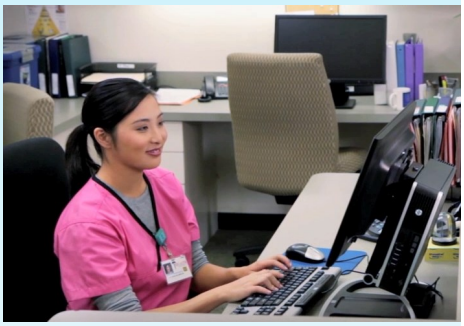
IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201782 DECEMBER 28, 2017

Coverage and billing information for the 2018 annual HCPCS codes update

The Indiana Health Coverage Programs (IHCP) has reviewed the 2018 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, 2018. This bulletin serves as a notice of the following information:

- Table 1: New alphanumeric, Current Procedural Terminology (CPT®[1]) and Current Dental Terminology (CDT®[2]) codes included in the 2018 annual HCPCS update, showing:
  - Procedure code
  - Description
  - Program coverage determination
  - Prior authorization (PA) requirement
  - National Drug Code (NDC) requirement
  - Special billing requirement
- Table 2: Pricing percentages for newly covered CPT codes from Table 1 that are manually priced codes.



- Table 3: Pricing percentages for newly covered CDT codes from Table 1 that are manually priced codes.
- Table 4: New modifiers included in the 2018 annual HCPCS update showing the modifier code, description, and type. Providers should follow CPT coding guidelines for reporting services using appropriate modifiers.
- Table 5: Identifies one existing modifier included in the annual update for which the description has been revised, effective for dates of service (DOS) on or after January 1, 2018.

The 2018 annual HCPCS, CPT, and CDT codes will be added to the claim-processing system. Established pricing will be posted on the appropriate IHCP fee schedule and codes added to the *LTC DME Per Diem Table* as well as the following code table documents on the *Code Sets* page at indianamedicaid.com:

- Procedure Codes That Require NDCs
- Durable and Home Medical Equipment and Supplies Codes
- Family Planning Eligibility Program Codes
- Dental Services Codes
- Hearing Services Codes
- Anesthesia Services Codes
- Therapy Services Codes

Providers may report these codes for DOS on or after January 1, 2018. The standard global billing procedures and edits apply when using the new codes. Reimbursement, prior authorization (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 2018 annual HCPCS update also includes modifications to descriptions for some 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 2018 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 CMS, the IHCP will issue a publication listing any IHCP-covered codes that were deleted for which there are associated codes effective as of January 1, 2018.

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 1-800-457-4584.

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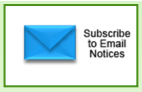

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TO PRINT

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Table 1 – New codes included in the 2018 annual HCPCS update, effective for DOS on or after January 1, 2018

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified	Covered for all programs	No	No	No
00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)	Covered for all programs	No	No	No
00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified	Covered for all programs	No	No	No
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	Covered for all programs	No	No	No
00813	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum	Covered for all programs	No	No	No
15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	Covered for all programs	No	No	No
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)	Covered for all programs	No	No	No
19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No
20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No
31241	Nasal/sinus endoscopy, surgical; with concha bullosa resection nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	Covered for all programs	No	No	No
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed	Covered for all programs	No	No	No
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	Covered for all programs	No	No	No
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	Covered for all programs	No	No	No
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	Covered for all programs	No	No	See Table 2 for manual pricing percentage
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	Covered for all programs	No	No	See Table 2 for manual pricing percentage

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

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
33927	Implantation of artificial heart	Covered for all programs	Yes	No	No
33928	Removal and replacement of total replacement heart system (artificial heart)	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (list separately in addition to code for primary procedure)	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
34701	Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	Covered for all programs	No	No	No
34702	Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	Covered for all programs	No	No	No
34703	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	Covered for all programs	No	No	No
34704	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
	iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)				
34705	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	Covered for all programs	No	No	No
34706	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	Covered for all programs	No	No	No
34707	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)	Covered for all programs	No	No	No
34708	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No
34710	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated	Covered for all programs	No	No	No
34711	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; each additional vessel treated (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No
34712	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No
34713	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No
34714	Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No
34715	Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No
34716	Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (list separately in addition to code for primary procedure)	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	Covered for all programs	No	No	See Table 2 for manual pricing percentage
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	Covered for all programs	No	No	See Table 2 for manual pricing percentage
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Covered for all programs	No	No	No
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; 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
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	Covered for all programs	No	No	No
38573	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling, peritoneal washings, peritoneal biopsy(ies), omentectomy, and diaphragmatic washings, including diaphragmatic and other serosal biopsy(ies), when performed	Covered for all programs	No	No	No
43286	Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, laparoscopic transhiatal esophagectomy)	Covered for all programs	No	No	Limited to 1 unit per lifetime
43287	Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (ie, laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)	Covered for all programs	No	No	Limited to 1 unit per lifetime
43288	Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle, and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy	Covered for all programs	No	No	Limited to 1 unit per lifetime

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
	or esophagogastrostomy (ie, thoracoscopic, laparoscopic and cervical incision esophagectomy, mckeown esophagectomy, tri-incisional esophagectomy)				
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	Covered for all programs	No	No	See Table 2 for manual pricing percentage
58575	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	Covered for all programs	No	No	No
64912	Nerve repair; with nerve allograft, each nerve, first strand (cable)	Covered for all programs	No	No	No
64913	Nerve repair; with nerve allograft, each additional strand (list separately in addition to code for primary procedure)	Covered for all programs	Yes	No	No
71045	Radiologic exam chest single view	Covered for all programs	No	No	No
71046	Radiologic exam chest 2 views	Covered for all programs	No	No	No
71047	Radiologic exam chest 3 views	Covered for all programs	No	No	No
71048	Radiologic exam chest 4+ views	Covered for all programs	No	No	No
74018	Radiologic exam abdomen 1 view	Covered for all programs	No	No	No
74019	Radiologic exam abdomen 2 views	Covered for all programs	No	No	No
74021	Radiologic exam abdomen 3+ views	Covered for all programs	No	No	No
81105	Human platelet antigen 1 genotyping (hpa-1), itgb3 (integrin, beta 3 [platelet glycoprotein iiia], antigen cd61 [gpiiia]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, hpa-1a/b (l33p)	Noncovered for all programs	N/A	N/A	N/A
81106	Human platelet antigen 2 genotyping (hpa-2), gp1ba (glycoprotein ib [platelet], alpha polypeptide [gpiba]) (eg, neonatal alloimmune thrombocytopenia [nait], post-transfusion purpura), gene analysis, common variant, hpa-2a/b (t145m)	Noncovered for all programs	N/A	N/A	N/A
81107	Human platelet antigen 3 genotyping (hpa-3), itga2b (integrin, alpha 2b [platelet glycoprotein iib of iib/iiia complex], antigen cd41 [gpiib]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, hpa-3a/b (i843s)	Noncovered for all programs	N/A	N/A	N/A
81108	Human platelet antigen 4 genotyping (hpa-4), itgb3 (integrin, beta 3 [platelet glycoprotein iiia], antigen cd61 [gpiiia]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, hpa-4a/b (r143q)	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
81109	Human platelet antigen 5 genotyping (hpa-5), itga2 (integrin, alpha 2 [cd49b, alpha 2 subunit of vla-2 receptor] [gpia]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant (eg, hpa-5a/b (k505e)	Noncovered for all programs	N/A	N/A	N/A
81110	Human platelet antigen 6 genotyping (hpa-6w), itgb3 (integrin, beta 3 [platelet glycoprotein iiia, antigen cd61] [gpiiia]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, hpa-6a/b (r489q)	Noncovered for all programs	N/A	N/A	N/A
81111	Human platelet antigen 9 genotyping (hpa-9w), itga2b (integrin, alpha 2b [platelet glycoprotein iib of iib/iiia complex, antigen cd41] [gpiib]) (eg, neonatal alloimmune thrombocytopenia [NAIT],post-transfusion purpura), gene analysis, common variant, hpa-9a/b (v837m)	Noncovered for all programs	N/A	N/A	N/A
81112	Human platelet antigen 15 genotyping (hpa-15), cd109 (cd109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, hpa-15a/b (s682y)	Noncovered for all programs	N/A	N/A	N/A
81120	Idh1 (isocitrate dehydrogenase 1 [nadp+], soluble) (eg, glioma), common variants (eg, r132h, r132c)	Noncovered for all programs	N/A	N/A	N/A
81121	Idh2 (isocitrate dehydrogenase 2 [nadp+], mitochondrial) (eg, glioma),common variants (eg, r140w, r172m)	Noncovered for all programs	N/A	N/A	N/A
81175	Asxl1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence	Noncovered for all programs	N/A	N/A	N/A
81176	Asxl1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)	Noncovered for all programs	N/A	N/A	N/A
81230	Cyp3a4 (cytochrome p450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81231	Cyp3a5 (cytochrome p450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6,*7)	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81232	Dpyd (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2a, *4, *5, *6)	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81238	F9 (coagulation factor ix) (eg, hemophilia b), full gene sequence.	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81247	G6pd (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, a, a-)	Noncovered for all programs	N/A	N/A	N/A
81248	G6pd (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
81249	G6pd (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence	Noncovered for all programs	N/A	N/A	N/A
81258	Hba1/hba2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, hb bart hydrops fetalis syndrome, hbh disease), gene analysis; known familial variant	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81259	Hba1/hba2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, hb bart hydrops fetalis syndrome, hbh disease), gene analysis; full gene sequence	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81269	Hba1/hba2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, hb bart hydrops fetalis syndrome, hbh disease), gene analysis; duplication/deletion variants	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81283	Ifnl3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	Noncovered for all programs	N/A	N/A	N/A
81328	Slco1b1 (solute carrier organic anion transporter family, member 1b1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, *5)	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81334	Runx1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis, targeted sequence analysis (eg, exons 3-8)	Noncovered for all programs	N/A	N/A	N/A
81335	Tpmt (thiopurine s-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81346	Tyms (thymidylate synthetase) (eg, 5-fluorouracil/5-fu drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	Covered for all programs	Yes	No	Limited to 1 unit per lifetime
81361	Hbb (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, hbs, hbc, hbe)	Noncovered for all programs	N/A	N/A	N/A
81362	Bb (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)	Noncovered for all programs	N/A	N/A	N/A
81363	Hbb (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)	Noncovered for all programs	N/A	N/A	N/A
81364	Hbb (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	Noncovered for all programs	N/A	N/A	N/A
81448	Hereditary peripheral neuropathies (eg, charcot-marie-tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, bscl2, gjb1, mfn2, mpz, reep1, spast, spg11, sptlc1)	Noncovered for all programs	N/A	N/A	N/A
81520	Oncology (breast), mrna gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
81521	Oncology (breast), mrna, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis	Noncovered for all programs	N/A	N/A	N/A
81541	Oncology (prostate), mrna gene expression profiling by real-time rt-pcr of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score	Noncovered for all programs	N/A	N/A	N/A
81551	Oncology (prostate), promoter methylation profiling by real-time pcr of 3 genes (gstp1, apc, rassf1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy	Noncovered for all programs	N/A	N/A	N/A
86008	Allergen specific ige; quantitative or semiquantitative, recombinant or purified component, each	Noncovered for all programs	N/A	N/A	N/A
86794	Antibody; zika virus, igm	Covered for all programs	No	No	No
87634	Infectious agent detection by nucleic acid (dna or rna); respiratory syncytial virus, amplified probe technique	Covered for all programs	No	No	No
87662	Infectious agent detection by nucleic acid (dna or rna); zika virus, amplified probe technique	Covered for all programs	No	No	No
90756	Influenza virus vaccine, quadrivalent (cciiv4), derived from cell cultures, subunit, antibiotic free, 0.5 ml dosage, for intramuscular use	Covered for all programs	No	No	No
93792	Patient/caregiver training for initiation of home international normalized ratio (inr) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the inr monitor, obtaining blood sample, instructions for reporting home inr test results, and documentation of patient's/caregiver's ability to perform testing and report results	Noncovered for all programs	N/A	N/A	N/A
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (inr) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	Noncovered for all programs	N/A	N/A	N/A
94617	Exercise test for bronchospasm, including pre- and post-spirometry, electrocardiographic recording(s), and pulse oximetry	Covered for all programs	No	No	No
94618	Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed	Covered for all programs	No	No	No
95249	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording	Covered for all programs	Yes	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	Covered for all programs	No	No	No
96574	Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	Covered for all programs	No	No	No
97127	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact	Covered for all programs	Yes, for traumatic brain injury (TBI) only	No	See Table 2 for manual pricing percentage
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	Covered for all programs	Yes	No	No
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: cognition-focused evaluation including a pertinent history and examination; medical decision making of moderate or high complexity; functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; use of standardized instruments for staging of dementia (eg, functional assessment staging test [fast], clinical dementia rating [CDR]); medication reconciliation and review for high-risk medications; evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); evaluation of safety (eg, home), including motor vehicle operation; identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan; creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
	education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.				
99484	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	N/A	N/A	N/A
99492	1st psychiatric collab care mgmt 1st 70 mins	Noncovered for all programs	N/A	N/A	N/A
99493	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	N/A	N/A	N/A
99494	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)	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
C9014	Injection, Cerliponase alfa, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
C9015	Injection, c-1 esterase inhibitor (human), Haegarda, 10 units	Covered for all programs	No	Yes	Linked to revenue code 636
C9016	Injection, Triptorelin extended release, 3.75 mg	Covered for all programs	No	Yes	Linked to revenue code 636
C9024	Injection, liposomal, 1 mg Daunorubicin and 2.27 mg Cytarabine	Covered for all programs	No	Yes	Linked to revenue code 636
C9028	Injection, Inotuzumab Ozogamicin, 0.1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
C9029	Injection, Guselkumab, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
C9738	Adjunctive blue light cystoscopy with fluorescent imaging agent (list separately in addition to code for primary procedure)	Noncovered for all programs	N/A	N/A	N/A
C9748	Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy	Noncovered for all programs	N/A	N/A	N/A
D0411	Hba1c in-office point of service testing	Covered for all programs	No	No	Limited to 1 unit per day See Table 3 for manual pricing percentage
D5511	Repair broken complete denture base, mandibular	Covered for all programs	Yes, for 21 years of age and older	No	Limited to 1 unit per day See Table 3 for manual pricing percentage
D5512	Repair broken complete denture base, maxillary	Covered for all programs	Yes, for 21 years of age and older	No	Limited to 1 unit per day See Table 3 for manual pricing percentage
D5611	Repair resin partial denture base, mandibular	Covered for all programs	Yes, for 21 years of age and older	No	Limited to 1 unit per day See Table 3 for manual pricing percentage
D5612	Repair resin partial denture base, maxillary	Covered for all programs	Yes, for 21 years of age and older	No	Limited to 1 unit per day See Table 3 for manual pricing percentage

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
D5621	Repair cast partial framework, mandibular	Covered for all programs	Yes, for 21 years of age and older	No	Limited to 1 unit per day See Table 3 for manual pricing percentage
D5622	Repair cast partial framework, maxillary	Covered for all programs	Yes, for 21 years of age and older	No	Limited to 1 unit per day See Table 3 for manual pricing percentage
D6096	Remove broken implant retaining screw	Covered for all programs	No	No	Requires tooth number Limited to 1 unit per day See Table 3 for manual pricing percentage
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	Noncovered for all programs	N/A	N/A	N/A
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	Noncovered for all programs	N/A	N/A	N/A
D7296	Corticotomy-one to three teeth or tooth spaces, per quadrant	Covered for all programs	Yes	No	Limited to 4 units per day See Table 3 for manual pricing percentage
D7297	Corticotomy - four or more teeth or tooth spaces, per quadrant	Covered for all programs	Yes	No	Limited to 4 units per day See Table 3 for manual pricing percentage
D7979	Non-surgical sialolithotomy	Covered for all programs	No	No	Limited to 1 unit per day See Table 3 for manual pricing percentage
D8695	Remove of fixed orthodontic appliances for reasons other than completion of treatment	Noncovered for all programs	N/A	N/A	N/A
D9222	Deep sedation/general anesthesia - first 15 minutes	Covered for all programs; covered for Package E	No	No	Limited to ages 0 through 20 Limited to 1 unit per day
D9239	Intravenous moderate (conscious sedation/analgesia - first 15 minutes	Covered for all programs; covered for Package E	No	No	Limited to 1 unit per day

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
D9995	Teledentistry - synchronous; real-time encounter	Noncovered for all programs	N/A	N/A	N/A
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Noncovered for all programs	N/A	N/A	N/A
E0953	Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each	Covered for all programs	Yes	No	No
E0954	Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot	Covered for all programs	Yes	No	No
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month	Noncovered for all programs	N/A	N/A	N/A
G0512	Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month	Noncovered for all programs	N/A	N/A	N/A
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	Covered for all programs	No	No	No
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code g0513 for additional 30 minutes of preventive service)	Covered for all programs	No	No	No
G0515	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes	Covered for all programs	No	No	Covered on *CMS-1500* crossover claims and *UB-04* outpatient crossover claims only
G0516	Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant)	Covered for all programs	No	No	No
G0517	Removal of non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	Covered for all programs	No	No	No
G0518	Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9890	Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity	Noncovered for all programs	N/A	N/A	N/A
G9891	Documentation of medical reason(s) for not performing a dilated macular examination	Noncovered for all programs	N/A	N/A	N/A
G9892	Documentation of patient reason(s) for not performing a dilated macular examination	Noncovered for all programs	N/A	N/A	N/A
G9893	Dilated macular exam was not performed, reason not otherwise specified	Noncovered for all programs	N/A	N/A	N/A
G9894	Androgen deprivation therapy prescribed/administered in combination with external beam radiotherapy to the prostate	Noncovered for all programs	N/A	N/A	N/A
G9895	Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (e.g., salvage therapy)	Noncovered for all programs	N/A	N/A	N/A
G9896	Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate	Noncovered for all programs	N/A	N/A	N/A
G9897	Patients who were not prescribed/administered androgen deprivation therapy in combination with external beam radiotherapy to the prostate, reason not given	Noncovered for all programs	N/A	N/A	N/A
G9898	Patient age 65 or older in institutional special needs plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 any time during the measurement period	Noncovered for all programs	N/A	N/A	N/A
G9899	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results documented and reviewed	Noncovered for all programs	N/A	N/A	N/A
G9900	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified	Noncovered for all programs	N/A	N/A	N/A
G9901	Patient age 65 or older in institutional special needs plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 any time during the measurement period	Noncovered for all programs	N/A	N/A	N/A
G9902	Patient screened for tobacco use and identified as a tobacco user	Noncovered for all programs	N/A	N/A	N/A
G9903	Patient screened for tobacco use and identified as a tobacco non-user	Noncovered for all programs	N/A	N/A	N/A
G9904	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)	Noncovered for all programs	N/A	N/A	N/A
G9905	Patient not screened for tobacco use, reason not given	Noncovered for all programs	N/A	N/A	N/A
G9906	Patient identified as a tobacco user received tobacco cessation intervention (counselling and/or pharmacotherapy)	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9907	Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)	Noncovered for all programs	N/A	N/A	N/A
G9908	Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given	Noncovered for all programs	N/A	N/A	N/A
G9909	Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user (eg, limited life expectancy, other medical reason)	Noncovered for all programs	N/A	N/A	N/A
G9910	Patients age 65 or older in institutional special needs plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54 or 56 anytime during the measurement period	Noncovered for all programs	N/A	N/A	N/A
G9911	Clinically node negative (t1n0m0 or t2n0m0) invasive breast cancer before or after neoadjuvant systemic therapy	Noncovered for all programs	N/A	N/A	N/A
G9912	Hepatitis b virus (HBV) status assessed and results interpreted prior to initiating anti-TNF (tumor necrosis factor) therapy	Noncovered for all programs	N/A	N/A	N/A
G9913	Hepatitis b virus (HBV) status not assessed and results interpreted prior to initiating anti-TNF (tumor necrosis factor) therapy, reason not given	Noncovered for all programs	N/A	N/A	N/A
G9914	Patient receiving an anti-TNF agent	Noncovered for all programs	N/A	N/A	N/A
G9915	No record of HBV results documented	Noncovered for all programs	N/A	N/A	N/A
G9916	Functional status performed once in the last 12 months	Noncovered for all programs	N/A	N/A	N/A
G9917	Documentation of medical reason(s) for not performing functional status (e.g., patient is severely impaired and caregiver knowledge is limited, other medical reason)	Noncovered for all programs	N/A	N/A	N/A
G9918	Functional status not performed, reason not otherwise specified	Noncovered for all programs	N/A	N/A	N/A
G9919	Screening performed and positive and provision of recommendations	Noncovered for all programs	N/A	N/A	N/A
G9920	Screening performed and negative	Noncovered for all programs	N/A	N/A	N/A
G9921	No screening performed, partial screening performed or positive screen without recommendations and reason is not given or otherwise specified	Noncovered for all programs	N/A	N/A	N/A
G9922	Safety concerns screen provided and if positive then documented mitigation recommendations	Noncovered for all programs	N/A	N/A	N/A
G9923	Safety concerns screen provided and negative	Noncovered for all programs	N/A	N/A	N/A
G9924	Documentation of medical reason(s) for not providing safety concerns screen or for not providing recommendations, orders or referrals for positive screen (e.g., patient in palliative care, other medical reason)	Noncovered for all programs	N/A	N/A	N/A
G9925	Safety concerns screening not provided, reason not otherwise specified	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9926	Safety concerns screening positive screen is without provision of mitigation recommendations, including but not limited to referral to other resources	Noncovered for all programs	N/A	N/A	N/A
G9927	Documentation of system reason(s) for not prescribing warfarin or another FDA-approved anticoagulation due to patient being currently enrolled in a clinical trial related to AF/atrial flutter treatment	Noncovered for all programs	N/A	N/A	N/A
G9928	Warfarin or another FDA-approved anticoagulant not prescribed, reason not given	Noncovered for all programs	N/A	N/A	N/A
G9929	Patient with transient or reversible cause of AF (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery)	Noncovered for all programs	N/A	N/A	N/A
G9930	Patients who are receiving comfort care only	Noncovered for all programs	N/A	N/A	N/A
G9931	Documentation of cha2ds2-vasc risk score of 0 or 1	Noncovered for all programs	N/A	N/A	N/A
G9932	Documentation of patient reason(s) for not having records of negative or managed positive TB screen (e.g., patient does not return for mantoux (PPD) skin test evaluation)	Noncovered for all programs	N/A	N/A	N/A
G9933	Adenoma(s) or colorectal cancer detected during screening colonoscopy	Noncovered for all programs	N/A	N/A	N/A
G9934	Documentation that neoplasm detected is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma	Noncovered for all programs	N/A	N/A	N/A
G9935	Adenoma(s) or colorectal cancer not detected during screening colonoscopy	Noncovered for all programs	N/A	N/A	N/A
G9936	Surveillance colonoscopy - personal history of colonic polyps, colon cancer, or other malignant neoplasm of rectum, rectosigmoid junction, and anus	Noncovered for all programs	N/A	N/A	N/A
G9937	Diagnostic colonoscopy	Noncovered for all programs	N/A	N/A	N/A
G9938	Patients age 65 or older in institutional special needs plans (SNP) or residing in long-term care with POS code 32, 33, 34, 54, or 56 any time during the measurement period	Noncovered for all programs	N/A	N/A	N/A
G9939	Pathologists/dermatopathologists is the same clinician who performed the biopsy	Noncovered for all programs	N/A	N/A	N/A
G9940	Documentation of medical reason(s) for not on a statin (e.g., pregnancy, in vitro fertilization, clomiphene RX, ESRD, cirrhosis, muscular pain and disease during the measurement period or prior year)	Noncovered for all programs	N/A	N/A	N/A
G9941	Back pain was measured by the visual analog scale (VAS) within three months preoperatively and at three months (6 - 20 weeks) postoperatively	Noncovered for all programs	N/A	N/A	N/A
G9942	Patient had any additional spine procedures performed on the same date as the lumbar discectomy/laminotomy	Noncovered for all programs	N/A	N/A	N/A
G9943	Back pain was not measured by the visual analog scale (VAS) within three months preoperatively and at three months (6 - 20 weeks) postoperatively	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9944	Back pain was measured by the visual analog scale (VAS) within three months preoperatively and at one year (9 to 15 months) postoperatively	Noncovered for all programs	N/A	N/A	N/A
G9945	Patient had cancer, fracture or infection related to the lumbar spine or patient had idiopathic or congenital scoliosis	Noncovered for all programs	N/A	N/A	N/A
G9946	Back pain was not measured by the visual analog scale (VAS) within three months preoperatively and at one year (9 to 15 months) postoperatively	Noncovered for all programs	N/A	N/A	N/A
G9947	Leg pain was measured by the visual analog scale (VAS) within three months preoperatively and at three months (6 to 20 weeks) postoperatively	Noncovered for all programs	N/A	N/A	N/A
G9948	Patient had any additional spine procedures performed on the same date as the lumbar discectomy/laminotomy	Noncovered for all programs	N/A	N/A	N/A
G9949	Leg pain was not measured by the visual analog scale (VAS) within three months preoperatively and at three months (6 to 20 weeks) postoperatively	Noncovered for all programs	N/A	N/A	N/A
G9954	Patient exhibits 2 or more risk factors for post-operative vomiting	Noncovered for all programs	N/A	N/A	N/A
G9955	Cases in which an inhalational anesthetic is used only for induction	Noncovered for all programs	N/A	N/A	N/A
G9956	Patient received combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	Noncovered for all programs	N/A	N/A	N/A
G9957	Documentation of medical reason for not receiving combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)	Noncovered for all programs	N/A	N/A	N/A
G9958	Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	Noncovered for all programs	N/A	N/A	N/A
G9959	Systemic antimicrobials not prescribed	Noncovered for all programs	N/A	N/A	N/A
G9960	Documentation of medical reason(s) for prescribing systemic antimicrobials	Noncovered for all programs	N/A	N/A	N/A
G9961	Systemic antimicrobials prescribed	Noncovered for all programs	N/A	N/A	N/A
G9962	Embolization endpoints are documented separately for each embolized vessel and ovarian artery angiography or embolization performed in the presence of variant uterine artery anatomy	Noncovered for all programs	N/A	N/A	N/A
G9963	Embolization endpoints are not documented separately for each embolized vessel or ovarian artery angiography or embolization not performed in the presence of variant uterine artery anatomy	Noncovered for all programs	N/A	N/A	N/A
G9964	Patient received at least one well-child visit with a PCP during the performance period	Noncovered for all programs	N/A	N/A	N/A
G9965	Patient did not receive at least one well-child visit with a PCP during the performance period	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G9966	Children who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report	Noncovered for all programs	N/A	N/A	N/A
G9967	Children who were not screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report	Noncovered for all programs	N/A	N/A	N/A
G9968	Patient was referred to another provider or specialist during the performance period	Noncovered for all programs	N/A	N/A	N/A
G9969	Provider who referred the patient to another provider received a report from the provider to whom the patient was referred	Noncovered for all programs	N/A	N/A	N/A
G9970	Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred	Noncovered for all programs	N/A	N/A	N/A
G9974	Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity	Noncovered for all programs	N/A	N/A	N/A
G9975	Documentation of medical reason(s) for not performing a dilated macular examination	Noncovered for all programs	N/A	N/A	N/A
G9976	Documentation of patient reason(s) for not performing a dilated macular examination	Noncovered for all programs	N/A	N/A	N/A
G9977	Dilated macular exam was not performed, reason not otherwise specified	Noncovered for all programs	N/A	N/A	N/A
J0565	Injection, Bezlotoxumab, 10 mg	Covered for all Programs	No	Yes	Linked to revenue code 636
J0604	Cinacalcet, oral, 1 mg, (for ESRD on dialysis)	Noncovered for all programs	N/A	N/A	N/A
J0606	Injection, Etelcalcetide, 0.1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J1428	Injection, Eteplirsen, 10 mg	Covered for all programs	Yes	Yes	Linked to revenue code 636
J1555	Injection, immune globulin (Cuvitru), 100 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J1627	Injection, granisetron, extended-release, 0.1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J1726	Injection, Hydroxyprogesterone caproate, (Makena), 10 mg	Covered for all programs	Yes	Yes	Limited to pregnancy only
J1729	Injection, Hydroxyprogesterone caproate, not otherwise specified, 10 mg	Noncovered for all programs	N/A	N/A	N/A
J2326	Injection, Nusinersen, 0.1 mg	Covered for all programs	Yes	Yes	Linked to revenue code 636
J2350	Injection, Ocrelizumab, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636

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

Table 1 – New codes included in the 2018 annual HCPCS update, effective for DOS on or after January 1, 2018

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
J3358	Ustekinumab, for intravenous injection, 1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J7210	Injection, factor viii, (antihemophilic factor, recombinant), (Afstyla), 1 i.u.	Covered for all programs	No	Yes	Linked to revenue code 636
J7211	Injection, factor viii, (antihemophilic factor, recombinant), (Kovaltry), 1 i.u.	Covered for all programs	No	Yes	Linked to revenue code 636
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	Covered for all programs; covered for Family Planning Eligibility Program	No	Yes	Separately reimbursable following inpatient delivery
J7345	Aminolevulinic acid HCL for topical administration, 10% gel, 10 mg	Noncovered for all programs	N/A	N/A	N/A
J9022	Injection, Atezolizumab, 10 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J9023	Injection, Avelumab, 10 mg	Covered for all programs	Yes	Yes	Linked to revenue code 636
J9203	Injection, Gemtuzumab Ozogamicin, 0.1 mg	Covered for all programs	No	Yes	Linked to revenue code 636
J9285	Injection, Olaratumab, 10 mg	Covered for all programs	No	Yes	Linked to revenue code 636
L3761	Elbow orthosis (EO), with adjustable position locking joint(s), prefabricated, off-the-shelf	Covered for all programs	No	No	Linked to revenue code 274
L7700	Gasket or seal, for use with prosthetic socket insert, any type, each	Covered for all programs	No	No	Linked to revenue code 274
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each	Covered for all programs	No	No	Linked to revenue code 274
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	Covered for all programs	Yes	No	Linked to revenue code 274
P9073	Platelets, pheresis, pathogen-reduced, each unit	Covered for all programs	No	No	No
P9100	Pathogen(s) test for platelets	Covered for all programs	No	No	No
Q0477	Power module patient cable for use with electric or electric/pneumatic ventricular assist device, replacement only	Covered for all programs	No	No	Linked to revenue code 274
Q2040	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	Covered for all programs	No	Yes	Linked to revenue code 636
Q4176	Neopatch, per square centimeter	Covered for all programs	No	No	No
Q4177	Floweramnioflo, 0.1 cc	Covered for all programs	No	No	No

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
Q4178	Floweramniopatch, per square centimeter	Covered for all programs	No	No	No
Q4179	Flowerderm, per square centimeter	Covered for all programs	No	No	No
Q4180	Revita, per square centimeter	Covered for all programs	No	No	No
Q4181	Amnio wound, per square centimeter	Covered for all programs	No	No	No
Q4182	Transcyte, per square centimeter	Covered for all programs	No	No	No
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children	Noncovered for all programs	N/A	N/A	N/A
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (list separately in addition to code for primary procedure)	Noncovered for all programs	N/A	N/A	N/A
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed	Noncovered for all programs	N/A	N/A	N/A
0482T	Absolute quantitation of myocardial blood flow, positron emission tomography (PET), rest and stress (list separately in addition to code for primary procedure)	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	Noncovered for all programs	N/A	N/A	N/A
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	Noncovered for all programs	N/A	N/A	N/A
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	Noncovered for all programs	N/A	N/A	N/A
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	Noncovered for all programs	N/A	N/A	N/A
0487T	Biomechanical mapping, transvaginal, with report	Noncovered for all programs	N/A	N/A	N/A
0488T	Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days	Noncovered for all programs	N/A	N/A	N/A
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage

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Table 1 – New codes included in the 2018 annual HCPCS update, effective for DOS on or after January 1, 2018

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0491T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; first 20 sq cm or less	Noncovered for all programs	N/A	N/A	N/A
0492T	Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)	Noncovered for all programs	N/A	N/A	N/A
0493T	Near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)	Noncovered for all programs	N/A	N/A	N/A
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (list separately in addition to code for primary procedure)	Covered for all programs	Yes	No	See Table 2 for manual pricing percentage
0497T	External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24 hour attended monitoring; in-office connection	Noncovered for all programs	N/A	N/A	N/A
0498T	External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24 hour attended monitoring; review and interpretation by a physician or other qualified health care professional per 30 days with at least one patient-generated triggered event	Noncovered for all programs	N/A	N/A	N/A

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Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0499T	Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis, including fluoroscopy, when performed	Noncovered for all programs	N/A	N/A	N/A
0500T	Infectious agent detection by nucleic acid (DNA or RNA), human papillomavirus (HPV) for five or more separately reported high-risk HPV types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) (ie, genotyping)	Covered for all programs; covered for Family Planning Eligibility Program	No	No	No
0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report	Covered for all programs	No	No	See Table 2 for manual pricing percentage
0024U	Glycosylated acute phase proteins (GLYCA), nuclear magnetic resonance spectroscopy, quantitative	Noncovered for all programs	N/A	N/A	N/A
0025U	Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative	Noncovered for all programs	N/A	N/A	N/A
0026U	Oncology (thyroid), DNA and mrna of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result (Positive, high probability of malignancy or Negative, low probability of malignancy)	Noncovered for all programs	N/A	N/A	N/A

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Table 1 – New codes included in the 2018 annual HCPCS update, effective for DOS on or after January 1, 2018

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15	Noncovered for all programs	N/A	N/A	N/A
0028U	Cyp2d6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis	Noncovered for all programs	N/A	N/A	N/A
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, cyp1a2, cyp2c19, cyp2c9, cyp2d6, cyp3a4, cyp3a5, cyp4f2, slco1b1, vkorc1 and rs12777823)	Noncovered for all programs	N/A	N/A	N/A
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, cyp2c9, cyp4f2, vkorc1, rs12777823)	Noncovered for all programs	N/A	N/A	N/A
0031U	Cyp1a2 (cytochrome P450 family 1, subfamily A, member 2) (eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7)	Noncovered for all programs	N/A	N/A	N/A
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant	Noncovered for all programs	N/A	N/A	N/A

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Table 2 – Pricing percentages for newly covered CPT codes that are manually priced

Procedure code	Description	Amount reimbursed as % of billed charges when billed on a *CMS-1500* claim
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	20%
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	20%
33928	Removal and replacement of total replacement heart system (artificial heart)	20%
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (list separately in addition to code for primary procedure)	20%
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	20%
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	20%
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	35%
97127	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact	40%
0482T	Absolute quantitation of myocardial blood flow, positron emission tomography (PET), rest and stress (list separately in addition to code for primary procedure)	90%
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	90%
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	90%
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	90%
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	90%
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (list separately in addition to code for primary procedure)	90%

Table 2 – Pricing percentages for newly covered CPT codes that are manually priced

Procedure code	Description	Amount reimbursed as % of billed charges when billed on a *CMS-1500* claim
0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report	90%
0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission	90%
0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model	90%
0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report	90%

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

Dental Procedure Code	Description	Amount reimbursed as % of billed charges when billed on a Dental claim form
D0411	HbA1c in-office point of service testing	90%
D5511	Repair broken complete denture base, mandibular	90%
D5512	Repair broken complete denture base, maxillary	90%
D5611	Repair resin partial denture base, mandibular	90%
D5612	Repair resin partial denture base, maxillary	90%
D5621	Repair cast partial framework, mandibular	90%
D5622	Repair cast partial framework, maxillary	90%
D6096	Remove broken implant retaining screw	90%
D7296	Corticotomy-one to three teeth or tooth spaces, per quadrant	90%
D7297	Corticotomy-one to three teeth or tooth spaces, per quadrant	90%
D7979	Non-surgical sialolithotomy	90%

Table 4 – New modifiers included in the 2018 annual HCPCS update, effective January 1, 2018

Modifier code	Description	Type
92	Alternative laboratory platform testing: When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703, and 87389). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.	Informational
96	Habilitative services: hen a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living	Informational
97	Rehabilitative services: When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled	Informational
FY	X-ray taken using computed radiography technology/cassette-based imaging	Informational
JG	340b acquired drug or biological acquired with 340b drug pricing program discount	Informational
TB	Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes	Informational
X1	Continuous/broad services: For reporting services by clinicians, who provide the principal care for a patient, with no planned endpoint of the relationship; services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role; reporting clinician service examples include, but are not limited to: primary care, and clinicians providing comprehensive care to patients in addition to specialty care	Informational
X2	Continuous/focused services: For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed with no planned endpoint to the relationship; reporting clinician service examples include but are not limited to: a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services	Informational
X3	Episodic/broad services: For reporting services by clinicians who have broad responsibility for the comprehensive needs of the patient that is limited to a defined period and circumstance such as a hospitalization; reporting clinician service examples include but are not limited to the hospitalist's services rendered providing comprehensive and general care to a patient while admitted to the hospital	Informational

Modifier code	Description	Type
X4	Episodic/focused services: For reporting services by clinicians who provide focused care on particular types of treatment limited to a defined period and circumstance; the patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention; reporting clinician service examples include but are not limited to, the orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period	Informational
X5	Diagnostic services requested by another clinician: For reporting services by a clinician who furnishes care to the patient only as requested by another clinician or subsequent and related services requested by another clinician; this modifier is reported for patient relationships that may not be adequately captured by the above alternative categories; reporting clinician service examples include but are not limited to, the radiologist's interpretation of an imaging study requested by another clinician	Informational

Table 5 – Modifier with revised description, effective for DOS on or after January 1, 2018

Modifier code	New Description
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system: synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face, but may be rendered via a real-time (synchronous) interactive audio and video telecommunications system