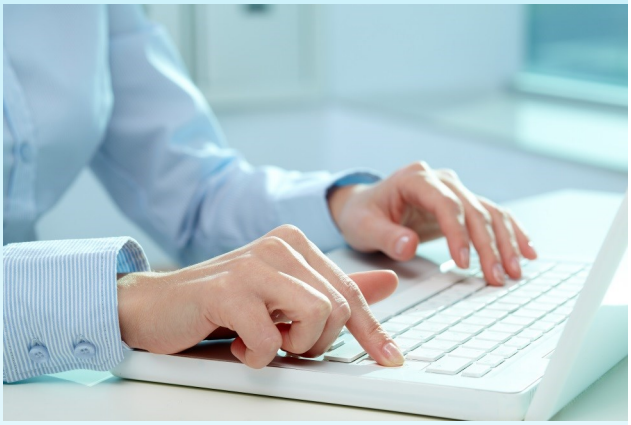
IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201694 DECEMBER 29, 2016

Coverage and billing information for the 2017 annual HCPCS codes update

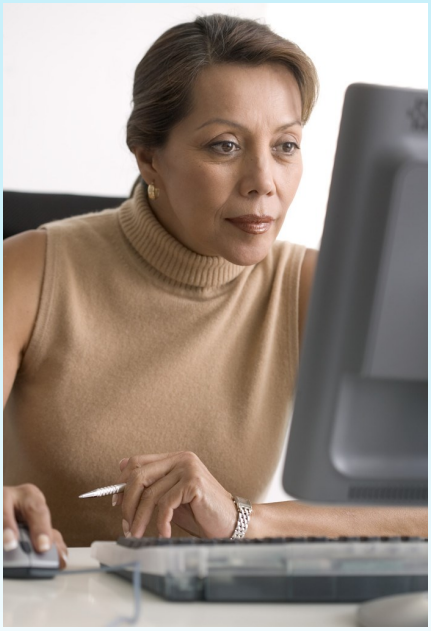
The Indiana Health Coverage Programs (IHCP) has reviewed the 2017 annual Healthcare Common Procedure Coding System (HCPCS) update to determine coverage and billing guidelines. IHCP coverage and billing information provided in this bulletin is effective January 1, 2017. This bulletin serves as notice of the following information:



- Table 1: New alphanumeric and Current Procedural Terminology (CPT®[1]) codes included in the 2017 annual HCPCS update, showing:
  - Procedure code
  - Description
  - Program coverage determination
  - Prior authorization (PA) requirement
  - National Drug Code (NDC) requirement
  - Special billing instructions
- Table 2: Pricing percentages for newly covered codes from Table 1 that are manually priced codes.
- Table 3: New modifiers included in the 2017 annual HCPCS update showing the modifier code, description, and type. Providers should follow CPT coding guidelines for reporting services using appropriate modifiers.
- Table 4: New code released in October 2016 after the fourth-quarter updates were completed. This code is effective retroactive to January 1, 2016.
- Table 5: Current vaccine administration HCPCS codes that have age restrictions revised or removed effective January 1, 2017.

The 2017 annual HCPCS, CPT, and Current Dental Terminology (CDT®[2]) codes will be added to the claim-processing system. Established pricing will be posted on the *Fee Schedule* and codes added to the following code tables on the *Code Sets* page at indianamedicaid.com:

- Procedure Codes that Require NDCs
- Chiropractic Services Codes
- Durable and Home Medical Equipment and Supplies Codes
- Vision Services Codes
- Family Planning Eligibility Program Codes



Providers may report these codes for dates of service (DOS) on or after January 1, 2017. The standard global billing procedures and edits apply when using the new codes. 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 Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing information within the managed care delivery system. Questions about managed care PA should be directed to the MCE with which the member is enrolled.

The 2017 annual HCPCS update also includes modifications to descriptions for some additional existing HCPCS codes. These modifications are available for reference or download from the Centers for Medicare & Medicaid Services (CMS) website at cms.gov. Any modifications to descriptions that affect IHCP reimbursement will be announced at a later date.

The 2017 annual HCPCS update also includes a list of deleted codes. These codes are available for reference or download from the CMS website at cms.gov. The CMS has not yet published the alternative codes associated with the deleted codes. After this information is announced by the 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, 2017.

The IHCP is awaiting the final posting of the CMS *Clinical Laboratory Fee Schedule* and the *Outpatient Fee Schedule,* which could affect pricing for some codes. The IHCP will issue a publication detailing any additional pricing information after final calculations are completed.

QUESTIONS?

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

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Table 1 − New codes included in the 2017 annual HCPCS update, effective for DOS on or after January 1, 2017

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Covered for all programs	No	No	No
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Covered for all programs	No	No	No
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
27197	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation	Covered for all programs	No	No	No
27198	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with	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.

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
	manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)				
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	Covered for all programs	No	No	No
28295	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method	Covered for all programs	No	No	No
31551	Laryngoscopy; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age	Covered for all programs	No	No	Limited to ages 0 through 11 years
31552	Laryngoscopy; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older	Covered for all programs	No	No	Limited to ages 12 years and older
31553	Laryngoscopy; for laryngeal stenosis, with graft, with indwelling younger than 12 years of age	Covered for all programs	No	No	Limited to ages 0 through 11 years
31554	Laryngoscopy; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older	Covered for all programs	No	No	Limited to ages 12 years and older
31572	Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral	Covered for all programs	No	No	No
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral	Covered for all programs	No	No	No
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	Covered for all programs	No	No	No
31591	Laryngoplasty, medialization, unilateral	Covered for all programs	No	No	No
31592	Cricotracheal resection	Covered for all programs	No	No	No
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	Covered for all programs	No	No	No
33390	Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)	Covered for all programs	No	No	No
33391	Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; complex (eg, leaflet extension, leaflet resection, leaflet reconstruction, or annuloplasty)	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
36456	Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn	Covered for all programs	No	No	Limited to ages 0 through 28 days
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Covered for all programs	No	No	See Table 2 for manual pricing percentage
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contract, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report	Covered for all programs	No	No	No
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contract, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	Covered for all programs	No	No	No
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contract, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting and all angioplasty within the peripheral dialysis segment	Covered for all programs	No	No	See Table 2 for manual pricing percentage

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation; diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	Covered for all programs	No	No	No
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation; diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision necessary to perform the angioplasty	Covered for all programs	No	No	No
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation; diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of an intravascular stent(s), peripheral dialysis segment, including all imaging radiological supervision and interpretation to perform the stenting and all angioplasty within the peripheral dialysis circuit	Covered for all programs	No	No	See Table 2 for manual pricing percentage
36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
36908	Transcatheter placement of an intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	Covered for all programs	No	No	See Table 2 for manual pricing percentage
36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	Covered for all programs	No	No	See Table 2 for manual pricing percentage

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	Covered for all programs	No	No	No
37247	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	Covered for all programs	No	No	No
37249	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	Covered for all programs	No	No	No
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band, including cruroplasty when performed	Covered for all programs	Yes	No	No
43285	Removal of esophageal sphincter augmentation device	Covered for all programs	No	No	No
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Covered for all programs	No	No	No
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	Covered for all programs	No	No	No
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	Covered for all programs	No	No	No
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	Covered for all programs	No	No	No
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution),not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	Covered for all programs	No	No	No
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	Covered for all programs	No	No	No
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	Covered for all programs	No	No	No
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	Covered for all programs	No	No	No
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	Covered for all programs	No	No	No
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	Covered for all programs	No	No	Limited to ages 65 years and older; Limited to one per lifetime

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	Covered for all programs	No	No	No
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	Covered for all programs	No	No	No
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	Covered for all programs	No	No	No
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service	Covered for all programs	No	No	No
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); read by instrument assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	Covered for all programs	No	No	No
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, per date of service	Covered for all programs	No	No	No
81327	SEPT9 (Septin9) (eg, colorectal cancer) methylation analysis	Noncovered for all programs	NA	NA	NA
81413	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A	Noncovered for all programs	NA	NA	NA
81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1	Noncovered for all programs	NA	NA	NA
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood	Noncovered for all programs	NA	NA	NA
81439	Inherited cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at least 5 genes, including DSG2, MYBPC3, MYH7, PKP2, and TTN	Covered for all programs	Yes	No	Limited to one per lifetime

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score	Noncovered for all programs	NA	NA	NA
84410	Testosterone; bioavailable, direct measurement (eg, differential precipitation)	Covered for all programs	No	No	No
87483	Infectious agent detection by nucleic acid (DNA or RNA); central nervous system pathogen (eg, Neisseria meningitidis, Streptococcus pneumoniae, Listeria, Haemophilus influenzae, E. coli, Streptococcus agalactiae, enterovirus, human parechovirus, herpes simplex virus type 1 and 2, human herpesvirus 6, cytomegalovirus, varicella zoster virus, Cryptococcus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets	Covered for all programs, including Family Planning Eligibility Program	No	No	No
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	Covered for all programs	No	No	No
90682	Influenza virus vaccine, quadrivalent (riv4), derived from recombinant DNA, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use	Noncovered for all programs	NA	NA	NA
90750	Zoster (shingles) vaccine (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection	Noncovered for all programs	NA	NA	NA
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral	Covered for all programs	No	No	No
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	Covered for all programs	No	No	No
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	Covered for all programs	No	No	No
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary service)	Covered for all programs	No	No	No
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	Covered for all programs	No	No	No
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	Covered for all programs	No	No	No
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection	Covered for all programs	No	No	See Table 2 for manual pricing percentage

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Covered for all programs	No	No	No
97162	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Covered for all programs	No	No	No
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.	Covered for all programs	Yes	No	No
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Covered for all programs	No	No	No
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.	Covered for all programs	No	No	No
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in-patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Covered for all programs	Yes	No	No
97169	Athletic training evaluation, low complexity, requiring these components: A history and physical activity profile with no comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing 1-2 elements from any of the following: body structures, physical activity, and/or participation deficiencies; and clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 15 minutes are spent face-to-face with the patient and/or family.	Noncovered for all programs	NA	NA	NA
97170	Athletic training evaluation, moderate complexity, requiring these components: A medical history and physical activity profile with 1-2 comorbidities that affect physical activity; An examination of affected body area and other symptomatic or related systems addressing a total of 3 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; and	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
	clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.				
97171	Athletic training evaluation, high complexity, requiring these components: A medical history and physical activity profile, with 3 or more comorbidities that affect physical activity; A comprehensive examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures, physical activity, and/or participation deficiencies; clinical presentation with unstable and unpredictable characteristics; and clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Noncovered for all programs	NA	NA	NA
97172	Re-evaluation of athletic training established plan of care requiring these components: An assessment of patient's current functional status when there is a documented change; and A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome with an update in management options, goals, and interventions. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Noncovered for all programs	NA	NA	NA
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age	Covered for all programs	No	No	Limited to ages 0 through 4 years
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	Covered for all programs	No	No	Limited to ages 5 years and older

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	Covered for all programs	No	No	No
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age	Covered for all programs	No	No	Limited to ages 0 through 4 years
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older	Covered for all programs	No	No	Limited to ages 5 years and older
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	Covered for all programs	No	No	No
A4224	Supplies for maintenance of insulin infusion catheter, per week	Covered for all programs	No	No	No
A4225	Supplies for external insulin infusion pump, syringe type cartridge, sterile, each	Covered for all programs	No	No	No
A4467	Belt, strap, sleeve, garment, or covering, any type	Covered for all programs	No	No	See Table 2 for manual pricing percentage
A4533	Non-disposable under-pads, all sizes	Noncovered for all programs	NA	NA	NA
A9285	Inversion/eversion correction device	Noncovered for all programs	NA	NA	NA
A9286	Hygienic item or device, disposable or non-disposable, any type, each	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
A9515	Choline c-11, diagnostic, per study dose up to 20 millicuries	Noncovered for all programs	NA	NA	NA
A9587	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie	Noncovered for all programs	NA	NA	NA
A9588	Fluciclovine f-18, diagnostic, 1 millicurie	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
A9597	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified	Covered for all programs	No	No	No
A9598	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified	Covered for all programs	No	No	No
C1889	Implantable/insertable device for device intensive procedure, not otherwise classified	Noncovered for all programs	NA	NA	NA
C9140	Injection, factor viii (antihemophilic factor, recombinant) (Afstyla), 1 i.u.	Covered for all programs	No	Yes	Linked to revenue code 636; Not separately reimbursable when billed on *CMS-1500*
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Noncovered for all programs	NA	NA	NA
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	Noncovered for all programs	NA	NA	NA
D1575	Distal shoe space maintainer – fixed – unilateral	Covered for all programs	No	No	Limited to ages 0 through 20 years; See Table 2 for manual pricing percentage
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	Covered for all programs	No	No	Limited to 1 per 3 years; See Table 2 for manual pricing percentage
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.	Covered for all programs	No	No	Attachment required: Dental chart and proof of dental implant; See Table 2 for manual pricing percentage
D6085	Provisional implant crown	Noncovered for all programs	NA	NA	NA
D9311	Consultation with a medical health care professional	Noncovered for all programs	NA	NA	NA
D9991	Dental case management – addressing appointment compliance barriers	Noncovered for all programs	NA	NA	NA
D9992	Dental case management – care coordination	Noncovered for all programs	NA	NA	NA
D9993	Dental case management – motivational interviewing	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
D9994	Dental case management – patient education to improve oral health literacy	Noncovered for all programs	NA	NA	NA
G0491	Dialysis procedure at a Medicare certified ESRD facility for acute kidney injury without ESRD	Noncovered for all programs	NA	NA	NA
G0492	Dialysis procedure with single evaluation by a physician or other qualified health care professional for acute kidney injury without ESRD	Noncovered for all programs	NA	NA	NA
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	Noncovered for all programs	NA	NA	NA
G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)	Noncovered for all programs	NA	NA	NA
G0495	Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes	Noncovered for all programs	NA	NA	NA
G0496	Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes	Noncovered for all programs	NA	NA	NA
G0499	Hepatitis B screening in non-pregnant, high risk individual includes hepatitis B surface antigen (HBSAG) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to HBSAG (anti-HBS) and hepatitis B core antigen (anti-HBC)	Covered for all programs	No	No	No
G0500	Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)	Noncovered for all programs	NA	NA	NA
G0501	Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G0502	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies	Noncovered for all programs	NA	NA	NA
G0503	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G0504	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure); (use G0504 in conjunction with G0502, G0503)	Noncovered for all programs	NA	NA	NA
G0505	Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home	Noncovered for all programs	NA	NA	NA
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	Noncovered for all programs	NA	NA	NA
G0507	Care management services for behavioral health conditions, 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: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/ psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team	Noncovered for all programs	NA	NA	NA
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	Noncovered for all programs	NA	NA	NA
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	Noncovered for all programs	NA	NA	NA
G9687	Hospice services provided to patient any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9688	Patients using hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9689	Patient admitted for performance of elective carotid intervention	Noncovered for all programs	NA	NA	NA
G9690	Patient receiving hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9691	Patient had hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9692	Hospice services received by patient any time during the measurement period	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9693	Patient use of hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9694	Hospice services utilized by patient any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9695	Long-acting inhaled bronchodilator prescribed	Noncovered for all programs	NA	NA	NA
G9696	Documentation of medical reason(s) for not prescribing a long-acting inhaled bronchodilator	Noncovered for all programs	NA	NA	NA
G9697	Documentation of patient reason(s) for not prescribing a long-acting inhaled bronchodilator	Noncovered for all programs	NA	NA	NA
G9698	Documentation of system reason(s) for not prescribing a long-acting inhaled bronchodilator	Noncovered for all programs	NA	NA	NA
G9699	Long-acting inhaled bronchodilator not prescribed, reason not otherwise specified	Noncovered for all programs	NA	NA	NA
G9700	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9701	Children who are taking antibiotics in the 30 days prior to the date of the encounter during which the diagnosis was established	Noncovered for all programs	NA	NA	NA
G9702	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9703	Children who are taking antibiotics in the 30 days prior to the diagnosis of pharyngitis	Noncovered for all programs	NA	NA	NA
G9704	AJCC breast cancer stage i: t1 mic or t1a documented	Noncovered for all programs	NA	NA	NA
G9705	AJCC breast cancer stage i: t1b (tumor > 0.5 cm but <= 1 cm in greatest dimension) documented	Noncovered for all programs	NA	NA	NA
G9706	Low (or very low) risk of recurrence, prostate cancer	Noncovered for all programs	NA	NA	NA
G9707	Patient received hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9708	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy	Noncovered for all programs	NA	NA	NA
G9709	Hospice services used by patient any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9710	Patient was provided hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9711	Patients with a diagnosis or past history of total colectomy or colorectal cancer	Noncovered for all programs	NA	NA	NA
G9712	Documentation of medical reason(s) for prescribing or dispensing antibiotic (e.g., intestinal infection, pertussis, bacterial infection, Lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis/ mastoiditis/bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia, gonococcal infections/venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis/UTI, acne, HIV disease/asymptomatic HIV, cystic fibrosis, disorders of the immune system, malignancy	Noncovered for all programs	NA	NA	NA

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	neoplasms, chronic bronchitis, emphysema, bronchiectasis, extrinsic allergic alveolitis, chronic airway obstruction, chronic obstructive asthma, pneumoconiosis and other lung disease due to external agents, other diseases of the respiratory system, and tuberculosis				
G9713	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9714	Patient is using hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9715	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9716	BMI is documented as being outside of normal limits, follow-up plan is not completed for documented reason	Noncovered for all programs	NA	NA	NA
G9717	Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required	Noncovered for all programs	NA	NA	NA
G9718	Hospice services for patient provided any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9719	Patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair	Noncovered for all programs	NA	NA	NA
G9720	Hospice services for patient occurred any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9721	Patient not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair	Noncovered for all programs	NA	NA	NA
G9722	Documented history of renal failure or baseline serum creatinine = 4.0 mg/dl; renal transplant recipients are not considered to have preoperative renal failure, unless, since transplantation, the CR has been or is 4.0 or higher	Noncovered for all programs	NA	NA	NA
G9723	Hospice services for patient received any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9724	Patients who had documentation of use of anticoagulant medications overlapping the measurement year	Noncovered for all programs	NA	NA	NA
G9725	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9726	Patient refused to participate	Noncovered for all programs	NA	NA	NA
G9727	Patient unable to complete the FOTO knee intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	Noncovered for all programs	NA	NA	NA
G9728	Patient refused to participate	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9729	Patient unable to complete the FOTO hip intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	Noncovered for all programs	NA	NA	NA
G9730	Patient refused to participate	Noncovered for all programs	NA	NA	NA
G9731	Patient unable to complete the FOTO foot or ankle intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	Noncovered for all programs	NA	NA	NA
G9732	Patient refused to participate	Noncovered for all programs	NA	NA	NA
G9733	Patient unable to complete the FOTO lumbar intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	Noncovered for all programs	NA	NA	NA
G9734	Patient refused to participate	Noncovered for all programs	NA	NA	NA
G9735	Patient unable to complete the FOTO shoulder intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	Noncovered for all programs	NA	NA	NA
G9736	Patient refused to participate	Noncovered for all programs	NA	NA	NA
G9737	Patient unable to complete the FOTO elbow, wrist or hand intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	Noncovered for all programs	NA	NA	NA
G9738	Patient refused to participate	Noncovered for all programs	NA	NA	NA
G9739	Patient unable to complete the FOTO general orthopedic intake prom at admission and discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available	Noncovered for all programs	NA	NA	NA
G9740	Hospice services given to patient any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9741	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9742	Psychiatric symptoms assessed	Noncovered for all programs	NA	NA	NA
G9743	Psychiatric symptoms not assessed, reason not otherwise specified	Noncovered for all programs	NA	NA	NA
G9744	Patient not eligible due to active diagnosis of hypertension	Noncovered for all programs	NA	NA	NA
G9745	Documented reason for not screening or recommending a follow-up for high blood pressure	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9746	Patient has mitral stenosis or prosthetic heart valves or patient has transient or reversible cause of AF (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery)	Noncovered for all programs	NA	NA	NA
G9747	Patient is undergoing palliative dialysis with a catheter	Noncovered for all programs	NA	NA	NA
G9748	Patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant	Noncovered for all programs	NA	NA	NA
G9749	Patient is undergoing palliative dialysis with a catheter	Noncovered for all programs	NA	NA	NA
G9750	Patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant	Noncovered for all programs	NA	NA	NA
G9751	Patient died at any time during the 24-month measurement period	Noncovered for all programs	NA	NA	NA
G9752	Emergency surgery	Noncovered for all programs	NA	NA	NA
G9753	Documentation of medical reason for not conducting a search for Dicom format images for prior patient CT imaging studies completed at non-affiliated external healthcare facilities or entities within the past 12 months that are available through a secure, authorized, media-free, shared archive (e.g., trauma, acute myocardial infarction, stroke, aortic aneurysm where time is of the essence)	Noncovered for all programs	NA	NA	NA
G9754	A finding of an incidental pulmonary nodule	Noncovered for all programs	NA	NA	NA
G9755	Documentation of medical reason(s) that follow-up imaging is indicated (e.g., patient has a known malignancy that can metastasize, other medical reason(s)	Noncovered for all programs	NA	NA	NA
G9756	Surgical procedures that included the use of silicone oil	Noncovered for all programs	NA	NA	NA
G9757	Surgical procedures that included the use of silicone oil	Noncovered for all programs	NA	NA	NA
G9758	Patient in hospice and in terminal phase	Noncovered for all programs	NA	NA	NA
G9759	History of preoperative posterior capsule rupture	Noncovered for all programs	NA	NA	NA
G9760	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9761	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9762	Patient had at least three HPV vaccines on or between the patient's 9th and 13th birthdays	Noncovered for all programs	NA	NA	NA
G9763	Patient did not have at least three HPV vaccines on or between the patient's 9th and 13th birthdays	Noncovered for all programs	NA	NA	NA
G9764	Patient has been treated with an oral systemic or biologic medication for psoriasis	Noncovered for all programs	NA	NA	NA
G9765	Documentation that the patient declined therapy change, has documented contraindications, or has not been treated with an oral systemic or biologic for at least six consecutive months (e.g.,	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
	experienced adverse effects or lack of efficacy with all other therapy options) in order to achieve better disease control as measured by PGA, BSA, PASI, or DLGI				
G9766	Patients who are transferred from one institution to another with a known diagnosis of CVA for endovascular stroke treatment	Noncovered for all programs	NA	NA	NA
G9767	Hospitalized patients with newly diagnosed CVA considered for endovascular stroke treatment	Noncovered for all programs	NA	NA	NA
G9768	Patients who utilize hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9769	Patient had a bone mineral density test in the past two years or received osteoporosis medication or therapy in the past 12 months	Noncovered for all programs	NA	NA	NA
G9770	Peripheral nerve block (PNB)	Noncovered for all programs	NA	NA	NA
G9771	At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time	Noncovered for all programs	NA	NA	NA
G9772	Documentation of one of the following medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (e.g., emergency cases, intentional hypothermia, etc.)	Noncovered for all programs	NA	NA	NA
G9773	At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) not achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time	Noncovered for all programs	NA	NA	NA
G9774	Patients who have had a hysterectomy	Noncovered for all programs	NA	NA	NA
G9775	Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	Noncovered for all programs	NA	NA	NA
G9776	Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)	Noncovered for all programs	NA	NA	NA
G9777	Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	Noncovered for all programs	NA	NA	NA
G9778	Patients who have a diagnosis of pregnancy	Noncovered for all programs	NA	NA	NA
G9779	Patients who are breastfeeding	Noncovered for all programs	NA	NA	NA
G9780	Patients who have a diagnosis of rhabdomyolysis	Noncovered for all programs	NA	NA	NA

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Table 1 − New codes included in the 2017 annual HCPCS update, effective for DOS on or after January 1, 2017

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9781	Documentation of medical reason(s) for not currently being a statin therapy user or receive an order (prescription) for statin therapy (e.g., patient with adverse effect, allergy or intolerance to statin medication therapy, patients who are receiving palliative care, patients with active liver disease or hepatic disease or insufficiency, and patients with end stage renal disease (ESRD)	Noncovered for all programs	NA	NA	NA
G9782	History of or active diagnosis of familial or pure hypercholesterolemia	Noncovered for all programs	NA	NA	NA
G9783	Documentation of patients with diabetes who have a most recent fasting or direct LDL- c laboratory test result < 70 mg/dl and are not taking statin therapy	Noncovered for all programs	NA	NA	NA
G9784	Pathologists/dermatopathologists providing a second opinion on a biopsy	Noncovered for all programs	NA	NA	NA
G9785	Pathology report diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma (to include in situ disease) sent from the pathologist/ dermatopathologist to the biopsying clinician for review within 7 business days from the time when the tissue specimen was received by the pathologist	Noncovered for all programs	NA	NA	NA
G9786	Pathology report diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma (to include in situ disease) was not sent from the pathologist/ dermatopathologist to the biopsying clinician for review within 7 business days from the time when the tissue specimen was received by the pathologist	Noncovered for all programs	NA	NA	NA
G9787	Patient alive as of the last day of the measurement year	Noncovered for all programs	NA	NA	NA
G9788	Most recent BP is less than or equal to 140/90 mm hg	Noncovered for all programs	NA	NA	NA
G9789	Blood pressure recorded during inpatient stays, emergency room visits, urgent care visits, and patient self-reported BPs (home and health fair BP results)	Noncovered for all programs	NA	NA	NA
G9790	Most recent BP is greater than 140/90 mm hg, or blood pressure not documented	Noncovered for all programs	NA	NA	NA
G9791	Most recent tobacco status is tobacco free	Noncovered for all programs	NA	NA	NA
G9792	Most recent tobacco status is not tobacco free	Noncovered for all programs	NA	NA	NA
G9793	Patient is currently on a daily aspirin or other antiplatelet	Noncovered for all programs	NA	NA	NA
G9794	Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g. history of gastrointestinal bleed or intra-cranial bleed or documentation of active anticoagulant use during the measurement period)	Noncovered for all programs	NA	NA	NA
G9795	Patient is not currently on a daily aspirin or other antiplatelet	Noncovered for all programs	NA	NA	NA
G9796	Patient is currently on a statin therapy	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9797	Patient is not on a statin therapy	Noncovered for all programs	NA	NA	NA
G9798	Discharge(s) for AMI between July 1 of the year prior measurement year to June 30 of the measurement period	Noncovered for all programs	NA	NA	NA
G9799	Patients with a medication dispensing event indicator of a history of asthma any time during the patient's history through the end of the measure period	Noncovered for all programs	NA	NA	NA
G9800	Patients who are identified as having an intolerance or allergy to beta-blocker therapy	Noncovered for all programs	NA	NA	NA
G9801	Hospitalizations in which the patient was transferred directly to a non-acute care facility for any diagnosis	Noncovered for all programs	NA	NA	NA
G9802	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9803	Patient prescribed a 180-day course of treatment with beta-blockers post discharge for AMI	Noncovered for all programs	NA	NA	NA
G9804	Patient was not prescribed a 180-day course of treatment with beta-blockers post discharge for AMI	Noncovered for all programs	NA	NA	NA
G9805	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9806	Patients who received cervical cytology or an HPV test	Noncovered for all programs	NA	NA	NA
G9807	Patients who did not receive cervical cytology or an HPV test	Noncovered for all programs	NA	NA	NA
G9808	Any patients who had no asthma controller medications dispensed during the measurement year	Noncovered for all programs	NA	NA	NA
G9809	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9810	Patient achieved a PDC of at least 75% for their asthma controller medication	Noncovered for all programs	NA	NA	NA
G9811	Patient did not achieve a PDC of at least 75% for their asthma controller medication	Noncovered for all programs	NA	NA	NA
G9812	Patient died including all deaths occurring during the hospitalization in which the operation was performed, even if after 30 days, and those deaths occurring after discharge from the hospital, but within 30 days of the procedure	Noncovered for all programs	NA	NA	NA
G9813	Patient did not die within 30 days of the procedure or during the index hospitalization	Noncovered for all programs	NA	NA	NA
G9814	Death occurring during hospitalization	Noncovered for all programs	NA	NA	NA
G9815	Death did not occur during hospitalization	Noncovered for all programs	NA	NA	NA
G9816	Death occurring 30 days post procedure	Noncovered for all programs	NA	NA	NA
G9817	Death did not occur 30 days post procedure	Noncovered for all programs	NA	NA	NA
G9818	Documentation of sexual activity	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9819	Patients who use hospice services any time during the measurement period	Noncovered for all programs	NA	NA	NA
G9820	Documentation of a chlamydia screening test with proper follow-up	Noncovered for all programs	NA	NA	NA
G9821	No documentation of a chlamydia screening test with proper follow-up	Noncovered for all programs	NA	NA	NA
G9822	Women who had an endometrial ablation procedure during the year prior to the index date (exclusive of the index date)	Noncovered for all programs	NA	NA	NA
G9823	Endometrial sampling or hysteroscopy with biopsy and results documented	Noncovered for all programs	NA	NA	NA
G9824	Endometrial sampling or hysteroscopy with biopsy and results not documented	Noncovered for all programs	NA	NA	NA
G9825	HER-2/NEU negative or undocumented/unknown	Noncovered for all programs	NA	NA	NA
G9826	Patient transferred to practice after initiation of chemotherapy	Noncovered for all programs	NA	NA	NA
G9827	HER2-targeted therapies not administered during the initial course of treatment	Noncovered for all programs	NA	NA	NA
G9828	HER2-targeted therapies administered during the initial course of treatment	Noncovered for all programs	NA	NA	NA
G9829	Breast adjuvant chemotherapy administered	Noncovered for all programs	NA	NA	NA
G9830	HER-2/NEU positive	Noncovered for all programs	NA	NA	NA
G9831	AJCC stage at breast cancer diagnosis = II or III	Noncovered for all programs	NA	NA	NA
G9832	AJCC stage at breast cancer diagnosis = I (IA or IB) and t-stage at breast cancer diagnosis does not equal = t1, t1a, t1b	Noncovered for all programs	NA	NA	NA
G9833	Patient transfer to practice after initiation of chemotherapy	Noncovered for all programs	NA	NA	NA
G9834	Patient has metastatic disease at diagnosis	Noncovered for all programs	NA	NA	NA
G9835	Trastuzumab administered within 12 months of diagnosis	Noncovered for all programs	NA	NA	NA
G9836	Reason for not administering Trastuzumab documented (e.g. patient declined, patient died, patient transferred, contraindication or other clinical exclusion, neoadjuvant chemotherapy or radiation not complete)	Noncovered for all programs	NA	NA	NA
G9837	Trastuzumab not administered within 12 months of diagnosis	Noncovered for all programs	NA	NA	NA
G9838	Patient has metastatic disease at diagnosis	Noncovered for all programs	NA	NA	NA
G9839	Anti-EGFR monoclonal antibody therapy	Noncovered for all programs	NA	NA	NA
G9840	KRAS gene mutation testing performed before initiation of anti-EGFR MOAB	Noncovered for all programs	NA	NA	NA
G9841	KRAS gene mutation testing not performed before initiation of anti-EGFR MOAB	Noncovered for all programs	NA	NA	NA
G9842	Patient has metastatic disease at diagnosis	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9843	KRAS gene mutation	Noncovered for all programs	NA	NA	NA
G9844	Patient did not receive anti-EGFR monoclonal antibody therapy	Noncovered for all programs	NA	NA	NA
G9845	Patient received anti-EGFR monoclonal antibody therapy	Noncovered for all programs	NA	NA	NA
G9846	Patients who died from cancer	Noncovered for all programs	NA	NA	NA
G9847	Patient received chemotherapy in the last 14 days of life	Noncovered for all programs	NA	NA	NA
G9848	Patient did not receive chemotherapy in the last 14 days of life	Noncovered for all programs	NA	NA	NA
G9849	Patients who died from cancer	Noncovered for all programs	NA	NA	NA
G9850	Patient had more than one emergency department visit in the last 30 days of life	Noncovered for all programs	NA	NA	NA
G9851	Patient had one or less emergency department visits in the last 30 days of life	Noncovered for all programs	NA	NA	NA
G9852	Patients who died from cancer	Noncovered for all programs	NA	NA	NA
G9853	Patient admitted to the ICU in the last 30 days of life	Noncovered for all programs	NA	NA	NA
G9854	Patient was not admitted to the ICU in the last 30 days of life	Noncovered for all programs	NA	NA	NA
G9855	Patients who died from cancer	Noncovered for all programs	NA	NA	NA
G9856	Patient was not admitted to hospice	Noncovered for all programs	NA	NA	NA
G9857	Patient admitted to hospice	Noncovered for all programs	NA	NA	NA
G9858	Patient enrolled in hospice	Noncovered for all programs	NA	NA	NA
G9859	Patients who died from cancer	Noncovered for all programs	NA	NA	NA
G9860	Patient spent less than three days in hospice care	Noncovered for all programs	NA	NA	NA
G9861	Patient spent greater than or equal to three days in hospice care	Noncovered for all programs	NA	NA	NA
G9862	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is = 66 years old, or life expectancy < 10 years old, other medical reasons)	Noncovered for all programs	NA	NA	NA
J0570	Buprenorphine implant, 74.2 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J0883	Injection, Argatroban, 1 mg (for non-ESRD use)	Covered for all programs	No	Yes	Linked to revenue code 636
J0884	Injection, Argatroban, 1 mg (for ESRD on dialysis)	Covered for all programs	No	Yes	Linked to revenue code 636

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
J1130	Injection, Diclofenac sodium, 0.5 mg	Covered for all programs	No	Yes	No
J1942	Injection, Aripiprazole Lauroxil, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J2182	Injection, Mepolizumab, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J2786	Injection, Reslizumab, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J2840	Injection, Sebelipase alfa, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J7175	Injection, factor x, (human), 1 i.u.	Covered for all programs	No	Yes	Linked to revenue code 636
J7179	Injection, von Willebrand factor (recombinant), (Vonvendi), 1 i.u. vwf:rco	Covered for all programs	No	Yes	Linked to revenue code 636
J7202	Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.	Covered for all programs	No	Yes	Linked to revenue code 636
J7207	Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u.	Covered for all programs	No	Yes	Linked to revenue code 636
J7209	Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u.	Covered for all programs	No	Yes	Linked to revenue code 636
J7320	Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg	Covered for all programs	No	No	No
J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg	Covered for all programs	No	No	No
J7342	Installation, ciprofloxacin otic suspension, 6 mg	Covered for all programs	No	Yes	No
J8670	Rolapitant, oral, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J9034	Injection, Bendamustine hcl (bendeka), 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J9145	Injection, Daratumumab, 10 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J9176	Injection, Elotuzumab, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J9205	Injection, Irinotecan liposome, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J9295	Injection, Necitumumab, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
J9325	Injection, Talimogene Laherparepvec, per 1 million plaque forming units	Covered for all programs	No	Yes	Linked to revenue code 636
J9352	Injection, Trabectedin, 0.1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
L1851	Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf	Covered for all programs	No	No	Linked to revenue code 274
L1852	Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf	Covered for all programs	No	No	Linked to revenue code 274
Q4166	Cytal, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4167	Truskin, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4168	Amnioband, 1 mg	Noncovered for all programs	NA	NA	NA
Q4169	Artacent wound, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4170	Cygnus, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4171	Interfyl, 1 mg	Noncovered for all programs	NA	NA	NA
Q4172	Puraply or Puraply am, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4173	Palingen or Palingen xplus, per square centimeter	Noncovered for all programs	NA	NA	NA
Q4174	Palingen or Promatrx, 0.36 mg per 0.25 cc	Noncovered for all programs	NA	NA	NA
Q4175	Miroderm, per square centimeter	Noncovered for all programs	NA	NA	NA
T1040	Medicaid certified community behavioral health clinic services, per diem	Noncovered for all programs	NA	NA	NA
T1041	Medicaid certified community behavioral health clinic services, per month	Noncovered for all programs	NA	NA	NA
0437T	Reinforcement of fascia of abdominal wall with synthetic implant	Noncovered for all programs	NA	NA	NA
0438T	Injection of biodegradable material adjacent to prostate, accessed by perineal region using imaging guidance	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0439T	Ultrasound of heart with injection of X-ray contrast material performed during rest or stress for assessment of heart muscle	Noncovered for all programs	NA	NA	NA
0440T	Freezing destruction of nerve in arm, accessed through the skin, using imaging guidance	Noncovered for all programs	NA	NA	NA
0441T	Freezing destruction of nerve in leg, accessed through the skin, using imaging guidance	Noncovered for all programs	NA	NA	NA

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0442T	Freezing destruction of nerve plexus, accessed through the skin, using imaging guidance	Noncovered for all programs	NA	NA	NA
0443T	Real time analysis of prostate tissue using fluorescence spectroscopy	Noncovered for all programs	NA	NA	NA
0444T	Initial insertion of drug-releasing implant under one or both eyelids	Noncovered for all programs	NA	NA	NA
0445T	Replacement of drug-releasing implant under one or both eyelids	Noncovered for all programs	NA	NA	NA
0446T	Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training	Noncovered for all programs	NA	NA	NA
0447T	Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision	Noncovered for all programs	NA	NA	NA
0448T	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation	Noncovered for all programs	NA	NA	NA
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device	Noncovered for all programs	NA	NA	NA
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)	Noncovered for all programs	NA	NA	NA
0451T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0452T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; aortic counterpulsation device and vascular hemostatic seal	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0453T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0454T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; subcutaneous electrode	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0455T	Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes	Covered for all programs	No	No	See Table 2 for manual pricing percentage

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0456T	Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device and vascular hemostatic seal	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0457T	Removal of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0458T	Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode	Covered for all programs	No	no	See Table 2 for manual pricing percentage
0459T	Relocation of skin pocket with replacement of implanted aortic counterpulsation ventricular assist device, mechano-electrical skin interface and electrodes	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0460T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0461T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; aortic counterpulsation device	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0462T	Programming device evaluation (in person) with iterative adjustment of the implantable mechanoelectrical skin interface and/or external driver to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable aortic counterpulsation ventricular assist system, per day	Noncovered for all programs	NA	NA	NA
0463T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable aortic counterpulsation ventricular assist system, per day	Noncovered for all programs	NA	NA	NA
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	Noncovered for all programs	NA	NA	NA
0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)	Noncovered for all programs	NA	NA	NA
0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (list separately in addition to code for primary procedure)	Noncovered for all programs	NA	NA	NA
0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator	Noncovered for all programs	NA	NA	NA
0468T	Removal of chest wall respiratory sensor electrode or electrode array	Noncovered for all programs	NA	NA	NA

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Table 2 − 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
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	20%	10%
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contract, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting and all angioplasty within the peripheral dialysis segment	20%	10%
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation; diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of an intravascular stent(s), peripheral dialysis segment, including all imaging radiological supervision and interpretation to perform the stenting and all angioplasty within the peripheral dialysis circuit	20%	10%
36908	Transcatheter placement of an intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	20%	10%
36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	20%	10%
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection	40%	15%
A4467	Belt, strap, sleeve, garment, or covering, any type	75% of MSRP/ 120% of cost	75% of MSRP/ 120% of cost
A9286	Hygienic item or device, disposable or non-disposable, any type, each	75% of MSRP/ 120% of cost	75% of MSRP/ 120% of cost
D1575	Distal shoe space maintainer – fixed – unilateral	90%	90%
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	90%	90%
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	90%	90%
0438T	Injection of biodegradable material adjacent to prostate, accessed by perineal region using imaging guidance	90%	90%

Table 2 − 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
0451T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)	90%	90%
0452T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; aortic counterpulsation device and vascular hemostatic seal	90%	90%
0453T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface	90%	90%
0454T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; subcutaneous electrode	90%	90%
0455T	Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes	90%	90%
0456T	Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device and vascular hemostatic seal	90%	90%
0457T	Removal of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface	90%	90%
0458T	Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode	90%	90%
0459T	Relocation of skin pocket with replacement of implanted aortic counterpulsation ventricular assist device, mechano-electrical skin interface and electrodes	90%	90%
0460T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode	90%	90%
0461T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; aortic counterpulsation device	90%	90%

Table 3 − New modifiers included in the 2017 annual HCPCS update, effective January 1, 2017

Modifier code	Description	Type
FX	X-ray taken using film	Informational
PN	Non-excepted service provided at an off-campus outpatient, provider-based department of a hospital	Informational
V1	Demonstration modifier 1	Informational
V2	Demonstration modifier 2	Informational
V3	Demonstration modifier 3	Informational

Table 4 – New HCPCS code released October 2016, with a retroactive effective date of January 1, 2016

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G0498	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic; includes follow up office/clinic visit at the conclusion of the infusion	Noncovered for all programs	NA	NA	NA

Table 5 – Current vaccine administration HCPCS codes with age restrictions revised or removed, effective January 1, 2017

Procedure Code	Description
90644	Vaccine for meningococcal and Hemophilus influenza B (4 dose schedule) injection into muscle, children 6 weeks-18 months of age
90655	Vaccine for influenza for administration into muscle, 0.25 ml dosage
90656	Vaccine for influenza for administration into muscle, 0.5 ml dosage
90657	Vaccine for influenza for administration into muscle, 0.25 ml dosage
90658	Vaccine for influenza for administration into muscle, 0.5 ml dosage
90685	Vaccine for influenza for administration into muscle, 0.25 ml dosage
90686	Vaccine for influenza for administration into muscle, 0.5 ml dosage
90688	Vaccine for influenza for administration into muscle, 0.5 ml dosage

* "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.