241
0323T	Removal of subcutaneous implantable defibrillator pulse generator with replacement of subcutaneous implantable defibrillator pulse generator only	33262-33264
0324T	Removal of subcutaneous defibrillator electrode	33272
0325T	Repositioning of subcutaneous implantable defibrillator electrode and/ or pulse generator	33273

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
0326T	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	33270
0327T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	93261
0328T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis; implantable subcutaneous lead defibrillator system	93260
0343T	Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (eg, CT or fluoroscopic)	33418
0344T	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)	33419
00452	Anesthesia for procedures on clavicle and scapula; radical surgery	NA
00622	Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy	NA
00634	Anesthesia for procedures in lumbar region; chemonucleolysis	NA
21800	Closed treatment of rib fracture, uncomplicated, each	Use the appropriate Evaluation and Management code
21810	Treatment of rib fracture requiring external fixation (flail chest)	21899
22520	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic	22510
22521	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar	22511
22522	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	22512
22523	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	22513
22524	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar	22514
22525	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	22515

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
29020	Application of turnbuckle jacket, body; only	NA
29025	Application of turnbuckle jacket, body; including head	NA
29715	Removal or bivalving; turnbuckle jacket	NA
33332	Insertion of graft, aorta or great vessels; with shunt bypass	NA
33472	Valvotomy, pulmonary valve, open heart; with inflow occlusion	NA
33960	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day	33946-33949
33961	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day	33948, 33949
36469	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face	NA
36822	Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)	33951-33956
42508	Parotid duct diversion, bilateral (Wilke type procedure); with excision of 1 submandibular gland	NA
43350	Esophagostomy, fistulization of esophagus, external; abdominal approach	NA
44383	Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)	44384
44393	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	44401
44397	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)	44402
45339	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	45346
45345	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)	45347
45355	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple	45399
45383	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	45388
45387	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)	45389
61334	Exploration of orbit (transcranial approach); with removal of foreign body	NA
61440	Craniotomy for section of tentorium cerebelli (separate procedure)	NA
61470	Craniectomy, suboccipital; for medullary tractotomy	NA
61490	Craniotomy for lobotomy, including cingulotomy	NA
61542	Craniotomy with elevation of bone flap; for total hemispherectomy	NA
61609	Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure)	NA
61875	Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical	NA
62116	Reduction of craniomegalic skull (eg, treated hydrocephalus); with simple cranioplasty	NA

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
64752	Transection or avulsion of; vagus nerve (vagotomy), transthoracic	NA
64761	Transection or avulsion of; pudendal nerve	NA
64870	Anastomosis; facial-phrenic	NA
66165	Fistulization of sclera for glaucoma; iridencleisis or iridotasis	NA
69400	Eustachian tube inflation, transnasal; with catheterization	69799
69401	Eustachian tube inflation, transnasal; without catheterization	Use the appropriate Evaluation and Management code: 99201-99205, 99211-99215
69405	Eustachian tube catheterization, transtympanic	69799
72291	Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance	22510-22515
72292	Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance	22510-22515
74291	Cholecystography, oral contrast; additional or repeat examination or multiple day examination	NA
76645	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation	76641, 76642
76950	Ultrasonic guidance for placement of radiation therapy fields	77387
77082	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment	77086
77305	Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)	77306
77310	Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)	77306, 77307
77315	Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)	77307
77326	Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)	77316
77327	Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)	77317
77328	Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)	77318
77403	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV	77402
77404	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV	77402
77406	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater	77402

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
77408	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV	77407
77409	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV	77407
77411	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater	77407
77413	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV	77412
77414	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV	77412
77416	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater	77412
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	NA
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	77387
80100	Drug screen, qualitative; multiple drug classes chromatographic method, each procedure	80300-80304
80101	Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class	80300-80304
80102	Drug confirmation, each procedure	80300-80304
80103	Tissue preparation for drug analysis	80300-80304
80104	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure	80300-80304
80152	Amitriptyline	80335-80337
80154	Benzodiazepines	80346, 80347
80160	Desipramine	80335-80337
80166	Doxepin	80335-80337
80172	Gold	80375
80174	Imipramine	80335-80337
80182	Nortriptyline	80335-80337
80196	Salicylate	80329-80331
82000	Acetaldehyde, blood	NA
82003	Acetaminophen	80329-80331
82055	Acetoacetic Acid	80320-80322
82101	Alkaloids, urine, quantitative	80323
82145	Amphetamine or methamphetamine	80324-80326

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
82205	Barbiturates, not elsewhere specified	80345
82520	Cocaine or metabolite	80353
82646	Dihydrocodeinone	80361
82649	Dihydromorphinone	80361
82651	Dihydrotestosterone (DHT)	80327, 80328
82654	Dimethadione	80339-80341
82666	Epiandrosterone	80327, 80328
82690	Ethchlorvynol	80320
82742	Flurazepam	80346, 80347
82953	Glucose; tolbutamide tolerance test	NA
82975	Glutamine (glutamic acid amide)	82127, 82128, 82131
82980	Glutethimide	NA
83005	Guanase, Blood	NA
83008	Guanosine monophosphate (GMP), cyclic	NA
83071	Hemosiderin; quantitative	NA
83634	Lactose, urine; quantitative	NA
83805	Meprobamate	80369, 80370
83840	Methadone	80358
83858	Methsuximide	80339-80341
83866	Mucopolysaccharides, acid; screen	NA
83887	Nicotine	80323
83925	Opiate(s), drug and metabolites, each procedure	80361-80364
84022	Phenothiazine	80342-80344
87620	Papillomavirus, human, direct probe technique	87623-87625
87621	Papillomavirus, human, amplified probe technique	87623-87625
87622	Papillomavirus, human, quantification	87623-87625
88343	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure	88344
88349	Electron microscopy; scanning	88348
99481	Total body systemic hypothermia in a critically ill neonate per day (List separately in addition to code for primary procedure)	99184
99482	Selective head hypothermia in a critically ill neonate per day (List separately in addition to code for primary procedure)	99184
99488	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month	Use the appropriate Evaluation and Management code
A7042	Implanted pleural catheter, each	NA

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
A7043	Vacuum drainage bottle and tubing for use with implanted catheter	NA
C1300	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	NA
C9021	Injection, obinutuzumab, 10 mg	NA
C9022	Injection, elosulfase alfa, 1 mg	J1322
C9023	Injection, testosterone undecanoate, 1 mg	J3145
C9133	Factor IX (antihemophilic factor, recombinant), Rixibus, per IU	NA
C9134	Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 IU	J7181
C9135	Factor IX (antihemophilic factor, recombinant), Alprolix, per IU	J7201
C9441	Injection, ferric carboxymaltose, 1 mg	NA
C9735	Anoscopy; with directed submucosal injection(s), any substance	NA
D6053	Implant/abutment supported removable denture for completely edentulous arch	D6110-D6111
D6054	Implant/abutment supported removable denture for partially edentulous arch	D6112-D6113
D6078	Implant/abutment supported fixed denture for completely edentulous arch	D6114-D6115
D6079	Implant/abutment supported fixed denture for partially edentulous arch	D6116-D6117
D6975	Coping	NA
G0173	Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session	NA
G0251	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment	NA
G0417	Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 21-40 specimens	NA
G0418	Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 41-60 specimens	NA
G0419	Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, >60 specimens	NA
G0456	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 sq cm	97607
G0457	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 sq cm	97608
G0461	Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain	88342
G0462	Immunohistochemistry or immunocytochemistry, per specimen; each additional single or multiplex antibody stain (list separately in addition to code for primary procedure)	88341

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
G0908	Most recent hemoglobin (HgB) level > 12.0 g/dl	NA
G0909	Hemoglobin level measurement not documented, reason not given	NA
G0910	Most recent hemoglobin level <= 12.0 g/dl	NA
G0919	Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit	NA
G0920	Type, anatomic location, and activity all documented	NA
G0921	Documentation of patient reason(s) for not being able to assess (e.g., patient refuses endoscopic and/or radiologic assessment)	NA
G0922	No documentation of disease type, anatomic location, and activity, reason not given	NA
G8126	Patient with a diagnosis of major depression documented as being treated with antidepressant medication during the entire 84 day (12 week) acute treatment phase	NA
G8127	Patient with a diagnosis of major depression not documented as being treated with antidepressant medication during the entire 84 day (12 week) acute treatment phase	NA
G8128	Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week acute treatment phase measure	NA
G8406	Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure	NA
G8464	Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; low or intermediate risk of recurrence or risk of recurrence not determined	NA
G8492	I intend to report the perioperative care measures group	NA
G8493	I intend to report the back pain measures group	NA
G8501	All quality actions for the applicable measures in the perioperative care measures group have been performed for this patient	NA
G8502	All quality actions for the applicable measures in the back pain measures group have been performed for this patient	NA
G8547	I intend to report the ischemic vascular disease (IVD) measures group	NA
G8552	All quality actions for the applicable measures in the ischemic vascular disease (IVD) measures group have been performed for this patient	NA
G8579	Antiplatelet medication at discharge	NA
G8580	Antiplatelet medication contraindicated	NA
G8581	No antiplatelet medication at discharge	NA
G8582	Beta-blocker at discharge	NA
G8583	Beta-blocker contraindicated	NA
G8584	No beta-blocker at discharge	NA
G8585	Antilipid treatment at discharge	NA
G8586	Antilipid treatment contraindicated	NA
G8587	No antilipid treatment at discharge	NA

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
G8593	Lipid profile results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)	NA
G8594	Lipid profile not performed, reason not given	NA
G8595	Most recent LDL-C < 100 mg/dL	NA
G8597	Most recent LDL-C >= 100 mg/dL	NA
G8629	Patient treated for swallowing but not scored on the swallowing functional communication measure at admission or at discharge	NA
G8630	Documentation that administration of prophylactic parenteral antibiotics was initiated within one hour (if fluoroquinolone or vancomycin, 2 hours) prior to surgical incision (or start of procedure when no incision is required), as ordered	NA
G8631	Clinician documented that patient was not an eligible candidate for ordering prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, 2 hours) prior to surgical incision (or start of procedure when no incision is required)	NA
G8632	Prophylactic parenteral antibiotics were not ordered to be given or given within one hour (if fluoroquinolone or vancomycin, 2 hours) prior to the surgical incision (or start of procedure when no incision is required), reason not given	NA
G8682	LVF testing documented as being performed prior to discharge or in the previous 12 months	NA
G8683	LVF testing not performed prior to discharge or in the previous 12 months for a medical or patient documented reason	NA
G8685	LVF testing not documented as being performed prior to discharge or in the previous 12 months, reason not given	NA
G8699	Rehabilitation services (occupational, physical or speech) ordered at or prior to discharge	NA
G8700	Rehabilitation services (occupational, physical or speech) not indicated at or prior to discharge	NA
G8701	Rehabilitation services were not ordered, reason not otherwise specified	NA
G8702	Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or intraoperatively	NA
G8703	Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor intraoperatively	NA
G8704	12-lead electrocardiogram (ECG) performed	NA
G8705	Documentation of medical reason(s) for not performing a 12-lead electrocardiogram (ECG)	NA
G8706	Documentation of patient reason(s) for not performing a 12-lead electrocardiogram (ECG)	NA
G8707	12-lead electrocardiogram (ECG) not performed, reason not given	NA
G8736	Most current ldl-c <100mg/dl	NA
G8737	Most current ldl-c >=100mg/dl	NA
G8738	Left ventricular ejection fraction (LVEF) < 40% or documentation of severely or moderately depressed left ventricular sysLeft ventricular ejection fraction (LVEF) >= 40% or documentation as normal or mildly depressed left ventricular systolic function tolic function	NA

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
G8739	Left ventricular ejection fraction (LVEF) >= 40% or documentation as normal or mildly depressed left ventricular systolic function	NA
G8740	Left ventricular ejection fraction (LVEF) not performed or assessed, reason not given	NA
G8751	Smoking status and exposure to second hand smoke in the home not assessed, reason not given	NA
G8763	All quality actions for the applicable measures in the hypertension (HTN) measures group have been performed for this patient	NA
G8764	All quality actions for the applicable measures in the cardiovascular prevention measures group have been performed for this patient	NA
G8767	Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)	NA
G8768	Documentation of medical reason(s) for not performing lipid profile (e.g., patients with palliative goals or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	NA
G8769	Lipid profile not performed, reason not given	NA
G8770	Urine protein test result documented and reviewed	NA
G8771	Documentation of diagnosis of chronic kidney disease	NA
G8772	Documentation of medical reason(s) for not performing urine protein test (e.g., patients with palliative goals or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	NA
G8773	Urine protein test was not performed, reason not given	NA
G8774	Serum creatinine test result documented and reviewed	NA
G8775	Documentation of medical reason(s) for not performing serum creatinine test (e.g., patients with palliative goals or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	NA
G8776	Serum creatinine test not performed, reason not given	NA
G8777	Diabetes screening test performed	NA
G8778	Documentation of medical reason(s) for not performing diabetes screening test (e.g., patients with a diagnosis of diabetes, or with palliative goals or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	NA
G8779	Diabetes screening test not performed, reason not given	NA
G8780	Counseling for diet and physical activity performed	NA
G8781	Documentation of medical reason(s) for patient not receiving counseling for diet and physical activity (e.g., patients with palliative goals or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	NA
G8782	Counseling for diet and physical activity not performed, reason not given	NA
G8859	Patient receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days	NA
G8860	Patients who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days	NA
G8862	Patients not receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days	NA

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
G8886	Most recent blood pressure under control	NA
G8887	Documentation of medical reason(s) for most recent blood pressure not being under control (e.g., patients with palliative goals or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	NA
G8889	No documentation of blood pressure measurement, reason not given	NA
G8890	Most recent LDL-C under control, results documented and reviewed	NA
G8891	Documentation of medical reason(s) for most recent LDL-C not under control (e.g., patients with palliative goals for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	NA
G8892	Documentation of medical reason(s) for not performing LDL-C test (e.g., patients with palliative goals or for whom treatment of hypertension with standard treatment goals is not clinically appropriate)	NA
G8893	Most recent LDL-C not under control, results documented and reviewed	NA
G8894	LDL-C not performed, reason not given	NA
G8895	Oral aspirin or other antithrombotic therapy prescribed	NA
G8896	Documentation of medical reason(s) for not prescribing oral aspirin or other antithrombotic therapy (e.g., patient documented to be low risk or patient with terminal illness or treatment of hypertension with standard treatment goals is not clinically appropriate, or for whom risk of aspirin or other antithrombotic therapy exceeds potential benefits such as for individuals whose blood pressure is poorly controlled)	NA
G8897	Oral aspirin or other antithrombotic therapy was not prescribed, reason not given	NA
G8904	I intend to report the hypertension (HTN) measures group	NA
G8905	I intend to report the cardiovascular prevention measures group	NA
G8930	Assessment of depression severity at the initial evaluation	NA
G8931	Assessment of depression severity not documented, reason not given	NA
G8932	Suicide risk assessed at the initial evaluation	NA
G8933	Suicide risk not assessed at the initial evaluation, reason not given	NA
G8943	LDL-C result not present or not within 12 months prior	NA
G8949	Documentation of patient reason(s) for patient not receiving counseling for diet and physical activity (e.g., patient is not willing to discuss diet or exercise interventions to help control blood pressure, or the patient said he/she refused to make these changes)	NA
G8957	Patient not receiving maintenance hemodialysis in an outpatient dialysis facility	NA
G9193	Clinician documented that patient with a diagnosis of major depression was not an eligible candidate for antidepressant medication treatment or patient did not have a diagnosis of major depression	NA
G9194	Patient with a diagnosis of major depression documented as being treated with antidepressant medication during the entire 180 day (6 month) continuation treatment phase	NA
G9195	Patient with a diagnosis of major depression not documented as being treated with antidepressant medication during the entire 180 day (6 months) continuation treatment phase	NA

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
G9199	Venous thromboembolism (VTE) prophylaxis not administered the day of or the day after hospital admission for documented reasons (e.g., patient is ambulatory, patient expired during inpatient stay, patient already on warfarin or another anticoagulant, other medical reason(s) or e.g., patient left against medical advice, other patient reason(s))	NA
G9200	Venous thromboembolism (VTE) prophylaxis was not administered the day of or the day after hospital admission, reason not given	NA
G9201	Venous thromboembolism (VTE) prophylaxis administered the day of or the day after hospital admission	NA
G9202	Patients with a positive hepatitis C antibody test	NA
G9214	CD4+ cell count or CD4+ cell percentage results documented	NA
G9215	CD4+ cell count or percentage not documented as performed, reason not given	NA
G9216	PCP prophylaxis was not prescribed at time of diagnosis of HIV, reason not given	NA
G9218	PCP prophylaxis was not prescribed within 3 months of low CD4+ cell count below 500 cells/mm3 or a CD4 percentage below 15%, reason not given	NA
G9220	Pneumocystis jiroveci pneumonia prophylaxis not prescribed within 3 months of low CD4+ cell count below 500 cells/mm3 or a CD4 percentage below 15% for medical reason (i.e., patient's CD4+ cell count above threshold within 3 months after CD4+ cell count below threshold, indicating that the patient's CD4+ levels are within an acceptable range and the patient does not require PCP prophylaxis)	NA
G9221	Pneumocystis jiroveci pneumonia prophylaxis prescribed	NA
G9224	Documentation of medical reason for not performing foot exam (e.g., patient with bilateral foot/leg amputation)	NA
G9248	Patient did not have a medical visit in the last 6 months	NA
G9249	Patient had a medical visit in the last 6 months	NA
G9252	Adenoma(s) or other neoplasm detected during screening colonoscopy	NA
G9253	Adenoma(s) or other neoplasm not detected during screening colonoscopy	NA
G9271	LDL value < 100	NA
G9272	LDL value >= 100	NA
J0150	Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270)	NA
J0151	Injection, adenosine for diagnostic use, 1 mg (not to be used to report any adenosine phosphate compounds, instead use A9270)	NA
J0900	Injection, testosterone enanthate and estradiol valerate, up to 1 cc	NA
J1060	Injection, testosterone cypionate and estradiol cypionate, up to 1 ml	NA
J1070	Injection, testosterone cypionate, up to 100 mg	NA
J1080	Injection, testosterone cypionate, 1 cc, 200 mg	NA
J2271	Injection, morphine sulfate, 100 mg	NA
J2275	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg	J2274
J3120	Injection, testosterone enanthate, up to 100 mg	NA

Table 3 − Deleted CPT and HCPCS codes, effective January 1, 2015, with alternate code considerations (Continued)

Procedure code	Description	Alternate code considerations
J3130	Injection, testosterone enanthate, up to 200 mg	NA
J3140	Injection, testosterone suspension, up to 50 mg	NA
J3150	Injection, testosterone propionate, up to 100 mg	NA
J7335	Capsaicin 8% patch, per 10 sq cm	NA
J9265	Injection, paclitaxel, 30 mg	NA
L6025	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, 2 batteries, charger, myoelectric control of terminal device	NA
L7260	Electronic wrist rotator, Otto Bock or equal	L7259
L7261	Electronic wrist rotator, for Utah arm	L7259
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders	NA
Q9970	Injection, ferric carboxymaltose, 1 mg	NA
Q9972	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	J0887
Q9973	Injection, epoetin beta, 1 microgram, (non-ESRD use)	J0888
Q9974	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg	J2274
S0144	Injection, propofol, 10 mg	J2704
S3855	Genetic testing for detection of mutations in the presenilin - 1 gene	NA

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