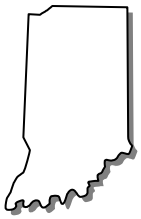

PROVIDER BULLETIN

BT200701 JANUARY 29, 2007

To: **All Providers**

Subject: **Coverage Determinations for the New 2007 Healthcare Common Procedure Coding System Codes**

Overview

The purpose of this bulletin is to notify providers of the coverage determinations for the new 2007 Annual Healthcare Common Procedure Coding System (HCPCS) codes. The Indiana Health Coverage Programs (IHCP) has reviewed the new 2007 annual HCPCS codes to determine coverage and billing guidelines. This bulletin includes the following information:

- Table 1: A listing of the new alpha-numeric and Current Procedural Codes Terminology (CPT®) codes for the 2007 annual HCPCS update by procedure code, description, prior authorization (PA) requirements, allowed modifiers, and program coverage determination.
- Table 2: A listing of the new modifier codes for the 2007 annual HCPCS update by modifier, description, type, and effective date.
- Table 3: A listing of the new codes that are still under review by the IHCP for the 2007 annual HCPCS update.

Refer to IHCP provider bulletin *BT200630*, published December 29, 2006, which provides a list of new 2007 alpha-numeric and CPT codes, modifier updates; and the list of codes that were deleted and the replacement codes that should be used when appropriate.

Direct questions about this bulletin to Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

New HCPCS Codes

The new 2007 annual HCPCS codes in this bulletin are identified by code, description, and coverage. The IHCP is advising providers of these determinations so that the appropriate codes can be billed beginning for dates of service on or after January 1, 2007.

These codes have been added to the Indiana*AIM* claims processing system and fees are posted on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp, with an effective date of January 1, 2007. Providers may bill these codes for dates of service on or after January 1, 2007. The standard global billing procedures and edits apply when using the new codes.

Note: As used in Table 1, **non-covered** *indicates that the IHCP does not cover the service described in the code;* **non-reimbursable** *indicates that the service described in the code is either billable under another code, or is part of global.*

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
15002	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR 1% OF BODY AREA OF INFANTS AND CHILDREN	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 76, 77, 78, 79	Covered for All Programs, Covered for Package C
15003	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 76, 77, 78, 79	Covered for All Programs, Covered for Package C
15004	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR 1% OF BODY AREA OF INFANTS AND CHILDREN	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 76, 77, 78, 79	Covered for All Programs, Covered for Package C
15005	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 76, 77, 78, 79	Covered for All Programs, Covered for Package C
15731	FOREHEAD FLAP WITH PRESERVATION OF VASCULAR PEDICLE (E.G., AXIAL PATTERN FLAP, PARAMEDIAN FOREHEAD FLAP)	No for All Programs, No for Package C	54, 55, 56, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY	Yes for All Programs, Yes for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
17311	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
17312	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
17313	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
17314	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
17315	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
19105	ABLATION, CRYOSURGICAL, OF FIBROADENOMA, INCLUDING ULTRASOUND GUIDANCE, EACH FIBROADENOMA	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
19300	MASTECTOMY FOR GYNECOMASTIA	Yes for All Programs, Yes for Package C	50, 51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C
19301	MASTECTOMY, PARTIAL (E.G., LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY);	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
19302	MASTECTOMY, PARTIAL (E.G., LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY); WITH AXILLARY LYMPHADENECTOMY	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C
19303	MASTECTOMY, SIMPLE, COMPLETE	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
19304	MASTECTOMY, SUBCUTANEOUS	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C
19305	MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY LYMPH NODES	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C
19306	MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY AND INTERNAL MAMMARY LYMPH NODES (URBAN TYPE OPERATION)	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C
19307	MASTECTOMY, MODIFIED RADICAL, INCLUDING AXILLARY LYMPH NODES, WITH OR WITHOUT PECTORALIS MINOR MUSCLE, BUT EXCLUDING PECTORALIS MAJOR MUSCLE	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C
22526	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY, UNILATERAL OR BILATERAL INCLUDING FLUOROSCOPIC GUIDANCE; SINGLE LEVEL	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
22527	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY, UNILATERAL OR BILATERAL INCLUDING FLUOROSCOPIC GUIDANCE; ONE OR MORE ADDITIONAL LEVELS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
22857	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), LUMBAR, SINGLE INTERSPACE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
22862	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC) ANTERIOR APPROACH, LUMBAR, SINGLE INTERSPACE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
22865	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, LUMBAR, SINGLE INTERSPACE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
25109	EXCISION OF TENDON, FOREARM AND/OR WRIST, FLEXOR OR EXTENSOR, EACH	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, RT, LT	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
25606	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIAL FRACTURE OR EPIPHYSEAL SEPARATION	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, RT, LT	Covered for All Programs, Covered for Package C
25607	OPEN TREATMENT OF DISTAL RADIAL EXTRA-ARTICULAR FRACTURE OR EPIPHYSEAL SEPARATION, WITH INTERNAL FIXATION	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, RT, LT	Covered for All Programs, Covered for Package C
25608	OPEN TREATMENT OF DISTAL RADIAL INTRA-ARTICULAR FRACTURE OR EPIPHYSEAL SEPARATION; WITH INTERNAL FIXATION OF 2 FRAGMENTS	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, RT, LT	Covered for All Programs, Covered for Package C
25609	OPEN TREATMENT OF DISTAL RADIAL INTRA-ARTICULAR FRACTURE OR EPIPHYSEAL SEPARATION; WITH INTERNAL FIXATION OF 3 OR MORE FRAGMENTS	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, RT, LT	Covered for All Programs, Covered for Package C
27325	NEURECTOMY, HAMSTRING MUSCLE	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, 80, 81, 82, AS, RT, LT	Covered for All Programs, Covered for Package C
27326	NEURECTOMY, POPLITEAL (GASTROCNEMIUS)	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, RT, LT	Covered for All Programs, Covered for Package C
28055	NEURECTOMY, INTRINSIC MUSCULATURE OF FOOT	No for All Programs, No for Package C	51, 54, 55, 56, 78, RT, LT	Covered for All Programs, Covered for Package C
32998	ABLATION THERAPY FOR REDUCTION OR ERADICATION OF ONE OR MORE PULMONARY TUMOR(S) INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, RADIOFREQUENCY, UNILATERAL	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
33202	INSERTION OF EPICARDIAL ELECTRODE(S); OPEN INCISION (E.G., THORACOTOMY, MEDIAN STERNOTOMY, SUBXIPHOID APPROACH)	No for All Programs, No for Package C	51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C
33203	INSERTION OF EPICARDIAL ELECTRODE(S); ENDOSCOPIC APPROACH (E.G., THORACOSCOPY, PERICARDIOSCOPY)	No for All Programs, No for Package C	51, 54, 55, 56, 78	Covered for All Programs, Covered for Package C
33254	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, LIMITED (E.G., MODIFIED MAZE PROCEDURE)	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
33255	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, EXTENSIVE (E.G., MAZE PROCEDURE); WITHOUT CARDIOPULMONARY BYPASS	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
33256	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, EXTENSIVE (E.G., MAZE PROCEDURE); WITH CARDIOPULMONARY BYPASS	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
33265	ENDOSCOPY, SURGICAL; OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, LIMITED (E.G., MODIFIED MAZE PROCEDURE), WITHOUT CARDIOPULMONARY BYPASS	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
33266	ENDOSCOPY, SURGICAL; OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, EXTENSIVE (E.G., MAZE PROCEDURE), WITHOUT CARDIOPULMONARY BYPASS	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
33675	CLOSURE OF MULTIPLE VENTRICULAR SEPTAL DEFECTS;	No for All Programs, No for Package C	51, 52, 54, 55, 56, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
33676	CLOSURE OF MULTIPLE VENTRICULAR SEPTAL DEFECTS; WITH PULMONARY VALVOTOMY OR INFUNDIBULAR RESECTION (ACYANOTIC)	No for All Programs, No for Package C	51, 52, 54, 55, 56, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
33677	CLOSURE OF MULTIPLE VENTRICULAR SEPTAL DEFECTS; WITH REMOVAL OF PULMONARY ARTERY BAND, WITH OR WITHOUT GUSSET	No for All Programs, No for Package C	51, 52, 54, 55, 56, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
33724	REPAIR OF ISOLATED PARTIAL ANOMALOUS PULMONARY VENOUS RETURN (E.G., SCIMITAR SYNDROME)	No for All Programs, No for Package C	51, 52, 54, 55, 56, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
33726	REPAIR OF PULMONARY VENOUS STENOSIS	No for All Programs, No for Package C	51, 52, 54, 55, 56, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
35302	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; SUPERFICIAL FEMORAL ARTERY	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
35303	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; POPLITEAL ARTERY	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
35304	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; TIBIOPERONEAL TRUNK ARTERY	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
35305	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; TIBIAL OR PERONEAL ARTERY, INITIAL VESSEL	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
35306	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; EACH ADDITIONAL TIBIAL OR PERONEAL ARTERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
35537	BYPASS GRAFT, WITH VEIN; AORTOILIAC	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80 81, 80, 82, AS	Covered for All Programs, Covered for Package C
35538	BYPASS GRAFT, WITH VEIN; AORTOBI-ILIAC	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80 81, 80, 82, AS	Covered for All Programs, Covered for Package C
35539	BYPASS GRAFT, WITH VEIN; AORTOFEMORAL	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80 81, 80, 82, AS	Covered for All Programs, Covered for Package C
35540	BYPASS GRAFT, WITH VEIN; AORTOBIFEMORAL	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80 81, 80, 82, AS	Covered for All Programs, Covered for Package C
35637	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOILIAC	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80 81, 80, 82, AS	Covered for All Programs, Covered for Package C
35638	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOBI-ILIAC	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80 81, 80, 82, AS	Covered for All Programs, Covered for Package C
35883	REVISION, FEMORAL ANASTOMOSIS OF SYNTHETIC ARTERIAL BYPASS GRAFT IN GROIN, OPEN; WITH NONAUTOGENOUS PATCH GRAFT (E.G., DACRON, EPTFE, BOVINE PERICARDIUM)	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80 81, 80, 82, AS	Covered for All Programs, Covered for Package C
35884	REVISION, FEMORAL ANASTOMOSIS OF SYNTHETIC ARTERIAL BYPASS GRAFT IN GROIN, OPEN; WITH AUTOGENOUS VEIN PATCH GRAFT	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80 81, 80, 82, AS	Covered for All Programs, Covered for Package C
37210	UTERINE FIBROID EMBOLIZATION (UFE, EMBOLIZATION OF THE UTERINE ARTERIES TO TREAT UTERINE FIBROIDS, LEIOMYOMATA), PERCUTANEOUS APPROACH INCLUSIVE OF VASCULAR ACCESS, VESSEL SELECTION, EMBOLIZATION, AND ALL RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE NECESSARY TO COMPLETE THE PROCEDURE	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78	Covered for All Programs, Covered for Package C
44157	COLECTOMY, TOTAL, ABDOMINAL, WITH PROCTECTOMY; WITH ILEOANAL ANASTOMOSIS, INCLUDES LOOP ILEOSTOMY, AND RECTAL MUCOSECTOMY, WHEN PERFORMED	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82	Covered for All Programs, Covered for Package C
44158	COLECTOMY, TOTAL, ABDOMINAL, WITH PROCTECTOMY; WITH ILEOANAL ANASTOMOSIS, CREATION OF ILEAL RESERVOIR (S OR J), INCLUDES LOOP ILEOSTOMY, AND RECTAL MUCOSECTOMY, WHEN PERFORMED	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
47719	ANASTOMOSIS, CHOLEDOCHAL CYST, WITHOUT EXCISION	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
48105	RESECTION OR DEBRIDEMENT OF PANCREAS AND PERIPANCREATIC TISSUE FOR ACUTE NECROTIZING PANCREATITIS	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
48548	PANCREATICOJEJUNOSTOMY, SIDE-TO-SIDE ANASTOMOSIS (PUESTOW-TYPE OPERATION)	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
49324	LAPAROSCOPY, SURGICAL; WITH INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER, PERMANENT	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78	Covered for All Programs, Covered for Package C
49325	LAPAROSCOPY, SURGICAL; WITH REVISION OF PREVIOUSLY PLACED INTRAPERITONEAL CANNULA OR CATHETER, WITH REMOVAL OF INTRALUMINAL OBSTRUCTIVE MATERIAL IF PERFORMED	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
49326	LAPAROSCOPY, SURGICAL; WITH OMENTOPEXY (OMENTAL TACKING PROCEDURE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
49402	REMOVAL OF PERITONEAL FOREIGN BODY FROM PERITONEAL CAVITY	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
49435	INSERTION OF SUBCUTANEOUS EXTENSION TO INTRAPERITONEAL CANNULA OR CATHETER WITH REMOTE CHEST EXIT SITE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	51, 54, 55, 56, 57, 56, 62, 76, 77, 78, 80, 81, 82, AS	Covered for All Programs, Covered for Package C
49436	DELAYED CREATION OF EXIT SITE FROM EMBEDDED SUBCUTANEOUS SEGMENT OF INTRAPERITONEAL CANNULA OR CATHETER	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 78, 79	Covered for All Programs, Covered for Package C
54865	EXPLORATION OF EPIDIDYMIS, WITH OR WITHOUT BIOPSY	No for All Programs, No for Package C	51, 54	Covered for All Programs, Covered for Package C
55875	TRANSPERINEAL PLACEMENT OF NEEDLES OR CATHETERS INTO PROSTATE FOR INTERSTITIAL RADIOELEMENT APPLICATION, WITH OR WITHOUT CYSTOSCOPY	No for All Programs, No for Package C	51, 54	Covered for All Programs, Covered for Package C
55876	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (E.G., FIDUCIAL MARKERS, DOSIMETER), PROSTATE (VIA NEEDLE, ANY APPROACH), SINGLE OR MULTIPLE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
56442	HYMENOTOMY, SIMPLE INCISION	No for All Programs, No for Package C	51	Covered for All Programs, Covered for Package C
57296	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT; OPEN ABDOMINAL APPROACH	Not Applicable for All Programs, Not Applicable for Package C	51, 54	Covered for All Programs, Covered for Package C
57558	DILATION AND CURETTAGE OF CERVICAL STUMP	No for All Programs, No for Package C	51	Covered for All Programs, Covered for Package C
58541	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
58542	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
58543	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
58544	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
58548	LAPAROSCOPY, SURGICAL, WITH RADICAL HYSTERECTOMY, WITH BILATERAL TOTAL PELVIC LYMPHADENECTOMY AND PARA-AORTIC LYMPH NODE SAMPLING (BIOPSY), WITH REMOVAL OF TUBE(S) AND OVARY(S), IF PERFORMED	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
58957	RESECTION (TUMOR DEBULKING) OF RECURRENT OVARIAN, TUBAL, PRIMARY PERITONEAL, UTERINE MALIGNANCY (INTRA-ABDOMINAL, RETROPERITONEAL TUMORS), WITH OMENTECTOMY, IF PERFORMED;	No for All Programs, No for Package C	51, 54	Covered for All Programs, Covered for Package C
58958	RESECTION (TUMOR DEBULKING) OF RECURRENT OVARIAN, TUBAL, PRIMARY PERITONEAL, UTERINE MALIGNANCY (INTRA-ABDOMINAL, RETROPERITONEAL TUMORS), WITH OMENTECTOMY, IF PERFORMED; WITH PELVIC LYMPHADENECTOMY AND LIMITED PARA-AORTIC LYMPHADENECTOMY	No for All Programs, No for Package C	51, 54	Covered for All Programs, Covered for Package C
64910	NERVE REPAIR; WITH SYNTHETIC CONDUIT OR VEIN ALLOGRAFT (E.G., NERVE TUBE), EACH NERVE	No for All Programs, No for Package C	80, 81, AS	Covered for All Programs, Covered for Package C
64911	NERVE REPAIR; WITH AUTOGENOUS VEIN GRAFT (INCLUDES HARVEST OF VEIN GRAFT), EACH NERVE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
67346	BIOPSY OF EXTRAOCULAR MUSCLE	No for All Programs, No for Package C	50, 51	Covered for All Programs, Covered for Package C
70554	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MRI; INCLUDING TEST SELECTION AND ADMINISTRATION OF REPETITIVE BODY PART MOVEMENT AND/OR VISUAL STIMULATION, NOT REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
70555	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MRI; REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION OF ENTIRE NEUROFUNCTIONAL TESTING	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
72291	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERCUTANEOUS VERTEBROPLASTY OR VERTEBRAL AUGMENTATION INCLUDING CAVITY CREATION, PER VERTEBRAL BODY; UNDER FLUOROSCOPIC GUIDANCE	No for All Programs, No for Package C	26	Covered for All Programs, Covered for Package C
72292	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERCUTANEOUS VERTEBROPLASTY OR VERTEBRAL AUGMENTATION INCLUDING CAVITY CREATION, PER VERTEBRAL BODY; UNDER CT GUIDANCE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
76776	ULTRASOUND, TRANSPLANTED KIDNEY, REAL TIME AND DUPLEX DOPPLER WITH IMAGE DOCUMENTATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
76813	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FIRST TRIMESTER FETAL NUCHAL TRANSLUCENCY MEASUREMENT, TRANSABDOMINAL OR TRANSVAGINAL APPROACH; SINGLE OR FIRST GESTATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
76814	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FIRST TRIMESTER FETAL NUCHAL TRANSLUCENCY MEASUREMENT, TRANSABDOMINAL OR TRANSVAGINAL APPROACH; EACH ADDITIONAL GESTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
76998	ULTRASONIC GUIDANCE, INTRAOPERATIVE	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
77001	FLUOROSCOPIC GUIDANCE FOR CENTRAL VENOUS ACCESS DEVICE PLACEMENT, REPLACEMENT (CATHETER ONLY OR COMPLETE), OR REMOVAL (INCLUDES FLUOROSCOPIC GUIDANCE FOR VASCULAR ACCESS AND CATHETER MANIPULATION, ANY NECESSARY CONTRAST INJECTIONS THROUGH ACCESS SITE	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77002	FLUOROSCOPIC GUIDANCE FOR NEEDLE PLACEMENT (E.G., BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77003	FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR PARASPINOUS DIAGNOSTIC OR THERAPEUTIC INJECTION PROCEDURES (EPIDURAL, TRANSFORAMINAL EPIDURAL, SUBARACHNOID, PARAVERTEBRAL FACET JOINT, PARAVERTEBRAL FACET JOINT NERVE, OR	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77011	COMPUTED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77012	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (E.G., BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77013	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR, AND MONITORING OF, PARENCHYMAL TISSUE ABLATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77014	COMPUTED TOMOGRAPHY GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77021	MAGNETIC RESONANCE GUIDANCE FOR NEEDLE PLACEMENT (E.G., FOR BIOPSY, NEEDLE ASPIRATION, INJECTION, OR PLACEMENT OF LOCALIZATION DEVICE) RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77022	MAGNETIC RESONANCE GUIDANCE FOR, AND MONITORING OF, PARENCHYMAL TISSUE ABLATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77031	STEREOTACTIC LOCALIZATION GUIDANCE FOR BREAST BIOPSY OR NEEDLE PLACEMENT (E.G., FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
77032	MAMMOGRAPHIC GUIDANCE FOR NEEDLE PLACEMENT, BREAST (E.G., FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77051	COMPUTER-AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES; DIAGNOSTIC MAMMOGRAPHY (LIST SEPARATELY IN A	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77052	COMPUTER-AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES; SCREENING MAMMOGRAPHY (LIST SEPARATELY IN AD	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77053	MAMMARY DUCTOGRAM OR GALACTOGRAM, SINGLE DUCT, RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77054	MAMMARY DUCTOGRAM OR GALACTOGRAM, MULTIPLE DUCTS, RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77055	MAMMOGRAPHY; UNILATERAL	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77056	MAMMOGRAPHY; BILATERAL	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77057	SCREENING MAMMOGRAPHY, BILATERAL (2-VIEW FILM STUDY OF EACH BREAST)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77058	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); UNILATERAL	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77059	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); BILATERAL	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77071	MANUAL APPLICATION OF STRESS PERFORMED BY PHYSICIAN FOR JOINT RADIOGRAPHY, INCLUDING CONTRALATERAL JOINT IF INDICATED	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
77072	BONE AGE STUDIES	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77073	BONE LENGTH STUDIES (ORTHOROENTGENOGRAM, SCANOGRAM)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77074	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; LIMITED (E.G., FOR METASTASES)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77075	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; COMPLETE (AXIAL AND APPENDICULAR SKELETON)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77076	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY, INFANT	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77077	JOINT SURVEY, SINGLE VIEW, 2 OR MORE JOINTS (SPECIFY)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77079	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77080	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77081	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL)	No for All Programs, No for Package C	26,TC	Covered for All Programs, Covered for Package C
77082	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; VERTEBRAL FRACTURE ASSESSMENT	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77083	RADIOGRAPHIC ABSORPTIOMETRY (E.G., PHOTODENSITOMETRY, RADIOGRAMMETRY), 1 OR MORE SITES	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77084	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BONE MARROW BLOOD SUPPLY	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
77371	RADIATION TREATMENT DELIVERY, STEREOTACTIC RADIOSURGERY (SRS), COMPLETE COURSE OF TREATMENT OF CEREBRAL LESION(S) CONSISTING OF 1 SESSION; MULTI-SOURCE COBALT 60 BASED	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
77372	RADIATION TREATMENT DELIVERY, STEREOTACTIC RADIOSURGERY (SRS), COMPLETE COURSE OF TREATMENT OF CEREBRAL LESION(S) CONSISTING OF 1 SESSION; LINEAR ACCELERATOR BASED	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
77373	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT DELIVERY, PER FRACTION TO 1 OR MORE LESIONS, INCLUDING IMAGE GUIDANCE, ENTIRE COURSE NOT TO EXCEED 5 FRACTIONS	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
77435	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT MANAGEMENT, PER TREATMENT COURSE, TO ONE OR MORE LESIONS, INCLUDING IMAGE GUIDANCE, ENTIRE COURSE NOT TO EXCEED 5 FRACTIONS	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
82107	ALPHA-FETOPROTEIN (AFP); AFP-L3 FRACTION ISOFORM AND TOTAL AFP (INCLUDING RATIO)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
83698	LIPOPROTEIN-ASSOCIATED PHOSPHOLIPASE A2, (LP-PLA2)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
83913	MOLECULAR DIAGNOSTICS; RNA STABILIZATION	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
86788	ANTIBODY; WEST NILE VIRUS, IGM	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
86789	ANTIBODY; WEST NILE VIRUS	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
87305	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVE OR SEMIQUANTITATIVE, MULTIPLE-STEP METHOD; ASPERGILLUS	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
87498	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); ENTEROVIRUS, AMPLIFIED PROBE TECHNIQUE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
87640	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); STAPHYLOCOCCUS AUREUS, AMPLIFIED PROBE TECHNIQUE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
87641	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); STAPHYLOCOCCUS AUREUS, METHICILLIN RESISTANT, AMPLIFIED PROBE TECHNIQUE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
87653	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); STREPTOCOCCUS, GROUP B, AMPLIFIED PROBE TECHNIQUE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
87808	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; TRICHOMONAS VAGINALIS	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
91111	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (E.G., CAPSULE ENDOSCOPY), ESOPHAGUS WITH PHYSICIAN INTERPRETATION AND REPORT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C
92025	COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT	Yes for All Programs, Yes for Package C		Covered for All Programs, Covered for Package C
92640	DIAGNOSTIC ANALYSIS WITH PROGRAMMING OF AUDITORY BRAINSTEM IMPLANT, PER HOUR	Yes for All Programs, Yes for Package C	26	Covered for All Programs, Covered for Package C
94002	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, INITIAL DAY	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
94003	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
94004	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; NURSING FACILITY, PER DAY	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
94005	HOME VENTILATOR MANAGEMENT CARE PLAN OVERSIGHT OF A PATIENT (PATIENT NOT PRESENT) IN HOME, DOMICILIARY OR REST HOME (E.G., ASSISTED LIVING) REQUIRING REVIEW OF STATUS, REVIEW OF LABORATORIES AND OTHER STUDIES AND REVISION OF ORDERS AND RESPIRATORY CARE	Yes for All Programs, Yes for Package C		Covered for All Programs, Covered for Package C
94610	INTRAPULMONARY SURFACTANT ADMINISTRATION BY A PHYSICIAN THROUGH ENDOTRACHEAL TUBE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
94644	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION FOR ACUTE AIRWAY OBSTRUCTION; FIRST HOUR	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
94645	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION FOR ACUTE AIRWAY OBSTRUCTION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
95012	NITRIC OXIDE EXPIRED GAS DETERMINATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
96020	NEUROFUNCTIONAL TESTING SELECTION AND ADMINISTRATION DURING NONINVASIVE IMAGING FUNCTIONAL BRAIN MAPPING, WITH TEST ADMINISTERED ENTIRELY BY A PHYSICIAN OR PSYCHOLOGIST, WITH REVIEW OF TEST RESULTS AND REPORT	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C
96040	MEDICAL GENETICS AND GENETIC COUNSELING SERVICES, EACH 30 MINUTES FACE-TO-FACE WITH PATIENT/FAMILY	Yes for All Programs, Yes for Package C		Covered for All Programs, Covered for Package C
96904	WHOLE BODY INTEGUMENTARY PHOTOGRAPHY, FOR MONITORING OF HIGH RISK PATIENTS WITH DYSPLASTIC NEVUS SYNDROME OR A HISTORY OF DYSPLASTIC NEVI, OR PATIENTS WITH A PERSONAL OR FAMILIAL HISTORY OF MELANOMA	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
99363	ANTICOAGULANT MANAGEMENT FOR AN OUTPATIENT TAKING WARFARIN, PHYSICIAN REVIEW AND INTERPRETATION OF INTERNATIONAL NORMALIZED RATIO (INR) TESTING, PATIENT INSTRUCTIONS, DOSAGE ADJUSTMENT (AS NEEDED), AND ORDERING OF ADDITIONAL TESTS; INITIAL 90 DAYS OF	No for All Programs, No for Package C	AK	Covered for All Programs, Covered for Package C
99364	ANTICOAGULANT MANAGEMENT FOR AN OUTPATIENT TAKING WARFARIN, PHYSICIAN REVIEW AND INTERPRETATION OF INTERNATIONAL NORMALIZED RATIO (INR) TESTING, PATIENT INSTRUCTIONS, DOSAGE ADJUSTMENT (AS NEEDED), AND ORDERING OF ADDITIONAL TESTS; EACH SUBSEQUENT 90	No for All Programs, No for Package C	AK	Covered for All Programs, Covered for Package C
0012F	COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA ASSESSMENT (INCLUDES ALL OF THE FOLLOWING COMPONENTS) (CAP):	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code.

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
0162T	ELECTRONIC ANALYSIS AND PROGRAMMING, REPROGRAMMING OF GASTRIC NEUROSTIMULATOR (IE, MORBID OBESITY)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0163T	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), LUMBAR, EACH ADDITIONAL INTERSPACE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0164T	REMOVAL OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH, LUMBAR, EACH ADDITIONAL INTERSPACE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0165T	REVISION OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH, LUMBAR, EACH ADDITIONAL INTERSPACE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0167T	TRANSMYOCARDIAL TRANSCATHETER CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH IMPLANT; WITH CARDIOPULMONARY BYPASS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
0168T	RHINOPHOTOTHERAPY, INTRANASAL APPLICATION OF ULTRAVIOLET AND VISIBLE LIGHT, BILATERAL	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0170T	REPAIR OF ANORECTAL FISTULA WITH PLUG (E.G., PORCINE SMALL INTESTINE SUBMUCOSA [SIS])	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0173T	MONITORING OF INTRAOCULAR PRESSURE DURING VITRECTOMY SURGERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0174T	COMPUTER AIDED DETECTION (CAD) (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S), PERFOR	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
0175T	COMPUTER AIDED DETECTION (CAD) (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S), PERFOR	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0176T	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITHOUT RETENTION OF DEVICE OR STENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0177T	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITH RETENTION OF DEVICE OR STENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
0505F	HEMODIALYSIS PLAN OF CARE DOCUMENTED (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
0507F	PERITONEAL DIALYSIS PLAN OF CARE DOCUMENTED (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C
1015F	CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) SYMPTOMS ASSESSED (INCLUDES ASSESSMENT OF AT LEAST ONE OF THE FOLLOWING: DYSPNEA, COUGH/SPUTUM, WHEEZING), OR RESPIRATORY SYMPTOM ASSESSMENT TOOL COMPLETED (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code C
1018F	DYSPNEA ASSESSED, NOT PRESENT (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
1019F	DYSPNEA ASSESSED, PRESENT (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1022F	PNEUMOCOCCUS IMMUNIZATION STATUS ASSESSED (CAP, COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1026F	CO-MORBID CONDITIONS ASSESSED (E.G., INCLUDES ASSESSMENT FOR PRESENCE OR ABSENCE OF: MALIGNANCY, LIVER DISEASE, CONGESTIVE HEART FAILURE, CEREBROVASCULAR DISEASE, RENAL DISEASE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, ASTHMA, DIABETES, OTHER CO-MORBID C	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1030F	INFLUENZA IMMUNIZATION STATUS ASSESSED (CAP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1034F	CURRENT TOBACCO SMOKER (CAD, CAP, COPD, PV) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1035F	CURRENT SMOKELESS TOBACCO USER (E.G., CHEW, SNUFF) (PV)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
1036F	CURRENT TOBACCO NON-USER (CAD, CAP, COPD, PV) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1038F	PERSISTENT ASTHMA (MILD, MODERATE OR SEVERE) (ASTHMA)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1039F	INTERMITTENT ASTHMA (ASTHMA)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1040F	DSM-IV(TM) CRITERIA FOR MAJOR DEPRESSIVE DISORDER DOCUMENTED (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1050F	HISTORY OBTAINED REGARDING NEW OR CHANGING MOLES (ML)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
1055F	VISUAL FUNCTIONAL STATUS ASSESSED (EC)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
2010F	VITAL SIGNS RECORDED (INCLUDES AT MINIMUM: TEMPERATURE, PULSE, RESPIRATION, AND BLOOD PRESSURE)(CAP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2014F	MENTAL STATUS ASSESSED (NORMAL/MILDLY IMPAIRED/SEVERELY IMPAIRED) (CAP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2018F	HYDRATION STATUS ASSESSED (NORMAL/MILDLY DEHYDRATED/SEVERELY DEHYDRATED) (CAP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2019F	DILATED MACULAR EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE AND THE LEVEL OF MACULAR DEGENERATION SEVERITY (EC)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2020F	DILATED FUNDUS EVALUATION PERFORMED WITHIN SIX MONTHS PRIOR TO CATARACT SURGERY (EC)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2021F	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY (EC)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
2022F	DILATED RETINAL EYE EXAM WITH INTERPRETATION BY AN OPHTHALMOLOGIST OR OPTOMETRIST DOCUMENTED AND REVIEWED (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2024F	SEVEN STANDARD FIELD STEREOSCOPIC PHOTOS WITH INTERPRETATION BY AN OPHTHALMOLOGIST OR OPTOMETRIST DOCUMENTED AND REVIEWED (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2026F	EYE IMAGING VALIDATED TO MATCH DIAGNOSIS FROM SEVEN STANDARD FIELD STEREOSCOPIC PHOTOS RESULTS DOCUMENTED AND REVIEWED (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2027F	OPTIC NERVE HEAD EVALUATION PERFORMED (EC)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2028F	FOOT EXAMINATION PERFORMED (INCLUDES EXAMINATION THROUGH VISUAL INSPECTION, SENSORY EXAM WITH MONOFILAMENT, AND PULSE EXAM – REPORT WHEN ANY OF THE THREE COMPONENTS ARE COMPLETED) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2029F	COMPLETE PHYSICAL SKIN EXAM PERFORMED (ML)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
2030F	HYDRATION STATUS DOCUMENTED, NORMALLY HYDRATED (PAG)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
2031F	HYDRATION STATUS DOCUMENTED, DEHYDRATED (PAG)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3006F	CHEST X-RAY RESULTS DOCUMENTED AND REVIEWED (CAP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3011F	LIPID PANEL RESULTS DOCUMENTED AND REVIEWED (MUST INCLUDE TOTAL CHOLESTEROL, HDL-C, TRIGLYCERIDES AND CALCULATED LDL-C) (CAD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3014F	SCREENING MAMMOGRAPHY RESULTS DOCUMENTED AND REVIEWED (PV)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3017F	COLORECTAL CANCER SCREENING RESULTS DOCUMENTED AND REVIEWED (PV)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
3020F	LEFT VENTRICULAR FUNCTION (LVF) ASSESSMENT (E.G., ECHOCARDIOGRAPHY, NUCLEAR TEST, OR VENTRICULOGRAPHY) DOCUMENTED IN THE MEDICAL RECORD (INCLUDES QUANTITATIVE OR QUALITATIVE ASSESSMENT RESULTS)(CHF)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3021F	LEFT VENTRICULAR EJECTION FRACTION (LVEF) 40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION (CAD, HF)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3022F	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >=40% OR DOCUMENTATION AS NORMAL OR MILDLY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION (CAD, HF)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3023F	SPIROMETRY RESULTS DOCUMENTED AND REVIEWED (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3025F	SPIROMETRY TEST RESULTS DEMONSTRATE FEV1/FVC70% WITH COPD SYMPTOMS (E.G., DYSPNEA, COUGH/SPUTUM, WHEEZING) (CAP, COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3027F	SPIROMETRY TEST RESULTS DEMONSTRATE FEV1/FVC>=70% OR PATIENT DOES NOT HAVE COPD SYMPTOMS (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
3028F	OXYGEN SATURATION RESULTS DOCUMENTED AND REVIEWED (INCLUDES ASSESSMENT THROUGH PULSE OXIMETRY OR ARTERIAL BLOOD GAS MEASUREMENT) (CAP, COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3035F	OXYGEN SATURATION <= 88 % OR A PA02 <= 55 MM HG (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3037F	OXYGEN SATURATION > 88% OR PAO2 > 55 MMHG (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3040F	FUNCTIONAL EXPIRATORY VOLUME (FEV1) 40% OF PREDICTED VALUE (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3042F	FUNCTIONAL EXPIRATORY VOLUME (FEV1) >= 40% OF PREDICTED VALUE (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3044F	MOST RECENT HEMOGLOBIN A1C LEVEL < 7.0% (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
3045F	MOST RECENT HEMOGLOBIN A1C LEVEL 7.0 - 9.0% (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3046F	MOST RECENT HEMOGLOBIN A1C LEVEL > 9.0% (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3047F	MOST RECENT HEMOGLOBIN A1C LEVEL <= 9.0% (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3048F	MOST RECENT LDL-C 100 MG/DL (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3049F	MOST RECENT LDL-C 100-129 MG/DL (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3050F	MOST RECENT LDL-C >=130 MG/DL (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
3060F	POSITIVE MICROALBUMINURIA TEST RESULT DOCUMENTED AND REVIEWED (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3061F	NEGATIVE MICROALBUMINURIA TEST RESULT DOCUMENTED AND REVIEWED (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
3062F	POSITIVE MACROALBUMINURIA TEST RESULT DOCUMENTED AND REVIEWED (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3066F	DOCUMENTATION OF TREATMENT FOR NEPHROPATHY (E.G., PATIENT RECEIVING DIALYSIS, PATIENT BEING TREATED FOR ESRD, CRF, ARF, OR RENAL INSUFFICIENCY, ANY VISIT TO A NEPHROLOGIST) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code C
3072F	LOW RISK FOR RETINOPATHY (NO EVIDENCE OF RETINOPATHY IN THE PRIOR YEAR) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3073F	PRE-SURGICAL (CATARACT) AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION DOCUMENTED WITHIN SIX MONTHS PRIOR TO SURGERY (EC)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE < 130 MM HG (DM), (HTN)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3075F	MOST RECENT SYSTOLIC BLOOD PRESSURE 130 - 139MM HG (DM), (HTN)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3076F	MOST RECENT SYSTOLIC BLOOD PRESSURE 140 MM HG (HTN) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3077F	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140 MM HG (HTN) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE 80 MM HG (HTN) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3079F	MOST RECENT DIASTOLIC BLOOD PRESSURE 80-89 MM HG (HTN) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
3080F	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90 MM HG (HTN) (DM)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3082F	KT/V 1.2 (CLEARANCE OF UREA (KT)/VOLUME (V)) (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3083F	KT/V EQUAL TO OR GREATER THAN 1.2 AND LESS THAN 1.7 (CLEARANCE OF UREA (KT)/VOLUME (V)) (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3084F	KT/V >= 1.7 (CLEARANCE OF UREA (KT)/VOLUME (V)) (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3085F	SUICIDE RISK ASSESSED (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3088F	MAJOR DEPRESSIVE DISORDER, MILD (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
3089F	MAJOR DEPRESSIVE DISORDER, MODERATE (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3090F	MAJOR DEPRESSIVE DISORDER, SEVERE WITHOUT PSYCHOTIC FEATURES (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3091F	MAJOR DEPRESSIVE DISORDER, SEVERE WITH PSYCHOTIC FEATURES (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3092F	MAJOR DEPRESSIVE DISORDER, IN REMISSION (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3093F	DOCUMENTATION OF NEW DIAGNOSIS OF INITIAL OR RECURRENT EPISODE OF MAJOR DEPRESSIVE DISORDER (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
3095F	CENTRAL DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) RESULTS DOCUMENTED (OP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
3096F	CENTRAL DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) ORDERED (OP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4005F	PHARMACOLOGIC THERAPY (OTHER THAN MINERALS/VITAMINS) FOR OSTEOPOROSIS PRESCRIBED (OP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4007F	ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT PRESCRIBED OR RECOMMENDED (EC)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4019F	DOCUMENTATION OF RECEIPT OF COUNSELING ON EXERCISE AND EITHER BOTH CALCIUM AND VITAMIN D USE OR COUNSELING REGARDING BOTH CALCIUM AND VITAMIN D USE (OP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4025F	INHALED BRONCHODILATOR PRESCRIBED (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4030F	LONG TERM OXYGEN THERAPY PRESCRIBED (MORE THAN FIFTEEN HOURS PER DAY) (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
4033F	PULMONARY REHABILITATION EXERCISE TRAINING RECOMMENDED (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4035F	INFLUENZA IMMUNIZATION RECOMMENDED (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4037F	INFLUENZA IMMUNIZATION ORDERED OR ADMINISTERED (COPD, PV)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4040F	PNEUMOCOCCAL IMMUNIZATION ORDERED OR ADMINISTERED (COPD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4045F	APPROPRIATE EMPIRIC ANTIBIOTIC PRESCRIBED (SEE MEASURE DEVELOPER'S WEB SITE FOR DEFINITION OF APPROPRIATE ANTIBIOTIC) (CAP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4050F	HYPERTENSION PLAN OF CARE DOCUMENTED AS APPROPRIATE (HTN)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
4051F	REFERRED FOR AN ARTERIO-VENOUS (AV) FISTULA (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code e for Package C
4052F	HEMODIALYSIS VIA FUNCTIONING ARTERIO-VENOUS (AV) FISTULA (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4053F	HEMODIALYSIS VIA FUNCTIONING ARTERIO-VENOUS (AV) GRAFT (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4054F	HEMODIALYSIS VIA CATHETER (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4055F	PATIENT RECEIVING PERITONEAL DIALYSIS (ESRD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4056F	APPROPRIATE ORAL REHYDRATION SOLUTION RECOMMENDED (PAG)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
4058F	PEDIATRIC GASTROENTERITIS EDUCATION PROVIDED TO CAREGIVER (PAG)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
4060F	PSYCHOTHERAPY SERVICES PROVIDED (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4062F	PATIENT REFERRAL FOR PSYCHOTHERAPY DOCUMENTED (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
4064F	ANTIDEPRESSANT PHARMACOTHERAPY PRESCRIBED (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4065F	ANTIPSYCHOTIC PHARMACOTHERAPY PRESCRIBED (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
4066F	ELECTROCONVULSIVE THERAPY (ECT) PROVIDED (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
4067F	PATIENT REFERRAL FOR ELECTROCONVULSIVE THERAPY (ECT) DOCUMENTED (MDD)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
5005F	PATIENT COUNSELED ON SELF-EXAMINATION FOR NEW OR CHANGING MOLES (ML)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
5010F	FINDINGS OF DILATED MACULAR OR FUNDUS EXAM COMMUNICATED TO THE PHYSICIAN MANAGING THE DIABETES CARE (EC)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
5015F	DOCUMENTATION OF COMMUNICATION THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS (OP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
6005F	RATIONALE (E.G., SEVERITY OF ILLNESS AND SAFETY) FOR LEVEL OF CARE (E.G., HOME, HOSPITAL) DOCUMENTED (CAP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
A4461	SURGICAL DRESSING HOLDER, NON-REUSABLE, EACH	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
A4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
A8000	HELMET, PROTECTIVE, SOFT, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
A8001	HELMET, PROTECTIVE, HARD, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
A9279	MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
A9568	TECHNETIUM TC-99M ARCITUMOMAB, DIAGNOSTIC, PER STUDY DOSE, UP TO 45 MILLICURIES	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
C1820	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), WITH RECHARGEABLE BATTERY AND CHARGING SYSTEM	No for All Programs, No for Package C	51, 54	Covered for All Programs, Covered for Package C
D0360	CONE BEAM CT - CRANIOFACIAL DATA CAPTURE	Not Applicable for All Programs, Not Applicable for All Programs		Non-Covered for All Programs, Non-Covered for Package C
D0362	CONE BEAM - TWO-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D0363	CONE BEAM - THREE-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D4230	ANATOMICAL CROWN EXPOSURE - FOUR OR MORE CONTIGUOUS TEETH PER QUADRANT	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D4231	ANATOMICAL CROWN EXPOSURE - ONE TO THREE TEETH PER QUADRANT	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D6092	RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
D6093	RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D7292	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE] REQUIRING SURGICAL FLAP	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D7293	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE REQUIRING SURGICAL FLAP	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D7294	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE WITHOUT SURGICAL FLAP	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D7998	INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D8693	REBONDING OR RECEMENTING; AND/OR REPAIR, AS REQUIRED, OF FIXED RETAINERS	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C
E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C
G0380	LEVEL 1 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE ST	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for Package C Billable with the with Evaluation and Management code 99281
G0381	LEVEL 2 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE ST	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with Evaluation and Management code 99282
G0382	LEVEL 3 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE ST	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with Evaluation and Management code 99283
G0383	LEVEL 4 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE S	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with Evaluation and Management code 99284
G0384	LEVEL 5 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE ST	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with Evaluation and Management code 99285

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G0389	ULTRASOUND B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; FOR ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C
G0390	TRAUMA RESPONSE TEAM ASSOCIATED WITH HOSPITAL CRITICAL CARE SERVICE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G0392	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; FOR MAINTENANCE OF HEMODIALYSIS ACCESS, ARTERIOVENOUS FISTULA OR GRAFT; ARTERIAL	No for All Programs, No for Package C	78, 79, LT, RT	Covered for All Programs, Covered for Package C
G0393	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; FOR MAINTENANCE OF HEMODIALYSIS ACCESS, ARTERIOVENOUS FISTULA OR GRAFT; VENOUS	No for All Programs, No for Package C	78, 79, LT, RT,	Covered for All Programs, Covered for Package C
G0394	BLOOD OCCULT TEST (E.G., GUAIAC), FECES, FOR SINGLE DETERMINATION FOR COLORECTAL NEOPLASM (I.E., PATIENT WAS PROVIDED THREE CARDS OR SINGLE TRIPLE CARD FOR CONSECUTIVE COLLECTION)	Not Applicable for All Programs, Not Applicable for Package C		Covered for All Programs, Covered for Package C
G8085	END-STAGE RENAL DISEASE PATIENT REQUIRING HEMODIALYSIS VASCULAR ACCESS WAS NOT AN ELIGIBLE CANDIDATE FOR AUTOGENOUS AV FISTULA	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8191	CLINICIAN DOCUMENTED TO HAVE GIVEN ORDER FOR PROPHYLACTIC ANTIBIOTIC TO BE GIVEN WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8192	CLINICIAN DOCUMENTED TO HAVE GIVEN THE PROPHYLACTIC ANTIBIOTIC WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO THE SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8193	CLINICIAN DID NOT DOCUMENT THAT AN ORDER FOR PROPHYLACTIC ANTIBIOTIC TO BE GIVEN WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED) WAS GIVEN	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8194	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PROPHYLACTIC ANTIBIOTIC	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8195	CLINICIAN DOCUMENTED TO HAVE GIVEN THE PROPHYLACTIC ANTIBIOTIC WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO THE SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8196	CLINICIAN DID NOT DOCUMENT A PROPHYLACTIC ANTIBIOTIC WAS ADMINISTERED WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8197	PATIENT DOCUMENTED TO HAVE ORDER FOR PROPHYLACTIC ANTIBIOTIC TO BE GIVEN WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8198	PATIENT DOCUMENTED TO HAVE ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8199	CLINICIAN DOCUMENTED TO HAVE GIVEN CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8200	ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS NOT DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8201	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8202	CLINICIAN DOCUMENTED AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 24 HOURS OF SURGICAL END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8203	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTICS WERE DISCONTINUED WITHIN 24 HOURS OF SURGICAL END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8204	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 24 HOURS OF SURGICAL END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8205	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PROPHYLACTIC ANTIBIOTIC DISCONTINUATION WITHIN 24 HOURS OF SURGICAL END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8206	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTIC WAS GIVEN	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8207	CLINICIAN DOCUMENTED AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 48 HOURS OF SURGICAL END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8208	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTICS WERE DISCONTINUED WITHIN 48 HOURS OF SURGICAL END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8209	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 48 HOURS OF SURGICAL END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8210	CLINICIAN DOCUMENTED PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DISCONTINUATION OF PROPHYLACTIC ANTIBIOTIC DISCONTINUATION WITHIN 48 HOURS OF SURGICAL END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8211	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTIC WAS GIVEN	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8212	CLINICIAN DOCUMENTED AN ORDER WAS GIVEN FOR APPROPRIATE VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS TO BE GIVEN WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8213	CLINICIAN DOCUMENTED TO HAVE GIVEN VTE PROPHYLAXIS WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8214	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN FOR APPROPRIATE VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS TO BE GIVEN WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8215	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS TO BE GIVEN WITHIN 24 HOURS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8216	PATIENT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY TWO	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8217	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8218	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2, INCLUDING PHYSICIAN DOCUMENTATION THAT PATIENT IS AMBULATORY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8219	PATIENT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8220	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8221	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DVT PROPHYLAXIS BY THE END OF HOSPITAL DAY 2, INCLUDING PHYSICIAN DOCUMENTATION THAT PATIENT IS AMBULATORY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8222	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED ANTIPLATELET THERAPY AT DISCHARGE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8223	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PRESCRIPTION FOR ANTIPLATELET THERAPY AT DISCHARGE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C
G8224	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIPLATELET THERAPY AT DISCHARGE, INCLUDING IDENTIFICATION FROM MEDICAL RECORD THAT PATIENT IS ON ANTICOAGULATION THERAPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8225	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED AN ANTICOAGULANT AT DISCHARGE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8226	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PRESCRIPTION FOR ANTICOAGULANT THERAPY AT DISCHARGE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8227	PATIENT NOT DOCUMENTED TO HAVE PERMANENT, PERSISTENT, OR PAROXYSMAL ATRIAL FIBRILLATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8228	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTICOAGULANT THERAPY AT DISCHARGE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8229	PATIENT DOCUMENTED TO HAVE BEEN ADMINISTERED OR CONSIDERED FOR T-PA	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8230	PATIENT NOT ELIGIBLE FOR T-PA ADMINISTRATION, ISCHEMIC STROKE SYMPTOM ONSET OF MORE THAN 3 HOURS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8231	PATIENT NOT DOCUMENTED TO HAVE RECEIVED T-PA OR NOT DOCUMENTED TO HAVE BEEN CONSIDERED A CANDIDATE FOR T-PA ADMINISTRATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8232	PATIENT DOCUMENTED TO HAVE RECEIVED DYSPHAGIA SCREENING PRIOR TO TAKING ANY FOODS, FLUIDS OR MEDICATION BY MOUTH	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8234	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DYSPHAGIA SCREENING	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8235	PATIENT NOT RECEIVING OR INELIGIBLE TO RECEIVE FOOD, FLUIDS OR MEDICATION BY MOUTH, OR DOCUMENTATION OF NPO (NOTHING BY MOUTH) ORDER	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8236	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DYSPHAGIA SCREENING PRIOR TO TAKING ANY FOODS, FLUIDS OR MEDICATION BY MOUTH	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8237	PATIENT DOCUMENTED TO HAVE RECEIVED ORDER FOR REHABILITATION SERVICES OR DOCUMENTATION OF CONSIDERATION FOR REHABILITATION SERVICES	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8238	PATIENT NOT DOCUMENTED TO HAVE RECEIVED ORDER FOR OR CONSIDERATION FOR REHABILITATION SERVICES	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8239	INTERNAL CAROTID STENOSIS PATIENT BELOW 30%, REFERENCE TO MEASUREMENTS OF DISTAL INTERNAL CAROTID DIAMETER AS THE DENOMINATOR FOR STENOSIS MEASUREMENT NOT NECESSARY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8240	INTERNAL CAROTID STENOSIS PATIENT IN THE 30-99% RANGE, AND NO DOCUMENTATION OF REFERENCE TO MEASUREMENTS OF DISTAL INTERNAL CAROTID DIAMETER AS THE DENOMINATOR FOR STENOSIS MEASUREMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8241	CLINICIAN DOCUMENTED THAT PATIENT WHOSE FINAL REPORT OF THE CAROTID IMAGING STUDY PERFORMED (NECK MRA, NECK CTA, NECK DUPLEX ULTRASOUND, CAROTID ANGIOGRAM), WITH CHARACTERIZATION OF AN INTERNAL CAROTID STENOSIS IN THE 30-99% RANGE, WAS NOT AN ELIGIBL	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8242	PATIENT DOCUMENTED TO HAVE RECEIVED CT OR MRI WITH PRESENCE OR ABSENCE OF HEMORRHAGE, MASS LESION AND ACUTE INFARCTION DOCUMENTED IN THE FINAL REPORT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8243	PATIENT NOT DOCUMENTED TO HAVE RECEIVED CT OR MRI AND THE PRESENCE OR ABSENCE OF HEMORRHAGE, MASS LESION AND ACUTE INFARCTION NOT DOCUMENTED IN THE FINAL REPORT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8245	CLINICIAN DOCUMENTED PRESENCE OR ABSENCE ALARM SYMPTOMS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8246	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MEDICAL HISTORY REVIEW WITH ASSESSMENT OF NEW OR CHANGING MOLES	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8247	PATIENT WITH ALARM SYMPTOM(S) DOCUMENTED TO HAVE HAD UPPER ENDOSCOPY PERFORMED OR REFERRAL FOR UPPER ENDOSCOPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8248	PATIENT WITH AT LEAST ONE ALARM SYMPTOM NOT DOCUMENTED TO HAVE HAD UPPER ENDOSCOPY OR REFERRAL FOR UPPER ENDOSCOPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8249	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR UPPER ENDOSCOPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8250	PATIENT WITH SUSPICION OF BARRETT'S ESOPHAGUS IN ENDOSCOPY REPORT AND DOCUMENTED TO HAVE RECEIVED AN ESOPHAGEAL BIOPSY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8251	PATIENT NOT DOCUMENTED TO HAVE RECEIVED AN ESOPHAGEAL BIOPSY WHEN SUSPICION OF BARRETT'S ESOPHAGUS IS INDICATED IN THE ENDOSCOPY REPORT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8252	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ESOPHAGEAL BIOPSY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8253	PATIENT DOCUMENTED TO HAVE RECEIVED AN ORDER FOR A BARIUM SWALLOW TEST	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8254	PATIENT WITH NO DOCUMENTATION ORDER FOR BARIUM SWALLOW TEST	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8255	CLINICIAN DOCUMENTATION THAT PATIENT WAS AN ELIGIBLE CANDIDATE FOR BARIUM SWALLOW TEST	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8256	CLINICIAN DOCUMENTED RECONCILIATION OF DISCHARGE MEDICATIONS WITH CURRENT MEDICATION LIST IN MEDICAL RECORD	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8257	CLINICIAN HAS NOT DOCUMENTED RECONCILIATION OF DISCHARGE MEDICATIONS WITH CURRENT MEDICATION LIST IN MEDICAL RECORD	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8258	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DISCHARGE MEDICATIONS REVIEW	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C
G8259	PATIENT DOCUMENTED TO HAVE SURROGATE DECISION MAKER OR ADVANCE CARE PLAN IN MEDICAL RECORD	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8260	PATIENT NOT DOCUMENTED TO HAVE SURROGATE DECISION MAKER OR ADVANCE CARE PLAN IN MEDICAL RECORD	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8261	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR SURROGATE DECISION MAKER OR ADVANCE CARE PLAN	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8262	PATIENT DOCUMENTED TO HAVE BEEN ASSESSED FOR PRESENCE OR ABSENCE OF URINARY INCONTINENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8263	PATIENT NOT DOCUMENTED TO HAVE BEEN ASSESSED FOR PRESENCE OR ABSENCE OF URINARY INCONTINENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8264	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR AN ASSESSMENT OF THE PRESENCE OR ABSENCE OF URINARY INCONTINENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8265	PATIENT DOCUMENTED TO HAVE RECEIVED CHARACTERIZATION OF URINARY INCONTINENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8266	PATIENT NOT DOCUMENTED TO HAVE RECEIVED CHARACTERIZATION OF URINARY INCONTINENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8267	PATIENT DOCUMENTED TO HAVE RECEIVED A PLAN OF CARE FOR URINARY INCONTINENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8268	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PLAN OF CARE FOR URINARY INCONTINENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8269	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME TO DEVELOP PLAN OF CARE FOR URINARY INCONTINENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8270	PATIENT DOCUMENTED TO HAVE RECEIVED SCREENING FOR FALL RISK (2 OR MORE FALLS IN THE PAST YEAR OR ANY FALL WITH INJURY IN THE PAST YEAR)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8271	PATIENT WITH NO DOCUMENTATION OF SCREENING FOR FALL RISKS (2 OR MORE FALLS IN THE PAST YEAR OR ANY FALL WITH INJURY IN THE PAST YEAR)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8272	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FALL RISK SCREENING	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8273	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME TO SCREEN FOR FALL RISK	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8274	CLINICIAN HAS NOT DOCUMENTED PRESENCE OR ABSENCE OF ALARM SYMPTOMS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8275	PATIENT DOCUMENTED TO HAVE MEDICAL HISTORY TAKEN WHICH INCLUDED ASSESSMENT OF NEW OR CHANGING MOLES	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8276	PATIENT NOT DOCUMENTED TO HAVE RECEIVED MEDICAL HISTORY WITH ASSESSMENT OF NEW OR CHANGING MOLES	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8277	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MEDICAL HISTORY REVIEW WITH ASSESSMENT OF NEW OR CHANGING MOLES	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8278	PATIENT DOCUMENTED TO HAVE RECEIVED COMPLETE PHYSICAL SKIN EXAM	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8279	PATIENT NOT DOCUMENTED TO HAVE RECEIVED A COMPLETE PHYSICAL SKIN EXAM	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8280	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR COMPLETE PHYSICAL SKIN EXAM DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8281	PATIENT DOCUMENTED TO HAVE RECEIVED COUNSELING TO PERFORM A SELF-EXAMINATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8282	PATIENT NOT DOCUMENTED TO HAVE RECEIVED COUNSELING TO PERFORM A SELF-EXAMINATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8283	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR COUNSELING TO PERFORM SELF-EXAMINATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8284	PATIENT DOCUMENTED TO HAVE RECEIVED A PRESCRIPTION FOR PHARMACOLOGIC THERAPY FOR OSTEOPOROSIS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8285	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PHARMACOLOGIC THERAPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8286	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PHARMACOLOGIC THERAPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8287	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR THE PHARMACOLOGIC THERAPY MEASURE	Not Applicable for All Programs, Not Applicable for Package C		Non- Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8288	PATIENT DOCUMENTED TO HAVE RECEIVED CALCIUM AND VITAMIN D OR COUNSELING ON BOTH CALCIUM AND VITAMIN D USE, AND EXERCISE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8289	PATIENT WITH NO DOCUMENTATION OF CALCIUM AND VITAMIN D USE OR COUNSELING REGARDING BOTH CALCIUM AND VITAMIN D USE, OR EXERCISE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8290	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CALCIUM AND VITAMIN D, AND EXERCISE DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8291	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR THE CALCIUM, VITAMIN D, AND EXERCISE MEASURE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8292	COPD PATIENT WITH SPIROMETRY RESULTS DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8293	COPD PATIENT WITHOUT SPIROMETRY RESULTS DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8294	COPD PATIENT WAS NOT ELIGIBLE FOR SPIROMETRY RESULTS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8295	COPD PATIENT DOCUMENTED TO HAVE RECEIVED INHALED BRONCHODILATOR THERAPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8296	COPD PATIENT NOT DOCUMENTED TO HAVE INHALED BRONCHODILATOR THERAPY PRESCRIBED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8297	COPD PATIENT WAS NOT ELIGIBLE FOR INHALED BRONCHODILATOR THERAPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8298	PATIENT DOCUMENTED TO HAVE RECEIVED OPTIC NERVE HEAD EVALUATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8299	PATIENT NOT DOCUMENTED TO HAVE RECEIVED OPTIC NERVE HEAD EVALUATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8300	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR OPTIC NERVE HEAD EVALUATION DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8301	CLINICIAN HAS NOT PROVIDED CARE FOR THE PRIMARY OPEN-ANGLE GLAUCOMA PATIENT FOR THE REQUIRED TIME FOR OPTIC NERVE HEAD EVALUATION MEASURE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code C
G8302	PATIENT DOCUMENTED TO HAVE A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8303	PATIENT NOT DOCUMENTED TO HAVE A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8304	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8305	CLINICIAN HAS NOT PROVIDED CARE FOR THE PRIMARY OPEN-ANGLE GLAUCOMA PATIENT FOR THE REQUIRED TIME FOR TREATMENT RANGE GOAL DOCUMENTATION MEASUREMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8306	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE ABOVE THE TARGET RANGE GOAL DOCUMENTED TO HAVE RECEIVED PLAN OF CARE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8307	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE AT OR BELOW GOAL, NO PLAN OF CARE NECESSARY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8308	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE ABOVE THE TARGET RANGE GOAL, AND NOT DOCUMENTED TO HAVE RECEIVED PLAN OF CARE DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8309	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED/RECOMMENDED ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8310	PATIENT NOT DOCUMENTED TO HAVE BEEN PRESCRIBED/RECOMMENDED AT LEAST ONE ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8311	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8312	CLINICIAN HAS NOT PROVIDED CARE FOR THE AGE-RELATED MACULAR DEGENERATION PATIENT FOR THE REQUIRED TIME FOR ANTIOXIDANT SUPPLEMENT PRESCRIPTION/RECOMMENDED MEASURE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8313	PATIENT DOCUMENTED TO HAVE RECEIVED MACULAR EXAM, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE AND THE LEVEL OF MACULAR DEGENERATION SEVERITY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8314	PATIENT NOT DOCUMENTED TO HAVE RECEIVED MACULAR EXAM WITH DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE AND NO DOCUMENTATION OF LEVEL OF MACULAR DEGENERATION SEVERITY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8315	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MACULAR EXAMINATION DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8316	CLINICIAN HAS NOT PROVIDED CARE FOR THE AGE-RELATED MACULAR DEGENERATION PATIENT FOR THE REQUIRED TIME FOR MACULAR EXAMINATION MEASUREMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8317	PATIENT DOCUMENTED TO HAVE VISUAL FUNCTIONAL STATUS ASSESSED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8318	PATIENT DOCUMENTED NOT TO HAVE VISUAL FUNCTIONAL STATUS ASSESSED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8319	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ASSESSMENT OF VISUAL FUNCTIONAL STATUS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8320	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR ASSESSMENT OF VISUAL FUNCTIONAL STATUS MEASUREMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8321	PATIENT DOCUMENTED TO HAVE HAD PRE-SURGICAL AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8322	PATIENT NOT DOCUMENTED TO HAVE HAD PRE-SURGICAL AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8323	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PRE-SURGICAL AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8324	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR PRE-SURGICAL MEASUREMENT AND INTRAOCULAR LENS POWER CALCULATION MEASURE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8325	PATIENT DOCUMENTED TO HAVE RECEIVED FUNDUS EVALUATION WITHIN SIX MONTHS PRIOR TO CATARACT SURGERY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8326	PATIENT NOT DOCUMENTED TO HAVE RECEIVED FUNDUS EVALUATION WITHIN SIX MONTHS PRIOR TO CATARACT SURGERY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8327	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PRE-SURGICAL FUNDUS EVALUATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8328	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR FUNDUS EVALUATION MEASUREMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8329	PATIENT DOCUMENTED TO HAVE RECEIVED DILATED MACULAR OR FUNDUS EXAM WITH LEVEL OF SEVERITY OF RETINOPATHY AND THE PRESENCE OR ABSENCE OF MACULAR EDEMA DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8330	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DILATED MACULAR OR FUNDUS EXAM WITH LEVEL OF SEVERITY OF RETINOPATHY AND THE PRESENCE OR ABSENCE OF MACULAR EDEMA NOT DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8331	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DILATED MACULAR OR FUNDUS EXAM DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8332	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC RETINOPATHY PATIENT FOR THE REQUIRED TIME FOR MACULAR EDEMA AND RETINOPATHY MEASUREMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8333	PATIENT DOCUMENTED TO HAVE HAD FINDINGS OF MACULAR OR FUNDUS EXAM COMMUNICATED TO THE PHYSICIAN MANAGING THE DIABETES CARE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C
G8334	DOCUMENTATION OF FINDINGS OF MACULAR OR FUNDUS EXAM NOT COMMUNICATED TO THE PHYSICIAN MANAGING THE PATIENT'S ONGOING DIABETES CARE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8335	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR THE FINDINGS OF THEIR MACULAR OR FUNDUS EXAM BEING COMMUNICATED TO THE PHYSICIAN MANAGING THEIR DIABETES CARE DURING THE REPORTING YEAR	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8336	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC RETINOPATHY PATIENT FOR THE REQUIRED TIME FOR PHYSICIAN COMMUNICATION MEASUREMENT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8337	CLINICIAN DOCUMENTED THAT COMMUNICATION WAS SENT TO THE PHYSICIAN MANAGING ONGOING CARE OF PATIENT THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code C
G8338	CLINICIAN HAS NOT DOCUMENTED THAT COMMUNICATION WAS SENT TO THE PHYSICIAN MANAGING ONGOING CARE OF PATIENT THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8339	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR COMMUNICATION WITH THE PHYSICIAN MANAGING THE PATIENT'S ONGOING CARE THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8340	PATIENT DOCUMENTED TO HAVE HAD CENTRAL DEXA PERFORMED AND RESULTS DOCUMENTED OR CENTRAL DEXA ORDERED OR PHARMACOLOGIC THERAPY PRESCRIBED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8341	PATIENT NOT DOCUMENTED TO HAVE HAD CENTRAL DEXA MEASUREMENT OR PHARMACOLOGIC THERAPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8342	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CENTRAL DEXA MEASUREMENT OR PRESCRIBING PHARMACOLOGIC	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8343	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGICAL THERAPY MEASURE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8344	PATIENT DOCUMENTED TO HAVE HAD CENTRAL DEXA ORDERED OR PERFORMED AND RESULTS DOCUMENTED OR PHARMACOLOGICAL THERAPY PRESCRIBED	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G8345	PATIENT NOT DOCUMENTED TO HAVE HAD CENTRAL DEXA MEASUREMENT ORDERED OR PERFORMED OR PHARMACOLOGIC THERAPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8346	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGIC THERAPY	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G8347	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGICAL THERAPY MEASURE	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G9131	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G9132	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY OR POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Not Applicable for All Programs, Not Applicable for Package C		Non- Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G9133	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
G9134	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G9135	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE III, IV, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G9136	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G9137	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, ANY CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G9138	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, ANY CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
G9139	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
H0049	ALCOHOL AND/OR DRUG SCREENING	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
H0050	ALCOHOL AND/OR DRUG SERVICES, BRIEF INTERVENTION, PER 15 MINUTES	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with the most appropriate Evaluation and Management code
J0129	INJECTION, ABATACEPT, 10 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J0348	INJECTION, ANADULAFUNGIN, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J0364	INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J0594	INJECTION, BUSULFAN, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J0894	INJECTION, DECITABINE, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J1458	INJECTION, GALSULFASE, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J1562	INJECTION, IMMUNE GLOBULIN, SUBCUTANEOUS, 100 MG	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J2170	INJECTION, MECASERMIN, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J2248	INJECTION, MICAFUNGIN SODIUM, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
J2315	INJECTION, NALTREXONE, DEPOT FORM, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J3243	INJECTION, TIGECYCLINE, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J3473	INJECTION, HYALURONIDASE, RECOMBINANT, 1 USP UNIT	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J7311	FLUOCINOLONE ACETONIDE, INTRAVITREAL IMPLANT	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J7319	HYALURONAN (SODIUM HYALURONATE) OR DERIVATIVE, INTRA-ARTICULAR INJECTION, PER INJECTION	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J7345	DERMAL (SUBSTITUTE) TISSUE OF NON-HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J7346	DERMAL (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, INJECTABLE, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, BUT WITHOUT METABOLICALLY ACTIVE ELEMENTS, 1 CC	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	No for All Programs, No for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with HCPCS code J7612
J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	No for All Programs, No for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with HCPCS code J7613
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with HCPCS code J7613

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	Not Applicable for All Programs, Not Applicable for Package C		Non-Reimbursable for All Programs, Non-Reimbursable for Package C Billable with HCPCS code J7612
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J7660	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J7667	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
J8650	NABILONE, ORAL, 1 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
J9261	INJECTION, NELARABINE, 50 MG	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY MATERIAL, ANY SIZE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L6704	TERMINAL DEVICE, SPORT/RECREATIONAL/WORK ATTACHMENT, ANY MATERIAL, ANY SIZE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L6706	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
L6707	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L6708	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L6709	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
Q4081	INJECTION, EPOETIN ALFA, 100 UNITS (FOR ESRD ON DIALYSIS)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
Q5001	HOSPICE CARE PROVIDED IN PATIENT'S HOME/RESIDENCE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
Q5002	HOSPICE CARE PROVIDED IN ASSISTED LIVING FACILITY	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
Q5003	HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
Q5004	HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C

Table 1 – New 2007 Annual HCPCS Codes, Effective January 1, 2007

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage
Q5005	HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
Q5006	HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
Q5007	HOSPICE CARE PROVIDED IN LONG TERM CARE FACILITY	Not Applicable for All Programs, Not Applicable for Package C.		Non-Covered for All Programs, Non-Covered for Package C
Q5008	HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
Q5009	HOSPICE CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS)	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
S0180	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C
S3855	GENETIC TESTING FOR DETECTION OF MUTATIONS IN THE PRESENILIN - 1 GENE	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C
T4543	DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, BARIATRIC, EACH	Not Applicable for All Programs, Not Applicable for Package C		Non-Covered for All Programs, Non-Covered for Package C

Table 2 – New Modifier Codes for the 2007 Annual HCPCS Update

Modifier Code	Description	Type	Date Effective
JA	ADMINISTERED INTRAVENOUSLY	Informational	2007/01/01
JB	ADMINISTERED SUBCUTANEOUSLY	Informational	2007/01/01
M2	MEDICARE SECONDARY PAYER (MSP)	Informational	2007/01/01
*FB	ITEM PROVIDED WITHOUT COST TO PROVIDER, SUPPLIER OR PRACTITIONER, OR CREDIT RECEIVED FOR REPLACED DEVICE (EXAMPLES, BUT NOT LIMITED TO COVERED UNDER WARRANTY, REPLACED DUE TO DEFECT, FREE SAMPLES)	Informational	2007/01/01

*This is an informational description change that will be effective January 1, 2007.

Table 3 – New 2007 Annual HCPCS Codes Under Review

Procedure Code	Description
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (E.G., ABDOMINOPLASTY) (INCLUDES UMBILICAL TRANSPOSITION AND FASCIAL PLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
00625	ANESTHESIA FOR PROCEDURES ON THE THORACIC SPINE AND CORD, VIA AN ANTERIOR TRANSTHORACIC APPROACH; NOT UTILIZING ONE LUNG VENTILATION
00626	ANESTHESIA FOR PROCEDURES ON THE THORACIC SPINE AND CORD, VIA AN ANTERIOR TRANSTHORACIC APPROACH; UTILIZING ONE LUNG VENTILATION
0166T	TRANSMYOCARDIAL TRANSCATHETER CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH IMPLANT; WITHOUT CARDIOPULMONARY BYPASS
0169T	STEREOTACTIC PLACEMENT OF INFUSION CATHETER(S) IN THE BRAIN FOR DELIVERY OF THERAPEUTIC AGENT(S), INCLUDING COMPUTERIZED STEREOTACTIC PLANNING AND BURR HOLE(S)
0171T	INSERTION OF POSTERIOR SPINOUS PROCESS DISTRACTION DEVICE (INCLUDING NECESSARY REMOVAL OF BONE OR LIGAMENT FOR INSERTION AND IMAGING GUIDANCE), LUMBAR; SINGLE LEVEL
0172T	INSERTION OF POSTERIOR SPINOUS PROCESS DISTRACTION DEVICE (INCLUDING NECESSARY REMOVAL OF BONE OR LIGAMENT FOR INSERTION AND IMAGING GUIDANCE), LUMBAR; EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
43647	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
43648	LAPAROSCOPY, SURGICAL; REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
43881	IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
43882	REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
94774	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; INCLUDES MONITOR ATTACHMENT, DOWNLOAD OF DATA, PHYSICIAN REVIEW, INTERPRETATION, AND PREPARATION OF A REPORT
94775	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITOR ATTACHMENT ONLY (INCLUDES HOOK-UP, INITIATION OF RECORDING AND DISCONNECTION)
94776	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITORING, DOWNLOAD OF INFORMATION, RECEIPT OF TRANSMISSION(S) AND ANALYSES BY COMPUTER ONLY
94777	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; PHYSICIAN REVIEW, INTERPRETATION AND PREPARATION OF REPORT ONLY
A4463	SURGICAL DRESSING HOLDER, REUSABLE, EACH
A4559	COUPLING GEL OR PASTE, FOR USE WITH ULTRASOUND DEVICE, PER OZ
A4601	LITHIUM ION BATTERY FOR NON-PROSTHETIC USE, REPLACEMENT
A8002	HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8003	HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8004	SOFT INTERFACE FOR HELMET, REPLACEMENT ONLY
A9527	IODINE I-125, SODIUM IODIDE SOLUTION, THERAPEUTIC, PER MILLICURIE

Table 3 – New 2007 Annual HCPCS Codes Under Review

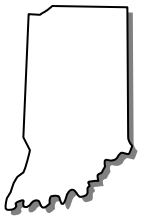
Procedure Code	Description
C9233	INJECTION, RANIBIZUMAB, 0.5 MG
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER
D0273	BITEWINGS - THREE FILMS
D0486	ACCESSION OF BRUSH BIOPSY SAMPLE, MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT
D1555	REMOVAL OF FIXED SPACE MAINTAINER
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES
D9120	FIXED PARTIAL DENTURE SECTIONING
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE
E2373	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL, COMPACT, OR SHORT THROW REMOTE JOYSTICK OR TOUCHPAD, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPLACEMENT ONLY, EACH
E2393	POWER WHEELCHAIR ACCESSORY, VALVE FOR PNEUMATIC TIRE TUBE, ANY TYPE, REPLACEMENT ONLY, EACH
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
G0377	ADMINISTRATION OF VACCINE FOR PART D DRUG
J1324	INJECTION, ENFUVIRTIDE, 1 MG
J7187	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR, PER IU VWF:RCO
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM

Table 3 – New 2007 Annual HCPCS Codes Under Review

Procedure Code	Description
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM
L1001	CERVICAL THORACIC LUMBAR SACRAL ORTHOSIS, IMMOBILIZER, INFANT SIZE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L3806	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
L3808	WRIST HAND FINGER ORTHOSIS, RIGID WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE MATERIAL; STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
L3915	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L5993	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, FOOT ONLY, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)
L5994	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, KNEE ONLY, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE
L6624	UPPER EXTREMITY ADDITION, FLEXION/EXTENSION AND ROTATION WRIST UNIT
L6639	UPPER EXTREMITY ADDITION, HEAVY DUTY FEATURE, ANY ELBOW
L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, REPLACEMENT
Q4083	HYALUROMAN OR DERIVATIVE, HYALGAN OR SUPARTZ , FOR INTRA-ARTICULA INJECTION, PER DOSE
Q4084	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Q4085	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION PER DOSE
Q4086	HYALURONAN OR DERIVAIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
S2344	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ENLARGEMENT OF SINUS OSTIUM OPENING USING INFLATABLE DEVICE (I.E., BALLOON SINUPLASTY)

HCPCS C Codes

HCPCS C codes are used for services paid by the Medicare Outpatient Prospective Payment System and are not listed in this bulletin. The IHCP does not reimburse HCPCS C codes with the exception of *C1300 - Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval*, and C1785, C1786, C2619, C2620, and C2621, pacemaker codes.



P R O V I D E R B U L L E T I N

B T 2 0 0 6 3 0 D E C E M B E R 2 9 , 2 0 0 6

To: All Providers

Subject: New 2007 Healthcare Common Procedure Coding System Codes

Overview

The purpose of this bulletin is to introduce the 2007 Annual Healthcare Common Procedure Coding System (HCPCS) code and modifier updates that will be added to the Indiana*AIM* claims processing system for dates of service on or after January 1, 2007. Table 1 lists the new alpha-numeric and Current Procedural Terminology (CPT®) codes, and modifiers. Future bulletins with additional coverage information will be forthcoming. A list of codes that were deleted and the replacement codes that should be used when appropriate, are identified in Table 2. . If there are any questions about the contents of this bulletin, contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

HIPAA Requirements for Code Set Usage

Provisions of the Health Insurance Portability and Accountability Act (HIPAA) require use of national medical code sets and modifiers that are valid at the time that the service is provided. The American Medical Association (AMA) issues new, deleted, and changed CPT codes annually, effective January 1, posted in the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) publishes the alpha-numeric codes in October, posted on the Alpha-numeric HCPCS file. The physician fee schedule and alpha-numeric code set-up dates can be found at http://www.cms.hhs.gov/providers/pufdownload/.

On January 1, 2007, new covered HCPCS and CPT codes become available in the Indiana*AIM* processing system for billing. The Indiana Health Coverage Programs (IHCP) will deny claims submitted with dates of service prior to January 1, 2007, with new covered codes. Before January 1, 2007, providers may continue to bill the 2007 deleted codes for current covered services; for services after December 31, 2006, providers may no longer bill the 2007 deleted codes or modifiers.

The following national codes in Table 1 will be loaded for claims processing effective January 1, 2007. Coverage determinations will be published in future bulletins with additional information. Table 2 contains deleted and crosswalked codes. Codes which have been non-covered will not be crosswalked and are noted as "No crosswalk applicable." Follow-up information will be posted on the IHCP Web site at http://www.indianamedicaid.com.

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
00625	ANESTHESIA FOR PROCEDURES ON THE THORACIC SPINE AND CORD, VIA AN ANTERIOR TRANSTHORACIC APPROACH; NOT UTILIZING ONE LUNG VENTILATION
00626	ANESTHESIA FOR PROCEDURES ON THE THORACIC SPINE AND CORD, VIA AN ANTERIOR TRANSTHORACIC APPROACH; UTILIZING ONE LUNG VENTILATION
15002	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE, TRUNK, ARMS, LEGLEGS; FIRST 100 SQ CM OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15003	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE, TRUNK, ARMS, LEGLEGS; EACH ADDITIONAL 100 SQ CM OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15004	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR 1% OF BODY AREA OF INFANTS AND CHILDREN
15005	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN
15731	FOREHEAD FLAP WITH PRESERVATION OF VASCULAR PEDICLE (E.G., AXIAL PATTERN FLAP, PARAMEDIAN FOREHEAD FLAP)
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (E.G., ABDOMINOPLASTY) (INCLUDES UMBILICAL TRANSPOSITION AND FASCIAL PLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
17311	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
17312	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN
17313	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN
17314	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN
17315	MOHS MICROGRAPHIC TECHNIQUE, INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND HISTOPATHOLOGIC PREPARATION INCLUDING ROUTINE STAIN
19105	ABLATION, CRYOSURGICAL, OF FIBROADENOMA, INCLUDING ULTRASOUND GUIDANCE, EACH FIBROADENOMA
19300	MASTECTOMY FOR GYNECOMASTIA
19301	MASTECTOMY, PARTIAL (E.G., LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY);
19302	MASTECTOMY, PARTIAL (E.G., LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY); WITH AXILLARY LYMPHADENECTOMY
19303	MASTECTOMY, SIMPLE, COMPLETE
19304	MASTECTOMY, SUBCUTANEOUS
19305	MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY LYMPH NODES
19306	MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY AND INTERNAL MAMMARY LYMPH NODES (URBAN TYPE OPERATION)
19307	MASTECTOMY, MODIFIED RADICAL, INCLUDING AXILLARY LYMPH NODES, WITH OR WITHOUT PECTORALIS MINOR MUSCLE, BUT EXCLUDING PECTORALIS MAJOR MUSCLE
22526	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY, UNILATERAL OR BILATERAL INCLUDING FLUOROSCOPIC GUIDANCE; SINGLE LEVEL

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
22527	PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY, UNILATERAL OR BILATERAL INCLUDING FLUOROSCOPIC GUIDANCE; ONE OR MORE ADDITIONAL LEVELS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
22862	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC) ANTERIOR APPROACH, LUMBAR, SINGLE INTERSPACE
22865	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, LUMBAR, SINGLE INTERSPACE
25109	EXCISION OF TENDON, FOREARM AND/OR WRIST, FLEXOR OR EXTENSOR, EACH
25606	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIAL FRACTURE OR EPIPHYSEAL SEPARATION
25607	OPEN TREATMENT OF DISTAL RADIAL EXTRA-ARTICULAR FRACTURE OR EPIPHYSEAL SEPARATION, WITH INTERNAL FIXATION
25608	OPEN TREATMENT OF DISTAL RADIAL INTRA-ARTICULAR FRACTURE OR EPIPHYSEAL SEPARATION; WITH INTERNAL FIXATION OF 2 FRAGMENTS
25609	OPEN TREATMENT OF DISTAL RADIAL INTRA-ARTICULAR FRACTURE OR EPIPHYSEAL SEPARATION; WITH INTERNAL FIXATION OF 3 OR MORE FRAGMENTS
27325	NEURECTOMY, HAMSTRING MUSCLE
27326	NEURECTOMY, POPLITEAL (GASTROCNEMIUS)
28055	NEURECTOMY, INTRINSIC MUSCULATURE OF FOOT
32998	ABLATION THERAPY FOR REDUCTION OR ERADICATION OF ONE OR MORE PULMONARY TUMOR(S) INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, RADIOFREQUENCY, UNILATERAL
33202	INSERTION OF EPICARDIAL ELECTRODE(S); OPEN INCISION (E.G., THORACOTOMY, MEDIAN STERNOTOMY, SUBXIPHOID APPROACH)
33203	INSERTION OF EPICARDIAL ELECTRODE(S); ENDOSCOPIC APPROACH (E.G., THORACOSCOPY, PERICARDIOSCOPY)
33254	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, LIMITED (E.G., MODIFIED MAZE PROCEDURE)
33255	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, EXTENSIVE (E.G., MAZE PROCEDURE); WITHOUT CARDIOPULMONARY BYPASS
33256	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, EXTENSIVE (E.G., MAZE PROCEDURE); WITH CARDIOPULMONARY BYPASS
33265	ENDOSCOPY, SURGICAL; OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, LIMITED (E.G., MODIFIED MAZE PROCEDURE), WITHOUT CARDIOPULMONARY BYPASS

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
33266	ENDOSCOPY, SURGICAL; OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, EXTENSIVE (E.G., MAZE PROCEDURE), WITHOUT CARDIOPULMONARY BYPASS
33675	CLOSURE OF MULTIPLE VENTRICULAR SEPTAL DEFECTS;
33676	CLOSURE OF MULTIPLE VENTRICULAR SEPTAL DEFECTS; WITH PULMONARY VALVOTOMY OR INFUNDIBULAR RESECTION (ACYANOTIC)
33677	CLOSURE OF MULTIPLE VENTRICULAR SEPTAL DEFECTS; WITH REMOVAL OF PULMONARY ARTERY BAND, WITH OR WITHOUT GUSSET
33724	REPAIR OF ISOLATED PARTIAL ANOMALOUS PULMONARY VENOUS RETURN (E.G., SCIMITAR SYNDROME)
33726	REPAIR OF PULMONARY VENOUS STENOSIS
35302	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; SUPERFICIAL FEMORAL ARTERY
35303	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; POPLITEAL ARTERY
35304	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; TIBIOPERONEAL TRUNK ARTERY
35305	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; TIBIAL OR PERONEAL ARTERY, INITIAL VESSEL
35306	THROMBOENDARTERECTOMY, INCLUDING PATCH GRAFT, IF PERFORMED; EACH ADDITIONAL TIBIAL OR PERONEAL ARTERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
35537	BYPASS GRAFT, WITH VEIN; AORTOILIAC
35538	BYPASS GRAFT, WITH VEIN; AORTOBI-ILIAC
35539	BYPASS GRAFT, WITH VEIN; AORTOFEMORAL
35540	BYPASS GRAFT, WITH VEIN; AORTOBIFEMORAL
35637	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOILIAC
35638	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOBI-ILIAC
35883	REVISION, FEMORAL ANASTOMOSIS OF SYNTHETIC ARTERIAL BYPASS GRAFT IN GROIN, OPEN; WITH NONAUTOGENOUS PATCH GRAFT (E.G., DACRON, EPTFE, BOVINE PERICARDIUM)
35884	REVISION, FEMORAL ANASTOMOSIS OF SYNTHETIC ARTERIAL BYPASS GRAFT IN GROIN, OPEN; WITH AUTOGENOUS VEIN PATCH GRAFT
37210	UTERINE FIBROID EMBOLIZATION (UFE, EMBOLIZATION OF THE UTERINE ARTERIES TO TREAT UTERINE FIBROIDS, LEIOMYOMATA), PERCUTANEOUS APPROACH INCLUSIVE OF VASCULAR ACCESS, VESSEL SELECTION, EMBOLIZATION, AND ALL RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE NECESSARY TO COMPLETE THE PROCEDURE

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
43647	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
43648	LAPAROSCOPY, SURGICAL; REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
43881	IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
43882	REVISION OR REMOVAL OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
44157	COLECTOMY, TOTAL, ABDOMINAL, WITH PROCTECTOMY; WITH ILEOANAL ANASTOMOSIS, INCLUDES LOOP ILEOSTOMY, AND RECTAL MUCOSECTOMY, WHEN PERFORMED
44158	COLECTOMY, TOTAL, ABDOMINAL, WITH PROCTECTOMY; WITH ILEOANAL ANASTOMOSIS, CREATION OF ILEAL RESERVOIR (S OR J), INCLUDES LOOP ILEOSTOMY, AND RECTAL MUCOSECTOMY, WHEN PERFORMED
47719	ANASTOMOSIS, CHOLEDOCHAL CYST, WITHOUT EXCISION
48105	RESECTION OR DEBRIDEMENT OF PANCREAS AND PERIPANCREATIC TISSUE FOR ACUTE NECROTIZING PANCREATITIS
48548	PANCREATICOJEJUNOSTOMY, SIDE-TO-SIDE ANASTOMOSIS (PUESTOW-TYPE OPERATION)
49324	LAPAROSCOPY, SURGICAL; WITH INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER, PERMANENT
49325	LAPAROSCOPY, SURGICAL; WITH REVISION OF PREVIOUSLY PLACED INTRAPERITONEAL CANNULA OR CATHETER, WITH REMOVAL OF INTRALUMINAL OBSTRUCTIVE MATERIAL IF PERFORMED
49326	LAPAROSCOPY, SURGICAL; WITH OMENTOPEXY (OMENTAL TACKING PROCEDURE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
49402	REMOVAL OF PERITONEAL FOREIGN BODY FROM PERITONEAL CAVITY
49435	INSERTION OF SUBCUTANEOUS EXTENSION TO INTRAPERITONEAL CANNULA OR CATHETER WITH REMOTE CHEST EXIT SITE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
49436	DELAYED CREATION OF EXIT SITE FROM EMBEDDED SUBCUTANEOUS SEGMENT OF INTRAPERITONEAL CANNULA OR CATHETER
54865	EXPLORATION OF EPIDIDYMIS, WITH OR WITHOUT BIOPSY
55875	TRANSPERINEAL PLACEMENT OF NEEDLES OR CATHETERS INTO PROSTATE FOR INTERSTITIAL RADIOELEMENT APPLICATION, WITH OR WITHOUT CYSTOSCOPY
55876	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (E.G., FIDUCIAL MARKERS, DOSIMETER), PROSTATE (VIA NEEDLE, ANY APPROACH), SINGLE OR MULTIPLE
56442	HYMENOTOMY, SIMPLE INCISION

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
57296	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT; OPEN ABDOMINAL APPROACH
57558	DILATION AND CURETTAGE OF CERVICAL STUMP
58541	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
58542	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58543	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;
58544	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
58548	LAPAROSCOPY, SURGICAL, WITH RADICAL HYSTERECTOMY, WITH BILATERAL TOTAL PELVIC LYMPHADENECTOMY AND PARA-AORTIC LYMPH NODE SAMPLING (BIOPSY), WITH REMOVAL OF TUBE(S) AND OVARY(S), IF PERFORMED
58957	RESECTION (TUMOR DEBULKING) OF RECURRENT OVARIAN, TUBAL, PRIMARY PERITONEAL, UTERINE MALIGNANCY (INTRA-ABDOMINAL, RETROPERITONEAL TUMORS), WITH OMENTECTOMY, IF PERFORMED;
58958	RESECTION (TUMOR DEBULKING) OF RECURRENT OVARIAN, TUBAL, PRIMARY PERITONEAL, UTERINE MALIGNANCY (INTRA-ABDOMINAL, RETROPERITONEAL TUMORS), WITH OMENTECTOMY, IF PERFORMED; WITH PELVIC LYMPHADENECTOMY AND LIMITED PARA-AORTIC LYMPHADENECTOMY
64910	NERVE REPAIR; WITH SYNTHETIC CONDUIT OR VEIN ALLOGRAFT (E.G., NERVE TUBE), EACH NERVE
64911	NERVE REPAIR; WITH AUTOGENOUS VEIN GRAFT (INCLUDES HARVEST OF VEIN GRAFT), EACH NERVE
67346	BIOPSY OF EXTRAOCULAR MUSCLE
70554	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MRI; INCLUDING TEST SELECTION AND ADMINISTRATION OF REPETITIVE BODY PART MOVEMENT AND/OR VISUAL STIMULATION, NOT REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION
70555	MAGNETIC RESONANCE IMAGING, BRAIN, FUNCTIONAL MRI; REQUIRING PHYSICIAN OR PSYCHOLOGIST ADMINISTRATION OF ENTIRE NEUROFUNCTIONAL TESTING
72291	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERCUTANEOUS VERTEBROPLASTY OR VERTEBRAL AUGMENTATION INCLUDING CAVITY CREATION, PER VERTEBRAL BODY; UNDER FLUOROSCOPIC GUIDANCE
72292	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERCUTANEOUS VERTEBROPLASTY OR VERTEBRAL AUGMENTATION INCLUDING CAVITY CREATION, PER VERTEBRAL BODY; UNDER CT GUIDANCE

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
76776	ULTRASOUND, TRANSPLANTED KIDNEY, REAL TIME AND DUPLEX DOPPLER WITH IMAGE DOCUMENTATION
76813	ULTRASOUND, REGPREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FIRST TRIMESTER FETAL NUCHAL TRANSLUCENCY MEASUREMENT, TRANSABDOMINAL OR TRANSVAGINAL APPROACH; SINGLE OR FIRST GESTATION
76814	ULTRASOUND, REGPREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FIRST TRIMESTER FETAL NUCHAL TRANSLUCENCY MEASUREMENT, TRANSABDOMINAL OR TRANSVAGINAL APPROACH; EACH ADDITIONAL GESTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
76998	ULTRASONIC GUIDANCE, INTRAOPERATIVE
77001	FLUOROSCOPIC GUIDANCE FOR CENTRAL VENOUS ACCESS DEVICE PLACEMENT, REPLACEMENT (CATHETER ONLY OR COMPLETE), OR REMOVAL (INCLUDES FLUOROSCOPIC GUIDANCE FOR VASCULAR ACCESS AND CATHETER MANIPULATION, ANY NECESSARY CONTRAST INJECTIONS THROUGH ACCESS SITE
77002	FLUOROSCOPIC GUIDANCE FOR NEEDLE PLACEMENT (E.G., BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE)
77003	FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR PARASPINOUS DIAGNOSTIC OR THERAPEUTIC INJECTION PROCEDURES (EPIDURAL, TRANSFORAMINAL EPIDURAL, SUBARACHNOID, PARAVERTEBRAL FACET JOINT, PARAVERTEBRAL FACET JOINT NERVE, OR
77011	COMPUTED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION
77012	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (E.G., BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), RADIOLOGICAL SUPERVISION AND INTERPRETATION
77013	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR, AND MONITORING OF, PARENCHYMAL TISSUE ABLATION
77014	COMPUTED TOMOGRAPHY GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS
77021	MAGNETIC RESONANCE GUIDANCE FOR NEEDLE PLACEMENT (E.G., FOR BIOPSY, NEEDLE ASPIRATION, INJECTION, OR PLACEMENT OF LOCALIZATION DEVICE) RADIOLOGICAL SUPERVISION AND INTERPRETATION
77022	MAGNETIC RESONANCE GUIDANCE FOR, AND MONITORING OF, PARENCHYMAL TISSUE ABLATION
77031	STEREOTACTIC LOCALIZATION GUIDANCE FOR BREAST BIOPSY OR NEEDLE PLACEMENT (E.G., FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION
77032	MAMMOGRAPHIC GUIDANCE FOR NEEDLE PLACEMENT, BREAST (E.G., FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
77051	COMPUTER-AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES; DIAGNOSTIC MAMMOGRAPHY (LIST SEPARATELY IN A
77052	COMPUTER-AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES; SCREENING MAMMOGRAPHY (LIST SEPARATELY IN AD
77053	MAMMARY DUCTOGRAM OR GALACTOGRAM, SINGLE DUCT, RADIOLOGICAL SUPERVISION AND INTERPRETATION
77054	MAMMARY DUCTOGRAM OR GALACTOGRAM, MULTIPLE DUCTS, RADIOLOGICAL SUPERVISION AND INTERPRETATION
77055	MAMMOGRAPHY; UNILATERAL
77056	MAMMOGRAPHY; BILATERAL
77057	SCREENING MAMMOGRAPHY, BILATERAL (2-VIEW FILM STUDY OF EACH BREAST)
77058	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); UNILATERAL
77059	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); BILATERAL
77071	MANUAL APPLICATION OF STRESS PERFORMED BY PHYSICIAN FOR JOINT RADIOGRAPHY, INCLUDING CONTRALATERAL JOINT IF INDICATED
77072	BONE AGE STUDIES
77073	BONE LENGTH STUDIES (ORTHOROENTGENOGRAM, SCANOGRAM)
77074	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; LIMITED (E.G., FOR METASTASES)
77075	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; COMPLETE (AXIAL AND APPENDICULAR SKELETON)
77076	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY, INFANT
77077	JOINT SURVEY, SINGLE VIEW, 2 OR MORE JOINTS (SPECIFY)
77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)
77079	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL)
77080	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
77081	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL)
77082	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; VERTEBRAL FRACTURE ASSESSMENT
77083	RADIOGRAPHIC ABSORPTIOMETRY (E.G., PHOTODENSITOMETRY, RADIOGRAMMETRY), 1 OR MORE SITES
77084	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BONE MARROW BLOOD SUPPLY
77371	RADIATION TREATMENT DELIVERY, STEREOTACTIC RADIOSURGERY (SRS), COMPLETE COURSE OF TREATMENT OF CEREBRAL LESION(S) CONSISTING OF 1 SESSION; MULTI-SOURCE COBALT 60 BASED
77372	RADIATION TREATMENT DELIVERY, STEREOTACTIC RADIOSURGERY (SRS), COMPLETE COURSE OF TREATMENT OF CEREBRAL LESION(S) CONSISTING OF 1 SESSION; LINEAR ACCELERATOR BASED
77373	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT DELIVERY, PER FRACTION TO 1 OR MORE LESIONS, INCLUDING IMAGE GUIDANCE, ENTIRE COURSE NOT TO EXCEED 5 FRACTIONS
77435	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT MANAGEMENT, PER TREATMENT COURSE, TO ONE OR MORE LESIONS, INCLUDING IMAGE GUIDANCE, ENTIRE COURSE NOT TO EXCEED 5 FRACTIONS
82107	ALPHA-FETOPROTEIN (AFP); AFP-L3 FRACTION ISOFORM AND TOTAL AFP (INCLUDING RATIO)
83698	LIPOPROTEIN-ASSOCIATED PHOSPHOLIPASE A2, (LP-PLA2)
83913	MOLECULAR DIAGNOSTICS; RNA STABILIZATION
86788	ANTIBODY; WEST NILE VIRUS, IGM
86789	ANTIBODY; WEST NILE VIRUS
87305	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVE OR SEMIQUANTITATIVE, MULTIPLE-STEP METHOD; ASPERGILLUS
87498	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); ENTEROVIRUS, AMPLIFIED PROBE TECHNIQUE
87640	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); STAPHYLOCOCCUS AUREUS, AMPLIFIED PROBE TECHNIQUE
87641	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); STAPHYLOCOCCUS AUREUS, METHICILLIN RESISTANT, AMPLIFIED PROBE TECHNIQUE
87653	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); STREPTOCOCCUS, GROUP B, AMPLIFIED PROBE TECHNIQUE
87808	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; TRICHOMONAS VAGINALIS

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
91111	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (E.G., CAPSULE ENDOSCOPY), ESOPHAGUS WITH PHYSICIAN INTERPRETATION AND REPORT
92025	COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT
92640	DIAGNOSTIC ANALYSIS WITH PROGRAMMING OF AUDITORY BRAINSTEM IMPLANT, PER HOUR
94002	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, INITIAL DAY
94003	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY
94004	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; NURSING FACILITY, PER DAY
94005	HOME VENTILATOR MANAGEMENT CARE PLAN OVERSIGHT OF A PATIENT (PATIENT NOT PRESENT) IN HOME, DOMICILIARY OR REST HOME (E.G., ASSISTED LIVING) REQUIRING REVIEW OF STATUS, REVIEW OF LABORATORIES AND OTHER STUDIES AND REVISION OF ORDERS AND RESPIRATORY CARE
94610	INTRAPULMONARY SURFACTANT ADMINISTRATION BY A PHYSICIAN THROUGH ENDOTRACHEAL TUBE
94644	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION FOR ACUTE AIRWAY OBSTRUCTION; FIRST HOUR
94645	CONTINUOUS INHALATION TREATMENT WITH AEROSOL MEDICATION FOR ACUTE AIRWAY OBSTRUCTION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
94774	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; INCLUDES MONITOR ATTACHMENT, DOWNLOAD OF DATA, PHYSICIAN REVIEW, INTERPRETATION, AND PREPARATION OF A REPORT
94775	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITOR ATTACHMENT ONLY (INCLUDES HOOK-UP, INITIATION OF RECORDING AND DISCONNECTION)
94776	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; MONITORING, DOWNLOAD OF INFORMATION, RECEIPT OF TRANSMISSION(S) AND ANALYSES BY COMPUTER ONLY
94777	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE, PATTERN AND HEART RATE PER 30-DAY PERIOD OF TIME; PHYSICIAN REVIEW, INTERPRETATION AND PREPARATION OF REPORT ONLY

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Procedure Code	Description
95012	NITRIC OXIDE EXPIRED GAS DETERMINATION
96020	NEUROFUNCTIONAL TESTING SELECTION AND ADMINISTRATION DURING NONINVASIVE IMAGING FUNCTIONAL BRAIN MAPPING, WITH TEST ADMINISTERED ENTIRELY BY A PHYSICIAN OR PSYCHOLOGIST, WITH REVIEW OF TEST RESULTS AND REPORT
96040	MEDICAL GENETICS AND GENETIC COUNSELING SERVICES, EACH 30 MINUTES FACE-TO-FACE WITH PATIENT/FAMILY
96904	WHOLE BODY INTEGUMENTARY PHOTOGRAPHY, FOR MONITORING OF HIGH RISK PATIENTS WITH DYSPLASTIC NEVUS SYNDROME OR A HISTORY OF DYSPLASTIC NEVI, OR PATIENTS WITH A PERSONAL OR FAMILIAL HISTORY OF MELANOMA
99363	ANTICOAGULANT MANAGEMENT FOR AN OUTPATIENT TAKING WARFARIN, PHYSICIAN REVIEW AND INTERPRETATION OF INTERNATIONAL NORMALIZED RATIO (INR) TESTING, PATIENT INSTRUCTIONS, DOSAGE ADJUSTMENT (AS NEEDED), AND ORDERING OF ADDITIONAL TESTS; INITIAL 90 DAYS OF
99364	ANTICOAGULANT MANAGEMENT FOR AN OUTPATIENT TAKING WARFARIN, PHYSICIAN REVIEW AND INTERPRETATION OF INTERNATIONAL NORMALIZED RATIO (INR) TESTING, PATIENT INSTRUCTIONS, DOSAGE ADJUSTMENT (AS NEEDED), AND ORDERING OF ADDITIONAL TESTS; EACH SUBSEQUENT 90
A4461	SURGICAL DRESSING HOLDER, NON-REUSABLE, EACH
A4463	SURGICAL DRESSING HOLDER, REUSABLE, EACH
A4559	COUPLING GEL OR PASTE, FOR USE WITH ULTRASOUND DEVICE, PER OZ
A4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH
A4601	LITHIUM ION BATTERY FOR NON-PROSTHETIC USE, REPLACEMENT
A8000	HELMET, PROTECTIVE, SOFT, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8001	HELMET, PROTECTIVE, HARD, PREFABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8002	HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8003	HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND ACCESSORIES
A8004	SOFT INTERFACE FOR HELMET, REPLACEMENT ONLY
A9279	MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED
A9527	IODINE I-125, SODIUM IODIDE SOLUTION, THERAPEUTIC, PER MILLICURIE

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
A9568	TECHNETIUM TC-99M ARCITUMOMAB, DIAGNOSTIC, PER STUDY DOSE, UP TO 45 MILLICURIES
C1820	GENERATOR, NEUROSTIMULATOR (IMPLANTABLE), WITH RECHARGEABLE BATTERY AND CHARGING SYSTEM
C1821	INTERSPINOUS PROCESS DISTRACTION DEVICE (IMPLANTABLE)
C9232	INJECTION, IDURSULFASE, 1 MG
C9233	INJECTION, RANIBIZUMAB, 0.5 MG
C9234	INJECTION, ALGLUCOSIDASE ALFA, 10 MG
C9235	INJECTION, PANITUMUMAB, 10 MG
C9350	MICROPOROUS COLLAGEN TUBE OF NON-HUMAN ORIGIN, PER CENTIMETER LENGTH
C9351	ACELLULAR DERMAL TISSUE MATRIX OF NON-HUMN ORIGIN, PER SQUARE CENTIMETER (DO NOT REPORT C9351 IN CONJUNCTION WITH J7345)
C9726	PLACEMENT AND REMOVAL (IF PERFORMED) OF APPLICATOR INTO BREAST FOR RADIATION THERAPY
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY REGCAREGIVER
D0273	BITEWINGS - THREE FILMS
D0360	CONE BEAM CT - CRANIOFACIAL DATA CAPTURE
D0362	CONE BEAM - TWO-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES
D0363	CONE BEAM - THREE-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES
D0486	ACCESSION OF BRUSH BIOPSY SAMPLE, MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS
D1555	REMOVAL OF FIXED SPACE MAINTAINER
D4230	ANATOMICAL CROWN EXPOSURE - FOUR OR MORE CONTIGUOUS TEETH PER QUADRANT
D4231	ANATOMICAL CROWN EXPOSURE - ONE TO THREE TEETH PER QUADRANT
D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT
D6092	RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN
D6093	RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE

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D7292	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE] REQUIRING SURGICAL FLAP
D7293	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE REQUIRING SURGICAL FLAP
D7294	SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE WITHOUT SURGICAL FLAP
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES
D7998	INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE
D8693	REBONDING OR RECEMENTING; AND/OR REPAIR, AS REQUIRED, OF FIXED RETAINERS
D9120	FIXED PARTIAL DENTURE SECTIONING
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED
E0936	CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE
E2373	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL, COMPACT, OR SHORT THROW REMOTE JOYSTICK OR TOUCHPAD, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY
E2375	POWER WHEELCHAIR ACCESSORY, NON-EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE
E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH

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Procedure Code	Description
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPLACEMENT ONLY, EACH
E2393	POWER WHEELCHAIR ACCESSORY, VALVE FOR PNEUMATIC TIRE TUBE, ANY TYPE, REPLACEMENT ONLY, EACH
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH
G0380	LEVEL 1 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE ST
G0381	LEVEL 2 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE ST
G0382	LEVEL 3 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE ST

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
G0383	LEVEL 4 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE S
G0384	LEVEL 5 HOSPITAL EMERGENCY VISIT PROVIDED IN A TYPE B DEPARTMENT OR FACILITY OF THE HOSPITAL: (THE DEPARTMENT OR FACILITY MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE ST
G0389	ULTRASOUND B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; FOR ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING
G0390	TRAUMA RESPONSE TEAM ASSOCIATED WITH HOSPITAL CRITICAL CARE SERVICE
G0392	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; FOR MAINTENANCE OF HEMODIALYSIS ACCESS, ARTERIOVENOUS FISTULA OR GRAFT; ARTERIAL
G0393	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; FOR MAINTENANCE OF HEMODIALYSIS ACCESS, ARTERIOVENOUS FISTULA OR GRAFT; VENOUS
G0394	BLOOD OCCULT TEST (E.G., GUAIAC), FECES, FOR SINGLE DETERMINATION FOR COLORECTAL NEOPLASM (I.E., PATIENT WAS PROVIDED THREE CARDS OR SINGLE TRIPLE CARD FOR CONSECUTIVE COLLECTION)
G8085	END-STAGE RENAL DISEASE PATIENT REQUIRING HEMODIALYSIS VASCULAR ACCESS WAS NOT AN ELIGIBLE CANDIDATE FOR AUTOGENOUS AV FISTULA
G8191	CLINICIAN DOCUMENTED TO HAVE GIVEN ORDER FOR PROPHYLACTIC ANTIBIOTIC TO BE GIVEN WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)
G8192	CLINICIAN DOCUMENTED TO HAVE GIVEN THE PROPHYLACTIC ANTIBIOTIC WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO THE SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)
G8193	CLINICIAN DID NOT DOCUMENT THAT AN ORDER FOR PROPHYLACTIC ANTIBIOTIC TO BE GIVEN WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED) WAS GIVEN
G8194	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PROPHYLACTIC ANTIBIOTIC
G8195	CLINICIAN DOCUMENTED TO HAVE GIVEN THE PROPHYLACTIC ANTIBIOTIC WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO THE SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)
G8196	CLINICIAN DID NOT DOCUMENT A PROPHYLACTIC ANTIBIOTIC WAS ADMINISTERED WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
G8197	PATIENT DOCUMENTED TO HAVE ORDER FOR PROPHYLACTIC ANTIBIOTIC TO BE GIVEN WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)
G8198	PATIENT DOCUMENTED TO HAVE ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS
G8199	CLINICIAN DOCUMENTED TO HAVE GIVEN CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS
G8200	ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS NOT DOCUMENTED
G8201	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS
G8202	CLINICIAN DOCUMENTED AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 24 HOURS OF SURGICAL END TIME
G8203	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTICS WERE DISCONTINUED WITHIN 24 HOURS OF SURGICAL END TIME
G8204	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 24 HOURS OF SURGICAL END TIME
G8205	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PROPHYLACTIC ANTIBIOTIC DISCONTINUATION WITHIN 24 HOURS OF SURGICAL END TIME
G8206	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTIC WAS GIVEN
G8207	CLINICIAN DOCUMENTED AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 48 HOURS OF SURGICAL END TIME
G8208	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTICS WERE DISCONTINUED WITHIN 48 HOURS OF SURGICAL END TIME
G8209	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 48 HOURS OF SURGICAL END TIME
G8210	CLINICIAN DOCUMENTED PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DISCONTINUATION OF PROPHYLACTIC ANTIBIOTIC DISCONTINUATION WITHIN 48 HOURS OF SURGICAL END TIME
G8211	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTIC WAS GIVEN
G8212	CLINICIAN DOCUMENTED AN ORDER WAS GIVEN FOR APPROPRIATE VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS TO BE GIVEN WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME
G8213	CLINICIAN DOCUMENTED TO HAVE GIVEN VTE PROPHYLAXIS WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME
G8214	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN FOR APPROPRIATE VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS TO BE GIVEN WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME

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Procedure Code	Description
G8215	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS TO BE GIVEN WITHIN 24 HOURS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME
G8216	PATIENT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY TWO
G8217	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2
G8218	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2, INCLUDING PHYSICIAN DOCUMENTATION THAT PATIENT IS AMBULATORY
G8219	PATIENT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2
G8220	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2
G8221	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DVT PROPHYLAXIS BY THE END OF HOSPITAL DAY 2, INCLUDING PHYSICIAN DOCUMENTATION THAT PATIENT IS AMBULATORY
G8222	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED ANTIPLATELET THERAPY AT DISCHARGE
G8223	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PRESCRIPTION FOR ANTIPLATELET THERAPY AT DISCHARGE
G8224	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIPLATELET THERAPY AT DISCHARGE, INCLUDING IDENTIFICATION FROM MEDICAL RECORD THAT PATIENT IS ON ANTICOAGULATION THERAPY
G8225	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED AN ANTICOAGULANT AT DISCHARGE
G8226	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PRESCRIPTION FOR ANTICOAGULANT THERAPY AT DISCHARGE
G8227	PATIENT NOT DOCUMENTED TO HAVE PERMANENT, PERSISTENT, OR PAROXYSMAL ATRIAL FIBRILLATION
G8228	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTICOAGULANT THERAPY AT DISCHARGE
G8229	PATIENT DOCUMENTED TO HAVE BEEN ADMINISTERED OR CONSIDERED FOR T-PA
G8230	PATIENT NOT ELIGIBLE FOR T-PA ADMINISTRATION, ISCHEMIC STROKE SYMPTOM ONSET OF MORE THAN 3 HOURS
G8231	PATIENT NOT DOCUMENTED TO HAVE RECEIVED T-PA OR NOT DOCUMENTED TO HAVE BEEN CONSIDERED A CANDIDATE FOR T-PA ADMINISTRATION

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
G8232	PATIENT DOCUMENTED TO HAVE RECEIVED DYSPHAGIA SCREENING PRIOR TO TAKING ANY FOODS, FLUIDS OR MEDICATION BY MOUTH
G8234	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DYSPHAGIA SCREENING
G8235	PATIENT NOT RECEIVING OR INELIGIBLE TO RECEIVE FOOD, FLUIDS OR MEDICATION BY MOUTH, OR DOCUMENTATION OF NPO (NOTHING BY MOUTH) ORDER
G8236	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DYSPHAGIA SCREENING PRIOR TO TAKING ANY FOODS, FLUIDS OR MEDICATION BY MOUTH
G8237	PATIENT DOCUMENTED TO HAVE RECEIVED ORDER FOR REHABILITATION SERVICES OR DOCUMENTATION OF CONSIDERATION FOR REHABILITATION SERVICES
G8238	PATIENT NOT DOCUMENTED TO HAVE RECEIVED ORDER FOR OR CONSIDERATION FOR REHABILITATION SERVICES
G8239	INTERNAL CAROTID STENOSIS PATIENT BELOW 30%, REFERENCE TO MEASUREMENTS OF DISTAL INTERNAL CAROTID DIAMETER AS THE DENOMINATOR FOR STENOSIS MEASUREMENT NOT NECESSARY
G8240	INTERNAL CAROTID STENOSIS PATIENT IN THE 30-99% RANGE, AND NO DOCUMENTATION OF REFERENCE TO MEASUREMENTS OF DISTAL INTERNAL CAROTID DIAMETER AS THE DENOMINATOR FOR STENOSIS MEASUREMENT
G8241	CLINICIAN DOCUMENTED THAT PATIENT WHOSE FINAL REPORT OF THE CAROTID IMAGING STUDY PERFORMED (NECK MRA, NECK CTA, NECK DUPLEX ULTRASOUND, CAROTID ANGIOGRAM), WITH CHARACTERIZATION OF AN INTERNAL CAROTID STENOSIS IN THE 30-99% RANGE, WAS NOT AN ELIGIBL
G8242	PATIENT DOCUMENTED TO HAVE RECEIVED CT OR MRI WITH PRESENCE OR ABSENCE OF HEMORRHAGE, MASS LESION AND ACUTE INFARCTION DOCUMENTED IN THE FINAL REPORT
G8243	PATIENT NOT DOCUMENTED TO HAVE RECEIVED CT OR MRI AND THE PRESENCE OR ABSENCE OF HEMORRHAGE, MASS LESION AND ACUTE INFARCTION NOT DOCUMENTED IN THE FINAL REPORT
G8245	CLINICIAN DOCUMENTED PRESENCE OR ABSENCE ALARM SYMPTOMS
G8246	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MEDICAL HISTORY REVIEW WITH ASSESSMENT OF NEW OR CHANGING MOLES
G8247	PATIENT WITH ALARM SYMPTOM(S) DOCUMENTED TO HAVE HAD UPPER ENDOSCOPY PERFORMED OR REFERRAL FOR UPPER ENDOSCOPY
G8248	PATIENT WITH AT LEAST ONE ALARM SYMPTOM NOT DOCUMENTED TO HAVE HAD UPPER ENDOSCOPY OR REFERRAL FOR UPPER ENDOSCOPY
G8249	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR UPPER ENDOSCOPY

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
G8250	PATIENT WITH SUSPICION OF BARRETT'S ESOPHAGUS IN ENDOSCOPY REPORT AND DOCUMENTED TO HAVE RECEIVED AN ESOPHAGEAL BIOPSY
G8251	PATIENT NOT DOCUMENTED TO HAVE RECEIVED AN ESOPHAGEAL BIOPSY WHEN SUSPICION OF BARRETT'S ESOPHAGUS IS INDICATED IN THE ENDOSCOPY REPORT
G8252	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ESOPHAGEAL BIOPSY
G8253	PATIENT DOCUMENTED TO HAVE RECEIVED AN ORDER FOR A BARIUM SWALLOW TEST
G8254	PATIENT WITH NO DOCUMENTATION ORDER FOR BARIUM SWALLOW TEST
G8255	CLINICIAN DOCUMENTATION THAT PATIENT WAS AN ELIGIBLE CANDIDATE FOR BARIUM SWALLOW TEST
G8256	CLINICIAN DOCUMENTED RECONCILIATION OF DISCHARGE MEDICATIONS WITH CURRENT MEDICATION LIST IN MEDICAL RECORD
G8257	CLINICIAN HAS NOT DOCUMENTED RECONCILIATION OF DISCHARGE MEDICATIONS WITH CURRENT MEDICATION LIST IN MEDICAL RECORD
G8258	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DISCHARGE MEDICATIONS REVIEW
G8259	PATIENT DOCUMENTED TO HAVE SURROGATE DECISION MAKER OR ADVANCE CARE PLAN IN MEDICAL RECORD
G8260	PATIENT NOT DOCUMENTED TO HAVE SURROGATE DECISION MAKER OR ADVANCE CARE PLAN IN MEDICAL RECORD
G8261	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR SURROGATE DECISION MAKER OR ADVANCE CARE PLAN
G8262	PATIENT DOCUMENTED TO HAVE BEEN ASSESSED FOR PRESENCE OR ABSENCE OF URINARY INCONTINENCE
G8263	PATIENT NOT DOCUMENTED TO HAVE BEEN ASSESSED FOR PRESENCE OR ABSENCE OF URINARY INCONTINENCE
G8264	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR AN ASSESSMENT OF THE PRESENCE OR ABSENCE OF URINARY INCONTINENCE
G8265	PATIENT DOCUMENTED TO HAVE RECEIVED CHARACTERIZATION OF URINARY INCONTINENCE
G8266	PATIENT NOT DOCUMENTED TO HAVE RECEIVED CHARACTERIZATION OF URINARY INCONTINENCE
G8267	PATIENT DOCUMENTED TO HAVE RECEIVED A PLAN OF CARE FOR URINARY INCONTINENCE
G8268	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PLAN OF CARE FOR URINARY INCONTINENCE

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
G8269	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME TO DEVELOP PLAN OF CARE FOR URINARY INCONTINENCE
G8270	PATIENT DOCUMENTED TO HAVE RECEIVED SCREENING FOR FALL RISK (2 OR MORE FALLS IN THE PAST YEAR OR ANY FALL WITH INJURY IN THE PAST YEAR)
G8271	PATIENT WITH NO DOCUMENTATION OF SCREENING FOR FALL RISKS (2 OR MORE FALLS IN THE PAST YEAR OR ANY FALL WITH INJURY IN THE PAST YEAR)
G8272	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FALL RISK SCREENING
G8273	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME TO SCREEN FOR FALL RISK
G8274	CLINICIAN HAS NOT DOCUMENTED PRESENCE OR ABSENCE OF ALARM SYMPTOMS
G8275	PATIENT DOCUMENTED TO HAVE MEDICAL HISTORY TAKEN WHICH INCLUDED ASSESSMENT OF NEW OR CHANGING MOLES
G8276	PATIENT NOT DOCUMENTED TO HAVE RECEIVED MEDICAL HISTORY WITH ASSESSMENT OF NEW OR CHANGING MOLES
G8277	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MEDICAL HISTORY REVIEW WITH ASSESSMENT OF NEW OR CHANGING MOLES
G8278	PATIENT DOCUMENTED TO HAVE RECEIVED COMPLETE PHYSICAL SKIN EXAM
G8279	PATIENT NOT DOCUMENTED TO HAVE RECEIVED A COMPLETE PHYSICAL SKIN EXAM
G8280	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR COMPLETE PHYSICAL SKIN EXAM DURING THE REPORTING YEAR
G8281	PATIENT DOCUMENTED TO HAVE RECEIVED COUNSELING TO PERFORM A SELF-EXAMINATION
G8282	PATIENT NOT DOCUMENTED TO HAVE RECEIVED COUNSELING TO PERFORM A SELF-EXAMINATION
G8283	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR COUNSELING TO PERFORM SELF-EXAMINATION
G8284	PATIENT DOCUMENTED TO HAVE RECEIVED A PRESCRIPTION FOR PHARMACOLOGIC THERAPY FOR OSTEOPOROSIS
G8285	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PHARMACOLOGIC THERAPY
G8286	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PHARMACOLOGIC THERAPY
G8287	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR THE PHARMACOLOGIC THERAPY MEASURE

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
G8288	PATIENT DOCUMENTED TO HAVE RECEIVED CALCIUM AND VITAMIN D OR COUNSELING ON BOTH CALCIUM AND VITAMIN D USE, AND EXERCISE
G8289	PATIENT WITH NO DOCUMENTATION OF CALCIUM AND VITAMIN D USE OR COUNSELING REGARDING BOTH CALCIUM AND VITAMIN D USE, OR EXERCISE
G8290	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CALCIUM AND VITAMIN D, AND EXERCISE DURING THE REPORTING YEAR
G8291	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR THE CALCIUM, VITAMIN D, AND EXERCISE MEASURE
G8292	COPD PATIENT WITH SPIROMETRY RESULTS DOCUMENTED
G8293	COPD PATIENT WITHOUT SPIROMETRY RESULTS DOCUMENTED
G8294	COPD PATIENT WAS NOT ELIGIBLE FOR SPIROMETRY RESULTS
G8295	COPD PATIENT DOCUMENTED TO HAVE RECEIVED INHALED BRONCHODILATOR THERAPY
G8296	COPD PATIENT NOT DOCUMENTED TO HAVE INHALED BRONCHODILATOR THERAPY PRESCRIBED
G8297	COPD PATIENT WAS NOT ELIGIBLE FOR INHALED BRONCHODILATOR THERAPY
G8298	PATIENT DOCUMENTED TO HAVE RECEIVED OPTIC NERVE HEAD EVALUATION
G8299	PATIENT NOT DOCUMENTED TO HAVE RECEIVED OPTIC NERVE HEAD EVALUATION
G8300	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR OPTIC NERVE HEAD EVALUATION DURING THE REPORTING YEAR
G8301	CLINICIAN HAS NOT PROVIDED CARE FOR THE PRIMARY OPEN-ANGLE GLAUCOMA PATIENT FOR THE REQUIRED TIME FOR OPTIC NERVE HEAD EVALUATION MEASURE
G8302	PATIENT DOCUMENTED TO HAVE A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL
G8303	PATIENT NOT DOCUMENTED TO HAVE A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL
G8304	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL
G8305	CLINICIAN HAS NOT PROVIDED CARE FOR THE PRIMARY OPEN-ANGLE GLAUCOMA PATIENT FOR THE REQUIRED TIME FOR TREATMENT RANGE GOAL DOCUMENTATION MEASUREMENT
G8306	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE ABOVE THE TARGET RANGE GOAL DOCUMENTED TO HAVE RECEIVED PLAN OF CARE

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
G8307	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE AT OR BELOW GOAL, NO PLAN OF CARE NECESSARY
G8308	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE ABOVE THE TARGET RANGE GOAL, AND NOT DOCUMENTED TO HAVE RECEIVED PLAN OF CARE DURING THE REPORTING YEAR
G8309	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED/RECOMMENDED ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT
G8310	PATIENT NOT DOCUMENTED TO HAVE BEEN PRESCRIBED/RECOMMENDED AT LEAST ONE ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT DURING THE REPORTING YEAR
G8311	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT DURING THE REPORTING YEAR
G8312	CLINICIAN HAS NOT PROVIDED CARE FOR THE AGE-RELATED MACULAR DEGENERATION PATIENT FOR THE REQUIRED TIME FOR ANTIOXIDANT SUPPLEMENT PRESCRIPTION/RECOMMENDED MEASURE
G8313	PATIENT DOCUMENTED TO HAVE RECEIVED MACULAR EXAM, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE AND THE LEVEL OF MACULAR DEGENERATION SEVERITY
G8314	PATIENT NOT DOCUMENTED TO HAVE RECEIVED MACULAR EXAM WITH DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE AND NO DOCUMENTATION OF LEVEL OF MACULAR DEGENERATION SEVERITY
G8315	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MACULAR EXAMINATION DURING THE REPORTING YEAR
G8316	CLINICIAN HAS NOT PROVIDED CARE FOR THE AGE-RELATED MACULAR DEGENERATION PATIENT FOR THE REQUIRED TIME FOR MACULAR EXAMINATION MEASUREMENT
G8317	PATIENT DOCUMENTED TO HAVE VISUAL FUNCTIONAL STATUS ASSESSED
G8318	PATIENT DOCUMENTED NOT TO HAVE VISUAL FUNCTIONAL STATUS ASSESSED
G8319	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ASSESSMENT OF VISUAL FUNCTIONAL STATUS
G8320	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR ASSESSMENT OF VISUAL FUNCTIONAL STATUS MEASUREMENT
G8321	PATIENT DOCUMENTED TO HAVE HAD PRE-SURGICAL AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
G8322	PATIENT NOT DOCUMENTED TO HAVE HAD PRE-SURGICAL AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION
G8323	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PRE-SURGICAL AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION
G8324	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR PRE-SURGICAL MEASUREMENT AND INTRAOCULAR LENS POWER CALCULATION MEASURE
G8325	PATIENT DOCUMENTED TO HAVE RECEIVED FUNDUS EVALUATION WITHIN SIX MONTHS PRIOR TO CATARACT SURGERY
G8326	PATIENT NOT DOCUMENTED TO HAVE RECEIVED FUNDUS EVALUATION WITHIN SIX MONTHS PRIOR TO CATARACT SURGERY
G8327	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PRE-SURGICAL FUNDUS EVALUATION
G8328	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR FUNDUS EVALUATION MEASUREMENT
G8329	PATIENT DOCUMENTED TO HAVE RECEIVED DILATED MACULAR OR FUNDUS EXAM WITH LEVEL OF SEVERITY OF RETINOPATHY AND THE PRESENCE OR ABSENCE OF MACULAR EDEMA DOCUMENTED
G8330	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DILATED MACULAR OR FUNDUS EXAM WITH LEVEL OF SEVERITY OF RETINOPATHY AND THE PRESENCE OR ABSENCE OF MACULAR EDEMA NOT DOCUMENTED
G8331	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DILATED MACULAR OR FUNDUS EXAM DURING THE REPORTING YEAR
G8332	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC RETINOPATHY PATIENT FOR THE REQUIRED TIME FOR MACULAR EDEMA AND RETINOPATHY MEASUREMENT
G8333	PATIENT DOCUMENTED TO HAVE HAD FINDINGS OF MACULAR OR FUNDUS EXAM COMMUNICATED TO THE PHYSICIAN MANAGING THE DIABETES CARE
G8334	DOCUMENTATION OF FINDINGS OF MACULAR OR FUNDUS EXAM NOT COMMUNICATED TO THE PHYSICIAN MANAGING THE PATIENT'S ONGOING DIABETES CARE
G8335	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR THE FINDINGS OF THEIR MACULAR OR FUNDUS EXAM BEING COMMUNICATED TO THE PHYSICIAN MANAGING THEIR DIABETES CARE DURING THE REPORTING YEAR
G8336	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC RETINOPATHY PATIENT FOR THE REQUIRED TIME FOR PHYSICIAN COMMUNICATION MEASUREMENT

Table 1 – **New** 2007 HCPCS Codes,
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G8337	CLINICIAN DOCUMENTED THAT COMMUNICATION WAS SENT TO THE PHYSICIAN MANAGING ONGOING CARE OF PATIENT THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS
G8338	CLINICIAN HAS NOT DOCUMENTED THAT COMMUNICATION WAS SENT TO THE PHYSICIAN MANAGING ONGOING CARE OF PATIENT THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS
G8339	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR COMMUNICATION WITH THE PHYSICIAN MANAGING THE PATIENT'S ONGOING CARE THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS
G8340	PATIENT DOCUMENTED TO HAVE HAD CENTRAL DEXA PERFORMED AND RESULTS DOCUMENTED OR CENTRAL DEXA ORDERED OR PHARMACOLOGIC THERAPY PRESCRIBED
G8341	PATIENT NOT DOCUMENTED TO HAVE HAD CENTRAL DEXA MEASUREMENT OR PHARMACOLOGIC THERAPY
G8342	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CENTRAL DEXA MEASUREMENT OR PRESCRIBING PHARMACOLOGIC
G8343	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGICAL THERAPY MEASURE
G8344	PATIENT DOCUMENTED TO HAVE HAD CENTRAL DEXA ORDERED OR PERFORMED AND RESULTS DOCUMENTED OR PHARMACOLOGICAL THERAPY PRESCRIBED
G8345	PATIENT NOT DOCUMENTED TO HAVE HAD CENTRAL DEXA MEASUREMENT ORDERED OR PERFORMED OR PHARMACOLOGIC THERAPY
G8346	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGIC THERAPY
G8347	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGICAL THERAPY MEASURE
G9131	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION
G9132	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-REFRACTORY/ANDROGEN-INDEPENDENT (E.G., RISING PSA ON ANTI-ANDROGEN THERAPY OR POST-ORCHIECTOMY); CLINICAL METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)

Table 1 – **New** 2007 HCPCS Codes,
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G9133	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; HORMONE-RESPONSIVE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
G9134	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
G9135	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, ANY CELLULAR CLASSIFICATION; STAGE III, IV, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
G9136	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, TRANSFORMED FROM ORIGINAL CELLULAR DIAGNOSIS TO A SECOND CELLULAR CLASSIFICATION (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
G9137	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, ANY CELLULAR CLASSIFICATION; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
G9138	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, ANY CELLULAR CLASSIFICATION; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSE TO THERAPY, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT
G9139	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, STAGING IN PROGRESS, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
H0049	ALCOHOL AND/OR DRUG SCREENING
H0050	ALCOHOL AND/OR DRUG SERVICES, BRIEF INTERVENTION, PER 15 MINUTES
J0129	INJECTION, ABATACEPT, 10 MG
J0348	INJECTION, ANADULAFUNGIN, 1 MG
J0364	INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG
J0594	INJECTION, BUSULFAN, 1 MG
J0894	INJECTION, DECITABINE, 1 MG
J1324	INJECTION, ENFUVIRTIDE, 1 MG
J1458	INJECTION, GALSULFASE, 1 MG
J1562	INJECTION, IMMUNE GLOBULIN, SUBCUTANEOUS, 100 MG
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG
J2170	INJECTION, MECASERMIN, 1 MG
J2248	INJECTION, MICAFUNGIN SODIUM, 1 MG
J2315	INJECTION, NALTREXONE, DEPOT FORM, 1 MG

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
J3243	INJECTION, TIGECYCLINE, 1 MG
J3473	INJECTION, HYALURONIDASE, RECOMBINANT, 1 USP UNIT
J7187	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR, PER IU VWF:RCO
J7311	FLUOCINOLONE ACETONIDE, INTRAVITREAL IMPLANT
J7319	HYALURONAN (SODIUM HYALURONATE) OR DERIVATIVE, INTRA-ARTICULAR INJECTION, PER INJECTION
J7345	DERMAL (SUBSTITUTE) TISSUE OF NON-HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER
J7346	DERMAL (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, INJECTABLE, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, BUT WITHOUT METABOLICALLY ACTIVE ELEMENTS, 1 CC
J7607	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG
J7609	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG
J7610	ALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG
J7615	LEVALBUTEROL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG
J7634	BUDESONIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 0.25 MILLIGRAM
J7645	IPRATROPIUM BROMIDE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM
J7647	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM
J7650	ISOETHARINE HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM
J7657	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER MILLIGRAM
J7660	ISOPROTERENOL HCL, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM
J7667	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, CONCENTRATED FORM, PER 10 MILLIGRAMS
J7670	METAPROTERENOL SULFATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS
J7685	TOBRAMYCIN, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MILLIGRAMS

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
J8650	NABILONE, ORAL, 1 MG
J9261	INJECTION, NELARABINE, 50 MG
L1001	CERVICAL THORACIC LUMBAR SACRAL ORTHOSIS, IMMOBILIZER, INFANT SIZE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L3806	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
L3808	WRIST HAND FINGER ORTHOSIS, RIGID WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE MATERIAL; STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
L3915	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L5993	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, FOOT ONLY, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)
L5994	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, KNEE ONLY, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)
L6611	ADDITION TO UPPER EXTREMITY PROSTHESIS, EXTERNAL POWERED, ADDITIONAL SWITCH, ANY TYPE
L6624	UPPER EXTREMITY ADDITION, FLEXION/EXTENSION AND ROTATION WRIST UNIT
L6639	UPPER EXTREMITY ADDITION, HEAVY DUTY FEATURE, ANY ELBOW
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY MATERIAL, ANY SIZE
L6704	TERMINAL DEVICE, SPORT/RECREATIONAL/WORK ATTACHMENT, ANY MATERIAL, ANY SIZE
L6706	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED
L6707	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED
L6708	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE
L6709	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC, CONTROLLED, PEDIATRIC
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT
L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, REPLACEMENT
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR
Q4081	INJECTION, EPOETIN ALFA, 100 UNITS (FOR ESRD ON DIALYSIS)
Q4082	DRUG OR BIOLOGICAL, NOT OTHERWISE CLASSIFIED, PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)
Q5001	HOSPICE CARE PROVIDED IN PATIENT'S HOME/RESIDENCE
Q5002	HOSPICE CARE PROVIDED IN ASSISTED LIVING FACILITY
Q5003	HOSPICE CARE PROVIDED IN NURSING LONG TERM CARE FACILITY (LTC) OR NON-SKILLED NURSING FACILITY (NF)
Q5004	HOSPICE CARE PROVIDED IN SKILLED NURSING FACILITY (SNF)
Q5005	HOSPICE CARE PROVIDED IN INPATIENT HOSPITAL
Q5006	HOSPICE CARE PROVIDED IN INPATIENT HOSPICE FACILITY
Q5007	HOSPICE CARE PROVIDED IN LONG TERM CARE FACILITY
Q5008	HOSPICE CARE PROVIDED IN INPATIENT PSYCHIATRIC FACILITY
Q5009	HOSPICE CARE PROVIDED IN PLACE NOT OTHERWISE SPECIFIED (NOS)
S0180	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES
S2344	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ENLARGEMENT OF SINUS OSTIUM OPENING USING INFLATABLE DEVICE (I.E., BALLOON SINUPLASTY)
S3855	GENETIC TESTING FOR DETECTION OF MUTATIONS IN THE PRESENILIN - 1 GENE
T4543	DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, BARIATRIC, EACH
0012F	COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA ASSESSMENT (INCLUDES ALL OF THE FOLLOWING COMPONENTS) (CAP):
0162T	ELECTRONIC ANALYSIS AND PROGRAMMING, REPROGRAMMING OF GASTRIC NEUROSTIMULATOR (IE, MORBID OBESITY)
0163T	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), LUMBAR, EACH ADDITIONAL INTERSPACE
0164T	REMOVAL OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH, LUMBAR, EACH ADDITIONAL INTERSPACE
0165T	REVISION OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH, LUMBAR, EACH ADDITIONAL INTERSPACE
0166T	TRANSMYOCARDIAL TRANSCATHETER CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH IMPLANT; WITHOUT CARDIOPULMONARY BYPASS
0167T	TRANSMYOCARDIAL TRANSCATHETER CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH IMPLANT; WITH CARDIOPULMONARY BYPASS

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
0168T	RHINOPHOTOTHERAPY, INTRANASAL APPLICATION OF ULTRAVIOLET AND VISIBLE LIGHT, BILATERAL
0169T	STEREOTACTIC PLACEMENT OF INFUSION CATHETER(S) IN THE BRAIN FOR DELIVERY OF THERAPEUTIC AGENT(S), INCLUDING COMPUTERIZED STEREOTACTIC PLANNING AND BURR HOLE(S)
0170T	REPAIR OF ANORECTAL FISTULA WITH PLUG (E.G., PORCINE SMALL INTESTINE SUBMUCOSA [SIS])
0171T	INSERTION OF POSTERIOR SPINOUS PROCESS DISTRACTION DEVICE (INCLUDING NECESSARY REMOVAL OF BONE OR LIGAMENT FOR INSERTION AND IMAGING GUIDANCE), LUMBAR; SINGLE LEVEL
0172T	INSERTION OF POSTERIOR SPINOUS PROCESS DISTRACTION DEVICE (INCLUDING NECESSARY REMOVAL OF BONE OR LIGAMENT FOR INSERTION AND IMAGING GUIDANCE), LUMBAR; EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0173T	MONITORING OF INTRAOCULAR PRESSURE DURING VITRECTOMY SURGERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0174T	COMPUTER AIDED DETECTION (CAD) (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S), PERFOR
0175T	COMPUTER AIDED DETECTION (CAD) (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION AND REPORT, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES, CHEST RADIOGRAPH(S), PERFOR
0176T	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITHOUT RETENTION OF DEVICE OR STENT
0177T	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITH RETENTION OF DEVICE OR STENT
0505F	HEMODIALYSIS PLAN OF CARE DOCUMENTED (ESRD)
0507F	PERITONEAL DIALYSIS PLAN OF CARE DOCUMENTED (ESRD)
1015F	CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) SYMPTOMS ASSESSED (INCLUDES ASSESSMENT OF AT LEAST ONE OF THE FOLLOWING: DYSPNEA, COUGH/SPUTUM, WHEEZING), OR RESPIRATORY SYMPTOM ASSESSMENT TOOL COMPLETED (COPD)
1018F	DYSPNEA ASSESSED, NOT PRESENT (COPD)
1019F	DYSPNEA ASSESSED, PRESENT (COPD)
1022F	PNEUMOCOCCUS IMMUNIZATION STATUS ASSESSED (CAP, COPD)

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
1026F	CO-MORBID CONDITIONS ASSESSED (E.G., INCLUDES ASSESSMENT FOR PRESENCE OR ABSENCE OF: MALIGNANCY, LIVER DISEASE, CONGESTIVE HEART FAILURE, CEREBROVASCULAR DISEASE, RENAL DISEASE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, ASTHMA, DIABETES, OTHER CO-MORBID C
1030F	INFLUENZA IMMUNIZATION STATUS ASSESSED (CAP)
1034F	CURRENT TOBACCO SMOKER (CAD, CAP, COPD, PV) (DM)
1035F	CURRENT SMOKELESS TOBACCO USER (E.G., CHEW, SNUFF) (PV)
1036F	CURRENT TOBACCO NON-USER (CAD, CAP, COPD, PV) (DM)
1038F	PERSISTENT ASTHMA (MILD, MODERATE OR SEVERE) (ASTHMA)
1039F	INTERMITTENT ASTHMA (ASTHMA)
1040F	DSM-IV(TM) CRITERIA FOR MAJOR DEPRESSIVE DISORDER DOCUMENTED (MDD)
1050F	HISTORY OBTAINED REGARDING NEW OR CHANGING MOLES (ML)
1055F	VISUAL FUNCTIONAL STATUS ASSESSED (EC)
2010F	VITAL SIGNS RECORDED (INCLUDES AT MINIMUM: TEMPERATURE, PULSE, RESPIRATION, AND BLOOD PRESSURE)(CAP)
2014F	MENTAL STATUS ASSESSED (NORMAL/MILDLY IMPAIRED/SEVERELY IMPAIRED) (CAP)
2018F	HYDRATION STATUS ASSESSED (NORMAL/MILDLY DEHYDRATED/SEVERELY DEHYDRATED) (CAP)
2019F	DILATED MACULAR EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE AND THE LEVEL OF MACULAR DEGENERATION SEVERITY (EC)
2020F	DILATED FUNDUS EVALUATION PERFORMED WITHIN SIX MONTHS PRIOR TO CATARACT SURGERY (EC)
2021F	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY (EC)
2022F	DILATED RETINAL EYE EXAM WITH INTERPRETATION BY AN OPHTHALMOLOGIST OR OPTOMETRIST DOCUMENTED AND REVIEWED (DM)
2024F	SEVEN STANDARD FIELD STEREOSCOPIC PHOTOS WITH INTERPRETATION BY AN OPHTHALMOLOGIST OR OPTOMETRIST DOCUMENTED AND REVIEWED (DM)
2026F	EYE IMAGING VALIDATED TO MATCH DIAGNOSIS FROM SEVEN STANDARD FIELD STEREOSCOPIC PHOTOS RESULTS DOCUMENTED AND REVIEWED (DM)
2027F	OPTIC NERVE HEAD EVALUATION PERFORMED (EC)

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
2028F	FOOT EXAMINATION PERFORMED (INCLUDES EXAMINATION THROUGH VISUAL INSPECTION, SENSORY EXAM WITH MONOFILAMENT, AND PULSE EXAM – REPORT WHEN ANY OF THE THREE COMPONENTS ARE COMPLETED) (DM)
2029F	COMPLETE PHYSICAL SKIN EXAM PERFORMED (ML)
2030F	HYDRATION STATUS DOCUMENTED, NORMALLY HYDRATED (PAG)
2031F	HYDRATION STATUS DOCUMENTED, DEHYDRATED (PAG)
3006F	CHEST X-RAY RESULTS DOCUMENTED AND REVIEWED (CAP)
3011F	LIPID PANEL RESULTS DOCUMENTED AND REVIEWED (MUST INCLUDE TOTAL CHOLESTEROL, HDL-C, TRIGLYCERIDES AND CALCULATED LDL-C) (CAD)
3014F	SCREENING MAMMOGRAPHY RESULTS DOCUMENTED AND REVIEWED (PV)
3017F	COLORECTAL CANCER SCREENING RESULTS DOCUMENTED AND REVIEWED (PV)
3020F	LEFT VENTRICULAR FUNCTION (LVF) ASSESSMENT (E.G., ECHOCARDIOGRAPHY, NUCLEAR TEST, OR VENTRICULOGRAPHY) DOCUMENTED IN THE MEDICAL RECORD (INCLUDES QUANTITATIVE OR QUALITATIVE ASSESSMENT RESULTS)(CHF)
3021F	LEFT VENTRICULAR EJECTION FRACTION (LVEF) 40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION (CAD, HF)
3022F	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >=40% OR DOCUMENTATION AS NORMAL OR MILDLY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION (CAD, HF)
3023F	SPIROMETRY RESULTS DOCUMENTED AND REVIEWED (COPD)
3025F	SPIROMETRY TEST RESULTS DEMONSTRATE FEV1/FVC70% WITH COPD SYMPTOMS (E.G., DYSPNEA, COUGH/SPUTUM, WHEEZING) (CAP, COPD)
3027F	SPIROMETRY TEST RESULTS DEMONSTRATE FEV1/FVC>=70% OR PATIENT DOES NOT HAVE COPD SYMPTOMS (COPD)
3028F	OXYGEN SATURATION RESULTS DOCUMENTED AND REVIEWED (INCLUDES ASSESSMENT THROUGH PULSE OXIMETRY OR ARTERIAL BLOOD GAS MEASUREMENT) (CAP, COPD)
3035F	OXYGEN SATURATION <= 88 % OR A PA02 <= 55 MM HG (COPD)
3037F	OXYGEN SATURATION > 88% OR PAO2 > 55 MMHG (COPD)
3040F	FUNCTIONAL EXPIRATORY VOLUME (FEV1) 40% OF PREDICTED VALUE (COPD)
3042F	FUNCTIONAL EXPIRATORY VOLUME (FEV1) >= 40% OF PREDICTED VALUE (COPD)
3044F	MOST RECENT HEMOGLOBIN A1C LEVEL < 7.0% (DM)
3045F	MOST RECENT HEMOGLOBIN A1C LEVEL 7.0 - 9.0% (DM)

Table 1 – **New** 2007 HCPCS Codes,
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Procedure Code	Description
3046F	MOST RECENT HEMOGLOBIN A1C LEVEL > 9.0% (DM)
3047F	MOST RECENT HEMOGLOBIN A1C LEVEL <= 9.0% (DM)
3048F	MOST RECENT LDL-C 100 MG/DL (DM)
3049F	MOST RECENT LDL-C 100-129 MG/DL (DM)
3050F	MOST RECENT LDL-C >=130 MG/DL (DM)
3060F	POSITIVE MICROALBUMINURIA TEST RESULT DOCUMENTED AND REVIEWED (DM)
3061F	NEGATIVE MICROALBUMINURIA TEST RESULT DOCUMENTED AND REVIEWED (DM)
3062F	POSITIVE MACROALBUMINURIA TEST RESULT DOCUMENTED AND REVIEWED (DM)
3066F	DOCUMENTATION OF TREATMENT FOR NEPHROPATHY (E.G., PATIENT RECEIVING DIALYSIS, PATIENT BEING TREATED FOR ESRD, CRF, ARF, OR RENAL INSUFFICIENCY, ANY VISIT TO A NEPHROLOGIST) (DM)
3072F	LOW RISK FOR RETINOPATHY (NO EVIDENCE OF RETINOPATHY IN THE PRIOR YEAR) (DM)
3073F	PRE-SURGICAL (CATARACT) AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION DOCUMENTED WITHIN SIX MONTHS PRIOR TO SURGERY (EC)
3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE < 130 MM HG (DM), (HTN)
3075F	MOST RECENT SYSTOLIC BLOOD PRESSURE 130 - 139MM HG (DM), (HTN)
3076F	MOST RECENT SYSTOLIC BLOOD PRESSURE 140 MM HG (HTN) (DM)
3077F	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140 MM HG (HTN) (DM)
3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE 80 MM HG (HTN) (DM)
3079F	MOST RECENT DIASTOLIC BLOOD PRESSURE 80-89 MM HG (HTN) (DM)
3080F	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90 MM HG (HTN) (DM)
3082F	KT/V 1.2 (CLEARANCE OF UREA (KT)/VOLUME (V)) (ESRD)
3083F	KT/V EQUAL TO OR GREATER THAN 1.2 AND LESS THAN 1.7 (CLEARANCE OF UREA (KT)/VOLUME (V)) (ESRD)
3084F	KT/V >= 1.7 (CLEARANCE OF UREA (KT)/VOLUME (V)) (ESRD)
3085F	SUICIDE RISK ASSESSED (MDD)
3088F	MAJOR DEPRESSIVE DISORDER, MILD (MDD)
3089F	MAJOR DEPRESSIVE DISORDER, MODERATE (MDD)
3090F	MAJOR DEPRESSIVE DISORDER, SEVERE WITHOUT PSYCHOTIC FEATURES (MDD)
3091F	MAJOR DEPRESSIVE DISORDER, SEVERE WITH PSYCHOTIC FEATURES (MDD)
3092F	MAJOR DEPRESSIVE DISORDER, IN REMISSION (MDD)

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
3093F	DOCUMENTATION OF NEW DIAGNOSIS OF INITIAL OR RECURRENT EPISODE OF MAJOR DEPRESSIVE DISORDER (MDD)
3095F	CENTRAL DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) RESULTS DOCUMENTED (OP)
3096F	CENTRAL DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) ORDERED (OP)
4005F	PHARMACOLOGIC THERAPY (OTHER THAN MINERALS/VITAMINS) FOR OSTEOPOROSIS PRESCRIBED (OP)
4007F	ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT PRESCRIBED OR RECOMMENDED (EC)
4019F	DOCUMENTATION OF RECEIPT OF COUNSELING ON EXERCISE AND EITHER BOTH CALCIUM AND VITAMIN D USE OR COUNSELING REGARDING BOTH CALCIUM AND VITAMIN D USE (OP)
4025F	INHALED BRONCHODILATOR PRESCRIBED (COPD)
4030F	LONG TERM OXYGEN THERAPY PRESCRIBED (MORE THAN FIFTEEN HOURS PER DAY) (COPD)
4033F	PULMONARY REHABILITATION EXERCISE TRAINING RECOMMENDED (COPD)
4035F	INFLUENZA IMMUNIZATION RECOMMENDED (COPD)
4037F	INFLUENZA IMMUNIZATION ORDERED OR ADMINISTERED (COPD, PV)
4040F	PNEUMOCOCCAL IMMUNIZATION ORDERED OR ADMINISTERED (COPD)
4045F	APPROPRIATE EMPIRIC ANTIBIOTIC PRESCRIBED (SEE MEASURE DEVELOPER'S WEB SITE FOR DEFINITION OF APPROPRIATE ANTIBIOTIC) (CAP)
4050F	HYPERTENSION PLAN OF CARE DOCUMENTED AS APPROPRIATE (HTN)
4051F	REFERRED FOR AN ARTERIO-VENOUS (AV) FISTULA (ESRD)
4052F	HEMODIALYSIS VIA FUNCTIONING ARTERIO-VENOUS (AV) FISTULA (ESRD)
4053F	HEMODIALYSIS VIA FUNCTIONING ARTERIO-VENOUS (AV) GRAFT (ESRD)
4054F	HEMODIALYSIS VIA CATHETER (ESRD)
4055F	PATIENT RECEIVING PERITONEAL DIALYSIS (ESRD)
4056F	APPROPRIATE ORAL REHYDRATION SOLUTION RECOMMENDED (PAG)
4058F	PEDIATRIC GASTROENTERITIS EDUCATION PROVIDED TO REGCAREGIVER (PAG)
4060F	PSYCHOTHERAPY SERVICES PROVIDED (MDD)
4062F	PATIENT REFERRAL FOR PSYCHOTHERAPY DOCUMENTED (MDD)
4064F	ANTIDEPRESSANT PHARMACOTHERAPY PRESCRIBED (MDD)
4065F	ANTIPSYCHOTIC PHARMACOTHERAPY PRESCRIBED (MDD)
4066F	ELECTROCONVULSIVE THERAPY (ECT) PROVIDED (MDD)
4067F	PATIENT REFERRAL FOR ELECTROCONVULSIVE THERAPY (ECT) DOCUMENTED (MDD)

Table 1 – **New** 2007 HCPCS Codes,
Effective for Dates of Service On or After January 1, 2007

Procedure Code	Description
5005F	PATIENT COUNSELED ON SELF-EXAMINATION FOR NEW OR CHANGING MOLES (ML)
5010F	FINDINGS OF DILATED MACULAR OR FUNDUS EXAM COMMUNICATED TO THE PHYSICIAN MANAGING THE DIABETES CARE (EC)
5015F	DOCUMENTATION OF COMMUNICATION THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS (OP)
6005F	RATIONALE (E.G., SEVERITY OF ILLNESS AND SAFETY) FOR LEVEL OF CARE (E.G., HOME, HOSPITAL) DOCUMENTED (CAP)

Deleted 2007 HCPCS Codes

Effective for dates of service on or after January 1, 2007, the HCPCS replacement codes must be used. Claims submitted with dates of service after December 31, 2006, with deleted codes will deny.

Table 2 – **Deleted** 2007 HCPCS Codes,
Effective for Dates of Service On or Before December 31, 2006

Procedure Code	Description	Replacement Code
01995	REGIONAL INTRAVENOUS ADMINISTRATION OF LOCAL ANESTHETIC AGENT OR OTHER MEDICATION (UPPER OR LOWER EXTREMITY)	Use appropriate anesthesia code
15000	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE; FIRST 100 SQ CM OR ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN	15002 or 15004
15001	SURGICAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF OPEN WOUNDS, BURN ESCHAR, OR SCAR (INCLUDING SUBCUTANEOUS TISSUES), OR INCISIONAL RELEASE OF SCAR CONTRACTURE; EACH ADDITIONAL 100 SQ CM OR EACH ADDITIONAL ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN	15003 or 15005
15831	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); ABDOMEN (ABDOMINOPLASTY)	15830

Table 2 – **Deleted** 2007 HCPCS Codes,
Effective for Dates of Service On or Before December 31, 2006

Procedure Code	Description	Replacement Code
17304	CHEMOSURGERY (MOHS MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION INCLUDING THE FIRST ROUTINE STAIN (E.G., HEMOTOXYLIN AND EOSIN, TOLUIDFINE BLUE; FIRST STAGE, FRESH TISSUE TECHNIQUE, UP TO 5 SPECIMENS	17311 or 17312
17305	CHEMOSURGERY (MOHS MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION INCLUDING THE FIRST ROUTINE STAIN (E.G., HEMOTOXYLIN AND EOSIN, TOLUIDFINE BLUE; SECOND STAGE, FIXED OR FRESH TISSUE, UP TO 5 SPECIMENS	Use most appropriate CPT code in 17311-17315 range
17306	CHEMOSURGERY (MOHS MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION INCLUDING THE FIRST ROUTINE STAIN (E.G., HEMOTOXYLIN AND EOSIN, TOLUIDFINE BLUE; THIRD STAGE, FIXED OR FRESH TISSUE, UP TO 5 SPECIMENS	Use most appropriate CPT code in 17311-17315 range
17307	CHEMOSURGERY (MOHS MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION INCLUDING THE FIRST ROUTINE STAIN (E.G., HEMOTOXYLIN AND EOSIN, TOLUIDFINE BLUE; ADDITIONAL STAGE(S) UP TO 5 SPECIMENS, EACH STAGE	Use most appropriate CPT code in 17311-17315 range
17310	CHEMOSURGERY (MOHS MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION	Use most appropriate CPT code in 17311-17315 range
19140	MASTECTOMY FOR GYNECOMASTIA	Use most appropriate CPT code in 19300-19307 range

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
19160	MASTECTOMY, PARTIAL (E.G., LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY);	19301
19162	MASTECTOMY, PARTIAL (E.G., LUMPECTOMY, TYLECTOMY, QUADRANTECTOMY, SEGMENTECTOMY); WITH AXILLARY LYMPHADENECTOMY	19302
19180	MASTECTOMY, SIMPLE, COMPLETE	19303
19182	MASTECTOMY, SUBCUTANEOUS	19304
19200	MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY LYMPH NODES	19305
19220	MASTECTOMY, RADICAL, INCLUDING PECTORAL MUSCLES, AXILLARY AND INTERNAL MAMMARY LYMPH NODES (URBAN TYPE OPERATION)	19306
19240	MASTECTOMY, MODIFIED RADICAL, INCLUDING AXILLARY LYMPH NODES, WITH OR WITHOUT PECTORALIS MINOR MUSCLE, BUT EXCLUDING PECTORALIS MAJOR MUSCLE	19307
21300	CLOSED TREATMENT OF SKULL FRACTURE WITHOUT OPERATION	Use most appropriate CPT Musculoskeletal System code
25611	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIAL FRACTURE (E.G., COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID, REQUIRING MANIPULATION, WITH OR WITHOUT EXTERNAL FIXATION	25606
25620	OPEN TREATMENT OF DISTAL RADIAL FRACTURE (E.G., COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION	25607, 25608, or 25609
26504	RECONSTRUCTION OF TENDON PULLEY, EACH TENDON; WITH TENDON PROSTHESIS (SEPARATE PROCEDURE)	26390
27315	NEURECTOMY, HAMSTRING MUSCLE	27325
27320	NEURECTOMY, POPLITEAL (GASTROCNEMIUS)	27326
28030	NEURECTOMY, INTRINSIC MUSCULATURE OF FOOT	28055
31700	CATHETERIZATION, TRANSGLOTTIC (SEPARATE PROCEDURE)	Use most appropriate CPT Respiratory System code
31708	INSTILLATION OF CONTRAST MATERIAL FOR LARYNGOGRAPHY OR BRONCHOGRAPHY, WITHOUT CATHETERIZATION	Use most appropriate CPT Respiratory System code

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
31710	CATHETERIZATION FOR BRONCHOGRAPHY, WITH OR WITHOUT INSTILLATION OF CONTRAST MATERIAL	31643
33200	INSERTION OF PERMANENT PACEMAKER WITH EPICARDIAL ELECTRODE(S); BY THORACOTOMY	33202
33201	INSERTION OF PERMANENT PACEMAKER WITH EPICARDIAL ELECTRODE(S); BY XIPHOID APPROACH	33202
33245	INSERTION OF EPICARDIAL SINGLE OR DUAL CHAMBER PACING CARDIOVERTER- DEFIBRILLATOR ELECTRODES BY THORACOTOMY;	33249
33246	INSERTION OF EPICARDIAL SINGLE OR DUAL CHAMBER PACING CARDIOVERTER- DEFIBRILLATOR ELECTRODES BY THORACOTOMY; WITH INSERTION OF PULSE GENERATOR	33249
33253	OPERATIVE INCISIONS AND RECONSTRUCTION OF ATRIA FOR TREATMENT OF ATRIAL FIBRILLATION OR ATRIAL FLUTTER (E.G., MAZE PROCEDURE)	33254, 33255, or 33256
35381	THROMBOENDARTERECTOMY, WITH OR WITHOUT PATCH GRAFT; FEMORAL AND/OR POPLITEAL, AND/OR TIBIOPERONEAL	35302, 35303, 35304, 35305, or 35306
35507	BYPASS GRAFT, WITH VEIN; SUBCLAVIAN-CAROTID	35506
35541	BYPASS GRAFT, WITH VEIN; AORTOILIAC OR BI-ILIAC	35537 or 35538
35546	BYPASS GRAFT, WITH VEIN; AORTOFEMORAL OR BIFEMORAL	35539 or 33540
35641	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOILIAC OR BI-ILIAC	35637 or 35638
44152	COLECTOMY, TOTAL, ABDOMINAL, WITHOUT PROCTECTOMY; WITH RECTAL MUCOSECTOMY, ILEOANAL ANASTOMOSIS, WITH OR WITHOUT LOOP ILEOSTOMY	44157
44153	COLECTOMY, TOTAL, ABDOMINAL, WITHOUT PROCTECTOMY; WITH RECTAL MUCOSECTOMY, ILEOANAL ANASTOMOSIS, CREATION OF ILEAL RESERVOIR (S OR J), WITH OR WITHOUT LOOP ILEOSTOMY	44158
47716	ANASTOMOSIS, CHOLEDOCHAL CYST, WITHOUT EXCISION	47719
48005	RESECTION OR DEBRIDEMENT OF PANCREAS AND PERIPANCREATIC TISSUE FOR ACUTE NECROTIZING PANCREATITIS	48105
48180	PANCREATICOJEJUNOSTOMY, SIDE-TO-SIDE ANASTOMOSIS (PUESTOW-TYPE OPERATION)	48548
49085	REMOVAL OF PERITONEAL FOREIGN BODY FROM PERITONEAL CAVITY	49402
54152	CIRCUMCISION, USING CLAMP OR OTHER DEVICE; EXCEPT NEWBORN	54161

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
54820	EXPLORATION OF EPIDIDYMIS, WITH OR WITHOUT BIOPSY	54865
55859	TRANSPERINEAL PLACEMENT OF NEEDLES OR CATHETERS INTO PROSTATE FOR INTERSTITIAL RADIOELEMENT APPLICATION, WITH OR WITHOUT CYSTOSCOPY	55875
56720	HYMENOTOMY, SIMPLE INCISION	56442
57820	DILATION AND CURETTAGE OF CERVICAL STUMP	57558
67350	BIOPSY OF EXTRAOCULAR MUSCLE	67346
75998	FLUOROSCOPIC GUIDANCE FOR CENTRAL VENOUS ACCESS DEVICE PLACEMENT, REPLACEMENT (CATHETER ONLY OR COMPLETE), OR REMOVAL (INCLUDES FLUOROSCOPIC GUIDANCE FOR VASCULAR ACCESS AND CATHETER MANIPULATION, ANY NECESSARY CONTRAST INJECTIONS THROUGH ACCESS SITE OR CATHETER WITH RELATED VENOGRAPHY RADIOLOGIC SUPERVISION AND INTERPRETATION, AND RADIOGRAPHIC DOCUMENTATION OF FINAL CATHETER POSITION)	77001
76003	FLUOROSCOPIC GUIDANCE FOR NEEDLE PLACEMENT (E.G., BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE)	77002
76005	FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR PARASPINOUS DIAGNOSTIC OR THERAPEUTIC INJECTION PROCEDURES (EPIDURAL, TRANSFORAMINAL EPIDURAL, SUBARACHNOID, PARAVERTEBRAL FACET JOINT, PARAVERTEBRAL FACET JOINT NERVE OR SACROILIAC JOINT), INCLUDING NEUROLYTIC AGENT DESTRUCTION	77003
76006	MANUAL APPLICATION OF STRESS PERFORMED BY PHYSICIAN FOR JOINT RADIOGRAPHY, INCLUDING CONTRALATERAL JOINT IF INDICATED	77071
76012	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERCUTANEOUS VERTEBROPLASTY OR VERTEBRAL AUGMENTATION INCLUDING CAVITY CREATION, PER VERTEBRAL BODY; UNDER FLUOROSCOPIC GUIDANCE	72291
76013	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERCUTANEOUS VERTEBROPLASTY OR VERTEBRAL AUGMENTATION INCLUDING CAVITY CREATION, PER VERTEBRAL BODY; UNDER CT GUIDANCE	72292
76020	BONE AGE STUDIES	77072
76040	BONE LENGTH STUDIES (ORTHOROENTGENOGRAM, SCANOGRAM)	77073
76061	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; LIMITED (E.G., FOR METASTASES)	77074

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
76062	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; COMPLETE (AXIAL AND APPENDICULAR SKELETON)	77075
76065	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY, INFANT	77076
76066	JOINT SURVEY, SINGLE VIEW, TWO OR MORE JOINTS (SPECIFY)	77077
76070	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, ONE OR MORE SITES; AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)	77078
76071	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL)	77079
76075	DUAL ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, ONE OR MORE SITES; AXIAL SKELETON (E.G., HIPS, PELVIS, SPINE)	77080
76076	DUAL ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL)	77081
76077	DUAL ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, ONE OR MORE SITES; VERTEBRAL FRACTURE ASSESSMENT	77082
76078	RADIOGRAPHIC ABSORPTIOMETRY (E.G., PHOTODENSITOMETRY, RADIOGRAMMETRY), ONE OR MORE SITES	77083
76082	COMPUTER AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES; DIAGNOSTIC MAMMOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	77051
76083	COMPUTER AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR LESION DETECTION) WITH FURTHER PHYSICIAN REVIEW FOR INTERPRETATION, WITH OR WITHOUT DIGITIZATION OF FILM RADIOGRAPHIC IMAGES; SCREENING MAMMOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	77052
76086	MAMMARY DUCTOGRAM OR GALACTOGRAM, SINGLE DUCT, RADIOLOGICAL SUPERVISION AND INTERPRETATION	77053
76088	MAMMARY DUCTOGRAM OR GALACTOGRAM, MULTIPLE DUCTS, RADIOLOGICAL SUPERVISION AND INTERPRETATION	77054
76090	MAMMOGRAPHY; UNILATERAL	77055

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
76091	MAMMOGRAPHY; BILATERAL	77056
76092	SCREENING MAMMOGRAPHY, BILATERAL (TWO VIEW FILM STUDY OF EACH BREAST)	77057
76093	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); UNILATERAL	77058
76094	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); BILATERAL	77059
76095	STEREOTACTIC LOCALIZATION GUIDANCE FOR BREAST BIOPSY OR NEEDLE PLACEMENT (E.G., FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION	77031
76096	MAMMOGRAPHIC GUIDANCE FOR NEEDLE PLACEMENT, BREAST (E.G., FOR WIRE LOCALIZATION OR FOR INJECTION), EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION	77032
76355	COMPUTED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION	77011
76360	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (E.G., BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), RADIOLOGICAL SUPERVISION AND INTERPRETATION	77012
76362	COMPUTED TOMOGRAPHY GUIDANCE FOR, AND MONITORING OF, VISCERAL TISSUE ABLATION	77013
76370	COMPUTED TOMOGRAPHY GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS	77014
76393	MAGNETIC RESONANCE GUIDANCE FOR NEEDLE PLACEMENT (E.G., FOR BIOPSY, NEEDLE ASPIRATION, INJECTION, OR PLACEMENT OF LOCALIZATION DEVICE) RADIOLOGICAL SUPERVISION AND INTERPRETATION	77021
76394	MAGNETIC RESONANCE GUIDANCE FOR, AND MONITORING OF, VISCERAL TISSUE ABLATION	77022
76400	MAGNETIC RESONANCE (E.G., PROTON) IMAGING, BONE MARROW BLOOD SUPPLY	77084
76778	ULTRASOUND, TRANSPLANTED KIDNEY, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION, WITH OR WITHOUT DUPLEX DOPPLER STUDY	76776
76986	ULTRASONIC GUIDANCE, INTRAOPERATIVE	76998
78704	KIDNEY IMAGING; WITH FUNCTION STUDY (IE, IMAGING RENOGRAM)	Use appropriate code in 78700 through 78725 series

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
78715	KIDNEY VASCULAR FLOW ONLY	78701
78760	TESTICULAR IMAGING;	78761
91060	GASTRIC SALINE LOAD TEST	91020
92573	LOMBARD TEST	No crosswalk applicable
94656	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; FIRST DAY	94002
94657	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; SUBSEQUENT DAYS	94003
95078	PROVOCATIVE TESTING (E.G., RINKEL TEST)	Use most appropriate CPT Medicine System code
A0800	AMBULANCE TRANSPORT PROVIDED BETWEEN THE HOURS OF 7PM AND 7AM	Use most appropriate Transportation code
A4348	MALE EXTERNAL CATHETER WITH INTEGRAL COLLECTION COMPARTMENT, EXTENDED WEAR, EACH (E.G., 2 PER MONTH)	A4349 with A4358
A4359	URINARY SUSPENSORY WITHOUT LEG BAG, EACH	A4349
A4462	ABDOMINAL DRESSING HOLDER, EACH	A4461 or A4463
A4632	REPLACEMENT BATTERY FOR EXTERNAL INFUSION PUMP, ANY TYPE, EACH	Use appropriate code in K0601 through K0604 series
A9549	TECHNETIUM TC-99M ARCITUMOMAB, DIAGNOSTIC, PER STUDY DOSE, UP TO 25 MILLICURIES	No crosswalk applicable
C1178	INJECTION, BUSULFAN, PER 6 MG	J0594
C2632	BRACHYTHERAPY SOLUTION, IODINE-125, PER MCI	A9527
C8950	INTRAVENOUS INFUSION FOR THERAPY/DIAGNOSIS; UP TO 1 HOUR	90765
C8951	INTRAVENOUS INFUSION FOR THERAPY/DIAGNOSIS; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO C8950)	90766
C8952	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION; INTRAVENOUS PUSH OF EACH NEW SUBSTANCE/DRUG	90774

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
C8953	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; PUSH TECHNIQUE	96409
C8954	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, UP TO ONE HOUR	96413
C8955	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO C8954)	96415
C9220	SODIUM HYALURONATE PER 30 MG DOSE, FOR INTRA-ARTICULAR INJECTION	J7319
C9221	ACELLULAR DERMAL TISSUE MATRIX, PER 16CM2	J7344
C9222	DECELLULARIZED SOFT TISSUE SCAFFOLD, PER 1 CC	J7346
C9224	INJECTION, GALSULFASE, PER 5 MG	J1458
C9225	INJECTION, FLUOCINOLONE ACETONIDE INTRAVITREAL IMPLANT, PER 0.59 MG	J7311
C9227	INJECTION, MICAFUNGIN SODIUM, PER 1 MG	J2488
C9228	INJECTION, TIGECYCLINE, PER 1 MG	J3243
C9229	INJECTION, IBANDRONATE SODIUM, PER 1 MG	J1740
C9230	INJECTION, ABATACEPT, PER 10 MG	J0129
C9231	INJECTION, DECITABINE, PER 1 MG	J0894
D1201	TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS)-CHILD	Report D1120, Prophylaxis-child and D1203, Topical application of fluoride (prophylaxis not included)-child
D1205	TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS)-ADULT	No coverage for topical application of fluoride for members older than 20 years old; For adults, Report D1110, Prophylaxis-adult; For members age 20 years old or younger, use D1120 and D1203

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
D6971	CAST POST AS PART OF BRIDGE RETAINER	No crosswalk applicable
E0164	COMMODE CHAIR, MOBILE, WITH FIXED ARMS	E0163
E0166	COMMODE CHAIR, MOBILE, WITH DETACHABLE ARMS	E0165
E0180	PRESSURE PAD, ALTERNATING WITH PUMP	E0181
E0701	HELMET WITH FACE GUARD AND SOFT INTERFACE MATERIAL, PREFABRICATED	A8000, A8001, A8002, A8003, or A8004
E0977	WEDGE CUSHION, WHEELCHAIR	E0190
E0997	CASTER WITH A FORK	Use most appropriate HCPCS E code
E0998	CASTER WITHOUT FORK	Use most appropriate HCPCS E code
E0999	PNEUMATIC TIRE WITH WHEEL	Use most appropriate HCPCS E code
E2320	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, REMOTE JOYSTICK OR TOUCHPAD, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, AND FIXED MOUNTING HARDWARE	E2373 or E2374
G0107	COLORECTAL CANCER SCREENING; FECAL-OCCULT BLOOD TEST, 1-3 SIMULTANEOUS DETERMINATIONS	82270
G0243	MULTI-SOURCE PHOTON STEREOTACTIC RADIOSURGERY, DELIVERY INCLUDING COLLIMATOR CHANGES AND CUSTOM PLUGGING, COMPLETE COURSE OF TREATMENT, ALL LESIONS	No crosswalk applicable
G9076	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, PRE-SURGICAL OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMO	No crosswalk applicable
G9081	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; NON-CASTRATE, INCOMPLETELY CASTRATE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
G9082	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; CASTRATE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9118	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9119	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; STAGE III, IV NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9120	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA; TRANSFORMED FROM FOLLICULAR LYMPHOMA TO DIFFUSE LARGE B-CELL LYMPHOMA (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9121	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9122	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSIVE	No crosswalk applicable
G9127	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
J2912	INJECTION, SODIUM CHLORIDE, 0.9%, PER 2 ML	Use most appropriate HCPCS code
J7188	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, IU	J7187
J7317	SODIUM HYALURONATE, PER 20 TO 25 MG DOSE FOR INTRA-ARTICULAR INJECTION	J7319

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
J7320	HYLAN G-F 20, 16 MG, FOR INTRA-ARTICULAR INJECTION	Use most appropriate NDC
J7350	DERMAL (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, INJECTABLE, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, BUT WITHOUT METABOLIZED ACTIVE ELEMENTS, PER 10 MG	J7346
K0090	REAR WHEEL TIRE FOR POWER WHEELCHAIR, ANY SIZE, EACH	No crosswalk applicable
K0091	REAR WHEEL TIRE TUBE OTHER THAN ZERO PRESSURE FOR POWER WHEELCHAIR, ANY SIZE, EACH	No crosswalk applicable
K0092	REAR WHEEL ASSEMBLY FOR POWER WHEELCHAIR, COMPLETE, EACH	No crosswalk applicable
K0093	REAR WHEEL, ZERO PRESSURE TIRE TUBE (FLAT FREE INSERT) FOR POWER WHEELCHAIR, ANY SIZE, EACH	No crosswalk applicable
K0094	WHEEL TIRE FOR POWER BASE, ANY SIZE, EACH	No crosswalk applicable
K0095	WHEEL TIRE TUBE OTHER THAN ZERO PRESSURE FOR EACH BASE, ANY SIZE, EACH	No crosswalk applicable
K0096	WHEEL ASSEMBLY FOR POWER BASE, COMPLETE, EACH	No crosswalk applicable
K0097	WHEEL ZERO PRESSURE TIRE TUBE (FLAT FREE INSERT) FOR POWER BASE, ANY SIZE, EACH	No crosswalk applicable
K0098	DRIVE BELT FOR POWER WHEELCHAIR	No crosswalk applicable
K0099	FRONT CASTER FOR POWER WHEELCHAIR, EACH	No crosswalk applicable
K0670	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	No crosswalk applicable
L0100	CRANIAL ORTHOSIS (HELMET), WITH OR WITHOUT SOFT INTERFACE, MOLDED TO PATIENT MODEL	A8000, A8001, A8002, A8003, A8004
L0110	CRANIAL ORTHOSIS (HELMET), WITH OR WITHOUT SOFT-INTERFACE, NON-MOLDED	A8000, A8001, A8002, A8003, A8004
L3902	WRIST HAND FINGER ORTHOSIS, EXTERNAL POWERED, COMPRESSED GAS, CUSTOM-FABRICATED	Use most appropriate HCPCS L code
L3914	WRIST HAND ORTHOSIS, WRIST EXTENSION COCK-UP, PREFABRICATED, INCLUDES FITTING/ADJUSTMENT	L3908

Table 2 – **Deleted** 2007 HCPCS Codes,
Effective for Dates of Service On or Before December 31, 2006

Procedure Code	Description	Replacement Code
L6700	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #3	L6704, L6706, or L6707
L6705	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5	L6704, L6706, or L6707
L6710	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5X	L6704, L6706, or L6707
L6715	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5XA	L6704, L6706, or L6707
L6720	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #6	L6704, L6706, or L6707
L6725	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #7	L6704, L6706, or L6707
L6730	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #7LO	L6704, L6706, or L6707
L6735	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #8	L6704, L6706, or L6707
L6740	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #8X	L6704, L6706, or L6707
L6745	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #88X	L6704, L6706, or L6707
L6750	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #10P	L6704, L6706, or L6707
L6755	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #10X	L6704, L6706, or L6707
L6765	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #12P	L6704, L6706, or L6707
L6770	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #99X	L6704, L6706, or L6707
L6775	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #555	L6704, L6706, or L6707
L6780	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #SS555	L6704, L6706, or L6707
L6790	TERMINAL DEVICE, HOOK-ACCU HOOK, OR EQUAL	L6704, L6706, or L6707
L6795	TERMINAL DEVICE, HOOK-2 LOAD, OR EQUAL	L6704, L6706, or L6707
L6800	TERMINAL DEVICE, HOOK-APRL VC, OR EQUAL	L6704, L6706, or L6707
L6806	TERMINAL DEVICE, HOOK, TRS GRIP, GRIP III, VC, OR EQUAL	L6704, L6706, or L6707

Table 2 – **Deleted** 2007 HCPCS Codes,
Effective for Dates of Service On or Before December 31, 2006

Procedure Code	Description	Replacement Code
L6807	TERMINAL DEVICE, HOOK, GRIP I, GRIP II, VC, OR EQUAL	L6704, L6706, or L6707
L6808	TERMINAL DEVICE, HOOK, TRS ADEPT, INFANT OR CHILD, VC, OR EQUAL	L6704, L6706, or L6707
L6809	TERMINAL DEVICE, HOOK, TRS SUPER SPORT, PASSIVE	L6704, L6706, or L6707
L6825	TERMINAL DEVICE, HAND, DORRANCE, VO	L6704
L6830	TERMINAL DEVICE, HAND, APRL, VC	L6704
L6835	TERMINAL DEVICE, HAND, SIERRA, VO	L6704
L6840	TERMINAL DEVICE, HAND, BECKER IMPERIAL	L6703 or L6704
L6845	TERMINAL DEVICE, HAND, BECKER LOCK GRIP	L6704
L6850	TERMINAL DEVICE, HAND, BECKER PLYLITE	L6704
L6855	TERMINAL DEVICE, HAND, ROBIN-AIDS, VO	L6703 or L6704
L6860	TERMINAL DEVICE, HAND, ROBIN-AIDS, VO SOFT	L6704
L6865	TERMINAL DEVICE, HAND, PASSIVE HAND	L6703
L6867	TERMINAL DEVICE, HAND, DETROIT INFANT HAND (MECHANICAL)	L6708 or L6709
L6868	TERMINAL DEVICE, HAND, PASSIVE INFANT HAND, (STEEPER, HOSMER OR EQUAL)	L6703
L6870	TERMINAL DEVICE, HAND, CHILD MITT	L6703
L6872	TERMINAL DEVICE, HAND, NYU CHILD HAND	L6708 or L6709
L6873	TERMINAL DEVICE, HAND, MECHANICAL INFANT HAND, STEEPER OR EQUAL	L6708 or L6709
L6875	TERMINAL DEVICE, HAND, BOCK, VC	L6707 or L6708
L6880	TERMINAL DEVICE, HAND, BOCK, VO	L6706 or L6707
L7010	ELECTRONIC HAND, OTTO BOCK, STEEPER OR EQUAL, SWITCH CONTROLLED	L7007 or L7008
L7015	ELECTRONIC HAND, SYSTEM TEKNIK, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED	L7007 or L7008
L7020	ELECTRONIC GREIFER, OTTO BOCK OR EQUAL, SWITCH CONTROLLED	Use most appropriate HCPCS L code
L7025	ELECTRONIC HAND, OTTO BOCK OR EQUAL, MYOELECTRONICALLY CONTROLLED	L7007 or L7008
L7030	ELECTRONIC HAND, SYSTEM TEKNIK, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED	L7008

Table 2 – **Deleted** 2007 HCPCS Codes,
Effective for Dates of Service On or Before December 31, 2006

Procedure Code	Description	Replacement Code
L7035	ELECTRONIC GREIFER, OTTO BOCK OR EQUAL, MYOELECTRONICALLY CONTROLLED	Use most appropriate HCPCS L code
S2262	ABORTION FOR MATERNAL INDICATION, 25 WEEKS OR GREATER	No crosswalk applicable
S4036	INTRAVAGINAL CULTURE (IVC), CASE RATE	No crosswalk applicable
1001F	TOBACCO USE, NON-SMOKING, ASSESSED	No crosswalk applicable
2003F	AUSCULTATION OF THE HEART PERFORMED	No crosswalk applicable
3000F	BLOOD PRESSURE ™ 140/90 MM HG	No crosswalk applicable
3002F	BLOOD PRESSURE > 140/90 MM HG	No crosswalk applicable
0003T	CERVICOGRAPHY	No crosswalk applicable
0008T	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE, WITH SUTURING OF THE ESOPHAGOGASTRIC JUNCTION	Use most appropriate CPT Digestive System code
0018T	DELIVERY OF HIGH POWER, FOCAL MAGNETIC PULSES FOR DIRECT STIMULATION TO CORTICAL NEURONS	0160T or 0161T
0021T	INSERTION OF TRANSCERVICAL OR TRANSVAGINAL FETAL OXIMETRY SENSOR	No crosswalk applicable
0044T	WHOLE BODY INTEGUMENTARY PHOTOGRAPHY, AT REQUEST OF A PHYSICIAN, FOR MONITORING OF HIGH-RISK PATIENTS; WITH DYSPLASTIC NEVUS SYNDROME OR FAMILIAL MELANOMA	No crosswalk applicable
0045T	WHOLE BODY INTEGUMENTARY PHOTOGRAPHY, AT REQUEST OF A PHYSICIAN, FOR MONITORING OF HIGH-RISK PATIENTS; WITH HISTORY OF DYSPLASTIC NEVI OR PERSONAL HISTORY OF MELANOMA	96904
0082T	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT DELIVERY, ONE OR MORE TREATMENT AREAS, PER DAY	Use most appropriate CPT code in 77373-77435 range
0083T	STEREOTACTIC BODY RADIATION THERAPY, TREATMENT MANAGEMENT, PER DAY	Use most appropriate CPT code in 77373-77435 range

Table 2 – **Deleted** 2007 HCPCS Codes,
Effective for Dates of Service On or Before December 31, 2006

Procedure Code	Description	Replacement Code
0091T	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); SINGLE INTERSPACE, LUMBAR	No crosswalk applicable
0094T	REMOVAL OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH; SINGLE INTERSPACE, LUMBAR	No crosswalk applicable
0097T	REVISION OF TOTAL DISC ARTHROPLASTY, ANTERIOR APPROACH; SINGLE INTERSPACE, LUMBAR	No crosswalk applicable
0120T	ABLATION, CRYOSURGICAL, OF FIBROADENOMA, INCLUDING ULTRASOUND GUIDANCE, EACH FIBROADENOMA	No crosswalk applicable
G9076	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, PRE-SURGICAL OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMO	No crosswalk applicable
G9081	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; NON-CASTRATE, INCOMPLETELY CASTRATE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9082	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; CASTRATE; CLINICAL METASTASES OR M1 AT DIAGNOSIS (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9118	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9119	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; STAGE III, IV NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9120	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA; TRANSFORMED FROM FOLLICULAR LYMPHOMA TO DIFFUSE LARGE B-CELL LYMPHOMA (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable

Table 2 – **Deleted** 2007 HCPCS Codes,
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Procedure Code	Description	Replacement Code
G9121	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; RELAPSED/REFRACTORY (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
G9122	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NON-RESPONSIVE	No crosswalk applicable
G9127	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)	No crosswalk applicable
K0099	FRONT CASTER FOR POWER WHEELCHAIR, EACH	No crosswalk applicable

Changed 2007 HCPCS Codes

In the 2007 HCPCS Update, the CMS issued description changes. The 2007 HCPCS code description changes will be added to the Indiana*AIM* claims processing system January 1, 2007. Providers will be notified in a future publication of any 2007 HCPCS Update code changes that may affect claims adjudication.
